2021 Employee Flexible Benefits Guide

Flexible Benefits Program for Full-Time Salaried and Full-Time Hourly Employees of Union Pacific Corporation and Affiliates

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GUIDE TO NONAGREEMENT BENEFITS

This booklet contains important information about how your health and welfare benefit plan works. It includes information about who is covered, the kinds of benefits provided, limitations or restrictions you should know about, and how to claim benefits. Many of these benefits are covered by provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA) – a federal law which governs the operation of employee benefit plans. It is important to understand some of the provisions of this law since they could affect you. A description of ERISA provisions is found in the ERISA section of this 2021 Employee Flexible Benefits Guide, beginning on page 260.

Flexible Benefits Program

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FLEXIBLE BENEFITS OVERVIEW

This document (Flex Guide) contains the terms of and summarizes the Union Pacific Corporation Flexible Benefits Program (Flexible Benefits Program) effective January 1, 2021. Included are eligibility information, available benefits, limitations or restrictions you should be aware of, and how to claim your benefits.

It is important to note that many benefits are covered by provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA), a federal law which governs the operation of employee benefit plans. ERISA requires that you receive easily understood descriptions of your benefits (summary plan descriptions).

The information about your employee benefit plans described in this document, together with the information on the BlueCross/BlueShield (BCBS) medical options and the Kaiser Health Maintenance Organizations (HMOs) in which you may be eligible to enroll, constitute the summary plan descriptions under ERISA. This document, together with the information on the BCBS medical options and the Kaiser HMOs in which you may be eligible to enroll, along with the insurance contracts under which life, accidental death & dismemberment, vision and long-term disability benefits are provided, serve as the official plan documents and will help you understand your benefits, as well as your rights under these plans and ERISA. For more information concerning your ERISA rights, see the ERISA section of this document.

While Union Pacific Corporation intends to continue these plans indefinitely, it reserves the right to terminate or amend any or all of the benefit plans described in this document for any reason. If Union Pacific Corporation, through its senior human resources officer, or such officer with similar authority, terminates or amends a welfare benefit plan, benefits under the plan for Employees would cease or change. Union Pacific Corporation may also increase the required Employee contributions at any time. Similarly, a participating employer can take such actions with respect to its Employees. Every effort will be made to provide plan participants with reasonable notice of any such change.

Note: The terms "you" and "your" used throughout this document refer to the Employee and all eligible Dependents covered under the Flexible Benefits Program, except where otherwise indicated.

The "Glossary" section, beginning on page 133, is an important reference tool to help you understand how the plans work by providing definitions of terms used throughout this Flex Guide. Also, you will find definitions of other terms in the various sections of this Flex Guide.

HISTORY AND BACKGROUND

Effective January 1, 1992, Union Pacific Corporation introduced the Flexible Benefits Program for employees eligible to participate in the various benefit plans offered under the Flexible Benefits Program. The Flexible Benefits Program is operated in compliance with a number of sections of the Internal Revenue Code, the primary Sections being 105, 125 and 129. This document describes the operation of the Flexible Benefits Program as of January 1, 2021.

Under Section 125, Union Pacific Corporation is allowed to offer certain benefits to its eligible employees in a tax-preferred manner. Contributions for elective coverage or contributions to specific accounts may be made on a "before-tax" or "salary reduction" basis under the portion of the Flexible Benefits Program subject to Section 125. This means that Federal, FICA, Railroad Retirement, and, in most instances, state and local taxes are taken from your pay after your contributions or premiums are deducted. The net effect is that your taxes are computed on a lower base, thus lowering your tax liability for the year.

As Social Security and/or Railroad Retirement taxes are not withheld on your before-tax contributions to the Flexible Benefits Program, it is possible that your future Social Security and/or Railroad Retirement benefits would be reduced.

In order to obtain the full impact of the tax benefits inherent in operating a portion of the Flexible Benefits Program in compliance with Section 125, the various benefits must be administered in accordance with the Internal Revenue Code. As a result, certain rules exist within the Flexible Benefits Program, which may be different from those of traditional plans.

CORE AND OPTIONAL BENEFITS

There are two types of benefits available to you – Core and Optional. Upon your initial enrollment and during annual open enrollment periods, you may choose among Core and Optional benefits. If you fail to affirmatively elect benefits when you initially enroll, you will be enrolled in Core benefits by default. If you fail to elect benefits during any subsequent open enrollment period, you generally will be enrolled for the following Calendar Year in the benefits you were previously enrolled in, but certain exceptions will apply. See page 9 "Healthcare Coverage Level Elections" for details. Many Core benefits (life, accidental death and dismemberment ("AD&D"), and short-term and Core long-term disability) are available to all eligible Employees at no cost. Core medical, dental and vision coverage are available to all eligible Employees at a charge. Optional benefits allow you to increase your coverage above the Core level. You may also elect to waive certain Core coverages.

The following chart shows Core and Optional benefits and what they can do for you.

	CORE BENEFITS	OPTIONAL BENEFITS
Employee, Spouse & Dependent Healthcare	• "Employee Only" Medical (UHC HDHP2 Option or the BCBS HDHP2 Option, depending on the Employee's home address ZIP Code). • "Employee Only" MetLife dental coverage for eligible Employees. • "Employee Only" EyeMed vision coverage for eligible Employees. • Employees receiving Core medical, dental and vision coverage will be charged for the coverage. • Core medical, dental and/or vision coverage can be waived.	• Choose among all medical options for which you are eligible with varying Deductibles, Coinsurance, Copayments, and out-of-pocket expenses for you and your Dependents, if any. • Choose dental coverage for you and your Dependents, if any. • Choose vision coverage for you and your Dependents, if any. • If you have a Domestic Partner, see the row "Domestic Partner Healthcare."
Health Savings Account Contribution Program	• Not a Core Benefit.	• If you enroll in a UHC or BCBS HDHP medical option and open a Health Savings Account through BenefitWallet, you receive the Union Pacific HSA Contribution plus you may elect to make "before-tax" Employee HSA Contributions.
Dependent Care Flexible Spending Account	• Not a Core Benefit.	• Establish a Dependent Care Flexible Spending Account. Use this account to pay for dependent care expenses on a "before-tax" basis.
Disability Income	• Short-term disability coverage to provide continued income to Employees who are temporarily unable to perform their duties due to sickness or accident (eligible after three months of continuous service). • Long-term disability coverage to provide continued income for extended periods of disability (eligible after three months of continuous service).	• Increase the monthly amount you receive in the event of your long-term disability (allowed once each year during open enrollment).
Life and Accidental Death & Dismemberment	• Financial protection for your beneficiaries through a lump sum payment upon your death or dismemberment.	• Add to your life and accident coverage; provide insurance for your Spouse and/or children.

	CORE BENEFITS	OPTIONAL BENEFITS
Domestic Partner Healthcare	• Not a Core Benefit	• Choose "Domestic Partner Only" medical (UHC or BCBS Non-HDHP PPO, depending on the Employee's home address ZIP code) or, if you are eligible to enroll in a California HMO medical option, you may instead enroll your registered Domestic Partner and the dependent(s) of your registered Domestic Partner in such HMO. See the information provided by the HMO for more details. • Choose "Domestic Partner" MetLife dental coverage. • Choose "Domestic Partner" EyeMed vision coverage

DEFINITIONS

Definition of Employee:
For purposes of the Flexible Benefits Program "Employee" means:

- An active, nonagreement, full-time salaried, reduced salaried, or full-time hourly person (other than any person classified as a co-op, or intern) employed by Union Pacific Corporation or Union Pacific Railroad Company; or
- Any other classification of employees specified by any other Union Pacific affiliate that becomes a participating employer in the Flexible Benefits Program.

The term "Employee" shall not include a person who is classified by Union Pacific Corporation, Union Pacific Railroad, or any other Union Pacific affiliate that becomes a participating employer in the Flexible Benefits Program (individually, "Flexible Benefit Programs Employer") as an independent contractor or a person who is not treated by a Flexible Benefit Plan Employer as an employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding. If an individual is engaged in an independent contractor or similar capacity and is subsequently classified by a Flexible Benefit Plan Employer, a governmental body or the judiciary as an Employee, such person, for purposes of the Flexible Benefits Program, shall be deemed to be an Employee from the actual (and not effective) date of such classification by a Flexible Benefits Program Employer or the date as of which such classification by the governmental body or judiciary is final and not appealable. Additionally, the term "Employee" excludes any person who, as to the United States, is a non-resident alien with no U.S. source income from a Flexible Benefit Programs Employer.

Definition of Dependent:
The following definition applies for purposes of the Medical Care Program Options (except HMOs), Vision Care Program, Dental Care Program, and the Life and AD&D Insurance Plan.

- "Dependent" means the Employee's "Spouse", if not legally separated from the Employee, or the Employee's "Child".

The Flexible Benefits Program reserves the right to require documentation with respect to any individual who elects to enroll in coverage, verifying that such individual satisfies the program's definition of Dependent and such other information necessary to administer the Plan, including but not limited to social security numbers.

Definition of Spouse:
The following definition applies for purposes of the Medical Care Program Options (except HMOs), Vision Care Program, Dental Care Program, and Dependent Care Flexible Spending Account:

- "Spouse" means the person with whom the Employee has entered into a valid marriage in accordance with the law of the jurisdiction in which the marriage between the Employee and such person is entered into, regardless of whether such marriage is recognized in the jurisdiction in which the Employee is domiciled. For purposes of eligibility under these programs, a person who is the Employee's Spouse is no longer considered a Dependent on the date a decree of divorce, legal separation, or annulment between the Employee and his or her Spouse is entered by a court.

For purposes of the Medical Care Program Options (except HMOs), Vision Care Program, Dental Care Program, and the Dependent Care Flexible Spending Account, a Spouse does not include an individual with whom the Employee has entered into a registered domestic partnership, civil union, or other formal relationship recognized under state law that is not denominated as a marriage under the law of the state in which such relationship is established.

For purposes of the Life and AD&D Insurance Plan, "Spouse" means the person who is your lawful spouse or Domestic Partner; however, for purposes of determining who may be covered for insurance, the term does not include any person who is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard.

- For the Life and AD&D Insurance Plan, a Domestic Partner means each of two people, one of whom is an Employee, who:
  - Either:
    - have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
    - are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other; and
  - Each person must be:
    1. 18 years of age or older;
    2. unmarried;
    3. the sole domestic partner of the other person and have been so for the immediately preceding 6 months;
    4. sharing a primary residence with the other person and have been so sharing for the immediately preceding 6 months; and
    5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

  A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the Employee.

Definition of Child:
For purposes of the Medical Care Program Options (except HMOs), Vision Care Program and the Dental Care Program, "Child" means any one of the following:

1. An individual (son, stepson, daughter, or stepdaughter) who is directly related to the Employee by blood, adoption (or placement for adoption), or marriage, or who is a foster child placed with the Employee by an authorized placement agency or by judgment, order, or decree of any court of competent jurisdiction, and who is under age 26.
2. An unmarried individual not described in 1, above, who satisfies both a) and b), below:
   a. Such individual is under age 26; and
   b. The individual's principal place of residence is the Employee's home and the Employee expects to claim the individual as a dependent on his/her federal income tax return for the Calendar Year. (For information regarding whether an individual may be claimed as your dependent, please see the instructions for IRS Form 1040 or consult your personal tax advisor.)
3. A Disabled Child.
4. An individual the Employee is required to enroll in coverage pursuant to a Qualified Medical Child Support Order (QMCSO).

- A "Disabled Child" means any unmarried Child described in paragraph 1 or 2 in the definition of Child above (without regard to the Child's age but otherwise subject to all other applicable eligibility requirements) who is not self-supporting due to physical handicap, mental handicap, or mental retardation. A Child who is not self-supporting must be mainly dependent on the Employee for care and support. Coverage is available for a Disabled Child on or after attaining age 26 if the Child was a covered Dependent on the day before the Child's 26th birthday and only for the period during which the disability and coverage continue without interruption. The Employee must submit proof to the Plan Administrator, when requested, that the Child meets these conditions at the time the Child attains the age of 26 and throughout the period in which coverage is provided.
- A "Disability" of a "Disabled Child" means the Child's inability to perform normal activities of a person of like age or sex.
- A "Qualified Medical Child Support Order" or "QMCSO" means any judgment, order, or decree issued by a court of competent jurisdiction that provides child support pursuant to a state domestic relations law or

pursuant to an administrative proceeding authorized by state statute as described in section 1908 of the Social Security Act which provides for health benefit coverage of an alternate recipient. A QMCSO cannot require a plan to provide any type or form of benefit or option not already provided under the plan. The QMCSO must specify the name, address, and social security number of the Employee and each alternate recipient, describe the coverage to be provided, identify the period for which the coverage is to be provided, and specify the plan to which the QMCSO applies. If you are required to enroll an alternate recipient pursuant to a QMCSO, your election under the Flexible Benefits Program may be changed to provide coverage for such alternate recipient. Additional information may be obtained by calling Union Pacific Workforce Shared Services at (877) 275-8747, Monday through Friday, from 9:00 a.m. to 5:00 p.m. Central Time, excluding holidays.

An individual who is enrolled in one of the Medical Care Program Options is generally referred to as Covered Person.

For purposes of life insurance coverage under the Life and AD&D Insurance Plan, "Child" means your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption), stepchild (including the child of a Domestic Partner), grandchild who resides with you, a child for whom you are the legally appointed guardian who resides with you, a blood relative who resides with you, or a foster child who resides with you; and who, in each case, is at least 14 days old, under age 26, unmarried and supported by you.

For purposes of AD&D coverage under the Life and AD&D Insurance Plan, "Child" means your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption), stepchild, grandchild who resides with you; a child for whom you are the legally appointed guardian who resides with you, a blood relative who resides with you, or a foster child who resides with you; and who, in each case, is under age 26, unmarried and supported by you.

For both Life and AD&D coverage, the definition of "Child" may be modified for residents of certain states. See your Certificate of Insurance for more details. Note that insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Metropolitan Life Insurance Company within 31 days after the Child attains the age limit and at reasonable intervals after such date. See your Certificate of Insurance for more details.

For both Life and AD&D coverage, "Child" does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an Employee.

Definitions Related to Domestic Partner Medical, Vision, and Dental Benefits:
For purposes of the Domestic Partner Medical Benefits, Dental Benefits and Vision Benefits, certain other definitions may apply, including who is considered your "Domestic Partner." Please see the Domestic Partner Medical Benefits, Domestic Partner Dental Benefits, and Domestic Partner Vision Benefits sections, on pages 173, 199 and 170 respectively, for additional information.

Definitions Related to HMO Medical Options: For the HMO medical options, all terms used by an HMO medical option are defined pursuant to the plan documents that govern the specific HMO option.

HEALTHCARE COVERAGE LEVEL ELECTIONS

Employees married to one another may make one of the following healthcare coverage elections:

1. You and your Employee Spouse each elect Employee Only coverage under the same or different medical, dental and/or vision program options; or
2. You or your Employee Spouse elects Family medical, dental and/or vision coverage (covering the other as a Dependent) and the other waives the medical, dental and/or vision coverage for which the other elected Family coverage; or
3. You or your Employee Spouse elect Employee Only medical, dental and/or vision coverage and the other waives such coverage; or
4. You and your Employee Spouse each waive medical, dental and/or vision coverage.

Note: If you are the Dependent of another Employee and such Employee has elected Family coverage under Medical, Dental Care and/or Vision Care Program coverage covering you as a Dependent, then during open enrollment, you must waive the medical, dental and/or vision coverage for which Family coverage was elected on your behalf. You are responsible for notifying the UP Workforce Shared Services at (877) 275-8747 that you are the Dependent of another Employee and that such Employee has elected Family coverage under Medical, Dental Care and/or Vision Care Program coverage, covering you as a Dependent.

PURCHASING FLEXIBLE BENEFITS

Who Pays for Your Benefits:
You and your Employer share the cost of providing benefits for you and your Dependents.

Benefit Type	Cost by Coverage Level	
	Employee Only	**Family**
Medical	Shared by Employee and Company	Shared by Employee and Company
Vision	Employee Paid	Employee Paid
Dental	Shared by Employee and Company	Shared by Employee and Company
Core Life, AD&D	Company Paid	Not Available
Voluntary Life	Employee Paid	Employee Paid
Voluntary AD&D	Employee Paid	Employee Paid
Core Disability	Company Paid	Not Available
Buy-Up Disability	Employee Paid	Not Available
Domestic Partner Medical	(Domestic Partner Non-HDHP PPO coverage) Shared by Employee and Company **Note:** *Fair Market Value of Company Paid Domestic Partner coverage is imputed as income to Employee.*	(Applicable only to California HMOs) Shared by Employee and Company **Note:** *Fair Market Value of Company paid medical coverage provided to your registered Domestic Partner (and/or dependent(s) of your registered Domestic Partner) is imputed as income to Employee.*
Domestic Partner Dental	(Domestic Partner coverage) Employee Paid	Not Available
Domestic Partner Vision	(Domestic Partner coverage) Employee Paid	Not Available

Tax Treatment for Your Benefit Premiums:
All optional benefits, Core medical, dental and vision coverage, and Domestic Partner medical, dental and vision coverage are offered at an additional cost to you. The cost is the annual amount you will have to pay to purchase the benefit.

Optional benefits are paid for by the Employee with either before-tax dollars (salary reduction) or after-tax dollars (salary deduction), depending on the benefit elected. Core medical, dental and vision coverage are paid by the Employee with before-tax dollars. Domestic Partner medical, dental and vision coverages are paid by the Employee with after-tax dollars.

The following benefits are offered under a cafeteria plan, which is subject to Section 125 of the Internal Revenue Code. If elected (or provided by default, in the case of Core coverages), these benefits are paid for by the Employee with before-tax dollars:

- Core "Employee Only" Medical.
- Core "Employee Only" Dental.
- Core "Employee Only" Vision.
- All non-Core medical plan options for the Employee, Spouse, and Dependents.
- Family Dental (Employee, Spouse, and Dependents).

- Family Vision (Employee, Spouse, and Dependents).
- Dependent Care Flexible Spending Account (Dependent Care FSA).
- Employee Health Savings Account (HSA) Contributions.

The following optional benefits are offered outside of the cafeteria plan. If elected, these benefits are paid for by the Employee with after-tax dollars:

- Voluntary Employee Life Insurance.
- Voluntary Spouse Life Insurance.
- Voluntary Child(ren) Life Insurance.
- Voluntary Employee AD&D Insurance.
- Voluntary Spouse and Child(ren) AD&D Insurance.
- Voluntary Spouse Only AD&D Insurance.
- Voluntary Child(ren) Only AD&D Insurance.
- Buy-Up Long-Term Disability.
- Medical Coverage provided to a Domestic Partner under the Domestic Partner Non-HDHP PPO coverage (whether UHC or BCBS depends on the Employee's home address ZIP code) or to a registered Domestic Partner and dependent(s) of a registered Domestic Partner through a California HMO.
- Domestic Partner Dental Coverage.
- Domestic Partner Vision Coverage.

ENROLLMENT

Newly Eligible during the Calendar Year:
If you are hired, or first become eligible during the Calendar Year, you have 30 days from the date you become an eligible Employee to make your benefit elections and 45 days from the date you become an eligible Employee to provide any requested documentation regarding the individuals you elect to enroll in coverage.

If you do not make an affirmative election (including an election to waive coverage) during this 30-day period, you will be defaulted to Core Benefits from the date you became an eligible Employee. Core Benefits are described at the beginning of this document on page 6. If you receive the default enrollment, your Dependents, if any, will not receive benefits for the remainder of the Calendar Year unless you are permitted to enroll your Dependents as a result of a "Life Event" as described in the "Life Events & Permissible Benefit Changes" charts on pages 28-63 and the benefit plan permits enrollment of your Dependents as a result of such Life Event.

Your Flexible Benefits Program elections (or default coverage) become effective on the date you become an eligible Employee. Any before-tax contributions will begin as soon as administratively practicable following your election(s). This includes your contribution to the Dependent Care FSA, which will be prorated over the remaining months in the Calendar Year.

Open Enrollment:
During the fall of each Calendar Year, you will be given the opportunity to enroll for the subsequent Calendar Year. Your enrollment must be completed during the open enrollment period and elections made during open enrollment are effective January 1st of the following Calendar Year provided that any requested documentation regarding the individuals you elect to enroll in coverage is provided within 45 days following the end of the open enrollment period. If you fail to timely provide any required documentation regarding the addition of a Dependent, coverage for such Dependent will not be added for the following Calendar Year. If you do not make an affirmative election (including an election to waive coverage), you will be defaulted to the same coverages in the new Calendar Year as you are receiving in the current Calendar Year, with these exceptions:

- If you have medical coverage in the current Calendar Year and your medical option is no longer available in the new Calendar Year, you will be defaulted to either the UHC HDHP2 Option or the BCBS HDHP2 Option, depending on your home address ZIP code, at the same level of coverage (i.e., Employee Only or Family) as you have in the current Calendar Year.
- Your Dependent Care FSA contribution election will terminate on December 31st and cannot be renewed without your affirmative election during open enrollment each Calendar Year.

Additional Information Regarding Open Enrollment:

- During open enrollment, you may change your Voluntary Employee Life and AD&D, Voluntary Spouse Life and AD&D and your Voluntary Child Life and AD&D coverage elections. If you wish to increase any of these coverage elections or elect any of these coverages for the first time, your elections during open enrollment are subject to specific rules and limitations, which are described in the Life and Accidental Death & Dismemberment Insurance Program section of this document beginning on page 210.
- Your Dependent Care FSA contribution election must be affirmatively elected in SAP-"My Benefits" for each Calendar Year through the open enrollment process.
- If in the current Calendar Year you are enrolled in a UHC HDHP or BCBS HDHP option and for the following Calendar Year during open enrollment you enroll (or are defaulted) in a UHC HDHP or BCBS HDHP option and you wish to begin making Employee HSA Contributions for 2021, you must affirmatively elect to do so in SAP-"My Benefits" However, if you have an Employee HSA Contribution election in place for 2020 and you wish to continue your HSA Contributions at the same level, you are not required to update the election for 2021. See the HSA Contribution Program section of this document beginning on page 184 for information regarding how to make your Employee HSA Contribution election.

If you elect Family medical coverage, but your Spouse or Child is not listed as one of your Dependents for medical coverage, such Spouse or Child will not be treated as your Dependent for any coverage offered under the Flexible Benefits Program, except that your Spouse or Child not listed as your Dependent for medical coverage may still be your Dependent for purposes of the Life and Accidental Death and Dismemberment Insurance Plan if such Spouse or Child meets the definition of "Spouse" or "Child", as applicable, for purposes of that program.

Important Dependent Information:

- When you enroll your Dependents in the Flexible Benefits Program, you are affirming that you have reviewed the program's eligibility terms and that each listed individual meets the applicable definition of a "Dependent." You are also affirming that you will advise Workforce Shared Services about any change in circumstances that affects your Dependent's eligibility for coverage.
- Coverage for you and your Dependents is available only through the date coverage is provided under the terms of the Flexible Benefits Program. See "When Coverage Ends" beginning on page 21.
- In the event of fraud or intentional misrepresentation of material fact regarding a Dependent's eligibility for coverage, coverage for such Dependent may be rescinded, and claims paid for Dependents who are found to be ineligible for coverage may be the responsibility of the Employee. Family Deductibles and annual out-of-pocket expenses or other plan limitations may also be recalculated and may cause further expense to the Employee. Further, unless a Life Event permits you to change your enrollment election, if you enroll in Family coverage and an individual listed as your dependent is not eligible, you will continue to be charged at the rate for Family coverage even if you are the only individual eligible for coverage.
- Each Flexible Benefits Program plan reserves the right to require documentation with respect to the individuals you elect to enroll in coverage, including (but not limited to) evidence of the "Life Event", if applicable; and, evidence that the individuals satisfy the plans' definition of a Dependent, and their social security numbers.

Notice of HIPAA Enrollment Rights:

The passage of the Health Insurance Portability and Accountability Act of 1996, or HIPAA, provides special enrollment rights to participate in group health plans (see the "Life Events & Permissible Benefit Changes" section on pages 28-63 for more information). If you are declining enrollment for yourself or your Dependents in a Medical Care Program option because of other health insurance or group health plan coverage, you may (in the future) be eligible to enroll yourself or your Dependents in a Medical Care Program option if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage), provided that you request enrollment within 30 days after you or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Solely for the purposes of these HIPAA enrollment rights, "Dependent" also includes individuals who are eligible for coverage under an HMO option or the Domestic Partner Non-HDHP PPO medical option because of a relationship to the Employee.

Notice of Special Enrollment Rights Related to Medicaid or SCHIP Coverage:
If you or your Dependent:

- Is covered under a Medicaid plan under Title XIX of the Social Security Act, or under a state child health insurance plan ("SCHIP") under Title XXI of such Act, and your coverage under the Medicaid or SCHIP plan is terminated as a result of loss of eligibility for such coverage; or
- Becomes eligible for Medicaid or SCHIP plan assistance with respect to coverage under a Medical Care Program option,

then you and your Dependent may enroll in a Medical Care Program option, provided you request enrollment within 60 days after the date the applicable event occurs (i.e., the termination of the Medicaid or SCHIP Plan coverage, or determination of eligibility for Medicaid or SCHIP plan assistance). If you request enrollment in a Medical Care Program option within such period, your Medical Care coverage will be effective the first day of the month following the date you provide notification of the event.

To request special enrollment or obtain more information, contact Union Pacific Workforce Shared Services at (877) 275-8747.

HIPAA Special Enrollment

Temporary Extension of Enrollment Right Deadline Due to COVID-19:
The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"). In response, the Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the of the 30 day period (or 60 day, period, if applicable) to request enrollment, as described in the preceding "Notice of HIPAA Enrollment Rights" and "Notice of Special Enrollment Rights Related to Medicaid or SCHIP Coverage" sections.

Generally speaking, the extension is intended to provide you with more time to exercise your enrollment rights while the National Emergency Declaration remains in effect. The deadline applicable to these enrollment rights will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If either of these enrollment rights apply to you and you are unable request enrollment by the deadline that ordinarily applies – as described in either the "Notice of HIPAA Enrollment Rights" or "Notice of Special Enrollment Rights Related to Medicaid or SCHIP Coverage" section, you may have additional time to do so. Please contact Union Pacific Workforce Shared Services at (877) 275-8747 for more information.

Special Enrollment Rights Applicable to the Kaiser HMOs:
Employees eligible to enroll in a Kaiser HMO may have a special enrollment right upon the occurrence of a "qualifying event" as defined in section 603 of ERISA. See the documents furnished by the Kaiser HMO for more information.

SPECIAL ELECTION FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER

If you remain an Employee after reaching age 65, you or your Spouse may choose to remain covered under a Medical Care Program Option without reduction for Medicare benefits or designate Medicare as the primary payer of benefits. If you choose to remain covered under a Medical Care Program Option, the Medical Care Program Option will be the primary payer of benefits and Medicare will be secondary. If you choose Medicare as primary, coverage under the Medical Care Program Option will end. If you do not specifically choose between Medicare and the Medical Care Program Option, the Medical Care Program Option will be primary. If you are under age 65 and your spouse is over age 65, he or she can make their own choice to choose Medicare or remain on your coverage in a Medical Care Program Option.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

Eligibility: You are eligible to participate in the Medical, Dental Care and Vision Care Programs, Life and AD&D Insurance Plan, and Dependent Care FSA, if you are an Employee.

Eligibility requirements applicable to the HSA Contribution Program, Union Pacific Corporation Short-Term and Long-Term Disability Plan ("STD/LTD Plan"), Domestic Partner Medical, Domestic Partner Dental Coverage, and Domestic Partner Vision Coverage are described in those sections. See pages 184, 228, 173, 199 and 170, respectively.

Effective Date of Coverage - Medical, Dental Care and Vision Care Programs:

- **Newly Eligible during the Year**: If you become newly eligible during the Calendar Year, your medical, dental and vision care elections will be effective on the date you become an eligible Employee (unless you waive coverage), assuming you complete your election within 30 days from the date you become an eligible Employee. Any monthly contribution required for your elections (affirmative or defaulted) will be taken from your pay as soon as administratively practicable following the date your completed elections are received. If you do not enroll (or waive coverage) during this 30-day period, you will be defaulted to "Core Benefits" (i.e., Employee Only HDHP2 medical and Employee Only vision and dental coverage). If you receive the default enrollment, your Dependents will not receive medical, dental or vision coverage for the remainder of the Calendar Year unless you are permitted to enroll your Dependents as a result of a "Life Event" as described in the "Life Events & Permissible Benefit Changes" charts on pages 28-63.
- **Open Enrollment**: Elections made during open enrollment are effective January 1st of the following year.
- **Life Events**: Once you have enrolled, you cannot change your elections until the next open enrollment period unless you experience a Life Event and the plan permits such a change. For more information regarding Life Events, including information regarding when your election change is effective as a result of a Life Event, see the "Life Events & Permissible Benefit Changes" section beginning on page 28.

Effective Date of Coverage - Life and AD&D Insurance Plan:

If you become newly eligible during the Calendar Year, your Core Employee Life and Core Employee Accidental Death and Dismemberment (AD&D) benefits will be effective as of the date you become eligible for these coverages, assuming you are actively at work. If you are not actively at work when you become eligible, your coverages will be effective on the date you return to work. For details, including information about when your coverage is effective as a result of a Life Event, consult the "Life Events & Permissible Benefit Changes" section beginning on page 28.

If you become newly eligible during the Calendar Year, the Optional Benefits that you elect for yourself and any of your eligible Dependents will become effective the first day of the month following the date you make your election, assuming you are actively at work and you complete your election form within 30 days from the date you become an eligible Employee. If you are not actively at work when you become an eligible Employee, you will have 30 days from the day you return to work to elect coverage. For any coverage for which you are not required to give your evidence of insurability, the effective date of your coverage will be the first of the month following the date your completed elections are received. For any coverage for which you are required to give your evidence of insurability and Metropolitan Life determines you are insurable, the effective date of such coverage will be specified by Metropolitan Life in writing. If you do not submit your completed elections within the 30-day election period, you will only receive Core Employee Life and Core Employee AD&D coverages.

Once you are covered, you will have the opportunity to change your Optional Benefits during the open enrollment period held in the fall of each Calendar Year. You may change the level of coverage for Optional Benefits during open enrollment, subject to specific rules and limitations, which are described in the Life and Accidental Death & Dismemberment Insurance Plan section of this document beginning on page 210 Any change you make as part of open enrollment will become effective January 1st of the following Calendar Year.

You may also change your Optional Benefits as a result of a "Life Event" during the Calendar Year. For details, including information about permissible changes and when your election change is effective as a result of a Life Event, consult the "Life Events & Permissible Benefit Changes" section beginning on page 28. Core Employee Life and Core Employee AD&D coverages are automatically provided and may not be changed.

When an Employee changes from full-time salaried, full-time hourly, or reduced salaried to part-time hourly status, the Employee may either keep current elections for Life and/or AD&D (at the same coverage and premium deduction level) or waive Life and/or AD&D coverage until January 1st of the following year. As of January 1st any new elections made during open enrollment or the Employee's default elections will become effective.

When an Employee changes from part-time hourly to full-time salaried, reduced salaried, or full-time hourly status, the Employee may either keep current elections for Life and/or AD&D (at the same coverage and premium deduction level) or waive Life and/or AD&D coverage until January 1st of the following year. As of January 1st, any new elections made during open enrollment or the Employee's default elections will become effective.

Effective Date of Coverage – Dependent Care FSA, HSA, Domestic Partner Medical Benefits, Domestic Partner Dental Benefits, Domestic Partner Vision Benefits, and STD/LTD:
Information regarding coverage effective dates applicable to the Dependent Care FSA, HSA Contribution Program, the Domestic Partner Medical, Domestic Partner Dental, Domestic Partner Vision coverage, and the STD/LTD Plan coverage are described in those sections. See pages 203, 184, 173, 199, 170,and 228, respectively.

ENROLLMENT CHANGES

Highlights of the Life Event Rules:
Except for your Employee HSA Contribution election, once you have enrolled, you cannot change elections until the next open enrollment period unless you experience a Life Event and the benefit program in which you enrolled permits such a change. Changes in elections resulting from a Life Event must be on account of and correspond with the Life Event. In addition, all such changes resulting from a Life Event (other than Special Enrollment Rights Related to Medicaid or SCHIP Coverage) must be made within 30 days of the event date. It is the Employee's responsibility to notify Union Pacific Workforce Shared Services at (877) 275-8747, and request a change within 30 days immediately following a Life Event. You must provide notification for a birth, adoption, marriage, or divorce, or to add or drop a Dependent through the UP Employee website SAP-"My Benefits" or by calling Union Pacific Workforce Shared Services at (877) 275-8747. See the "Life Events & Permissible Benefit Changes" section on pages 28-63 of the Flex Guide for more information about Life Events and when it is permissible to make a change to your benefit elections.

Note: If you gain a Child through birth or adoption, the Covered Health Services incurred by the Child during the first 31 days of life will be covered by the Medical Care Program, regardless of whether you make an affirmative election to enroll the Child in a medical coverage option. If you do not provide notification and supporting documentation to Union Pacific Workforce Shared Services as described in the "Life Events & Permissible Benefit Changes" table on page 30, the Child's coverage will be cancelled effective the 32nd day.

CHANGES IN EMPLOYMENT STATUS

Termination or Transfer to an Ineligible Status:
With the exception of the STD/LTD Plan, benefit plan coverage and salary reduction contributions under the Flexible Benefits Program will cease at the end of the month in which you terminate employment or become ineligible to continue participation. Coverage and applicable salary deductions under the STD/LTD Plan cease upon your termination of employment or the date you otherwise become ineligible to participate in the plan. If you are rehired or return to eligible status within the same Calendar Year, you will be automatically re-enrolled in the same plan coverages at the same levels as were in effect on the date you ceased participation, except that if you terminate employment and are re-hired, your eligibility for STD/LTD Plan coverage is determined based on your most recent hire date. Before-tax salary reductions and any after-tax payroll deductions will begin as of the monthly pay cycle following the month you start participation.

Relocation or Transfer to a New Work Location:
(Applies only to the Medical Care Program Options)

- If you have medical coverage at your current location and a relocation or transfer causes you to lose coverage under your current medical coverage option, you may enroll in coverage under any medical coverage option offered at the new location at the same coverage level currently elected (Employee Only or Family). If the relocation or transfer causes you to become newly eligible for a medical coverage option not otherwise available at your former location (i.e. certain geographical locations may have access to an HMO), you may enroll in coverage under the newly available coverage option at the same coverage level currently elected (Employee Only or Family).

You must change your address on the UP Employees website SAP-"My Profile", Your Personal Information, or notify Union Pacific Workforce Shared Services of your new address within 30 days following your move. If you are eligible

to make an election and you fail to do so within 30 days of your move, your medical coverage will be as follows:

- If your current medical coverage option is available in your new location, you will receive the same medical coverage option as received at your old location at the same level of coverage (i.e., Employee Only or Family) received at your old location; or
- If your current medical coverage option is not available in your new location, you will be defaulted to the HDHP2 medical option at the same level of coverage (i.e., Employee only or Family) received at your old location. Your Network will depend upon the home address ZIP code of your new residence; either UHC or BCBS.
- If you previously waived coverage at the old location, you will not receive coverage at the new location unless you experience another "Life Event" as described in the "Life Events & Permissible Benefit Changes" section on pages 28-63 of this document that would allow you to enroll in coverage.

Your new medical election (or default coverage if you fail to make a new election) will be effective the first day of the month coinciding with or next following the date your address is updated on the UP Employees website as described above, so long as your completed election(s) are received within 30 days from the date you relocate or otherwise move because of a transfer and you provide any requested documentation regarding the individuals you elect to enroll in coverage within 45 days of making your elections. Any before-tax contributions or waiver of medical payments for your new election will begin as soon as administratively practicable following the date your completed elections are received.

If You Retire:
(Applies only to the Medical Care Program)
You are eligible to participate in Union Pacific's Retiree Medical Care Program if you meet ALL of the following requirements:

- Your original hire date with: (i) Union Pacific Corporation; or (ii) any Union Pacific Corporation affiliate that was a participating employer in the Union Pacific Corporation Flexible Benefits Program on December 31, 2003, was before January 1, 2004;
- You participate in the Union Pacific Corporation Flexible Benefits Program immediately before you terminate employment;
- You do not elect COBRA continuation coverage with respect to your active employee medical coverage under the Union Pacific Corporation Group Health Plan (or your surviving spouse did not elect COBRA coverage if your active medical coverage terminated because of your death); and
- Upon termination of employment, you are at least age 65 or at least age 55 with 10 years of vesting service. For this purpose, vesting service is calculated by applying the rules for "Vesting Service" under the Pension Plan for Salaried Employees of Union Pacific Corporation and Affiliates ("UPC Pension Plan"), regardless of whether you were ever a participant in the UPC Pension Plan.

Union Pacific will determine whether you satisfy the above-described requirements based on its employment records and may, in its sole discretion, make reasonable assumptions regarding such records as may be necessary or appropriate in order to make such determination.

If you satisfy all the above requirements, the Retiree Medical Program is available to you, your Spouse and/or Dependents as defined in this document on page 7, provided that each person you wish to enroll in Retiree Medical Program coverage – including you – is not Medicare eligible at the time of enrollment.

At the time you retire, you must elect and begin retiree medical coverage or you will permanently waive your rights to this coverage unless, at a later time, you qualify for special enrollment provisions. Further information about election procedures and coverage can be found in the Retiree Medical Guide, which is available at http://www.up.com/employee/retirees/benefits/healthcare/index.htm. You may also obtain a copy by contacting Union Pacific Workforce Shared Services at (877) 275-8747.

Your surviving Spouse is eligible to participate in the Retiree Medical Care Program if the above requirements are satisfied after substituting the terms 'die' and 'when you die' for 'terminate employment' and 'upon termination of employment', respectively, where they appear in the above requirements, and subject to the same exclusion if your surviving Spouse is Medicare eligible.

Leaves of Absence:

Unpaid Leave of Absence: If you go on an unpaid leave of absence, you will be treated as a terminated employee (except if such leave is: (a) family and medical leave under the terms of a policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating employer in the Flexible Benefits Program) that complies with the Family and Medical Leave Act, (b) leave under the Unpaid Sabbatical Program, (c) unpaid vacation, (d) leave under the terms of a policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating employer in the Flexible Benefits Program) that complies with a family military leave law enacted by the state in which you reside, (e) leave under the Uniformed Services Employment and Reemployment Rights Act of 1994), (f) unpaid leave Status Assessment, (g) unpaid leave Suspension or (h) required unpaid leave of absence (RULA). This means that your benefit coverages terminate at the end of the calendar month in which the unpaid leave begins unless your unpaid leave falls within one of the categories identified above. If you return from an unpaid leave within the same Calendar Year in which the leave began, you will be automatically reenrolled in the same coverages at the same levels as were in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you return from your unpaid leave of absence in a Calendar Year subsequent to the Calendar Year in which your unpaid leave began, you may re-enroll for benefits upon your return from unpaid leave. Your enrollment rights are covered in the "Life Events & Permissible Benefit Changes" section on page 44 of the Flex Guide.

Unpaid Family and Medical Leave:

If you go on family and medical leave under the terms of a policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating employer in the Flexible Benefits Program) that complies with the terms of the Family and Medical Leave Act, core life coverage, core AD&D coverage, and your short-term disability coverage and your Core level long-term disability coverage under the STD/LTD Plan will continue at no cost to you . In addition, you will be permitted to continue medical, dental, vision, voluntary life and AD&D coverage, Buy-up level of long-term disability coverage and your domestic partner medical, dental and/or vision coverage on an after-tax basis. If you discontinue your coverage during your Family Medical Leave and you return from your Family Medical Leave in the same Calendar Year in which the Family Medical Leave commenced, you will be automatically re-enrolled for benefits upon your return to work in the same coverages at the same levels as were in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you discontinue your coverage during your Family Medical Leave and you return from your Family Medical Leave in a Calendar Year subsequent to the Calendar Year in which the Family Medical Leave commenced, you may re-enroll for benefits upon your return to work. Your enrollment rights are covered in the "Life Events & Permissible Benefit Changes" section on page 46 of the Flex Guide.

Unpaid Family Military Leave: If you go on an unpaid leave of absence under the terms of a policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating employer in the Flexible Benefits Program) that complies with a family military leave law enacted by the state in which you reside, coverage under the Flexible Benefits Program, except Dependent Care FSA, will continue for the duration of such leave, as long as you continue your required employee contributions for such coverage. Salary reduction and after-tax payroll deductions will continue in the same way they are taken for active employees, to the extent your required employee contributions can be taken from your pay earned in the month your leave begins and/or ends. For months of your unpaid leave in which such amounts cannot be taken from your pay, you may continue such coverage, except Employee HSA Contributions and Dependent Care FSA coverage, by making payments directly to Union Pacific. To make arrangements for making payments, contact Union Pacific Workforce Shared Services at (877) 275-8747.

Employee Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid family military leave. If you return from such family military leave in the same Calendar Year in which the family military leave began, you will be automatically re-enrolled upon return to work at the same level as was in effect on the date you ceased participation. If you return to work in the Calendar Year subsequent to the Calendar Year in which the family military leave began, you may re-enroll upon return to work.

Unpaid Military Leave:

If you go on an unpaid leave due to military service (not including Reservists and National Guard Members called to active duty during Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn, or other military operations related to national security designated by Union Pacific) for less than 31 days, coverage under Flexible Benefits Program, except Dependent Care FSA, will continue for the duration of the military leave. Salary reductions

and after-tax payroll deductions will continue in the same way they are taken for active employees, to the extent your required employee contributions can be taken from your pay. If such amounts cannot be taken from your pay, you may continue such coverage, except Employee HSA Contributions and Dependent Care FSA coverage, by making a payment directly to MetLife for Life and AD&D and Union Pacific for all other coverage. To make arrangements for making the payment, contact Union Pacific Workforce Shared Services at (877) 275-8747.

If you go on an unpaid leave due to military service (not including Reservists and National Guard Members called to active duty during Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn, or other military operations related to national security designated by Union Pacific) for more than 30 days, your benefits coverage will terminate at the end of the month in which your leave started. However, core life, core AD&D, your short-term disability coverage and your Core level long-term disability coverage under the STD/LTD Plan will continue at no cost to you and you will be permitted to continue your medical, dental, vision (including domestic partner medical, dental and/or vision coverage), voluntary life and AD&D, and/or buy-up long-term disability coverages on an after-tax basis. To do so, you must first provide a copy of your orders to Union Pacific Workforce Shared Services prior to starting your military leave, unless you are precluded by military necessity from doing so, or it is otherwise impossible or unreasonable to do so under the circumstances. Upon being notified of your military leave, Union Pacific will notify the Plan Administrator of your military leave and you will be offered the right to continue these coverages. You will have the right to elect to continue these coverages on behalf of you, your Spouse and other Dependents, if any. You must make your election no more than 60 days after receiving the Plan Administrator's notice of the right to continue such coverages. Your right to continue medical, dental and vision coverages is temporary.

You may continue medical, dental and vision coverages until the earlier of:

1) 24 months following the date on which your leave began or
2) the date you fail to return to work or apply for re-employment within the time period prescribed by USERRA.

Your coverage may be cut short if Union Pacific no longer provides group health coverage for any of its employees or the premium for your coverage is not paid within 30 days of the date due. You will be charged 102% of the full premium cost for coverage. The 102% of full premium cost will be effective on the first day of the month following the start of your military leave. You will be notified as to the amount of your required premium when you receive the notice of your right to continue coverage. The required premium is adjusted each plan 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.

If you discontinue your coverage during military leave and you return from your military leave in the same Calendar Year in which your military leave commenced, you will be automatically re-enrolled for benefits upon your return to work in the same coverages at the same levels as were in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you discontinue your coverage during your military leave and you return from your military leave in a Calendar Year subsequent to the Calendar Year in which your military leave commenced, you may re-enroll for benefits upon your return to work. Your enrollment rights are covered in the "Life Events & Permissible Benefit Changes" section on page 48 of the Flex Guide.

Employees who are Reservists and National Guard Members and who are called to active duty during Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn, or other military operations related to national security designated by Union Pacific should refer to the Nonagreement Benefits Policy for Reservists and National Guard Members Called to Active Duty, a copy of which may be found on the Workforce Resources page via the UP Employees website www.up.com for rules governing their benefit options while on leave of absence.

Employee Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid military leave. If you return from such family military leave in the same Calendar Year in which the family military leave began, you will be automatically re-enrolled upon return to work at the same level as was in effect on the date you ceased participation. If you return to work in the Calendar Year subsequent to the Calendar Year in which the family military leave began, you may re-enroll upon return to work.

Unpaid Sabbatical Leave:
If you go on an unpaid sabbatical leave under the Unpaid Sabbatical Program for Nonagreement Employees, you may elect to continue your medical, dental, vision, voluntary life and AD&D, your Buy-up level of long-term disability coverage, and your domestic partner medical , dental, and/or vision coverage on an after-tax basis. If you have enough salary for the month in which you start your unpaid sabbatical, benefit deductions will be deducted from pay. If salary for the month is insufficient to cover the benefit deductions, you will be billed for the required contribution amount for the coverages you elect to continue while on unpaid sabbatical leave.

Employee HSA Contributions, as well as Dependent Care FSA coverage, terminate at the end of the month in which you begin unpaid sabbatical leave.

With respect to the above coverages that are discontinued while on unpaid sabbatical leave (either at your election or automatically), if you return from such sabbatical in the same Calendar Year in which the sabbatical began, you will be automatically re-enrolled upon return to work in the same coverages and at the same levels as were in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you return to work in the Calendar Year subsequent to the Calendar Year in which the sabbatical began, you may re-enroll upon return to work.

Unpaid Status Assessment Leave:
If you are on a temporary unpaid status assessment leave for Nonagreement Employees, which is a leave of absence during which an assessment regarding your ability to return to a specific position or to work generally is occurring, you may elect to continue your medical, dental, vision, voluntary life and AD&D, your Buy-up level of long-term disability coverage, and your domestic partner medical, dental and/or vision coverage on an after-tax basis. If you have enough salary for the month in which you start your unpaid status assessment leave, benefit deductions will be deducted from pay. If salary for the month is insufficient to cover the benefit deductions, you will be billed for the required contribution amount for the coverages you elect to continue while on unpaid sabbatical leave.

Employee HSA Contributions, as well as Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid status assessment leave.

If you return from such status assessment leave in the same Calendar Year in which the status assessment leave began, you will be automatically re-enrolled upon return to work in the same coverage and at the same level as was in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you return to work in the Calendar Year subsequent to the Calendar Year in which the status assessment leave began, you may re-enroll upon return to work.

Unpaid Suspension Leave:
If you are on an unpaid suspension leave, which is a period of time a nonagreement employee is off work for rule or policy violations, you may elect to continue your medical, dental, vision, voluntary life and AD&D, your Buy-up level of long-term disability coverage, and your domestic partner medical, dental and/or vision coverage on an after-tax basis. If you have enough salary for the month in which you start your unpaid suspension, benefit deductions will be deducted from pay. If salary for the month is insufficient to cover the benefit deductions, you will be billed for the required contribution amount for the coverages you elect to continue while on unpaid suspension leave.

Employee HSA Contributions, as well as Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid suspension leave.

If you return from such suspension leave in the same Calendar Year in which the suspension leave began, you will be automatically re-enrolled upon return to work in the same coverages and at the same levels as were in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you return to work in the Calendar Year subsequent to the Calendar Year in which the suspension leave began, you may re-enroll upon return to work.

Unpaid Vacation Leave or Required Unpaid Leave of Absence ("RULA"):
If you go on unpaid vacation under the Unpaid Vacation Policy for Nonagreement Employees or a required unpaid leave of absence of short duration initiated by Union Pacific in response to changing business requirements ("RULA"),

coverage under the Flexible Benefits Program will continue for the duration of such leave, as long as you continue your required employee contributions for such coverage. Salary reduction and after-tax payroll deductions will continue in the same way they are taken for active employees, to the extent your required employee contributions can be taken from your pay earned in the month your leave begins or ends. If such amounts cannot be taken from your pay, you may continue such coverage, except for Employee HSA Contributions and Dependent Care FSA coverage, by making payments directly to Union Pacific. To make arrangements for making payments, contact Union Pacific Workforce Shared Services at (877) 275-8747.

Absence Due To Disability:
If you receive short-term disability benefits under the STD/LTD Plan, coverage under the Flexible Benefits Program will continue for the duration of the short-term disability. Salary reduction and after-tax payroll deductions will continue in the same way they are taken for active employees.

If you receive long-term disability benefits under the STD/LTD Plan, coverage under the Flexible Benefits Program will generally cease at the end of the month in which you begin receiving long- term disability benefits. However, you will be given the opportunity to continue certain benefits during your disability.

Continuation of coverage will require contributions made on an after-tax basis. See the "Union Pacific Corporation Short-Term and Long-Term Disability Plan" on page 228 of this document for more details.

Death:
If you die while covered as an active Employee, healthcare coverage for your Dependents may continue under COBRA for up to 36 months. These rights are explained in detail beginning on page 25under the "How is COBRA Coverage Provided?" section of this document.

If you die while an Employee:

- either after attaining age 65 or after attaining at least age 55 with 10 years of vesting service (For this purpose, vesting service is calculated by applying the rules for "Vesting Service" under the Pension Plan for Salaried Employees of Union Pacific Corporation and Affiliates ("UPC Pension Plan"), regardless of whether you were ever a participant in the UPC Pension Plan);
- your original hire date with: (i) Union Pacific Corporation; or (ii) any Union Pacific Corporation affiliate that was a participating employer in the Flexible Benefits Program on December 31, 2003, was before January 1, 2004; **and**
- you participated in the Union Pacific Corporation Flexible Benefits Program immediately before your death,

then your non-Medicare eligible covered surviving Spouse may elect retiree medical coverage. Alternatively, regardless of whether your covered surviving Spouse is Medicare eligible, he or she may elect COBRA continuation coverage. A covered surviving Spouse cannot elect both retiree medical coverage and COBRA coverage. If there is no surviving Spouse, covered Dependent children may only elect COBRA continuation coverage.

Union Pacific will determine whether you satisfy the above-described requirements based on its employment records and may, in its sole discretion, make reasonable assumptions regarding such records as may be necessary or appropriate in order to make such determination.

Change in Your Hours of Work:
Change from full-time salaried, reduced salaried, or full-time hourly to part-time hourly status:
When an Employee changes from full-time salaried, reduced salaried, or full-time hourly to part-time hourly status, medical, dental, vision, disability and Domestic Partner medical, dental and vision coverages terminate and the Employee becomes subject to the Flexible Benefits Program provisions for Part-Time Hourly Employees (*see* Part-Time Hourly Benefits Guide). If the Employee enrolls in an HDHP medical option under the plan provisions for Part-Time Hourly Employees, the Employee's then-current Employee HSA Contribution election, if any, will remain in effect unless changed by the Employee. For purposes of Life and/or AD&D coverages, the Employee may keep current elections at the same coverage and premium deduction level or waive coverage for the remainder of the Calendar Year. An individual changing to a part-time hourly status should refer to the *Part-Time Hourly Benefits Guide*, which provides the terms of the Flexible Benefits Program applicable to part-time hourly nonagreement employees.

Change from part-time hourly to full-time salaried, reduced salaried, or full-time hourly status:

When an Employee changes from part-time hourly to full-time salaried, reduced salaried, or full-time hourly status, the Employee's health coverages terminate and the Employee may newly enroll in medical, dental and/or vision coverages for the Employee, the Spouse/Domestic Partner, and/ or Dependents. If the Employee enrolls in an HDHP medical option, the Employee's then-current Employee HSA Contribution election, if any, will remain in effect unless changed by the Employee. For purposes of Life and/or AD&D coverages, the Employee may keep current elections at the same coverage level and premium deduction level or waive coverage for the remainder of the Calendar Year.

Upon completion of three months of continuous service, short-term disability ("STD") and Core long-term disability ("LTD") coverage will be provided under the STD/LTD Plan for the remainder of the Calendar Year in which you change from part-time hourly to full-time salaried, reduced salaried, or full-time hourly status. During Open Enrollment, you may elect Buy-Up LTD coverage for the next Calendar Year.

WHEN COVERAGE ENDS

Medical Care Program, Vision Care Program, and Dental Care Program:
Coverage under this Medical Care Program (other than Domestic Partner medical benefits), Vision Care Benefits (other than domestic Partner vision benefits), and/or Dental Care Program (other than Domestic Partner dental benefits) for you and/or your Dependents will, unless otherwise stated, end as of the last day of the month in which:

1. You terminate employment;
2. You cease to be an Employee;
3. You cease making any required contribution;
4. Your dependent no longer meets the definition of an eligible dependent ("Dependent"); or
5. Any of these plans, programs, policies, options thereunder end; and/or, with respect to a program that is insured, the Group Contract providing such insurance ends.

Notwithstanding #4 above, medical, dental, and vision coverage provided to a Dependent on a Medically Necessary Leave of Absence* will not terminate until the end of the month in which the earliest of the following events occurs:

- The date that is one year after the first day of the Medically Necessary Leave of Absence; or
- The date such individual is no longer a Dependent for a reason other than being on a Medically Necessary Leave of Absence from a post-secondary educational institution.

*A Medically Necessary Leave of Absence must be from an accredited post-secondary educational institution that the individual had been attending full-time in accordance with the institution's policies immediately before the first day of the leave of absence. A Medically Necessary Leave of Absence is a leave of absence that:

- Commences while the individual is suffering from a serious illness or injury;
- Is medically necessary;
- Results in the individual losing student status at the post-secondary educational institution the individual had been attending; and
- For which the Plan has received written certification by a treating physician of the individual which states that the individual is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. This certification must be provided to Union Pacific Workforce Shared Services within 30 days of the commencement of the leave of absence.

It is the Employee's responsibility to provide notification within 30 days of any other event affecting the eligibility of a covered Dependent, such as attainment of age 26, commencing or ceasing a Medically Necessary Leave of Absence or any other reason that would cause the individual to fail to be a Dependent. COBRA continuation rights and obligations for the Medical, Dental Care and Vision Care Programs are explained in the "Continuation of Coverage under COBRA" section of this document beginning on page 23.

Domestic Partner Medical Coverage:
Medical coverage for your Domestic Partner or registered Domestic Partner (and/or dependents of your registered Domestic Partner) will end as of the last day of the month in which:

1. You terminate employment;
2. You cease to be an Employee;
3. You cease making any required contribution;

4. Your Domestic Partner no longer meets the definition of a Domestic Partner as defined in the "Medical Care Program-Domestic Partners" section of this document on page 173;
5. Your registered Domestic Partner (and/or dependents of your registered Domestic Partner) is no longer eligible for coverage under the terms of the California HMO in which he/she is enrolled; or
6. The Flexible Benefits Program or the medical options under which Domestic Partner medical coverage is available ends.

Notwithstanding #5 above, medical coverage provided under a California HMO to a dependent of your registered Domestic Partner who is on a Medically Necessary Leave of Absence* will not terminate until the end of the month in which the earliest of the following events occurs:

- The date that is one year after the first day of the Medically Necessary Leave of Absence; or
- The date such individual is no longer is an eligible dependent for a reason other than being on a Medically Necessary Leave of Absence from a post-secondary educational institution.

*A Medically Necessary Leave of Absence must be from an accredited post-secondary educational institution that the individual had been attending full-time in accordance with the institution's policies immediately before the first day of the leave of absence. A Medically Necessary Leave of Absence is a leave of absence that:

- Commences while the individual is suffering from a serious illness or injury;
- Is medically necessary;
- Results in the individual losing student status at the post-secondary educational institution the individual had been attending; and
- For which the Plan has received written certification by a treating physician of the individual which states that the individual is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. This certification must be provided to Union Pacific Workforce Shared Services within 30 days of the commencement of the leave of absence.

Domestic Partner Dental Coverage:
Dental coverage for your Domestic Partner will end as of the last day of the month in which:

- You terminate employment;
- You cease to be an Employee;
- You cease making any required contribution;
- Your Domestic Partner no longer meets the definition of a Domestic Partner; or
- The Flexible Benefits Program or the Domestic Partner dental benefit option thereunder ends.

Domestic Partner Vision Coverage:
Vision coverage for your Domestic Partner will end as of the last day of the month in which:

- You terminate employment;
- You cease to be an Employee;
- You cease making any required contribution;
- Your Domestic Partner no longer meets the definition of a Domestic Partner; or
- The Flexible Benefits Program or the Domestic Partner vision benefit option thereunder ends.

It is the Employee's responsibility to provide notification within 30 days of any event affecting the eligibility of a Domestic Partner, registered Domestic Partner or a dependent of a registered Domestic Partner.

A Domestic Partner, registered Domestic Partner or dependent of a registered Domestic Partner is not a "qualified beneficiary" and thus, is not eligible to elect COBRA continuation coverage. However, an Employee who elects to continue medical coverage under COBRA may also elect to continue Domestic Partner medical coverage for a Domestic Partner who (a) was covered under Domestic Partner coverage immediately before the date the Employee's medical coverage ended and (b) lost coverage as a result of the Employee's COBRA qualifying event. The Employee will be entitled to continue Domestic Partner coverage until the Employee's COBRA continuation coverage ends. The same rule applies with respect to an Employee who elects to continue dental and/or vision coverage under COBRA and wants to continue such Domestic Partner coverage.

If You are No Longer HSA Eligible:

If during the Calendar Year you are no longer enrolled in a Union Pacific HDHP option, your Employee HSA Contribution election will terminate at the end of the month in which your Union Pacific HDHP coverage terminates. Any Employee HSA contributions or Union Pacific HSA Contribution made after you are no longer enrolled in Union Pacific HDHP coverage will be included in your compensation and is subject to applicable income and employment taxes. Such amounts may also be subject to an additional 6% excise tax. You should contact BenefitWallet or your tax or legal advisor if you have questions regarding this excise tax.

In addition, the HSA Contribution Program is not a health plan and as a result, COBRA continuation coverage rights do not apply to it. This means that although you may have a COBRA right to continue group health plan coverage under a Union Pacific HDHP Option, you cannot make Employee HSA Contributions via payroll deduction and you will not receive the Union Pacific HSA Contribution when continuing group health plan coverage under COBRA.

Life and AD&D Plan:

- Life Insurance and AD&D coverage will end on the last day of the calendar month in which your employment ends or you no longer meet the conditions of eligibility. However, a death benefit is payable if the death occurs within 31 days after ceasing to be a covered person while entitled to conversion of the insurance to an individual contract.
- Dependent Life and AD&D coverage will end at the end of the month in which your death occurs.
- All Dependent coverage will end at the end of the month that Dependent ceases to meet the definition of a Dependent. However, a death benefit is payable if the death occurs within 31 days after ceasing to be a covered person while entitled to conversion of the insurance to an individual contract.
- If a covered person does not make a payment that is required, that coverage will end on the last day of the period for which a required payment was made.
- If the plan ends in whole or in part, your benefits that are affected will end.

Such termination of coverage will not affect a claim that is incurred before the coverage ended.

STD/LTD Plan:
Information regarding when coverage ends for the STD/LTD Plan is provided in that section. See page 228.

CONTINUATION OF COVERAGE UNDER COBRA

Introduction:
This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage available under the Union Pacific Corporation Group Health Plan (the "Group Health Plan"). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, 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. It can also become available to other members of your family who are covered under the Group Health Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Group Health Plan and under federal law, you should contact Union Pacific Workforce Shared Services at (877) 275-8747.

Of the benefits described in this document, COBRA continuation rights apply ONLY to the medical, dental, and vision Programs. COBRA continuation rights apply separately to each of these programs. COBRA continuation rights do not apply to the Life and AD&D, Dependent Care FSA, HSA, or Short-Term & Long- Term Disability Plans.

A Domestic Partner, registered Domestic Partner, or dependent of a registered Domestic Partner is not a "qualified beneficiary" and thus, is not eligible to elect COBRA continuation coverage. However, an Employee who elects to continue medical coverage under COBRA may also elect to continue Domestic Partner medical coverage for a Domestic Partner who was covered under Domestic Partner coverage immediately before the date the Employee's medical coverage ended as a result of the Employee's COBRA qualifying event. The Employee will be entitled to

continue Domestic Partner coverage until the Employee's COBRA continuation coverage ends.

You may have other options available to you when you lose Group Health Plan coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Group Health Plan coverage 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, your Spouse, and your Dependent Children could become qualified beneficiaries if coverage under the Group Health Plan is lost because of the qualifying event. Under the Group Health Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Group Health Plan because either one of the following qualifying events happens:

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

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Group Health Plan because any of the following qualifying events happens:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B (or both), or Part D); or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Group Health Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B (or both), or Part D);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Group Health Plan as a "Dependent Child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Union Pacific Corporation, and that bankruptcy results in the loss of coverage of any retired employee with Retiree Medical Care Program coverage under the Group Health Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their Retiree Medical Care Program coverage under the Group Health Plan.

When is COBRA Coverage Available?
The Group Health Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B (or both), or Part D), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events:
For the other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days of the date on

which coverage would end under the Group Health Plan because of the qualifying event. You must provide this notice by calling Union Pacific Workforce Shared Services at (877) 275-8747. When providing this notice, you must provide your name, employee identification number (or Social Security number), a description of the qualifying event, the date the qualifying event occurred, and the names of the individual(s) losing coverage as a result of the qualifying event.

The Employee, Spouse or Dependent, or any person representing any of these individuals can provide this notification. Notification by the Employee, Spouse, or Dependent (or their representative) will satisfy this notification requirement with respect to all individuals who will lose coverage because of the qualifying event.

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. COBRA continuation coverage and the applicable notice period will commence with the date of loss of coverage as a result of the qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A qualified beneficiary must make a COBRA election no more than 60 days after receiving the Plan Administrator's notice of the right to elect COBRA. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B (or both), or Part D), your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension beyond an 18-month period of continuation coverage: If you or anyone in your family covered under the Group Health Plan is determined by the Social Security Administration/Railroad Retirement Board to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family 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: PayFlex Systems USA, Inc., Attn: Benefit Billing Dept., P.O. Box 953374, St. Louis, MO 63195-3374. The notice can also be faxed to (402) 231-4302. The notice must be provided before the end of the 18-month period of continuation coverage and 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 the 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, Spouse or Dependent, or any person representing any of these individuals can provide this notice. Notification by the Employee, Spouse, or Dependent (or their representative) will satisfy this notice requirement with respect to all individuals who may extend continuation coverage because of this disability determination. The disability would have to have started at some time 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 Plan Administrator 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: PayFlex Systems USA, Inc., Attn: Benefit Billing Dept., P.O. Box 953374, St. Louis, MO 63195-3374. The notice can also be faxed to (402) 231-4302. The notice must contain your name, account or Social Security number, and include a copy of the Social Security/Railroad Retirement determination. The Employee, Spouse or Dependent, or any person representing any of these individuals can provide this notice.

Notification by the Employee, Spouse, or Dependent (or their representative) will satisfy this notice requirement with respect to all individuals who may lose continuation coverage because of the determination that the individual is no longer disabled.

Second qualifying event extension beyond an 18-month period of continuation coverage: If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Group Health Plan. This extension may be available to the Spouse and any Dependent Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B (or both), or Part D), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Group Health Plan had the first qualifying event not occurred. If you experience an event that permits you to extend continuation coverage, you must provide the Plan Administrator with written notice of the event. The notice must be sent within 60 days from the date continuation coverage would end under the Group Health Plan because of such other event and must be addressed as follows: PayFlex Systems USA, Inc., Attn: Benefit Billing Dept., P.O. Box 953374, St. Louis, MO 63195-3374. The notice can also be faxed to (402) 231-4302. The Employee, Spouse or Dependent, or any person representing any of these individuals can provide this notice. Notification by the Employee, Spouse, or Dependent (or their representative) will satisfy this notice requirement with respect to all individuals who may extend continuation coverage because of the event. The notice must contain your name, account or Social Security number, and a description of the event, along with the following documentation, depending on the event:

- Loss of Dependent Status – If the individual no longer satisfies the Group Health Plan's definition of Dependent because the individual marries, you must provide a copy of the marriage certificate. If the loss of Dependent status is for any other reason, you must indicate the reason in writing.
- Divorce or Legal Separation – A copy of the Divorce Decree or Legal Separation document.
- Employee's Medicare Entitlement – A copy of the Employee's Medicare card.
- Death – A copy of the death certificate.

Premium for COBRA Continuation Coverage: You will be notified as to the amount of your required premium when you receive the notice of your right to continue coverage. The required premium is adjusted each plan 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. At the end of the 18-month or 3-year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under the Group Health Plan, if any.

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

1. The employer no longer provides group health coverage for any of its employees;
2. The premium for your continuation coverage is not paid within 30 days of the date due;
3. 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;
4. You become entitled to Medicare benefits; or
5. You have the special extended disability continuation coverage and 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 Plan Administrator 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 3 years from the date coverage was lost under the Group Health Plan as a result of the qualifying event that originally made a qualified beneficiary eligible to elect coverage.

Are There Other Coverage Options Besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a

spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

If You Have Questions:
Questions concerning the Group Health Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, 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, visit the EBSA website at www.dol.gov/ebsa, or contact EBSA at (866) 444-3272. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Temporary Extension of Certain Deadlines Due to COVID-19:
The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"). The Internal Revenue Service and Department of Labor have issued rules for the temporary extensions of the following deadlines as expressed in this "Continuation of Coverage Under COBRA" section:

- the 60-day election period for electing COBRA continuation coverage;
- the date for making COBRA premium payments;
- the deadline for you to notify the Plan Administrator of a COBRA qualifying event (i.e., your divorce or legal separation, or a family member's loss of dependent status), or of a determination of disability that may extend the maximum COBRA continuation period from 18 to 29 months; and
- the deadline by which the Plan Administrator or COBRA Administrator must provide a COBRA election notice to a qualified beneficiary.

Generally speaking, the deadline extensions are intended to provide you with more time to make a COBRA election, pay COBRA premiums and provide the above-described COBRA-related information while the National Emergency Declaration is in effect. Deadlines applicable to these or other COBRA-related activities will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. Please contact PayFlex Systems USA, Inc. 844-PAYFLEX (844-729-3539) for more information.

If you are unable to elect COBRA or pay COBRA premiums by the deadlines that ordinarily apply – as described in this "Continuation of Coverage Under COBRA" section – you may have additional time to do so. However, keep in mind that you do not have COBRA continuation coverage unless and until you elect it. If you incur medical costs before you have elected COBRA, your medical provider may be advised that you have no coverage and may require you to pay those costs yourself. Also, if you elect COBRA and do not pay the required premium for a coverage month by the due date – generally speaking, the first day of the month – your COBRA coverage may be suspended subject to reinstatement provided you pay the premium by the end of the grace period as may be extended in accordance with the above-described rules. If you incur medical costs during a period in which your COBRA coverage is suspended, your medical provider may be advised that you have no coverage and may require you to pay these costs yourself.

Keep Your Plan Informed of Address Changes:
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:
For general information about the Group Health Plan and COBRA continuation coverage, you may contact:

Union Pacific Workforce Shared Services
1400 Douglas Street, Stop 0320
Omaha, NE, 68179
(877) 275-8747.

If you are currently receiving COBRA continuation coverage and have questions about such coverage, please contact the Group Health Plan's COBRA Administrator:

PayFlex Systems USA, Inc.
Attn: Benefit Billing Dept
P.O. Box 953374
St. Louis, MO 63195-3374
844-PAYFLEX (844-729-3539)

HIPAA Special Enrollment Rights:
The passage of the Health Insurance Portability and Accountability Act of 1996, or HIPAA, provides special enrollment rights to participate in group health plans (see the "Life Events & Permissible Benefits Changes" section on pages 28-63 for more information).

COBRA and USERRA Administration:
Union Pacific has retained PayFlex COBRA Services to provide certain COBRA and USERRA services. In this capacity, PayFlex COBRA Services handles notifications, eligibility transmittals, record keeping, and billing services.

If you have questions about these services, please contact PayFlex COBRA Services at the following address:

PayFlex Systems USA, Inc.
Attn: Benefit Billing Dept
P.O. Box 953374
St. Louis, MO 63195-3374
844-PAYFLEX (844-729-3539)

If you have any questions about your current COBRA or USERRA continuation coverage, please contact PayFlex COBRA Services at 844-PAYFLEX (844-729-3539). If you have additional benefits questions, call Union Pacific Workforce Shared Services at (877) 275-8747. If you have changed marital status or you or your Spouse have changed addresses while receiving continuation of benefits under COBRA or USERRA, you should notify PayFlex COBRA Services.

LIFE EVENTS & PERMISSIBLE CHANGES

Except for your Employee HSA Contribution election, once you have enrolled, your elections remain in effect until the end of the Calendar year and you cannot change your elections until the next open enrollment period unless you experience a Life Event and the benefit program in which you enrolled through the Flexible Benefits Program permits such a change. The rules for changing your Employee HSA Contribution election are found in the "Employee HSA Contribution Election Change Rules" section on page 63.

Changes in elections resulting from a Life Event must be on account of and correspond with the Life Event. In addition, your election change must be made within 30 days of the event date (unless the election change is the result of a Special Enrollment Right related to a Medicaid or SCHIP, as described below). It is your responsibility to notify Union Pacific Workforce Shared Services at (877) 275-8747, to update your plan benefits as needed. You must provide notification for a birth, adoption, marriage, or divorce or to add or drop a domestic partner or dependent through the UP Employees website SAP-"My Benefits" or by calling Union Pacific Workforce Shared Services. Changes after 30 days can only be made during the next annual open enrollment period for coverage effective January 1st of the following year.

The Plan Administrator requires written documentation of a Life Event change. You generally have 45 days following the Life Event date to provide such written documentation. The documentation that must be provided with respect to the applicable Life Event is indicated in the table below. In the event you do not provide the required documentation by

this deadline, effective with the first month following the month in which the deadline expired, your coverages (and any salary reduction or salary deduction amounts) that were changed as a result of the Life Event will automatically revert back to the coverages (and salary reduction or salary deduction amounts) that were in effect prior to the Life Event change. Also, it may be necessary for the Plan Administrator to change your election to prevent the Flexible Benefits Program from violating certain rules set forth in the Internal Revenue Code. You will be advised if the Plan Administrator determines that any change in your election is necessary.

Changes in elections resulting from a Life Event will generally be effective on the first day of the month following the event date (for example, if the event occurred on January 15th, benefits will take effect on February 1st) or on the first day of the month coinciding with or next following the event date, with these exceptions:

- Medical, dental and vision coverage resulting from the birth, adoption, or placement for adoption of a Dependent Child will be effective on the event date.
- Benefit elections, excluding Voluntary Life and AD&D Insurance, resulting from transfers from an Agreement position to a Nonagreement position will be effective on the date of the Nonagreement position.
- Generally, Voluntary Life Insurance and Voluntary AD&D Insurance coverage elections will be effective on the first day of the month following receipt of the election. However, see the Life and AD&D section of this Flex Guide beginning on page 210, which describes rules regarding actively at work and evidence of insurability requirements that may affect the date your new election becomes effective.
- Any required salary reductions, salary deductions or waiver of medical payment will begin as soon as administratively practicable following the date of your completed elections.

Remember, an election change cannot be made unless the election change is on account of and corresponds with the Life Event and Union Pacific Workforce Shared Services is notified of the change within 30 days of the event. The following table describes all permissible changes that can be made as a result of a particular Life Event. Whether a particular change is available will depend on the facts and circumstances of the Life Event. For example, if the Employee changes the day care provider for a Dependent Child, the Employee may make a new Dependent Care FSA election to reflect the change in cost for providing such dependent care.

LIFE EVENTS & PERMISSIBLE BENEFIT CHANGES	
I. EVENT: Marriage (Employee has entered into a valid marriage in accordance with the laws of the jurisdiction in which the marriage is entered into, regardless of whether such marriage is recognized in the jurisdiction in which the Employee is domiciled.) **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the date of marriage. **Required Documentation:** Copy of marriage license must be provided to Union Pacific Workforce Shared Services within 45 days of the marriage. If children are brought into the marriage, copies of the birth certificates must be provided to Union Pacific Workforce Shared Services within 45 days of the marriage.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May enroll in Employee Only or Family coverage (or change from Employee Only to Family coverage) under any medical option in which you are eligible. May enroll in Family dental coverage (or change from Employee Only to Family coverage). May enroll in Family vision coverage (or change from Employee Only to Family coverage). May drop coverage under current medical, dental, and/or vision option if Employee and any eligible Dependents under currently effective elections are enrolled in new Spouse's plan. May change from Family to Employee Only coverage under current medical, dental, and/or vision option if all eligible Dependents enrolled under current option are enrolled in new Spouse's plan.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May elect to enroll in, discontinue, increase or decrease all Life & AD&D coverage levels. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	May elect to participate, increase, decrease or discontinue salary reduction contributions.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	If participating in Domestic Partner medical, dental and/or vision coverage, marriage ends eligibility for Domestic Partner benefits. Otherwise, not applicable.
EFFECTIVE DATE	Employee and/or Dependent medical, dental, and/or vision coverage and FSA coverage effective the first day of the month coinciding with or next following the date of marriage. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following the elections if elections are made within 30 days of the event. See the Life and AD&D section for more details. If the Marriage life event results in dropped or "Waived" coverage, then the coverage terminates the end of the month in which the marriage occurred.

II. EVENT: Divorce or Legal Separation or Annulment **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the date of event. **Required Documentation:** Copy of divorce or legal separation decree must be provided to Union Pacific Workforce Shared Services within 45 days of the event date. For purposes of medical, dental and vision coverage and the dependent care flexible spending account, **a Spouse ceases to be the Employee's Dependent on the date a decree of divorce, legal separation or annulment is entered by a court.** For purposes of Life and AD&D Insurance, a Spouse ceases to be the Employee's Dependent on the date the individual is no longer the Employee's lawful Spouse.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Drop coverage under current option for Spouse and if Spouse was the only Dependent covered, switch to Employee Only coverage. If Dependent Child(ren) are covered, maintain coverage under current option for Dependent Child(ren) if Dependent Child(ren) continue to meet definition of an eligible Dependent. If Employee's coverage was through Spouse's plan, Employee may enroll Self and any eligible Dependents previously covered under Spouse's plan. If Dependents' coverage was through Spouse's plan, Employee may elect Family coverage and enroll Self and eligible Dependents.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Must drop Spouse Life and Spouse AD&D. May elect to enroll in, discontinue, increase or decrease all Employee and Child Life & AD&D coverage levels All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	May elect to participate, increase, decrease or discontinue salary reduction contributions
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Not applicable.
EFFECTIVE DATE	Coverage terminates the end of the month in which event occurs. Employee and/or Dependent medical, dental, and/or vision coverage and FSA coverage effective the first of the month following event date. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following the election if the election is received within 30 days of event. See the Life and AD&D section for more details.

III. EVENT: Death of Dependent (Death of Spouse and/or Dependent Child) **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the date of death. **Required Documentation:** Copy of death certificate must be provided to Union Pacific Workforce Shared Services within 45 days of the death.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May change from Family to Employee only coverage under current option if deceased Spouse or Dependent was only other person covered under current option. If Employee's coverage was through Spouse's plan, Employee may enroll Self and any eligible Dependents previously covered under Spouse's plan. If Dependents' coverage was through Spouse's plan, Employee may elect Family coverage and enroll eligible Dependents under current coverage election.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May elect to enroll in, discontinue, increase or decrease all Life & AD&D coverage levels. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	May elect to participate, increase, decrease or discontinue salary reduction contributions.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Not applicable.
EFFECTIVE DATE	Coverage terminates the end of the month in which death occurred. Employee and/or Dependent medical, dental, and/or vision coverage and FSA coverage effective the first of the month following death. Generally, Voluntary Life and Voluntary AD&D elections are effective the first of the month following the election if the election is received within 30 days of event.

IV. EVENT: Change in Dependent Care Provider **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** None required	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Not applicable.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Not applicable
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	May elect to participate, increase, decrease or discontinue salary reduction contributions to reflect the cost of the new dependent care provider.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Not applicable.
EFFECTIVE DATE	Dependent Care FSA coverage election change is effective the first of the month coinciding with or next following the event.

V.A. EVENT: Addition of Dependent (Birth, Adoption, Placement for Adoption of Dependent Child(ren), or any other event (*except marriage*) that changes an Employee's number of Dependents as defined in the Plan). **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** Copy of birth certificate, adoption or placement for adoption papers, or other documentation that establishes the Child as your Dependent must be provided to Union Pacific Workforce Shared Services within 45 days of the event date.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	For dependents added other than through birth, adoption, or placement for adoption, may elect Family coverage, change from Employee Only to Family coverage, or enroll Dependent Child(ren) in current Family coverage option. For Dependents added through birth, adoption, or placement for adoption, may enroll in Employee Only or Family coverage or change from Employee Only to Family coverage under any medical option in which you are eligible. May enroll in Family dental coverage or change from Employee Only to Family dental coverage. May enroll in Family vision coverage or change from Employee Only to Family vision coverage. May drop coverage under current medical, dental, and/or vision option if Employee and any eligible Dependents under currently effective elections are enrolled in Spouse's plan. May change from Family to Employee Only coverage under current medical, dental, and/or vision option if all eligible Dependents enrolled under current option are enrolled in Spouse's plan. Note: If you gain a Child through birth or adoption, the Covered Health Services incurred by the Child during the first 31 days of life will be covered by the Plan, regardless of whether you make an affirmative election to enroll the Child in medical coverage. If you do not provide notification and required documentation for the Child as described above, the Child's coverage will be cancelled effective the 32nd day.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May elect to enroll in, discontinue, increase or decrease all Life & AD&D coverage levels. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	May elect to participate or increase salary reduction contributions.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Not applicable.
EFFECTIVE DATE	Medical, dental, and vision coverage added because of birth, adoption, or placement for adoption will be effective on the event date. If Dependent is added other than through birth, adoption, or placement for adoption; medical, dental, and vision elections will be effective the first of the month following event date. In all cases, FSA coverage effective the first of the month following event date. Generally, Voluntary Life and Voluntary AD&D elections are effective the first of the month following the election if the election is received within 30 days of event.

V.B. EVENT: Addition of registered Domestic Partner's dependent. (Applicable to Employees eligible for or enrolled in a California HMO medical option.) **Required Notification:** Notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** Copy of birth certificate, adoption or placement for adoption papers, or other documentation that establishes the individual as a dependent of your registered Domestic Partner must be provided to Union Pacific Workforce Shared Services within 45 days of the event date.	
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Under the California HMO: for individuals added as a dependent of a registered Domestic Partner other than through birth, adoption, or placement for adoption, may enroll dependents of a registered Domestic Partner in current California HMO medical option. For individuals added as a dependent of a registered Domestic Partner through birth, adoption, or placement for adoption, may enroll in Employee Only or Family coverage (or change from Employee Only to Family coverage) and enroll a registered Domestic Partner's dependent(s) under any California HMO medical option in which the Employee is eligible.
EFFECTIVE DATE	If dependent of a registered Domestic Partner is added other than through a birth, adoption or placement for adoption, medical coverage election will be effective the first of the month following event date. Medical coverage added because of a birth, adoption or placement for adoption will be effective on the event date.

VI. EVENT: Employee Changes Place of Residence (regardless of whether Employee transfers to a new work location or moves as a result of a relocation). **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** None required	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	If the relocation causes the Employee to lose coverage under his/her current medical option, the Employee may enroll in coverage under any medical program option offered at the new location at the same coverage level currently elected (Employee Only or Family). If the relocation causes the Employee to become newly eligible for medical coverage not otherwise available at the Employee's former location, the Employee may enroll in coverage under the newly available program option at the same coverage level currently elected (Employee Only or Family). See "Domestic Partner Medical and Dental" row if you have a Domestic Partner and you move into, within, or out of California. May waive coverage in new location only if coverage had been waived in old location. However, if relocation results in Spouse commencing employment and gaining health coverage see "Spouse Gains Other Coverage" page 40.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	No changes permitted.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	No changes permitted. However, if relocation results in: 1) A change in dependent care provider, see "Change in Dependent Care Provider" OR 2) Results in Spouse terminating employment, see "Spouse Terminates Employment".
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	If you relocate into or within California and, as a result of your change in place of residence, you are newly eligible to enroll in a California HMO medical option, you may enroll Self, Dependents, your registered Domestic Partner, and dependents of your registered Domestic Partner. If you have a Domestic Partner and move within or out of California and, as a result of your change in place of residence, you lose coverage under the California HMO medical option covering such Domestic Partner, you may enroll your Domestic Partner in the Domestic Partner Non-HDHP PPO medical option (depending on your new home address) within 30 days of the change of residence.
EFFECTIVE DATE	New coverage effective date is the first day of the month coinciding with or next following the date the address is updated in UP Employees website. Current coverage terminates at the end of the month in which notification occurs.

VII. LOSS OF OTHER HEALTHCARE COVERAGE (i.e., MEDICAL):	
VII.A. EVENT: Employee, Spouse or other Dependent, Domestic Partner, registered Domestic Partner or dependent of registered Domestic Partner is no longer eligible for other healthcare coverage (i.e., medical) that was in place when Employee previously declined medical coverage under the Flexible Benefits Program for individuals enrolled in such other coverage. **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** Letter from employer must be provided to Union Pacific Workforce Shared Services within 45 days of the event date.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Employee, Spouse or other Dependent no longer eligible for other medical coverage: May enroll Self, Spouse, and Dependents in any medical option in which you and the individuals you seek to enroll in coverage are eligible. No change for dental or vision coverage, but see "Loss of Non-Healthcare Coverage" below for such circumstances.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Not applicable.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Not applicable.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Domestic Partner, registered Domestic Partner or registered Domestic Partner's dependent is no longer eligible for other medical coverage: May enroll your registered Domestic Partner and dependent(s) of your registered Domestic Partner in a California HMO medical option, if eligible, or your Domestic Partner in the Domestic Partner PPO Option (depending on the Employee's home address ZIP code). No changes for Domestic Partner dental or vision coverage, but see "Loss of Non-Healthcare Coverage" below for such circumstances.
EFFECTIVE DATE	Coverage effective the first of the month following event date.

VII.B. EVENT: An employer has stopped paying for other healthcare coverage (i.e., medical) for Employee, Spouse or other Dependent, Domestic Partner, registered Domestic Partner or dependent of registered Domestic Partner that was in place when Employee previously declined medical coverage under the Flexible Benefits Program for individuals enrolled in such other coverage. **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** Letter from employer must be provided to Union Pacific Workforce Shared Services within 45 days of the event.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Payment stopped for Employee, Spouse or other Dependent: May enroll Self, Spouse, and Dependents in any medical option in which you and the individuals you seek to enroll in coverage are eligible. No change for dental or vision coverage, but see "Loss of Non-Healthcare Coverage" below for such circumstances.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Not applicable.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Not applicable.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Payment stopped for Domestic Partner, registered Domestic Partner or registered Domestic Partner's dependent: May enroll your registered Domestic Partner and dependent(s) of your registered Domestic Partner in a California HMO medical option, if eligible, or your Domestic Partner in the Domestic Partner Non-HDHP PPO Option (depending on the Employee's home address ZIP code). No changes for Domestic Partner dental or vision coverage, but see "Loss of Non-Healthcare Coverage" below for such circumstances.
EFFECTIVE DATE	Coverage effective the first of the month following event date.
VII.C. EVENT: COBRA continuation coverage under another group health plan for Employee, Spouse or other Dependent, Domestic Partner, registered Domestic Partner or dependent of registered Domestic Partner has stopped for reasons other than non- payment of premiums or termination for cause, and COBRA coverage was in place when Employee previously declined medical coverage under the Flexible Benefits Program for individuals enrolled in COBRA coverage. **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** COBRA termination letter from employer must be provided to Union Pacific Workforce Shared Services within 45 days of the event.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	COBRA coverage stopped for Employee, Spouse or other Dependent: May enroll Self, Spouse, and Dependents in any medical option in which you and the individuals you seek to enroll in coverage are eligible. No change for dental or vision coverage, but see "Loss of Non-Healthcare Coverage" below.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Not applicable.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Not applicable.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	COBRA coverage stopped for Domestic Partner, registered Domestic Partner or registered Domestic Partner's dependent: May enroll registered Domestic Partner and dependents of your registered Domestic Partner in a California HMO medical option, if eligible, or your Domestic Partner in the Domestic Partner Non-HDHP PPO Option (depending on the Employee's home address ZIP code). No changes for Domestic Partner dental or vision coverage, but see "Loss of Non-Healthcare

	Coverage" below for such circumstances.
EFFECTIVE DATE	Coverage effective the first of the month following event date.

VIII. LOSS OF NON-HEALTHCARE COVERAGE:	
VIII.A. EVENT: Loss of non-healthcare coverage because Spouse's employment terminates. **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** Letter from employer must be provided to Union Pacific Workforce Shared Services within 45 days of the event.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May enroll Self, Spouse and Dependent Child(ren) in dental and/or vision coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May elect to enroll in, discontinue, increase or decrease all Life & AD&D coverage levels. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	May elect to participate, increase, decrease or discontinue salary reduction contributions.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Not applicable.
EFFECTIVE DATE	Employee and/or Dependent dental and/or vision coverage and FSA coverage effective the first of the month following the termination. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following the election if the election is received within 30 days of the termination date.

VIII.B. EVENT: Spouse terminates employment and had no benefit coverage through employer. **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** Letter from employer must be provided to Union Pacific Workforce Shared Services within 45 days of the event.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	No change permitted.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May elect to enroll in, discontinue, increase or decrease all Life & AD&D coverage levels. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	May elect to participate, increase, decrease or discontinue salary reduction contributions.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Not applicable.
EFFECTIVE DATE	FSA coverage effective the first of the month following event date. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following the election if the election is received within 30 days of event.

VIII.C. EVENT: Dependents' loss of dental or vision coverage, life insurance, and/or AD&D insurance coverage because Dependent Child(ren)'s employment terminates. **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** Letter from Child(ren)'s employer must be provided to Union Pacific Workforce Shared Services within 45 days of the event.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May enroll Dependent Child(ren) in dental and/or vision coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May elect to enroll in, discontinue, increase or decrease all Life & AD&D coverage levels. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Not applicable.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Not applicable.
EFFECTIVE DATE	Dental and/or vision coverage effective the first of the month following termination. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following the election if the election is received within 30 days of event.

IX. SPOUSE OR OTHER DEPENDENT BECOMES EMPLOYED OR NEWLY ELIGIBLE FOR COVERAGE	
IX.A. EVENT: Spouse or other dependent gains other coverage due to commencement of employment. **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the effective date of the new coverage. **Required Documentation:** Letter from Spouse's or other Dependent's employer with effective date of Spouse's or other Dependent's coverage must be provided to Union Pacific Workforce Shared Services (within 45 days of the effective date) before coverage will be terminated.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May drop coverage for Self, Spouse, or Dependent(s) who become covered by Spouse's or other Dependent's plan.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May elect to enroll in, discontinue, increase or decrease all Life & AD&D coverage levels. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If Spouse becomes employed, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Not applicable.
EFFECTIVE DATE	Coverage terminates at the end of the month in which event occurs. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following the election if the election is received within 30 days of the event.

IX.B. EVENT: Spouse or other dependent becomes newly eligibly for coverage through employer. **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** Letter from Spouse's or other Dependent's employer with effective date of Spouse's or other Dependent's coverage must be provided to Union Pacific Workforce Shared Services (within 45 days of the effective date) before coverage will be terminated.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May drop coverage for Self, Spouse, or Dependent(s) who become covered by Spouse's or other Dependent's plan.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May elect to enroll in, discontinue, increase or decrease all Life & AD&D coverage levels. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If Spouse becomes employed, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Not applicable.
EFFECTIVE DATE	Coverage terminates at the end of the month in which event occurs. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following the election if the election is received within 30 days of the event.

IX.C. EVENT: Spouse or other Dependent has an annual open enrollment right under a benefit plan sponsored by Spouse's or other Dependent's employer, Spouse or other Dependent makes an election change under such benefits plan and period of coverage for such benefits plan is not a Calendar Year.

Required Notification: Must notify Union Pacific Workforce Shared Services within 30 days of the effective date of the new coverage.

Required Documentation: Letter from Spouse's or other Dependent's employer with effective date of change to Spouse's or other Dependent's coverage must be provided to Union Pacific Workforce Shared Services (within 45 days of the effective date of the new coverage).

EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May drop corresponding coverage for Self, Spouse, or Dependent(s) who become covered by Spouse's or other Dependent's medical, dental, and/or vision plan. May add corresponding coverage for Self, Spouse, or Dependent(s) who lose coverage under Spouse's or other Dependent's medical, dental and/or vision plan.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May elect to enroll in, discontinue, increase or decrease all Life and AD&D coverage levels. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	No changes permitted.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If the Spouse has the annual open enrollment right, may make corresponding election to participate or discontinue salary reduction contributions.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Not applicable.
EFFECTIVE DATE	Current medical, dental, vision coverage terminates at the end of the month immediately preceding the month in which the other coverage begins and Employee may make a corresponding election under FSA. Employee and/or Dependent medical, dental and/or vision coverage and FSA coverage effective the first of the month following the date the other coverage ends. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following election if election is received within 30 days of event.

X. TRANSFER BETWEEN AGREEMENT AND NONAGREEMENT STATUS	
X.A. EVENT: Agreement to Nonagreement **Required Notification:** Not applicable **Required Documentation:** Copy of applicable marriage license, signed Domestic Partner Affidavit and dependent children's birth certificates must be provided to Union Pacific Workforce Shared Services within 45 days of the transfer.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May enroll Self, Spouse, and Dependent Child(ren).
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May enroll Self, Spouse, and Dependent Child(ren). All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	Employee eligible for STD and Core LTD coverage after 3 months of continuous service, which includes continuous months of Agreement service immediately prior to transfer to nonagreement service. If eligible, Employee may elect Buy-Up LTD coverage. See the Union Pacific Corporation Short-Term and Long-Term Disability Plan section beginning on page 228 for details.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	May elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	May enroll Domestic Partner in the Domestic Partner PPO Option (depending on the Employee's home address ZIP code), or if Employee is eligible to participate in a California HMO medical option, may enroll Self, Dependents, your registered Domestic Partner, and dependents of your registered Domestic Partner in such HMO. May enroll Domestic Partner in Domestic Partner dental and vision coverage.
EFFECTIVE DATE	Employee and/or Dependent medical, dental, vision and/or LTD Buy up coverages, and Domestic Partner medical, dental and vision coverages are effective on the transfer date. DCFSA is effective the first of the month following the transfer date. Core Life and Core AD&D coverages are effective on the transfer date. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following election if election is received within 30 days of event. STD/LTD coverage is effective on the transfer date, provided eligibility requirements have been met.

X.B. EVENT: Nonagreement to Agreement **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Nonagreement benefits terminate at the end of the month in which Employee terminates nonagreement status.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Nonagreement benefits terminate at the end of the month in which Employee terminates nonagreement status.
STD/LTD COVERAGE	Coverage terminates on the date of transfer.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Nonagreement benefits terminate at the end of the month in which Employee terminates nonagreement status.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Nonagreement benefits terminate at the end of the month in which Employee terminates nonagreement status.
EFFECTIVE DATE	Employment and/or Dependent medical, dental and/or vision coverages; Domestic Partner medical, dental, and vision coverages; Life and AD&D coverages and DCFSA coverage cease at the end of the month in which the transfer occurs. STD/LTD coverage terminates upon the date of the transfer.

XI. TRANSFER BETWEEN PART-TIME HOURLY AND FULL-TIME SALARIED, REDUCED SALARIED, OR FULL-TIME HOURLY STATUS	
XI.A. EVENT: Part-Time Hourly to Full-Time Salaried, Reduced Salaried, or Full-Time Hourly **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Medical, vision, and dental coverages terminate for Self, Spouse and Dependent Children under part-time hourly plan; may enroll Self, Spouse, and Dependent Child(ren) under full-time salaried, reduced salaried and full-time hourly plan.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May keep current coverage or waive.
STD/LTD COVERAGE	Employee eligible for STD and Core LTD coverage after 3 months of continuous service, which includes continuous months of part-time hourly service immediately prior to transfer to full-time salaried, reduced salaried or full-time hourly status. If eligible, Employee may elect Buy-Up LTD coverage. See the Union Pacific Corporation Short-Term and Long-Term Disability Plan section beginning on page 228 for details.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	No changes permitted.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	May enroll Domestic Partner in the Domestic Partner Non-HDHP PPO Option (depending on the Employee's home address ZIP code); or if Employee is eligible to participate in a California HMO medical option, may enroll Self and Dependents Self, registered Domestic Partner, and Domestic Partner's dependents in such HMO. May enroll Domestic Partner in Domestic Partner dental and vision coverage.
EFFECTIVE DATE	Coverage under the part-time hourly medical program terminates at end of the month in which Employee ceases to be a part-time Employee. Coverage under the full-time salaried, reduced salaried or full-time hourly Employee medical program, if any, is effective the first of the month following transfer date. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following election if election is received within 30 days of event. STD/LTD coverage are effective on the later of your transfer date or the date you satisfy the 3 month continuous service requirement.

XI.B. EVENT: Full-Time Salaried, Reduced Salaried, or Full-Time Hourly to Part-Time Hourly **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Coverage terminates under full-time salaried, reduced salaried and full-time hourly plan and becomes subject to provisions for part-time hourly Employees.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	May keep current coverage or waive.
STD/LTD COVERAGE	STD/LTD coverage terminates as of the date of the transfer.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	No changes permitted.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Coverage terminates under full-time salaried or full-time hourly plan and becomes subject to provisions for part-time hourly Employees.
EFFECTIVE DATE	Coverage under the full-time salaried, reduced salaried and full-time hourly medical program terminates at end of the month in which Employee ceases to be a full-time salaried, reduced salaried or full-time hourly Employee. Coverage under the part-time hourly medical program, if any, is effective the first of the month following transfer date. Generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following election if election is received within 30 days of event. STD/LTD coverage terminates as of the date of the transfer.

XII. LEAVES OF ABSENCE	
XII.A.1. EVENT: Employee goes on unpaid leave, but such leave does not comply with the terms of any of the following: the Family and Medical Leave Act, unpaid Family Military Leave, unpaid USERRA (Employee Military Leave), unpaid Sabbatical Leave, unpaid Status Assessment Leave, unpaid Suspension Leave, unpaid Vacation Leave, or required unpaid leave of absence (RULA). **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Coverage terminates at the end of the month in which the unpaid leave begins. May elect COBRA continuation coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Coverage terminates at the end of the month in which the unpaid leave begins.
STD/LTD COVERAGE	Coverage terminates on effective date of unpaid leave.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage terminates at the end of the month in which the unpaid leave begins.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Coverage terminates at the end of the month in which the unpaid leave begins.
EFFECTIVE DATE	Employee and/or Dependent medical, dental and/or vision coverages, Domestic Partner medical, dental and vision coverages, Life and AD&D coverage and FSA coverage cease at the end of the month in which unpaid leave begins. STD/LTD coverage terminates upon the effective date of unpaid leave.

XII.A.2. EVENT: Employee ends unpaid leave that did not comply with the terms of any of the following: the Family and Medical Leave Act, unpaid Family Military Leave, unpaid USERRA (Employee Military Leave), unpaid Sabbatical Leave, unpaid Status Assessment Leave, unpaid Suspension Leave, unpaid Vacation Leave, or required unpaid leave of absence (RULA). **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	If Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in the same coverage on the same terms (i.e., HDHP to HDHP, Non-HDHP PPO to Non-HDHP PPO; Family to Family, Employee Only to Employee Only) as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect to enroll in Employee Only or Family coverage under any medical option in which Employee is eligible, and may enroll in Employee Only or Family dental and/or Employee Only or Family vision coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	If Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled for Self, Spouse, or Dependent Child(ren) in the same coverages on the same terms prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may enroll for eligible coverages. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	If Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in the same coverage on the same terms prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect to enroll in Buy up option in which Employee is eligible.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If returning from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled on the same terms prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	If Domestic Partner was enrolled in Domestic Partner medical, dental, and/or vision coverage and Employee returns from leave within the same Calendar Year in which the leave commenced, the Domestic Partner will be automatically re-enrolled in the same coverage(s) (i.e., medical, dental, and/or vision) as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began: • Employee may elect to enroll Domestic Partner in Domestic Partner Non-HDHP PPO medical coverage; or alternatively, if Employee enrolls in a California HMO medical option, Employee may enroll Employee's registered Domestic Partner and dependent(s) of the registered Domestic Partner in the California HMO medical option. • Employee may elect to enroll Domestic Partner in Domestic Partner dental and/or Domestic Partner vision coverage.

XII.A.2. EVENT: Employee ends unpaid leave that did not comply with the terms of the Family and Medical Leave Act, unpaid Family Military Leave, unpaid USERRA (Employee Military Leave), unpaid Sabbatical Leave, unpaid Vacation Leave, or required unpaid leave of absence (RULA). **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EFFECTIVE DATE	Employee and/or Dependent medical, dental, and/or vision coverage, Domestic Partner medical, dental and vision coverages and FSA coverage effective the first day of the month coinciding with or next following the return date. Core Life and Core AD&D coverages are effective the first day of the month coinciding with or next following the return date. If Employee returns from leave within the same Calendar Year in which the leave commenced, Voluntary Life and Voluntary AD&D elections are effective the first day of the month coinciding with or next following the return date, if notification received within 30 days of the return. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following election if election is received within 30 days of return. STD/LTD coverage is effective as of the return date from the leave.

XII.B.1. EVENT: Employee goes on unpaid family and medical leave under a policy that complies with the terms of the Family and Medical Leave Act. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May revoke coverage or continue medical, dental and/or vision coverage on an after-tax basis.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
STD/LTD COVERAGE	STD and Core LTD coverage continues while on leave. LTD Buy-Up coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made. If required contributions cannot be taken from your pay, you may continue coverage by making payments to Union Pacific.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage terminates at the end of the month in which the unpaid leave begins.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	May revoke or continue on an after-tax basis Domestic Partner Non-HDHP PPO medical, dental, and/or vision coverage. If Employee participates in a California HMO medical option and covers a registered Domestic Partner and/or dependents of a registered Domestic Partner, may revoke coverage or continue coverage on an after-tax basis. May revoke or continue on an after-tax basis Domestic Partner dental and vision coverage.
EFFECTIVE DATE	Medical, dental, vision, life and AD&D insurance coverage and Domestic Partner medical, dental and vision coverages terminate effective the end of the month in which the leave begins unless coverage is continued on an after-tax basis. If you choose to continue all coverages, and the required Employee contribution is not made for a month, coverage is terminated at the end of such month. If revoked LTD Buy-Up coverage, coverage will end as of the effective date of the leave.

XII.B.2. EVENT: Employee ends unpaid family and medical leave under a policy that complies with the terms of the Family and Medical Leave Act. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	If coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in the same coverage on the same terms (i.e., HDHP to HDHP, Non-HDHP PPO to Non-HDHP PPO; Family to Family, Employee Only to Employee Only) as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began and coverage terminated during the leave, may elect to enroll in Employee Only or Family coverage under any medical option in which Employee is eligible, and may enroll in Employee Only or Family dental coverage and/or Employee Only or Family vision coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	If Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled on the same terms as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may enroll for eligible coverage subject to plan limits and conditions. All initial enrollments or increases in coverage are subject to specific rules and limitations and overall plan limits. See the Life and AD&D Insurance Plan section beginning on page 210 for details.
STD/LTD COVERAGE	If LTD Buy-Up coverage terminated during the leave and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in LTD Buy-Up coverage. If LTD Buy-Up coverage terminated during the leave and Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect LTD Buy-Up coverage.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If returning from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled on the same terms prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	If Domestic Partner medical, dental, and/or vision coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, the Domestic Partner will be automatically re-enrolled under the same coverage(s) (i.e., medical, dental, and/or vision) as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began and Domestic Partner medical, dental, and/or vision coverage terminated during the leave: • Employee may elect to enroll Domestic Partner in Domestic Partner Non-HDHP PPO medical coverage; or alternatively, if Employee enrolls in a California HMO medical option, Employee may enroll Employee's registered Domestic Partner and dependent(s) of the registered Domestic Partner in the California HMO medical option. • Employee may elect to enroll Domestic Partner in Domestic Partner dental and/or Domestic Partner vision coverage.

XII.B.2. EVENT: Employee ends unpaid family and medical leave under a policy that complies with the terms of the Family and Medical Leave Act. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EFFECTIVE DATE	Employee and/or Dependent medical, dental, and/or vision coverage, Domestic Partner medical, dental and vision coverages and FSA coverage effective the first day of the month coinciding with or next following the return date. If Employee returns from leave within the same Calendar Year in which the leave commenced, Voluntary Life and Voluntary AD&D elections are effective the first day of the month coinciding with or next following the return date, if notification received within 30 days of the return. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following election if election is received within 30 days of return. Core Life and Core AD&D coverages are effective the first day of the month coinciding with or next following the return date. STD/LTD coverage is effective as of the return date from the leave.

XII.C.1. EVENT: Employee goes on unpaid leave of absence that complies with a family military leave law enacted by the state in which the Employee resides. (Note: This type of leave is for an Employee who is a spouse or parent of an individual in the military.) **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made. NOTE: Your Spouse or Child is not your Dependent for purposes of the Life and AD&D Plan while such individual is on active duty in the armed forces of any country.
STD/LTD COVERAGE	STD and Core LTD coverage continues while on leave. LTD Buy-Up coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made. If required contributions cannot be taken from your pay, you may continue coverage by making payments to Union Pacific.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage terminates at the end of the month in which the unpaid leave begins.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
EFFECTIVE DATE	Medical, dental, vision, life and AD&D insurance coverage and Domestic Partner medical, dental, and vision coverages terminate effective the end of the month in which the leave begins unless coverage is continued on an after-tax basis. If you choose to continue all coverages, and the required Employee contribution is not made for a month, coverage is terminated at the end of such month. If revoked LTD Buy-Up coverage, coverage will end as of the effective date of the leave.

XII.C.2. EVENT: Employee returns from unpaid leave of absence that complies with a family military leave law enacted by the state in which the Employee resides. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	If coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in the same coverage on the same terms (i.e, HDHP to HDHP, Non-HDHP PPO to Non-HDHP PPO; Family to Family, Employee Only to Employee Only) as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began and coverage terminated during the leave, may elect to enroll in Employee Only or Family coverage under any medical option in which Employee is eligible and may enroll in Employee Only or Family dental coverage and/or Employee Only or Family vision coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	If Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled for Self, Spouse, or Dependent Child(ren) on the same terms as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may enroll for eligible coverage (subject to plan limits and conditions.) NOTE: Your Spouse or Child is not your Dependent for purposes of the Life and AD&D Plan while such individual is on active duty in the armed forces of any country.
STD/LTD COVERAGE	If LTD Buy-Up coverage terminated during the leave and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in LTD Buy-Up coverage. If LTD Buy-Up coverage terminated during the leave and Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect LTD Buy-Up coverage.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If returning from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled on the same terms prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	If Domestic Partner medical, dental, and/or vision coverage terminated during the leave, and Employee returns from leave within the Calendar Year in which they leave commenced, the Domestic Partner will be automatically re-enrolled under the same coverage(s) (i.e, medical, dental and/or vision) as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began and Domestic Partner medical, dental and/or vision coverage terminated during the leave: • Employee may elect to enroll Domestic Partner in Domestic Partner Non-HDHP PPO medical coverage; or alternatively, if Employee enrolls in a California HMO medical option, Employee may enroll Employee's registered Domestic Partner and dependent(s) of the registered Domestic Partner in the California HMO medical option. • Employee may elect to enroll Domestic Partner in Domestic Partner dental and/or Domestic Partner vision coverage.

XII.C.2. EVENT: Employee returns from unpaid leave of absence that complies with a family military leave law enacted by the state in which the Employee resides. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EFFECTIVE DATE	Employee and/or Dependent medical, dental, and/or vision coverage, Domestic Partner medical, dental and vision coverages and FSA coverage effective the first day of the month coinciding with or next following the return date. If Employee returns from leave within the same Calendar Year in which the leave commenced, Voluntary Life and Voluntary AD&D elections are effective the first day of the month coinciding with or next following the return date, if notification received within 30 days of the return. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following election if election is received within 30 days of return. Core Life and Core AD&D coverages are effective the first day of the month coinciding with or next following the return date. STD/LTD coverage is effective as of the return date from the leave.
XII.D.1. EVENT: Employee goes on a Uniformed Services Employment and Re-employment Rights Act (USERRA) leave of more than 30 days. **Required Notification:** Must notify Union Pacific Workforce Shared Services in advance of military leave, unless precluded by military necessity from doing so or it is otherwise impossible or unreasonable to do so under the circumstances. **Required Documentation:** A copy of your military orders.	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Unless the Company otherwise provides in its military leave policy(ies), may revoke coverage or continue medical, dental and/or vision coverage on an after-tax basis for up to 24 months following the date in which your leave begins.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
STD/LTD COVERAGE	STD and Core LTD coverage continues while on leave. LTD Buy-Up coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made. If required contributions cannot be taken from your pay, you may continue coverage by making payments to Union Pacific.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Unless the Company otherwise provides in its military leave policy(ies), coverage will terminate at the end of the month in which the leave begins.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Unless the Company otherwise provides in its military leave policy(ies), may revoke or continue Domestic Partner Non-HDHP PPO medical, dental and/or vision coverage for up to 24 months following the date in which your leave begins. Unless the Company otherwise provides, if Employee participates in a California HMO medical option and covers a registered Domestic Partner and/or dependents of a registered Domestic Partner, may revoke coverage or continue coverage on an after-tax basis for up to 24 months following the date in which your leave begins.
EFFECTIVE DATE	Medical, dental, vision, life and AD&D insurance coverage and Domestic Partner medical, dental and vision coverages terminate effective the end of the month in which the leave begins unless coverage is continued on an after-tax basis. If you choose to continue all coverages, and the required Employee contribution is not made for a month, coverage is terminated at the end of such month. If revoked LTD Buy-Up coverage, coverage will end as of the effective date of the leave.

XII.D.2. EVENT: Employee returns from Uniformed Services Employment and Re-employment Rights Act (USERRA) leave of more than 30 days. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Unless the Company otherwise provides in its military leave policy(ies), if coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in the same coverage on the same terms (i.e., HDHP to HDHP, Non-HDHP PPO to Non-HDHP PPO; Family to Family, Employee Only to Employee Only) as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began and coverage terminated during the leave, may elect to enroll in Employee Only or Family coverage under any medical option in which Employee is eligible, and may enroll in Employee Only or Family dental coverage and/or Employee Only or Family vision coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	If Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re- enrolled for Self, Spouse, or Dependent Child(ren) on the same terms as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may enroll for eligible coverages (subject to plan limits and conditions).
STD/LTD COVERAGE	If LTD Buy-Up coverage terminated during the leave and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in LTD Buy-Up coverage. If LTD Buy-Up coverage terminated during the leave and Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect LTD Buy-Up coverage.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Unless the Company otherwise provides in its military leave policy(ies), if returning from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled on the same terms prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Unless the Company otherwise provides in its military leave policy(ies), if Domestic Partner medical, dental, and/or vision coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, the Domestic Partner will be automatically re- enrolled under the same coverage(s) (i.e., medical, dental and/or vision) as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began and Domestic Partner medical, dental and/or vision coverage terminated during the leave: • Employee may elect to enroll Domestic Partner in Domestic Partner Non-HDHP PPO medical coverage; or alternatively, if Employee enrolls in a California HMO medical option, Employee may enroll Employee's registered Domestic Partner and dependent(s) of the registered Domestic in the California HMO medical option. • Employee may elect to enroll Domestic Partner in Domestic Partner dental and/or Domestic Partner vision coverage.
EFFECTIVE DATE	If Employee returns from leave within the same Calendar Year in which the leave commenced, coverage is effective on the date of re-employment. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, coverage elections (or default coverage elections) are effective on the date of re-employment. You have 30 days from your date of re-employment to make your benefit elections.

XII.E.1. EVENT: Employee goes on unpaid sabbatical. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May revoke coverage or continue medical, dental and/or vision coverage on an after-tax basis.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
STD/LTD COVERAGE	STD and Core LTD coverage continues while on leave. LTD Buy-Up coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made. If required contributions cannot be taken from your pay, you may continue coverage by making payments to Union Pacific.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage terminates at the end of the month in which the unpaid leave begins.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	May revoke or continue Domestic Partner Non-HDHP PPO medical coverage. If Employee participates in a California HMO medical option and covers a registered Domestic Partner and/or dependents of a registered Domestic Partner, may revoke coverage or continue coverage on an after-tax basis. May revoke or continue Domestic Partner dental and vision coverage.
EFFECTIVE DATE	Medical, dental, vision, life and AD&D insurance coverage and Domestic Partner medical, dental and vision coverages terminate effective the end of the month in which the leave begins unless coverage is continued on an after-tax basis. If you choose to continue all coverages, and the required Employee contribution is not made for a month, coverage is terminated at the end of such month. If revoked LTD Buy-Up coverage, coverage will end as of the effective date of the leave.

XII.E.2. EVENT: Employee returns from unpaid sabbatical. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	If coverage terminated during the sabbatical, and Employee returns from sabbatical within the same Calendar Year in which the sabbatical commenced, will be automatically re-enrolled in the same coverage on the same terms (i.e., HDHP to HDHP, Non-HDHP PPO to Non-HDHP PPO; Family to Family, Employee Only to Employee Only) prior to sabbatical. If Employee returns from sabbatical in a Calendar Year subsequent to the Calendar Year in which the sabbatical began and coverage terminated during the sabbatical, may elect to enroll in Employee Only or Family coverage under any medical option in which Employee is eligible, and may enroll in Employee Only or Family dental coverage and/or Employee Only or Family vision coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	If Employee returns from sabbatical within the same Calendar Year in which the sabbatical commenced, will be automatically re-enrolled for Self, Spouse, or Dependent Child(ren) on the same terms prior to sabbatical. If Employee returns from sabbatical in a Calendar Year subsequent to the Calendar Year in which the sabbatical began, may enroll for eligible coverages (subject to plan limits and conditions.)
STD/LTD COVERAGE	If LTD Buy-Up coverage terminated during the leave and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in LTD Buy-Up coverage. If LTD Buy-Up coverage terminated during the leave and Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect LTD Buy-Up coverage.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If returning from sabbatical within the same Calendar Year in which the sabbatical commenced, will be automatically re-enrolled on the same terms prior to sabbatical. If Employee returns from sabbatical in a Calendar Year subsequent to the Calendar Year in which the sabbatical began, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	If Domestic Partner medical, dental, and/or vision coverage terminated during the sabbatical, and Employee returns from sabbatical within the same Calendar Year in which the sabbatical commenced, the Domestic Partner will be automatically re- enrolled under the same coverage(s) (i.e., medical, dental and/or vision) as prior to sabbatical. If Employee returns from sabbatical in a Calendar Year subsequent to the Calendar Year in which the sabbatical began and Domestic Partner medical, dental and/or vision coverage terminated during the sabbatical: • Employee may elect to enroll Domestic Partner in Domestic Partner Non-HDHP PPO medical coverage; or alternatively, if Employee enrolls in a California HMO medical option, Employee may enroll Employee's registered Domestic Partner and dependent(s) of the registered Domestic Partner in the California HMO medical option. • Employee may elect to enroll Domestic Partner in Domestic Partner dental and/or Domestic Partner vision coverage.

XII.E.2. EVENT: Employee returns from unpaid sabbatical. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EFFECTIVE DATE	Employee and/or Dependent medical, dental, and/or vision coverage, Domestic Partner medical, dental and vision coverages and FSA coverage effective the first day of the month coinciding with or next following the return date. If Employee returns from leave within the same Calendar Year in which the leave commenced, Voluntary Life and Voluntary AD&D elections are effective the first day of the month coinciding with or next following the return date, if notification received within 30 days of the return. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following election if election is received within 30 days of return. STD/LTD coverage is effective as of the return date from the leave.

XII.F.1. EVENT: Employee goes on unpaid status assessment leave. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May revoke coverage or continue medical, dental and/or vision coverage on an after-tax basis.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
STD/LTD COVERAGE	STD and Core LTD coverage continues while on leave. LTD Buy-Up coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made. If required contributions cannot be taken from your pay, you may continue coverage by making payments to Union Pacific.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage terminates at the end of the month in which the unpaid leave begins.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	May revoke or continue Domestic Partner Non-HDHP PPO medical coverage. If Employee participates in a California HMO medical option and covers a registered Domestic Partner and/or Dependents of a registered Domestic Partner, may revoke coverage or continue coverage on an after-tax basis. May revoke or continue Domestic Partner dental and vision coverage.
EFFECTIVE DATE	Medical, dental, vision, life and AD&D insurance coverage and Domestic Partner medical, dental and vision coverages terminate effective the end of the month in which the leave begins unless coverage is continued on an after-tax basis. If you choose to continue all coverages, and the required Employee contribution is not made for a month, coverage is terminated at the end of such month. If revoked LTD Buy-Up coverage, coverage will end as of the effective date of the leave.

XII.F.2. EVENT: Employee returns from unpaid status assessment leave. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	If coverage terminated during the status assessment, and Employee returns from the status assessment within the same Calendar Year in which the status assessment commenced, will be automatically re-enrolled in the same coverage on the same terms (i.e., HDHP to HDHP, Non-HDHP PPO to Non-HDHP PPO; Family to Family, Employee Only to Employee Only) as prior to sabbatical. If Employee returns from the status assessment in a Calendar Year subsequent to the Calendar Year in which the status assessment began and coverage terminated during the status assessment, may elect to enroll in Employee Only or Family coverage under any medical option in which Employee is eligible, and may enroll in Employee Only or Family dental coverage and/or Employee Only or Family vision coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	If Employee returns from the status assessment within the same Calendar Year in which the status assessment commenced, will be automatically re-enrolled for Self, Spouse, or Dependent Child(ren) on the same terms prior to sabbatical. If Employee returns from status assessment in a Calendar Year subsequent to the Calendar Year in which the status assessment began, may enroll for eligible coverages (subject to plan limits and conditions.)
STD/LTD COVERAGE	If LTD Buy-Up coverage terminated during the leave and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in LTD Buy-Up coverage. If LTD Buy-Up coverage terminated during the leave and Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect LTD Buy-Up coverage.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If returning from status assessment within the same Calendar Year in which the leave commenced, will be automatically re-enrolled on the same terms prior to sabbatical. If Employee returns from status assessment in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	If Domestic Partner medical, dental, and/or vision coverage terminated during the status assessment, and Employee returns from the status assessment within the same Calendar Year in which the status assessment commenced, the Domestic Partner will be automatically re-enrolled under the same coverage(s) (i.e., medical, dental and/or vision) as prior to the status assessment. If Employee returns from the status assessment in a Calendar Year subsequent to the Calendar Year in which the status assessment began and Domestic Partner medical, dental, and/or vision coverage terminated during the status assessment: • Employee may elect to enroll Domestic Partner in Domestic Partner Non-HDHP PPO medical coverage; or alternatively, if Employee enrolls in a California HMO medical option, Employee may enroll Employee's registered Domestic Partner and dependent(s) of the registered Domestic Partner in the California HMO medical option. • Employee may elect to enroll Domestic Partner in Domestic Partner dental and/or Domestic Partner vision coverage.

XII.F.2. EVENT: Employee returns from unpaid status assessment leave. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EFFECTIVE DATE	Employee and/or Dependent medical, dental, and/or vision coverage, Domestic Partner medical, dental and vision coverages and FSA coverage effective the first day of the month coinciding with or next following the return date. If Employee returns from leave within the same Calendar Year in which the leave commenced, Voluntary Life and AD&D elections are effective the first day of the month coinciding with or next following the return date, if notification received within 30 days of the return. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, generally, Voluntary Life and AD&D elections are effective the first day of the month following election if election is received within 30 days of return. STD/LTD coverage is effective as of the return date from the leave.

XII.G.1. EVENT: Employee goes on unpaid suspension leave. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	May revoke coverage or continue medical, dental and/or vision coverage on an after-tax basis.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
STD/LTD COVERAGE	STD and Core LTD coverage continues while on leave. LTD Buy-Up coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made. If required contributions cannot be taken from your pay, you may continue coverage by making payments to Union Pacific.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage terminates at the end of the month in which the unpaid leave begins.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	May revoke or continue Domestic Partner Non-HDHP PPO medical coverage. If Employee participates in a California HMO medical option and covers a registered Domestic Partner and/or Dependents of a registered Domestic Partner, may revoke coverage or continue coverage on an after-tax basis. May revoke or continue Domestic Partner dental and vision coverage.
EFFECTIVE DATE	Medical, dental, vision, life and AD&D insurance coverage and Domestic Partner medical, dental, and vision coverages terminate effective the end of the month in which the leave begins unless coverage is continued on an after-tax basis. If you choose to continue all coverages, and the required Employee contribution is not made for a month, coverage is terminated at the end of such month. If revoked LTD Buy-Up coverage, coverage will end as of the effective date of the leave.

XII.G.2. EVENT: Employee returns from unpaid suspension leave. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	If coverage terminated during the suspension, and Employee returns from suspension within the same Calendar Year in which the suspension commenced, will be automatically re-enrolled in the same coverage on the same terms (i.e., HDHP to HDHP, Non-HDHP PPO to Non-HDHP PPO; Family to Family, Employee Only to Employee Only) as prior to suspension. If Employee returns from suspension in a Calendar Year subsequent to the Calendar Year in which the suspension began and coverage terminated during the suspension, may elect to enroll in Employee Only or Family coverage under any medical option in which Employee is eligible, and may enroll in Employee Only or Family dental coverage and/or Employee Only or Family vision coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	If Employee returns from suspension within the same Calendar Year in which the suspension commenced, will be automatically re-enrolled for Self, Spouse, or Dependent Child(ren) on the same terms prior to suspension. If Employee returns from suspension in a Calendar Year subsequent to the Calendar Year in which the suspension began, may enroll for eligible coverages (subject to plan limits and conditions.)
STD/LTD COVERAGE	If LTD Buy-Up coverage terminated during the leave and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in LTD Buy-Up coverage. If LTD Buy-Up coverage terminated during the leave and Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect LTD Buy-Up coverage.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If returning from suspension within the same Calendar Year in which the suspension commenced, will be automatically re-enrolled on the same terms prior to suspension. If Employee returns from suspension in a Calendar Year subsequent to the Calendar Year in which the suspension began, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	If Non-HDHP PPO medical, dental, and/or vision coverage terminated during the suspension, and Employee returns from suspension within the same Calendar Year in which the suspension commenced, the Domestic Partner will be automatically re- enrolled under the same coverage(s) (i.e., medical, dental and/or vision) as prior to suspension. If Employee returns from suspension in a Calendar Year subsequent to the Calendar Year in which the suspension began and Domestic Partner medical, dental and/or vision coverage terminated during the suspension: • Employee may elect to enroll Domestic Partner in Domestic Partner Non-HDHP PPO medical coverage; or alternatively, if Employee enrolls in a California HMO medical option, Employee may enroll Employee's registered Domestic Partner and dependent(s) of the registered Domestic Partner in the California HMO medical option. • Employee may elect to enroll Domestic Partner in Domestic Partner dental and/or Domestic Partner vision coverage.

XII.G.2. EVENT: Employee returns from unpaid suspension leave. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EFFECTIVE DATE	Employee and/or Dependent medical, dental, and/or vision coverage, Domestic Partner medical, dental and vision coverages and FSA coverage effective the first day of the month coinciding with or next following the return date. If Employee returns from leave within the same Calendar Year in which the leave commenced, Voluntary Life and AD&D elections are effective the first day of the month coinciding with or next following the return date, if notification received within 30 days of the return. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, generally, Voluntary Life and AD&D elections are effective the first day of the month following election if election is received within 30 days of return. STD/LTD coverage is effective as of the return date from the leave.

XII.H.1. EVENT: Employee goes on unpaid vacation or required unpaid leave of absence (RULA). **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
STD/LTD COVERAGE	STD and Core LTD coverage continues while on leave. LTD Buy-Up coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage terminates at the end of the month in which required Employee contribution cannot be taken from Employee's pay.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made.
EFFECTIVE DATE	If required Employee contributions is not made for a month, coverage is terminated at the end of such month.

XII.H.2. EVENT: Employee returns from unpaid vacation or required unpaid leave of absence (RULA). **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	If coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in the same coverage on the same terms (i.e., HDHP to HDHP, Non-HDHP PPO to Non-HDHP PPO; Family to Family, Employee Only to Employee Only) as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began and coverage terminated during the leave, may elect to enroll in Employee Only or Family coverage under any medical option in which Employee is eligible and may enroll in Employee Only or Family dental coverage and/or Employee Only or Family vision coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	If Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled for Self, Spouse, or Dependent Child(ren) on the same terms prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may enroll for eligible coverages.
STD/LTD COVERAGE	If LTD Buy-Up coverage terminated during the leave and Employee returns from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled in LTD Buy-Up coverage. If LTD Buy-Up coverage terminated during the leave and Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect LTD Buy-Up coverage.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If returning from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled on the same terms prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	If Domestic Partner medical, dental, and/or vision coverage terminated during the leave, and Employee returns from leave within the Calendar Year in which they leave commenced, the Domestic Partner will be automatically re-enrolled under the same coverage(s) (i.e,, medical, dental and/or vision) as prior to leave. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began and Domestic Partner Non-HDHP PPO medical, dental, and/or vision coverage terminated during the leave: • Employee may elect to enroll Domestic Partner in Domestic Partner Non-HDHP PPO medical coverage; or alternatively, if Employee enrolls in a California HMO medical option, Employee may enroll Employee's registered Domestic Partner and dependent(s) of the registered Domestic Partner in the California HMO medical option. • Employee may elect to enroll Domestic Partner in Domestic Partner dental and/or Domestic Partner vision coverage.
EFFECTIVE DATE	Employee and/or Dependent medical, dental, and/or vision coverage, Domestic Partner medical, dental and vision coverages and FSA coverage effective the first day of the month coinciding with or next following the return date. If Employee returns from leave within the same Calendar Year in which the leave commenced, Voluntary Life and Voluntary AD&D elections are effective the first day of the month coinciding with or next following the return date, if notification received within 30 days of the return. If Employee returns from leave in a Calendar Year subsequent to the Calendar Year in which the leave began, generally, Voluntary Life and Voluntary AD&D elections are effective the first day of the month following election if election is received within 30 days of return. STD/LTD coverage is effective as of the return date from the leave.

XII.I.1. EVENT: Employee goes on Long-Term Disability. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Will remain in current medical coverage, unless coverage is changed to UHC or BCBS Non-HDHP PPO because of Medicare eligibility. Medical, dental, and vision coverage while on LTD are offered on an after-tax basis.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Core Employee Life coverage continues. Core Employee AD&D coverage terminates. Voluntary Employee Life, Voluntary Spouse Life, Voluntary Child Life, and Voluntary Employee AD&D, Voluntary Child AD&D, and Voluntary Spouse AD&D Insurance for the duration of the leave can be continued as long as the required Employee contributions for such coverage are made directly through MetLife. This process is referred to as the "Direct Bill" period.
STD/LTD COVERAGE	Not applicable.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage terminates at the end of the month in which the unpaid leave begins.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	No changes permitted.
EFFECTIVE DATE	Coverages that terminate will do so at the end of the month in which Employee begins receiving LTD benefits.

XII..2. EVENT: Employee returns to work from Long-Term Disability. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT MEDICAL, DENTAL & VISION	Will remain in current dental and vision coverage, as well as medical coverage and resume pre-tax contributions, unless enrolled in the Medicare-primary Non-HDHP PPO while on LTD. If coverage was changed to Medicare primary Non-HDHP PPO, Employee may elect to enroll in Employee Only or Family coverage under any medical option in which Employee is eligible.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Will continue in Core Life and the Voluntary Employee Life, Voluntary Spouse Life, Voluntary Child Life, and Voluntary AD&D coverages that he/she had elected to continue during LTD and will resume after-tax payroll deductions. If Voluntary Life & AD&D coverages were not continued during LTD, then Employee must wait until the next open enrollment period to enroll in these coverages, with the effective date commencing with the following January 1st. Will be enrolled in Core AD&D.
STD/LTD COVERAGE	If returning to work within the same Calendar Year in which LTD benefits commenced, will automatically be re-enrolled in LTD Buy-Up coverage. If Employee returns to work in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect LTD Buy-Up coverage.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	If returning to work within the same Calendar Year in which LTD benefits commenced, may re-enroll on the same terms prior to leave. If Employee returns to work in a Calendar Year subsequent to the Calendar Year in which the leave began, may elect to participate.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	No changes permitted.

EFFECTIVE DATE	Coverage is available as of the date of return with exception to: • FSA coverage, which is effective the first of the month following the return date. • If Voluntary Life and AD&D coverages were not continued during LTD, then Employee must wait until the next Open Enrollment period to enroll in these coverages, with the effective date commencing with the following January 1st.

XIII. DOMESTIC PARTNER LIFE EVENTS (THE FOLLOWING LIFE EVENT RULES GOVERNING MEDICAL, AND DENTAL AND VISION COVERAGE SPECIFCIALLY APPLY TO 1) DOMESTIC PARTNER RELATIONSHIPS, AND 2) REGISTERED DOMESTIC PARTNER RELATIONSHIPS UNDER A CALIFORNIA HMO)	
XIII.A. EVENT: Establishment of a Domestic Partner relationship. **Required Notification:** Notify Union Pacific Workforce Shared Services within 30 days of the establishment of the relationship. **Required Documentation:** An "Affidavit of Domestic Partnership" must be provided to Union Pacific Workforce Shared Services within 45 days of notification of the event.	
DOMESTIC PARTNER MEDICAL, DENTAL, VISIONDOMESTIC PARTNER MEDICAL AND DENTAL	May enroll Domestic Partner in the Domestic Partner PPO medical coverage (depending on the Employee's home address ZIP code) or, if employee participates in a California HMO medical option, may enroll a registered Domestic Partner and dependents of the Domestic Partner. May enroll Domestic Partner in Domestic Partner dental and vision coverage.
EFFECTIVE DATE	Coverage effective the first of the month following the establishment of the relationship.

XIII.B. EVENT: Domestic Partner dies or no longer meets the definition of a Domestic Partner. **Required Notification:** Notify Union Pacific Workforce Shared Services within 30 days of the event. **Required Documentation:** Not required	
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Domestic Partner medical, and/or dental and/or vision coverage is terminated.
EFFECTIVE DATE	Coverage terminates at the end of the month in which the event occurs.

XIII.C. EVENT: Domestic Partner gains other medical, dental and/or vision coverage (becomes employed or newly eligible for coverage). **Required Notification:** Notify Union Pacific Workforce Shared Services within 30 days of the event. **Required Documentation:** Letter from Domestic Partner's employer with effective date of change to Domestic Partner's coverage must be provided to Union Pacific Workforce Shared Services (within 45 days of the effective date of the new coverage).	
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	May drop Domestic Partner Non-HDHP PPO medical, Domestic Partner dental and/or Domestic Partner vision coverage or, if a registered Domestic Partner and dependents of a registered Domestic Partner are covered under a California HMO medical option, may drop the registered Domestic Partner and dependents of the registered Domestic Partner from such coverage.
EFFECTIVE DATE	Coverage terminates as of the end of the month in which event occurs.

XIII.D. EVENT: Domestic Partner Loses Dental and/or Vision coverage because Domestic Partner's employment terminates. **Required Notification:** Notify Union Pacific Workforce Shared Services within 30 days of the event date. **Required Documentation:** Letter from employer must be provided to Union Pacific Workforce Shared Services within 45 days of the event date.	
DOMESTIC PARTNER DENTAL AND VISION	May enroll Domestic Partner in Domestic Partner dental and/or vision coverage.
EFFECTIVE DATE	Coverage effective the first of the month following the termination.

XIII.E. EVENT: Domestic Partner terminates employment and had no medical, dental or vision coverage through employer.	
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	No changes permitted.
EFFECTIVE DATE	Not applicable.

XIII.F. Domestic Partner has an annual open enrollment right under a non-Calendar Year benefit plan sponsored by Domestic Partner's employer and Domestic Partner makes an election change under such benefit plan. **Required Notification:** Must notify Union Pacific Workforce Shared Services within 30 days of the effective date of the new coverage. **Required Documentation:** Letter from Domestic Partner's employer with effective date of change to Domestic Partner's coverage must be provided to Union Pacific Workforce Shared Services (within 45 days of the effective date of the Domestic Partner coverage change).	
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	May make corresponding change to Domestic Partner medical (Non-HDHP PPO or California HMO, as applicable), dental and/or vision coverages, based on Domestic Partner's elections(s) under his/her employer's benefit plan(s).
EFFECTIVE DATE	Current Domestic Partner medical, dental and/or vision coverage terminates at the end of the month immediately preceding the month in which the other coverage begins. Added Domestic Partner medical, dental and/or vision coverage is effective the first of the month following the date the other coverage ends.

EMPLOYEE HSA CONTRIBUTION ELECTION CHANGE RULES

Once you have enrolled in a HDHP medical option, you may change your Employee HSA Contribution election on a monthly basis. Your Employee HSA Contribution election change and revised HSA Employee Contribution salary reduction amount will be prospectively effective. An Employee HSA Contribution election change or revocation must be made prior to the payroll cutoff date for the month in order for such change or revocation to be effective on your next following payroll date from which Employee HSA Contribution salary reduction amounts are deducted. For example, if your Employee HSA Contribution salary reduction amount is deducted from pay you receive on the last business day of the month and you elect prior to the September payroll cutoff date to change or revoke your Employee HSA Contribution election, then such change or revocation will be effective with your end of September paycheck. If you change or revoke your Employee HSA contribution election after the September payroll cutoff date, such change or revocation will be effective with your end of October paycheck. To change your Employee HSA contribution election, you must access your account using the UP Employee Website SAP-"My Benefits" and complete your election in the HSA section

Medical Care Program

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ELIGIBILITY – EMPLOYEE, SPOUSE & OTHER DEPENDENTS

You are eligible to participate in Union Pacific's Medical Care Program ("Medical Care Program") on the date you become an eligible Employee. You may elect medical coverage for you and your Dependents, regardless of whether you elect any other type of coverage. For purposes of the Medical Care Program, the terms "Employee", "Spouse," and "Children" have the same meaning as defined on page 7 in the "Eligibility" section of this 2021 Flexible Benefits Guide document. Whomever you elect to cover under the Medical Care Program is considered a "Covered Person" for purposes of the Medical Care Program section of this document.

Note: COBRA continuation rights and obligations for the Medical Care Program are explained beginning on page 23 of this 2021 Flexible Benefits Guide.

MEDICAL OPTION TYPES: AN OVERVIEW

The Medical Care Program offers Employees and Dependents the following types of medical plan options:

- Preferred Provider Organizations (PPOs) that are Non-High Deductible Health Plans ("Non-HDHPs") under the Internal Revenue code;
- PPOs that are High Deductible Health Plans ("HDHPs") under the Internal Revenue Code; and
- Health Maintenance Organizations (HMOs).

Note – only the Non-HDHP PPO medical option is available to: 1) Medicare-eligible Employees receiving long-term disability benefits under the STD/LTD Plan ("Medicare LTD Employees"); and 2) Domestic Partners of Employees.

All of these options, except for the HMOs, are self-insured by Union Pacific. This means that for the non-HMO medical options Union Pacific, not an insurance company, pays for covered services that are incurred, subject to applicable Medical Care Program limits. Union Pacific contracts with third parties to provide for administrative services, claims processing, network access, and related medical benefit support services for its Medical Options.

A brief overview of each plan type is presented below.

PPO:
A Preferred Provider Organization (PPO) is a network of providers who have agreed to charge discounted rates for medical services in exchange for increased business opportunity. PPO medical options provide participants an incentive to use Preferred Providers (also known as In-Network Providers) by offering higher benefit levels whenever a Preferred Provider is used. These incentives are in the form of lower Deductibles (the portion of the medical expense paid by you before the Medical Care Program begins to pay for healthcare services), lower Coinsurance (the portion of the medical expense paid by you after the Deductible has been met), and lower Coinsurance Maximums. If you go outside the PPO Network for medical care, your expenses will be greater. The amount of Deductibles and Coinsurance, as applicable, is described in the materials for each PPO option. The term Preferred Provider may also be referred to as a Network Provider or a Provider that is In-Network. Similarly, the term Non-Preferred Provider may also be referred to as a Non-Network Provider or a Provider that is Out-of-Network.

PPO members typically pay a monthly premium through a before-tax deduction under the Flexible Benefits Program. PPO Coverage for Medicare LTD Employees, Domestic Partners, and Employees with PPO coverage while on an unpaid leave of absence is paid on an after-tax basis. In addition, the member typically pays for covered services until a Deductible has been met. After the Deductible has been met, the member pays a percentage of costs (Coinsurance) until a Coinsurance Maximum has been met. Consult the documents of the particular PPO option for specific coverage and limitations. PPO providers have agreed to accept contracted payments for covered services as payments in full, except for any Deductible and Coinsurance amounts. Charges for non-covered services are your responsibility. PPO providers also file claims for you. The claims processor typically pays the provider directly and sends you a notice of payment that identifies what amounts have been paid and the amounts for which you are responsible. This notice is often called an Explanation of Benefits (EOB). If you use a provider that is Out-of-Network, you will likely need to file the claim with your plan's claim administrator.

You can select the Doctors of your choice that are In-Network, and you do not need to select a Primary Care Physician (PCP) in order to receive benefits. However, it is still recommended that you select and contact a Doctor prior to requiring medical services. Quantum Health will assist you in finding Hospitals, Doctors, and other providers that are In-Network.

The UHC Choice Plus Preferred Provider Directory is available through the MyQHealth website at www.UPMyQHealth.com or by calling Quantum Health at (855) 649-3855 for assistance.

High Deductible Health Plans:
A High Deductible Health Plan (HDHP) is a PPO designed to meet the requirements of a "high deductible health plan" as defined in Internal Revenue Code section 223. As the name implies, an HDHP typically has a higher Deductible than a PPO that is not designed to meet these requirements. An individual covered by a HDHP may be eligible to contribute to a Health Savings Account (HSA).

HMO:
An HMO is one type of managed healthcare arrangement. As the name "Health Maintenance Organization" implies, the typical HMO approach to healthcare emphasizes preventive medical care. The Kaiser HMOs use a "gatekeeper" model, requiring referrals from a Primary Care Physician (PCP) to see a specialist. In this type of HMO, members choose or are assigned a PCP who is affiliated with the HMO. The PCP is responsible for coordinating the medical care of the HMO member and handles much of the member's routine care, such as physicals, checkups, and diagnostic procedures. In these HMOs, the PCP determines the need for the services of a healthcare specialist and makes a referral when a specialist is needed. If you are eligible for the Kaiser HMO, you can access a list of Hospitals, Doctors, and other providers affiliated with the HMO, via the Kaiser website at www.kp.org, then click "Locate our services". You may also call the Kaiser Member Service toll free number, listed within the Benefit Contacts section at the end of this Flex Guide, page 270, applicable for your region to request Kaiser HMO Network information.

HMOs are government-regulated providers of healthcare services. They provide a specified set of coverage and benefits with stated limits and conditions. They contract with Doctors who deliver care to its members. Doctors may receive a per member payment from the HMO to provide a full range of health services for HMO members. The per-member or "per-capita" payment arrangement is often called "capitation." Capitation means the provider receives a fixed amount of money per person regardless of how many services are used. It is to the provider's benefit if the HMO member stays healthy and requires few services. The PCP plays a key role in determining the need for healthcare services and is responsible for controlling costs of providing medical care.

HMO members typically pay a monthly fee through a before-tax payroll deduction under the Flexible Benefits Program. The fee is paid on an after-tax basis by HMO members enrolled in HMO coverage while on an unpaid leave of absence. In addition, when a HMO member sees a PCP, a Copay is paid at the time of the office visit. Other Copays/Deductibles often apply to certain services, including: prescription drugs, vision care, emergency room services, hospitalization, and visits to specialists. Other medical services may be fully covered by the HMO if determined by the PCP to be necessary. Consult the documents of a particular HMO for specific coverage and limitations.

MEDICAL COVERAGES: YOUR OPTIONS

Unless you are a Medicare LTD Employee, if you reside in a ZIP code designated as a UnitedHealthcare (UHC) Network area, you will have the following medical options (administered by Quantum Health and UMR) available to you:

- UHC HDHP1
- UHC HDHP2
- UHC Non-HDHP PPO

If you are a Medicare LTD Employee and reside in a ZIP code designated as a UHC Network area, you will have the UHC Non-HDHP PPO (administered by Quantum Health and UMR) available to you.

The UHC HDHP PPO options and the UHC Non-HDHP PPO option are collectively referred to as the "UHC Medical Options."

Unless you are a Medicare LTD Employee, if you reside in a ZIP code designated as a BlueCross/BlueShield (BCBS) Network area, you will have the following medical options (administered by Quantum Health and BCBS of Nebraska) available to you:

- BCBS HDHP1
- BCBS HDHP2
- BCBS Non-HDHP PPO

If you are a Medicare LTD Employee and reside in a ZIP code designated as a BCBS Network area, you will have the BCBS Non-HDHP PPO (administered by Quantum Health and BCBS of Nebraska) available to you.

The BCBS HDHP PPO options and the BCBS Non-HDHP PPO option are collectively referred to as the "BCBS Medical Options."

Employees have either the UHC Medical Options (within the UHC "Choice Plus" Network) or the BCBS Medical Options (within the BlueCard Network) available to them, but not both.

In addition, in certain geographical locations, you may be eligible to enroll in a Kaiser HMO. You may also waive coverage.

UHC Medical Options:
The UHC Medical Options are Preferred Provider Organization (PPO) arrangements self-insured by Union Pacific. Union Pacific has contracted with Quantum Health and UMR, a subsidiary of UHC, to administer claims and medical management services for medical benefits and Mental Health and Substance-Related and Addictive Disorders Treatment benefits. In order to carry out their specific responsibilities under the Medical Care Program, Quantum Health and UMR have been granted discretionary authority to interpret terms of the UHC Medical Options and to determine entitlement to plan benefits in accordance with the terms of these options. UHC Medical Option medical benefits are offered through the UHC "Choice Plus" PPO Network. To access the UHC "Choice Plus" Preferred Provider Directory list of Hospitals, Doctors, and other providers affiliated with the UHC PPO Network, you may view online through the MyQHealth website at www.UPMyQHealth.com or by calling Quantum Health at (855) 649-3855 for assistance. Mental Health and Substance-Related and Addictive Disorders Treatment benefits are administered separately from the UHC PPO Network through a network of providers maintained by United Behavioral Health ("UBH"). The UHC Medical Options also include pharmacy benefits, which also are administered separately from the UHC PPO Network by OptumRx. The UHC Medical Options are described in this 2021 Flexible Benefits Guide.

BCBS Medical Options:
The BCBS Medical Options are self-insured arrangements. Union Pacific has contracted with Quantum Health and BCBS of Nebraska (BCBS) to administer the BlueCard Network and to administer claims and medical management services for medical benefits and mental healthcare, substance use disorder treatment benefits. In order to carry out their specific responsibilities under the Medical Care Program, Quantum Health and BCBS have been granted discretionary authority to interpret the terms of the BCBS Medical Options and to determine entitlement to plan benefits in accordance with the terms of the BCBS Medical Options. To access the BCBS Preferred Provider Directory list of Hospitals, Doctors, and other providers affiliated with their BlueCard Network, you may view online through the MyQHealth website at www.UPMyQHealth.com or by calling Quantum Health at (855) 649-3855 for assistance. In addition to medical benefits, the BCBS Medical Options include pharmacy benefits. The pharmacy benefit is administered by OptumRx. The BCBS Medical Options are offered to eligible Employees who reside in certain geographical areas based on their residential address ZIP code.

The specific healthcare coverage is governed by the *2021 BlueCross/Blue Shield Healthcare Benefit Plan Medical Options* document (the "BCBS Plan Document"). Be sure to consult the materials describing the BCBS Medical Options, including the BCBS Plan Document, for more detailed information. You may access these materials on the Workforce Resources page via the UP Employees website (www.up.com). You may also request these materials from Quantum Health at no cost to you. Among other things, these materials will provide information on the nature of coverage provided, conditions associated with the provisions, the circumstances under which coverage may be denied,

the procedures that must be followed to obtain coverage for services, and the guidelines for making an appeal of coverage that is denied to you. If there is a difference between this overview and the information provided by the BCBS BlueCard Network, the BCBS BlueCard Network information will govern. The information provided in this section of this document is an overview of the material found in the BCBS Plan Document. The description of benefits provided by the BCBS Plan Document is incorporated herein by this reference.

Kaiser Health Maintenance Organizations:
The Health Maintenance Organizations (HMOs) are provided on a fully insured basis. The Kaiser HMOs have discretionary authority to interpret the terms of its option and to determine entitlement to the option's benefits in accordance with the terms of its option. The name and address of the Kaiser HMO in which you are eligible to enroll, if applicable, will be available with your enrollment materials. The HMO for which you are eligible will provide you, without charge, a list of providers affiliated with the HMO. In addition, a benefit summary can be accessed on the Workforce Resources page via the UP Employees website (www.up.com).

While the specific healthcare coverage is governed by the HMO's own documents, this section provides a general overview. Be sure to consult the materials provided by the HMO for more detailed information. You may also request these materials from the HMO at no cost to you. Among other things, these materials will provide information about the nature of services provided, conditions associated with their provisions, the circumstances under which they may be denied, the procedures that must be followed to obtain them, and the guidelines for making an appeal if services are denied to you. In the event there is a difference between this general overview and the information provided by an HMO, the HMO's information will govern. The description of benefits provided by the HMO that you receive from the HMO is incorporated herein by reference.

Waiving Medical Coverage:
An Employee may waive medical coverage. To waive medical coverage, you must affirmatively elect to do so. However, once you affirmatively waive medical coverage, your waiver election will remain in effect unless you change your election either as a result of a Life Event or during an annual open enrollment period for a subsequent Calendar Year.

You are responsible for notifying Union Pacific if you are the Spouse of another Employee and your Spouse has elected Family coverage under any of the medical options covering you as a Dependent. To do so, contact Union Pacific Workforce Shared Services at (877) 275-8747.

CLAIMS FOR BENEFITS

If you enroll in a medical option, you will receive information from your specific medical option concerning the process of submitting claims for benefits. This information will be provided to you at no cost. However, information concerning the process of submitting claims for benefits under the UHC Medical Options is contained in this 2021 Flexible Benefits Guide. If participating network providers are used, the provider generally submits the claim.

APPEAL PROCEDURES

If your claim for benefits is denied, you will receive written notice regarding the reason. The notice will state what (if any) additional information is needed to possibly change the claim denial. The notice will also explain how to have the decision reviewed. If you enroll in a medical option, you will receive information from your specific medical option concerning their appeal procedures. This information may be a part of the information that you receive during the enrollment process. This information will be provided to you at no cost. However, information concerning the process of appealing a claim denial under the UHC Medical Options is contained in this 2021 Flexible Benefits Guide.

The Kaiser HMOs and the third party administrators of the UHC Medical Options and BCBS Medical Options have been given authority to make factual findings and make claims determinations in accordance with the terms of the medical option.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND OTHER FIDUCIARIES

In carrying out their respective responsibilities under the medical options and the Medical Care Program, the Plan Administrator and other plan fiduciaries, including the Kaiser HMOs and the third party claims administrators of the UHC Medical Options and the BCBS Medical Options, shall have discretionary authority to make factual findings, to interpret the terms of the medical options, and to determine eligibility for and entitlement to plan benefits in accordance with the terms of the medical option and the Medical Care Program. Any finding, interpretation, or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the finding, interpretation, or determination was arbitrary and capricious.

Medical Options: UnitedHealthcare

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UHC MEDICAL OPTIONS: COMPONENTS AND NETWORK INFORMATION

The UHC HDHP1 Option, UHC HDHP2 Option, and UHC Non-HDHP PPO each consist of three components, and each component has its own network of Preferred Providers:

1. **Medical Benefits:** These benefits are self-insured by Union Pacific. Union Pacific has contracted with Quantum Health and UMR, a subsidiary of UnitedHealthcare (UHC), to administer claims and medical management services. In order to carry out their specific responsibilities under the Medical Care Program, Quantum Health and UMR have been granted discretionary authority to interpret terms of the UHC HDHP1 Option, the UHC HDHP2 Option, and the UHC Non-HDHP PPO to determine entitlement to plan benefits in accordance with the terms of the Medical Care Program.
2. **Mental Health and Substance-Related and Addictive Disorders Treatment Benefits:** These benefits are self-insured by Union Pacific and are administered by Quantum Health and UMR. In order to carry out their specific responsibilities under the Medical Care Program, Quantum Health and UMR have discretionary authority to make factual findings and interpret the terms of Mental Health and Substance-Related and Addictive Disorders Treatment benefits and to determine entitlement to plan benefits in accordance with the terms of the Medical Care Program.
3. **Pharmacy Benefits:** These benefits are self-insured by Union Pacific and are administered by OptumRx. In this capacity, OptumRx has discretionary authority to make factual findings and interpret the terms of the pharmacy benefits and to determine entitlement to plan benefits in accordance with the terms of the Medical Care Program. Although OptumRx administers the pharmacy benefits, Quantum Health serves as the primary point of contact for you and your covered Dependents to answer questions and provide information about your pharmacy benefits. For more information about the OptumRx pharmacy benefits, refer to the Pharmacy Benefits section of this document beginning on page 139.

Preferred Provider:
The medical benefits portion of the UHC HDHP Options and the UHC Non-HDHP PPO are offered through UHC's "Choice Plus" PPO Network. The UHC PPO Network refers to the network of providers maintained by UHC for medical services and supplies and made available to the UHC Medical Options. The pharmacy benefit is administered separately from the UHC PPO Network. United Behavioral Health (UBH) maintains its own network of Mental Health and Substance-Related and Addictive Disorders Treatment providers. A Preferred Provider is also referred to as a Network Provider or an In-Network Provider. Similarly, a Non-Preferred Provider is also referred to as a Non-Network Provider or an Out-of-Network Provider.

The UHC Medical Options allow the designation of a Primary Care Physician. You have the right to designate any primary care physician who participates in either the UHC PPO Network or UBH Preferred Provider Program and who is available to accept you or your covered Dependent(s). For Children, you may designate a pediatrician as the primary care Provider. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, contact Quantum Health at (855) 649-3855 or view online through the MyQHealth website at www.UPMyQHealth.com.

You do not need Prior Authorization from a UHC Medical Option in which you are enrolled or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the UHC PPO Network who specializes obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Quantum Health at (855) 649-3855 or view online through the MyQHealth website at www.UPMyQHealth.com.

It is the Employee's or Dependent's responsibility to verify that his/her provider is a Preferred Provider for each visit to ensure that the status of the provider has not changed. If the provider's status has changed and is no longer in the UHC PPO Network or UBH Preferred Provider Program, out-of-network criteria will apply.

UHC and UBH maintain their own networks of providers and are solely responsible for the selection, credentialing, and monitoring of their providers. However, neither UHC nor UBH assure the quality of the services provided. All providers selected by UHC and UBH are independent contractors.

To the extent an item or service is otherwise a Covered Health Service under the Medical Care Program, and consistent with reasonable medical management techniques specified under the Medical Care Program with respect to the frequency, method, treatment or setting for an item or service, the Medical Care Program shall not discriminate based on a health care Provider's license or certification, to the extent the Provider is acting within the scope of the Provider's license or certification under applicable state law. This provision does not require the Medical Care Program to accept all types of providers into a Network.

Union Pacific and its participating subsidiaries do not guarantee the quality of care provided under the UHC PPO Network or UBH Preferred Provider Program. You are responsible for choosing a Doctor or Hospital for your care and determining the appropriate course of medical treatment. When using a Preferred Provider, you should bring along your Medical Identification Card.

How does the UHC PPO Network and UBH Preferred Provider Program add value?
In areas where the UHC PPO Network or a provider in the UBH Preferred Provider Program is available, you will generally receive a higher level of Medical Care Program benefits when you obtain your services from a Preferred Provider. When a Preferred Provider is used, a lower Deductible applies. You will also receive a higher level of Medical Care Program Medical Coinsurance after the Deductible has been met. Further, the provider's bill will be at a contracted rate generally lower than rates charged by Non-Preferred Providers. By the terms of their contract with UHC or UBH, Preferred Providers accept the contracted rate as payment in full. Your portion of the Medical Coinsurance is calculated as a percent of the contracted rate.

If you are in an area where the UHC PPO Network or a provider in the UBH Preferred Provider Program is available and a Non-Preferred Provider is used, a higher Deductible will apply. You will receive lower Medical Care Program Medical Coinsurance after the Deductible is met and will be subject to the provider's billing for the difference between his/her bill and the amount determined by UHC or UBH to be Reasonable and Customary. The lower Medical Care Program Medical Coinsurance will be calculated as a percent of the Reasonable and Customary amount. In addition, the Coinsurance Maximum will be higher if a Non-Preferred Provider is used.

NOTE: SPECIAL PROVISIONS THAT APPLY TO PREFERRED PROVIDER NETWORKS

- **Out-of-Network expenses may be covered at the In-Network level.** Even in the UHC PPO Network area, occasionally a provider in a particular specialty is not readily available. To accommodate these cases, whenever a network provider is not available within a 30-mile radius of an Employee's residence, the Employee may use an Out-of-Network provider and still obtain the network level of benefits (i.e., lower Deductibles and higher Medical Care Program Coinsurance, if applicable). Since the Out-of-Network provider does not have a contract with UHC, Medical Care Program benefits payable will be based on Reasonable and Customary Charges. If an eligible Dependent does not reside with the Employee, his/her residence is deemed to be the same as the Employee's residence. **To qualify for coverage of Out-of-Network expenses at the In-Network benefit level, the participant must contact Quantum Health at** (855) 649-3855 **BEFORE services are rendered** to verify that the Out-of-Network Doctor/specialist qualifies for coverage at the network level and to facilitate the appropriate payment of applicable claim(s).
- **Services performed by Out-of-Network radiologists, anesthesiologists, pathologists, CRNAs or laboratories:** If a member is referred by an In-Network Doctor to an Out-of-Network radiologist, anesthesiologist, pathologist, CRNA or laboratory or receives inpatient care or outpatient surgery care from an In-Network Hospital or In-Network Ambulatory Surgical Center, but services are performed by Out-of-Network radiologists, anesthesiologists, pathologists, CRNAs or laboratories, these services will be considered In-Network for the purpose of determining Medical Care Program benefits. If the radiologists, anesthesiologists, pathologists, CRNAs or laboratories are not members of the UHC PPO Network, In-Network benefits will be based on billed charges.

Under certain circumstances, you will be required to notify Quantum Health in order to avoid having your benefits reduced. See "Covered Health Services" beginning on page 85 for additional information.

Mental Health and Substance-Related and Addictive Disorders Treatment Services: Your use of In-Network or Out-of-Network Mental Health and Substance-Related and Addictive Disorders Treatment providers determines the benefits available to you. Under certain circumstances, you will be required to notify Quantum Health in order to avoid having your benefits reduced. (See section "Prior Authorization" on page 80 for additional information.) The Claims Administrator – either Quantum Health or UMR – determines whether and to what extent benefits will be paid for

inpatient and alternate care Mental Health and Substance-Related and Addictive Disorders Treatment services and supplies. (See, "Medical Claims & Appeals" beginning on page 124, which explains the types of claims for which either Quantum Health or UMR serves as the "Claims Administrator.") You may call Quantum Health at (855) 649-3855 for a confidential referral to an appropriate clinician or to insure proper Prior Authorization of your behavioral healthcare.

Pharmacy benefits are governed by whether you use network pharmacies (see section "Pharmacy Benefits" on page 139 of this document).

PLAN FEATURES

This section describes the UHC Medical Options, the benefits provided ("Covered Health Services") under each, how to file claims for benefits, the appeal procedures to be used if you are denied benefits, and the coordination of benefit provisions.

Note: All Employees (other than Medicare LTD Employees) will have either the UHC Medical Options or the BCBS Medical Options (depending upon their residential ZIP code) available to them, but not both. You should consult the materials provided for the BCBS Medical Options if those options are available to you. If you elect coverage under one of the BCBS Medical Options, your medical benefits are described in the document entitled "2021 BlueCross/BlueShield Healthcare Benefit Plan Medical Options Administered by BCBS of Nebraska for Full-Time Salaried, Reduced Salaried, and Full-Time Hourly Nonagreement Employees of Union Pacific Corporation and Affiliates," which can be found at http://home.www.uprr.com/emp/ec/benefits/2021/medical/bcbs/index.shtml

Cost Sharing Features of the UHC Medical Options:
This section describes the cost sharing features of the UnitedHealthcare (UHC) High Deductible Health Plan medical options (HDHPs) and the UHC Non-HDHP PPO, each hereafter referred to separately as the "Plan."

"Cost sharing features" is a phrase that refers to the ways in which the Plan and the Employee each pay for a portion of the cost of medical care coverage. Under the HDHPs and the Non-HDHP PPO, cost of medical coverage is shared through a combination of premium contributions and subsidies, as well as through pay-as-you-go Deductibles and Coinsurance. Each of these features is described in the paragraphs that follow.

Premium Contribution:
You pay a portion of the cost of your medical coverage in the form of a premium contribution. The amount of the premium contribution depends on both the UHC Medical Option in which you are enrolled and your coverage level (Employee Only or Family). The services of an actuary and/or underwriter are used to determine premiums for each UHC Medical Option.

Deductible:
The Deductible is the amount you pay each Calendar Year before expenses are paid by the Plan. Under each UHC HDHP Option, there is a single Deductible for medical expenses (including Mental Health and Substance-Related and Addictive Disorders Treatment) and pharmacy expenses. Under the UHC Non-HDHP PPO, there is only a Deductible for medical expenses (including Mental Health and Substance-Related and Addictive Disorders Treatment). The UHC Non-HDHP PPO pays a portion of all expenses for covered Prescription Drug Products, which are those Prescription Drug Products on the Prescription Drug List. (See the "Pharmacy Benefits" Section for the definition of "Prescription Drug Product" and "Prescription Drug List" on page 160).

In a family, each covered individual must either satisfy the individual Deductible or a combination of covered family members must satisfy the family Deductible before Coinsurance applies. The annual Deductible for a family is capped regardless of family size. The family Deductible will be satisfied for all covered members of the family for the remainder of the Calendar Year once two or more members of your family incur expenses which together equal the family Deductible.

- The amounts you pay for contracted rates with a Preferred Provider for Covered Health Services are applied against the Deductible. If a Non-Preferred Provider is used to receive Covered Health Services, only the

amount you pay for Reasonable and Customary Charges for Covered Health Services is applied against the Deductible.

- If you are enrolled in a UHC HDHP Option, the amount paid at an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List is applied against the HDHP Deductible. If you obtain a Prescription Drug Product from an Out-of-Network Pharmacy, only the amount you pay up to the Predominant Reimbursement Rate for a Prescription Drug Product on the Prescription Drug List are applied against the HDHP Deductible. Medications not listed on the Pharmacy Drug List are excluded from coverage.
- Amounts paid for over-the-counter drugs and dental or vision care Copayments do not count toward your Deductible.
- Each UHC Medical Option has a higher Deductible to meet if Non-Preferred Providers are used. Any eligible expenses incurred will apply to both the In-Network and Out-of-Network Deductible amounts.

Specific Deductible features of each UHC Medical Option are presented in the "Schedule of Benefits" starting on page 78.

Agreement Employee Transfers: If you transfer from a Union Pacific Agreement position to a Nonagreement position during a Calendar Year and elect coverage under any of the UHC Medical Options or the BCBS Medical Options, the amounts counted during the same Calendar Year against your Deductible under the Railroad Employees National Health and Welfare Plan will be credited toward your Deductible under the newly elected nonagreement medical plan option. To initiate this process, you must contact Union Pacific Workforce Shared Services at (877) 275-8747.

Coinsurance Amount:
UHC HDHP Options*:* After the HDHP Deductible is met, the UHC HDHP Option in which you are enrolled pays a specified portion of the Covered Health Services and covered Prescription Drug Products and you pay the remaining portion, up to the Coinsurance Maximum.

- The medical Coinsurance is a percentage of the contracted rate if a Preferred Provider is used. If a Non-Preferred Provider is used, a lower percentage of the Reasonable and Customary Charges for Covered Health Services applies. Medical Coinsurance payments are capped by the annual HDHP Coinsurance Maximum.
- The pharmacy Coinsurance benefit depends on the Plan's Prescription Drug List. The member pays a flat dollar amount for Tier-1 (typically Generic drugs), a percentage for Tier-2 (typically preferred brand-name drugs), and a higher percentage for Tier-3 (typically Non-Preferred brand name drugs). In addition, the pharmacy Coinsurance is a portion of the Prescription Drug Cost if the prescription is dispensed by an In-Network Pharmacy. If an Out-of-Network Pharmacy is used, the pharmacy Coinsurance is a portion of the Prescription Drug Product's Predominant Reimbursement Rate. The lesser of actual costs or a minimum pharmacy Coinsurance amount applies; and for each Tier-2 and Tier-3 prescription or refill, a maximum pharmacy Coinsurance applies. Pharmacy Coinsurance payments are capped by the annual HDHP Coinsurance Maximum.

UHC Non-HDHP PPO: After the Deductible is met, the UHC Non-HDHP PPO pays a specified percentage of the Covered Health Services for the rest of the Calendar Year and you pay the remaining percentage. The medical Coinsurance is a percentage of the contracted rate if a Preferred Provider is used. If a Non-Preferred Provider is used, a lower percentage of the Reasonable and Customary Charges for Covered Health Services applies. Medical Coinsurance payments are capped by the annual Coinsurance Maximum.

Participants in the UHC Non-HDHP PPO pay a pharmacy Coinsurance amount for Prescription Drug Products on the Prescription Drug List. No prescription drug Deductibles apply. Cost sharing through pharmacy Coinsurance begins with the first prescription. Pharmacy Coinsurance payments are capped by the annual Coinsurance Maximum. The Pharmacy Coinsurance does not count toward the Deductible.

The pharmacy Coinsurance benefit depends on the Plan's Prescription Drug List, with the member paying a flat dollar amount for Tier-1 (typically Generic drugs), a percentage for Tier-2 (typically preferred brand name drugs), and a higher percentage for Tier-3 (typically Non-Preferred brand name drugs). The lesser of actual costs or a minimum pharmacy Coinsurance amount applies; and for each Tier-2 and Tier-3 prescription or refill, a maximum pharmacy Coinsurance applies.

Specific Medical Coinsurance features of each UHC Medical Option are presented in the "Schedule of Benefits", starting on page 78.

Specific pharmacy Coinsurance features, minimum and maximum costs, and annual out-of-pocket limit features are presented in the "Schedule of Benefits", starting on page 78.

Coinsurance Maximum:
The Coinsurance Maximum is the amount you pay each year before the UHC Medical Option in which you are enrolled pays 100% of the contracted Preferred Provider rate or the Reasonable and Customary Charges for Covered Health Services and 100% of the Prescription Drug Cost or Predominant Reimbursement Rate for covered Prescription Drug Products, for the remainder of the Calendar Year. Under all UHC Medical Options, there is a single Coinsurance Maximum for medical and pharmacy expenses.

- Expenses above Reasonable and Customary Charges for Covered Health Services and the Predominant Reimbursement Rate for Prescription Drug Products do not count toward a Coinsurance Maximum.
- Expenses you pay to satisfy a Deductible do not count toward a Coinsurance Maximum.
- Any benefit reduction for not obtaining Prior Authorization from Quantum Health as described in the "Prior Authorization" on page 80 does not count toward the Coinsurance Maximum.
- Any expense incurred for any health service that is not a Covered Service does not count toward the Coinsurance Maximum.

In a family, each Covered Person must either satisfy the individual Coinsurance Maximum or a combination of covered family members must satisfy the family Coinsurance Maximum. The annual Coinsurance Maximum for a family is capped regardless of family size. The individual Coinsurance Maximum will be satisfied for all covered family members of the family for the remainder of the Calendar Year once two or more members of your family incur expenses which together equal the family Coinsurance Maximum.

Specific Coinsurance Maximum features of each plan are presented in the "Schedule of Benefits", starting on page 78.

Provider Charges:
Your provider will charge you a fee for medical services or supplies provided as part of your medical care. If the provider is an In-Network provider, the fees will be at contracted rates, often at a considerable discount from fees otherwise charged to patients. Plan benefits are based on contracted rates whenever an In-Network provider is used. You will not be responsible for the difference between the amount your In-Network provider bills and the contracted rates.

Use of In-Network Providers: The Plan offers a broad network of providers and provides the highest level of benefits when Covered Persons utilize In-Network providers. These networks will be indicated on your Plan identification card. **Services provided by Out-of-Network providers will not be eligible for the highest benefits.** Specific benefit levels are shown in the Schedule of Benefits beginning on page 78.

When Covered Health Services are received from Out-of-Network providers as a result of an Emergency or as otherwise arranged through Quantum Health, eligible expenses are the amounts billed by the provider, unless UMR negotiates lower rates. Charges for non-Emergency services received from Out-of-Network providers are limited to the Reasonable and Customary amounts as determined by UMR.

Eligible expenses for non-Emergency services received from Out-of-Network providers are determined by UMR at the billed rate up to the Reasonable and Customary limit. If the provider is not an In-Network provider, the Plan will only consider the fees up to a Reasonable and Customary amount. The Out-of-Network provider may bill you for the balance between his/her fee and the amount determined by UMR to be Reasonable and Customary. This practice is known as "balance billing." Amounts charged above Reasonable and Customary limits are not "covered" expenses and do not count toward Deductibles or Coinsurance Maximums.

To save money and time, you should use an In-Network provider whenever possible to:

- Receive contracted rates, often at a substantial discount;
- Avoid "balance billing;" and
- Eliminate claim forms.

Reasonable and Customary:
Reasonable and Customary Charges are the charges for Covered Health Services, which are determined solely in accordance with UMR's reimbursement policy guidelines. The reimbursement policy guidelines are developed at UMR's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UMR accepts.

Lifetime Maximum Benefit: Except as otherwise indicated in the "Covered Health Services" section beginning on page 85, there is no lifetime maximum benefit for Covered Health Services.

Note: Additional limitations that apply to specific benefits are described throughout this Flexible Benefits Guide.

PLAN BENEFITS OFFERED

Benefits are payable under the UHC Medical Options for Covered Health Services performed and supplies prescribed by a Doctor, which are deemed Medically Necessary as determined by the Claims Administrator for medical services and medical supplies, Mental Health and Substance-Related and Addictive Disorders Treatment services or supplies and/or OptumRx for prescription drugs. Such services and supplies must be provided while coverage is in effect.

The following table provides an overview of the UHC Medical Options. Certain limitations and exclusions may apply. It is important that you refer to the provisions that follow for details about your benefits.

2021 SCHEDULE OF BENEFITS						
UNITEDHEALTHCARE	**HDHP 1**		**HDHP 2**		**Non-HDHP PPO**	
Plan Feature	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**[**]
HEALTHCARE						
Annual Deductible Employee Only Family: 2+ Persons	$3,000 $6,000	$6,000 $12,000	$4,500 $9,000	$9,000 $18,000	$1,250 $2,500	$2,500 $5,000
Health Savings Account: Maximum Company Contribution [+*] Employee Only Family: 2+ Persons	$900 $2,100		$900 $2,100		N/A	
Annual Deductible "Gap" Employee Only Family: 2+ Persons	$2,100 $3,900	$5,100 $9,900	$3,600 $6,900	$ 8,100 $15,900	N/A	
Medical Coinsurance After Deductible Plan pays You pay	85% 15%	65% 35%	85% 15%	65% 35%	85% 15%	65% 35%
Coinsurance Maximum (Annual Limit after Deductible) Employee Only Family: 2+ Persons	$2,000 $4,000	$4,000 $8,000	$1,500 $3,000	$3,000 $6,000	$2,750 $5,500	$5,500 $11,000
Preventive Care (As outlined under "Health Management Programs" see page 117 and "Preventive Pharmacy Benefits" see page 147)	Paid at 100%	No benefits are paid for an Out-of-Network Provider	Paid at 100%	No benefits are paid for an Out-of-Network Provider	Paid at 100%	No benefits are paid for an Out-of-Network Provider
Maximum Lifetime Benefit	Unlimited, except as otherwise indicated in the "Covered Health Services" section beginning on page 85.					

[+]A Health Savings Account (HSA) is not an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, amended (ERISA).
[*]The HSA contributions reflected in this Schedule of Benefits are intended only to illustrate how amounts contributed to an HSA may be used to offset HDHP Deductibles. These amounts would apply for a full-year participant who receives the maximum annual Union Pacific HSA contribution.
[**]There is no network requirement for Medicare LTD Employees. In-network benefits apply.

PHARMACY PROGRAM			
UNITEDHEALTHCARE	**HDHP 1**	**HDHP 2**	**Non-HDHP PPO**
Retail			
Annual Deductible	Combined Medical and Pharmacy Deductible See "Deductible"	Combined Medical and Pharmacy Deductible See "Deductible"	N/A
Pharmacy Coinsurance You pay: Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	Up to 31-day Supply* After the Deductible $10 Copay 30% 40%	Up to the 31-day Supply* After the Deductible $10 Copay 30% 40%	Up to 31-day Supply* No Deductible $10 Copay 30% 40%
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	After the Deductible N/A $30/$90 $60/$150	After the Deductible N/A $30/$90 $60/$150	No Deductible N/A $30/$90 $60/$150
Mail Order			
Annual Deductible	Combined Medical and Pharmacy Deductible See "Deductible"	Combined Medical and Pharmacy Deductible See "Deductible"	N/A
Pharmacy Coinsurance You pay: Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	Up to 90-day Supply After the Deductible $25 Copay 25% 40%	Up to 90-day Supply After the Deductible $25 Copay 25% 40%	Up to 90-day Supply No Deductible $25 Copay 25% 40%
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	After the Deductible N/A $75/$225 $150/$375	After the Deductible N/A $75/$225 $150/$375	No Deductible N/A $75/$225 $150/$375
Pharmacy Coinsurance Maximum	Combined Medical and Pharmacy Coinsurance Maximum See "Coinsurance Maximum"		
*Certain generic drugs may be purchased at a Retail Pharmacy for a supply up to 90-days. **If the actual cost of the drug is less than the stated minimum, the member will pay the actual drug cost.			

OUT-OF-POCKET MAXIMUM						
Annual Deductible and Coinsurance Maximum	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Employee Only	$5,000	$10,000	$6,000	$12,000	$4,000	$8,000
Family: 2 +Persons	$10,000	$20,000	$12,000	$24,000	$8,000	$16,000

CARE COORDINATION PROCESS

Introduction

The Plan incorporates a "Care Coordination" process by Quantum Health. This process includes a staff of Care Coordinators who receive a notification regarding most healthcare services sought by Covered Persons, and coordinate activities and information flow between the providers.

Care Coordination is intended to help Covered Persons obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and for early identification of complex medical conditions. The Care Coordinators are available to Covered Persons and their providers for information, assistance, and guidance, and can be reached toll-free by calling (855) 649-3855

Process of Care Requirements

In order to receive the highest benefits available in the Plan, Covered Persons must follow the "Care Coordination Process" outlined in this section as well as other provisions in the Plan. In some cases, failure to follow this process of care can result in penalties. The process of care generally includes:

- Designating a coordinating Primary Care Physician (PCP). This is encouraged but not required.
- Review and coordination process, including:
  - Prior Authorization of certain procedures
  - Utilization Review
  - Concurrent Review of hospitalization and courses of care
  - Case Management
  - Chronic Condition Management/Disease Management

As described below, Prior Authorizations are generally requested by the providers on behalf of their Covered Persons. If Prior Authorization for a Covered Health Service is required, the Covered Person is responsible for obtaining Prior Authorization if services requiring Prior Authorization are provided by an Out-of-Network provider. If such services are provided by an In-Network provider, the provider is generally responsible for obtaining Prior Authorization.

Designated Coordinating Physician

All Covered Persons are asked to designate a coordinating Primary Care Physician (PCP) for each Covered Person of their family when registering for the MyQHealth site or talking with a Care Coordinator. While such designation is not mandatory, it is strongly recommended. **To ensure the highest level of benefits, and the best coordination of your care, all Covered Persons are encouraged to designate an In-Network Primary Care Physician (PCP) to be their coordinating Physician.**

The care coordination process generally begins with the "**coordinating Physician**," an In-Network Primary Care Physician who maintains a relationship with the Covered Person and provides general healthcare guidance, evaluation, and management. The following types of physicians are typically selected by Covered Persons as their coordinating PCP:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrician (for Children)
- OB/GYN may serve as the Primary Care Physician ONLY during the course of a woman's pregnancy

Covered Persons are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP, who will guide patients as appropriate. In addition to providing care coordination and submitting referral and Prior Authorization requests, the PCP may also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Care Coordinators may be able to assist you by providing a list of available PCPs and even contacting PCP offices on your behalf. Please contact the Care Coordinators at (855) 649-3855.

Review and Coordination Process

The Care Coordination process includes the following components:

- ***Prior Authorization of Certain Procedures***
  To be covered at the highest level of benefit and to ensure complete care coordination, the Plan requires that certain care, services and procedures receive approval (i.e., Prior Authorization) before they are provided. Prior Authorization requests must be submitted to the Care Coordinators by a specialty Physician, designated PCP, other

PCP, or other healthcare provider, including an Out-of-Network provider, providing the care, service or procedure. Your Plan identification card includes instructions. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the need for the Prior Authorization request and to ensure that the care, service and/or procedure meet Plan criteria. If a Prior Authorization request

does not meet Plan criteria, the Care Coordinators will contact the Covered Person and healthcare provider and assist in redirecting care if appropriate.

The following services require Prior Authorization, provided it is not an Emergency*:

- Inpatient and Skilled Nursing Facility Admissions
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy and radiation therapy)
- Genetic Testing
- Home Health Care
- Hospice Care
- DME – all rentals and any purchase over $1,500
- Organ, Tissue and Bone Marrow Transplants
- Dialysis
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Abuse

***"Emergency" admissions and procedures**
Any Hospital admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the patient's health is considered an emergency and does not require Prior Authorization.

All Prior Authorization requests are reviewed by Quantum Health, unless the request requires Clinical Review of services provided by an In-Network provider. All In-Network provider Clinical Review services are conducted by UMR Care Management which is part of your overall Care Coordinators team. Care Coordinators will assist Covered Persons in understanding what services require Prior Authorization and to facilitate contact with the UMR Care Management team to initiate and complete the process.

"Clinical Review" means a process in which information about the Covered Person is collected and reviewed against established criteria to determine if the service, treatment or supply is Medically Necessary and is a Covered Health Service.

***Penalties for Not Obtaining Prior Authorization*:**

A non-Prior Authorization penalty is the amount you must pay if Prior Authorization is not obtained for a Covered Service listed above prior to receiving the service. A penalty of $300 will be applied if a Covered Person receives but did not obtain Prior Authorization for a Covered Service for which Prior Authorization is required.

The phone number to call for Prior Authorization is listed on the Plan identification card.

- ***Utilization Review***
  The Care Coordinators will review each Prior Authorization request to evaluate whether the care, requested procedures, and requested care setting all meet utilization criteria established by the Plan. The Plan has adopted the utilization criteria in use by the Care Coordinators. If a Prior Authorization request does not meet these criteria, the request will be reviewed by one of the medical directors for Quantum Health, who will review all available information and if needed consult with the requesting provider. If required, the medical director will also consult with other professionals and medical experts with knowledge in the appropriate field. He or she will then provide, through the Care Coordinators, a recommendation to UMR whether the request should be approved or denied. In this manner, the Plan ensures that Prior Authorization requests are reviewed according to nationally accepted standards of medical care, based on community healthcare resources and practices.

- ***Concurrent Review***

The Care Coordinators will regularly monitor a hospital stay, other institutional admission, or ongoing course of care for any Covered Person, and examine the possible use of alternate facilities or forms of care. The Care Coordinators will communicate regularly with attending Physicians, the utilization management staff of facilities providing services, and the Covered Person and/or family, to monitor the patient's progress and anticipate and initiate planning for future needs (discharge planning). Such concurrent review, and authorization for Plan coverage of hospital days, is conducted in accordance with the utilization criteria adopted by the Plan and Quantum Health.

- ***Case Management***
  Case Management is ongoing, proactive coordination of a Covered Person's care in cases where the medical condition is, or is expected to become catastrophic, chronic, or when the cost of treatment is expected to be significant. Examples of conditions that could prompt case management intervention include but are not limited to, cancer, chronic obstructive pulmonary disease, multiple trauma, spinal cord injury, stroke, head injury, AIDS, multiple sclerosis, severe burns, severe psychiatric disorders, high risk pregnancy, and premature birth.

  Case Management is a collaborative process designed to meet a Covered Person's health care needs, maximize their health potential, while effectively managing the costs of care needed to achieve this objective. The case manager will consult with the Covered Person, their family (if requested), the attending Physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care which provides the most appropriate health care and services in a timely, efficient and cost-effective manner.

  During the process of Case Management, services may be recommended that are subject to Clinical Review determinations. These Clinical Review functions are the sole responsibility of UMR Care Management. The case manager will assist providers and Covered Persons with ensuring that this is coordinated and timely.

  If the case manager, Covered Person, his or her provider and UMR all agree on alternative care that can reasonably be expected to achieve the desired results without sacrificing the quality of care provided, UMR may alter or waive the normal provisions of this Plan to cover such alternative care, at the benefit level determined by UMR.

  In developing an alternative plan of treatment, the case manager will consider:

  - The Covered Person's current medical status;
  - The current treatment plan;
  - The potential impact of the alternative plan of treatment;
  - The effectiveness of such care; and
  - The short-term and long-term implications this treatment plan could have.

  Quantum Health retains the right to review the Covered Person's medical status while the alternative plan of treatment is in process, and to discontinue the alternative plan of treatment with respect to medical services and supplies which are not Covered Services under the Plan if:

  - The attending physician does not provide medical records or information necessary to determine the effectiveness of the alternative plan of treatment;
  - The goal of the alternative care of treatment has been met; or
  - The alternative plan of care is not achieving the desired results or is no longer beneficial to the Covered Person as determined by the Claims Administrator.

- ***Chronic Condition Management***
  Chronic Condition Management (also referred to as Disease Management) is specialized support and coordination for Covered Persons with lifelong, chronic conditions such as diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and asthma. Chronic Condition Management is a collaborative process that is designed to help Covered Persons with such conditions self-manage based on care pathways with respect to such disease state, including but not limited to assisting Covered Persons in understanding the care pathway, assisting Covered Persons in setting goals, facilitating dialog with physicians if there are complications or conflicts with the patient's care, evaluating ways to eliminate barriers to successful self-management and generally maximize their health. Covered Persons who are identified from claims or other sources will be assessed for level of risk for each disease state and may be contacted proactively by a Chronic Condition Case Manager (also referred to as Disease Manager). Covered Persons whose information indicates they are high risk will be contacted by a

Chronic Condition Case Manager for an assessment and ongoing assistance and will be asked to update their care pathway information bi-annually. Covered Persons who are low or moderate risk may request assistance of a Chronic Condition Case Manager and will also be asked to update their care pathway information on a bi-annual

basis. Participation in chronic condition care management is voluntary, but participants may receive various prescription medications and/or supplies at a reduced cost or may be entitled to benefits that non-participants do not receive.

GENERAL PROVISIONS FOR CARE COORDINATION

Care Coordination Representative
The Covered Person is ultimately responsible for ensuring that all Prior Authorizations are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual Prior Authorization process will be executed by the Covered Person's Physician(s) or other providers. By enrolling in this Plan, the Covered Person authorizes the Plan and its designated service providers (including Quantum Health, UMR and others) to accept healthcare providers making Prior Authorization submissions, or who otherwise have knowledge of the Covered Person's medical condition, as their care coordination representative in matters of Care Coordination. Communications with and notification to such healthcare providers shall be considered notification to the Covered Person.

Time of Notice
Prior Authorization requests and other required notifications should be made to the Care Coordinators within the following timeframe:

- At least **three business days,** before a scheduled (elective) Inpatient Hospital admission
- By the next business day after, an emergency Hospital admission
- Upon being identified as a potential organ or tissue transplant recipient
- At least **three business days** before receiving any other services requiring Prior Authorization

Maternity Admissions
A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the care coordination process complies with all state and federal regulations regarding utilization review for maternity admissions. This Plan complies with the Newborns and Mothers Health Protection Act. The Plan will not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require Prior Authorization for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the Plan will only consider benefits for the actual length of the stay. The Plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48 or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Care Coordination is not a guarantee of payment of benefits
The Care Coordination process including the services provided by UMR Care Management is not a guarantee of payment and is not intended as authorization for services to be provided. All specific Plan exclusions and limitations will be applied at the time the claim is processed. Eligibility and benefit summary information is based upon the information currently available to UMR and is subject to change without notice.

Result of Not Following the Coordinated Process of Care
Failure to comply with the care coordination "process of care" may result in reduction or loss in benefits. The Penalties for Not Obtaining Prior Authorization section specifies applicable penalties. Charges you must pay due to any penalty for failure to follow the care coordination process do not count toward satisfying any Deductible, Coinsurance or out-of-pocket limits of the Plan.

Appeal of Care Coordination Determinations
Covered Persons have certain appeal rights regarding adverse determinations in the Care Coordination process, including

reduction of benefits and penalties. The appeal process is detailed in the Claims and Appeal Procedures section within this document.

It is important to refer to other sections of this document which defines terms, covered benefits, exclusions and other important information. If you need help locating information in the document, please contact a Care Coordinator and we would be happy to assist you.

Care Coordinators: 1-855-649-3855

Definition of Covered Health Services:
Covered Health Services – those health services, including services, supplies or pharmaceutical products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this section of the Flex Guide.
- Provided to a Covered Person who meets the Medical Care Program's eligibility requirements. (See "Eligibility and Effective Date of Coverage" section on Page 13 of this Flex Guide.)
- Not otherwise excluded by the Medical Care Program.

MEDICAL AND MENTAL HEALTH COVERED HEALTH SERVICES

This section generally describes the Covered Health Services and limits that may apply to the benefits provided by the UHC Medical Options which are administered by Quantum Health and UMR. To obtain information about a specific medical service or supply, call Quantum Health at (855) 649-3855.

This Medical Care Program does not claim to cover all medical expenses that you may incur. To be covered by the Medical Care Program, the Claims Administrator must determine that the services and supplies are Medically Necessary and given for the diagnosis or treatment of an accidental injury or illness. (See, "Medical Claims & Appeals" beginning on page 124, which explains the types of claims for which either Quantum Health or UMR serves as the "Claims Administrator.") These requirements apply to the UHC Medical Options and whether or not you receive services or supplies from participating or non-participating providers.

Important: You and your Doctor decide which services and supplies are provided, but this Medical Care Program only pays for Covered Health Services which are deemed Medically Necessary as defined below and determined by the Claims Administrator.

Medically Necessary – for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons upon request by calling Quantum Health at (855) 649-3855.

COVERED HEALTH SERVICES

Benefits paid for the Covered Health Services shown in the chart below depend on the UHC Medical Option in which you are enrolled and on the In-Network status of the provider. What you pay and what the Medical Care Program pays is described in the "Schedule of Benefits" section starting on page 78.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Acupuncture	Acupuncture services provided in an office setting by a provider who is practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body: Doctor of Medicine, Doctor of Osteopathy, Chiropractor, or Acupuncturist. Limited to 20 visits per year.	Acupuncture services by a non-qualified provider or in excess of 20 visits per year.
Allergy Care	Testing in a Doctor's office and treatment (including injection administered by a Nurse).	
Ambulance Services	**Emergency Only:** Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. **Non-Emergency:** Local transportation by professional ambulance, other than air ambulance, to and from a medical facility. Longer distance transportation by ambulance or air ambulance, to the nearest medical facility qualified to give the required treatment where Medically Necessary. Air ambulance transport is covered in the following circumstances: Patient requires transport to a Hospital or from one Hospital to another because the first Hospital does not have the required services and/or facilities to treat the patient, and ground ambulance transportation is not Medically Necessary because of the distance involved, or because the patient has an unstable condition requiring medical supervision and rapid transport.	Air ambulance benefits in excess of a $25,000 maximum per occurrence will not be paid.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Anesthesia	Anesthesia and related services provided in connection with a covered surgical procedure. Dental anesthesia fees and related facility fees at outpatient hospital, inpatient hospital or ambulatory surgical center for the following: • Children under the age of 8, or • Developmentally disabled (any age) – the patient's physician will determine whether the patient qualifies as developmentally disabled.	For dental anesthesia services, no coverage for dentist professional fees.
Audiologists	Charges by a licensed or certified audiologist for Doctor prescribed hearing evaluations to determine the location of a disease within the auditory system; for validation or organicity tests to confirm an organic hearing problem.	Charges for services relating to prescription hearing aids or basic hearing evaluations.
Breast Pumps	Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following: • Which pump is the most cost effective; • Whether the pump should be purchased or rented; • Duration of a rental; and • Timing of an acquisition. Benefits are only available if breast pumps are obtained from a DME provider or Physician.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Breast Reconstruction	Breast reconstruction required as a result of a mastectomy. Special Notice Regarding Mastectomies: If you or your Dependent receives a mastectomy, the covered benefits for the patient also include coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed, 2) surgery and reconstruction of the other breast to produce a symmetrical appearance, 3) prostheses including mastectomy bras and lymphedema stockings for the arm, 4) treatment of physical complications in all stages of mastectomy, including lymphedemas, 5) replacement of an existing breast implant if the initial breast implant followed mastectomy, and 6) other services required by the Women's Health and Cancer Rights Act of 1998, including breast treatment of complications. Benefits payable will be determined in a manner in consultation with the attending Doctor and patient. Such coverage is subject to annual Deductibles, Coinsurance, and other provisions that are applicable to other benefits of the UHC Medical Options.	Breast Reconstruction, other than in conjunction with a mastectomy, that does not meet the criteria established through the Prior Authorization process.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Breast Reduction	Breast reduction surgery is a Covered Service with documentation of the following functional impairments: • Shoulder grooving or excoriation resulting from the brassiere shoulder straps, due to the weight of the breasts; AND • Documentation from medical records of medical services related to complaints of the shoulder, neck or back pain attributable to macromastia. In addition, the surgery must be determined not to be cosmetic by the Claims Administrator. Breast reduction surgery is covered when a reconstruction has been performed on the other breast (see Special Notice Regarding Mastectomies, above).	Breast reduction surgery is NOT a Covered Health Service when performed to improve appearance or for the purpose of improving athletic performance.
Cardiac and Pulmonary Rehabilitation Services	Services must be performed by a licensed therapy provider under the direction of a Doctor. Benefits are available only for the rehabilitation services that are expected to result in significant physical improvement in the patient's condition within 2 months of the start of treatment. The primary intent is to improve the functional capacity of the heart and/or lungs and provide the necessary skills for self-monitoring of unsupervised exercise. Limited to 36 visits per year. Additional visits beyond the 36 visit limit may be available if Medically Necessary.	Memberships to health clubs or equipment to use at home are not covered. The Medical Care Program excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
Chiropractic Care/Spinal Manipulation	Services of a spinal treatment specialist in the specialist's office for chiropractic and osteopathic manipulative therapy, including diagnosis and related treatment. Limited to 30 visits per Calendar Year.	Massage therapy is NOT covered. The Medical Care Program excludes treatment that ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**

Clinical Trials	Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:
	• cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
	• cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as the Claims Administrator determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below;
	• surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as the Claims Administrator determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below; and
	• other diseases or disorders which are not life threatening for which, as the Claims Administrator determines, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.
	Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.
	Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.
	Routine patient care costs for qualifying Clinical Trials include:
	• Covered Health Services for which Benefits are typically provided absent a Clinical Trial; Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications; and
	• Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.
	With respect to cancer or other life- threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition
		Routine costs for Clinical Trials do not include:
		• the Experimental or Investigational Service(s) or item. The only exceptions to this are:
		  • certain Category B devices;
		  • certain promising interventions for patients with terminal illnesses; and
		  • other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies;
		• items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
		• a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
		• items and services provided by the research sponsors free of charge for any person enrolled in the trial.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Clinical Trials (Continued)	and which meets any of the following criteria in the bulleted list below. With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below. • Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: — *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*); — *Centers for Disease Control and Prevention (CDC)*; — *Agency for Healthcare Research and Quality (AHRQ)*; — *Centers for Medicare and Medicaid Services (CMS)*; — a cooperative group or center of any of the entities described above or the *Department of Defense* (*DOD)* or the *Veterans Administration (VA)*; — a qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Clinical Trials (cont.)	— The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria: • comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and • ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. • The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*; • the study or investigation is a drug trial that is exempt from having such an investigational new drug a*pplication;* • *the Clinical Trial mus*t have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial; or • the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Medical Care Program.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Cochlear Implant	Covered if diagnosis of severe to profound bilateral sensorineural hearing loss and severely difficult speech discrimination, or post-lingual sensorineural deafness in an adult.	
Congenital Heart Disease Surgery	See Surgery	
Cosmetic Services	The following cosmetic procedures are covered, provided the procedure has been determined to be reconstructive rather than cosmetic: • Correction of a congenital anomaly. • Repair, following accidental injury or sickness. • Reconstructive Surgery (See Surgery)	Cosmetic services that do not meet the criteria listed will not be covered.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Dental Services	The following services and supplies are covered only if needed because of accidental injury to natural teeth: • Oral surgery • Full or partial dentures • Fixed bridgework • Prompt repair to natural teeth • Crowns • Required anesthesia to perform covered dental services Accident/injury must have occurred while coverage is in effect. Dental treatment is covered only if needed because of accidental injury to natural teeth. Services must be: • Provided by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). • As a result of damage that is severe enough that the initial contact with the Doctor or Dentist occurred within 72 hours of the accident. Benefits are available only for treatment of sound, natural teeth. The Dentist must certify that the injury to the tooth was a virgin or unrestored tooth; has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally during chewing and speech. Services for final treatment to repair the damage must be completed within 12 months of the accident.	Dental services that are not a result of an accident. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of teeth.
Diabetic Supplies	Diabetic supplies including syringes, test strips and lancets are covered under the Pharmacy Program (beginning on page 139). Insulin pump and Glucose Monitors are covered under Durable Medical Equipment.	
Dialysis	See Therapeutics - Outpatient	
Disposable Medical Supplies	Must be prescribed by Doctor, including ostomy supplies.	Non-prescribed supplies.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Doctor Services	Medical care and treatment by a Doctor including Hospital, office and home visits, and emergency room services. Covered Health Services received in a Doctor's office including: • Treatment of a sickness or injury. Preventive medical care. • Voluntary family planning. • Well-baby and well-child care. • Routine well woman examinations, including pap smears, pelvic examinations, and mammograms. • Routine physical examinations, including hearing screenings. • Immunizations.	
Durable Medical Equipment (including durable Diabetes Equipment)	Durable Medical Equipment that meets each of the following criteria: 1) Ordered or provided by a Doctor for outpatient use; 2) Used for medical purposes 3) Not consumable or disposable; and 4) Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet the patient's functional needs, DME benefits are available only for the most cost-effective piece of equipment. Examples include: • Equipment to assist mobility such as wheelchairs and Hospital-type beds, oxygen concentrator units and the purchase or rental of equipment to administer oxygen (including tubing and connectors). • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure is covered. • Burn garments • Insulin pumps • Cranial banding. Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that treat curvature of the spine are covered under the DME benefit. The Medical Care Program also covers tubings, nasal cannulas, connectors and masks used in connection with DME.	A brace that straightens or changes the shape of the body part is an orthotic device and is not covered under the DME benefit, except for cranial banding. Dental braces are also excluded from coverage. Air conditioners, humidifiers, dehumidifiers, air purifiers, and filters are not covered. Tanning beds are not covered. Hearing aids, fittings, and replacement hearing aids are not covered**.** All rentals or purchases of any DME expense over $1,500 is subject to the Prior Authorization requirements**.**

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Emergency Health Services (i.e. Emergency Room)	A true Emergency is paid at the In-Network level regardless of the network status of the facility that provides the Emergency health services. A true Emergency is defined as a serious medical condition or symptom resulting from injury, sickness or mental illness which arises suddenly, and in the judgment of a reasonable person requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health. Notification should be provided to a Quantum Health Care Coordinator within 24 hours of the first business day after receiving Emergency care and a subsequent and corresponding Hospital admittance.	
Enteral Nutrition	Defined as the delivery of nutrients in liquid form directly into the stomach, duodenum, or jejunum and used when the patient's condition precludes oral intake. Enteral nutrition is covered when it is the sole source of nutrition or when a certain nutritional formula treats inborn error of metabolism.	
Family Planning	See Reproductive Services.	
Gender Dysphoria	Non-surgical treatment: See Mental Health Benefits (page 98). Laboratory testing to monitor the safety of continuous hormone therapy. Hormone replacement therapy covered under the Pharmacy Program. Surgical treatment: See Surgery (page 107).	• Sperm preservation in advance of hormone treatment or gender surgery • Cryopreservation of fertilized embryos • Treatment received outside of the United States
Hearing Care	Hearing screenings as part of a routine preventive office visit are covered under the Preventive Services Benefit.	Hearing aids, fittings, and replacement hearing aids are not covered.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Home Healthcare	Services received from a home health agency that are both ordered by a Doctor and provided by or supervised by a registered Nurse in your home. Benefits are available only when the home health agency services are provided on a part-time, intermittent schedule and when skilled home healthcare is required. Skilled home healthcare is skilled nursing, skilled teaching, and skilled rehabilitation services when the care: 1) Is administered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; 2) Is ordered by the Doctor; 3) Is not delivered for the purpose of assisting with the activities of daily living; 4) Requires clinical training in order to be delivered safely and effectively; and 5) Is not custodial care. The Claims Administrator will decide if skilled home healthcare is required by reviewing both the skilled nature of the service and the need for Doctor-directed medical management. Limited to any combination of 40 In-Network and Out-of-Network visits per Calendar Year.	Custodial care or care for the purpose of assisting with the activities of daily living, including (but not limited to) dressing, feeding, bathing, or transferring from a bed to a chair, are not covered. A service will not be determined to be "skilled" simply because there is not an available caregiver.
Hospice Care	Hospice care that is recommended by a Doctor. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and for short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. The following Hospice care benefits are covered: • Room and board charges in a hospice facility, except for charges that exceed the Hospital's most common semi-private room rate for any day you are Hospital confined or charges that exceed the hospice facility's most common semi-private room rate for any day you are confined in a freestanding hospice facility.	Volunteer services or services normally provided at no charge. Private duty nursing. Legal or financial advice. Counseling by clergy or any volunteer group not specifically rendered by and charged for by the hospice. Services provided by a person who lives in your home or who is a member of your immediate family.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Hospice Care (Continued)	A hospice facility must offer a hospice program that is approved by the Claims Administrator and must either be a Hospital, a freestanding hospice facility that provides inpatient care, or an organization that provides healthcare services in your home. The facility can provide these services using its own staff or by contracting with other organizations; • Skilled nursing or home health aide services provided by a Nurse or a licensed practical Nurse; • Counseling to enhance your peace of mind if your Doctor determines that your mental state is caused by your terminal illness. Such counseling is also covered for members of your family for up to 6 months after your death; • Up to 7 visits of respite care when part of an integrated hospice program; • Physical, respiratory, or speech therapy; Services of a licensed nutritionist or dietician if needed as part of your hospice care; • Local ambulance or special transport service between your home and the hospice facility; and • Other services which your Doctor, The Claims Administrator determine to be Medically Necessary and which are provided through the hospice program, such as medical supplies, medicines, drugs, Doctor's services, and the rental or purchase of durable medical equipment, whichever is less expensive.	
Hospital – Inpatient Stay	Benefits available for services and supplies (including room and board) received during the inpatient stay in a semi- private room (two or more beds). Private rooms are covered up to the highest semi- private room rate for that facility, except that the extra costs of a private room can be covered: • When the Hospital is an all private room Hospital; • When the Hospital's semi-private rooms are filled and only a private room is available; or • When a private room must be used to keep the patient isolated because of the patient's diagnosis.	Charges over and above the highest semi- private room rate are not covered, except as noted in the adjacent covered benefits paragraph.
Infertility	See Reproductive Services.	
Infertility – Assisted Reproductive Technology	See Reproductive Services.	
Inpatient Prescription Drugs	See Prescribed Drugs and Medicines within this Covered Health Services chart, below.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Laboratory Services	Laboratory tests for diagnosis or treatment are covered expenses.	
Maternity Care	See Reproductive Services.	
Medical Supplies	Surgical supplies (such as bandages and dressings). Supplies provided during surgery or a diagnostic procedure is included in the overall cost for that surgery or diagnostic procedure. Blood or blood derivatives only if not donated or replaced. Ostomy supplies.	
Mental Health Services	Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits for Mental Health Services include: • mental health evaluations and assessment; • diagnosis; • treatment planning; • referral services; • medication management; • inpatient services; • Partial Hospitalization/Day Treatment; • Intensive Outpatient Treatment; • services at a Residential Treatment facility; • individual, family and group therapeutic services; • crisis intervention; and • psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses. • eating disorders The Claims Administrator will determine if an inpatient stay is Medically Necessary. If an inpatient stay is required, it is covered on a Semi-private Room basis; except: • When the Hospital is an all private room Hospital; • When the Hospital's semi-private rooms are filled and only a private room is available; or	• Personality disorders • Behavior and impulse control disorders • "Z" codes (please call Quantum Health for further explanation) In addition, wilderness therapy (including Outward bound wilderness camping, tall ship programs and other similar activities) is excluded under the Medical Care Program as it is Unproven and not Medically Necessary for the treatment of emotional, addiction, and/or psychological problems including, but not limited to: • Adjustment disorders • Mood disorders • Anxiety disorders • Conduct disorders • Impulse disorders • Social functioning disorders • Substance related disorders; and • Attention-deficit hyperactivity disorder

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Mental Health Services (Continued)	You are encouraged to contact Quantum Health for referrals to providers and coordination of care. Mental Health and Substance-Related and Addictive Disorders Treatment services and supplies are subject to Deductibles and Coinsurance as presented in the "Schedule of Benefits" (starting on page 78).	
Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders	The Medical Care Program pays benefits for psychiatric services for Autism Spectrum Disorders that are both of the following: • Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and • Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning. These benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which benefits are available under the applicable medical Covered Health Services categories as described in this section. Benefits include: • diagnostic evaluations and assessment; treatment planning; • referral services; medical management; • inpatient/24-hour supervisory care; • Partial Hospitalization/Day Treatment; • Intensive Outpatient Treatment; • Services at a Residential Treatment Facility; • Individual, family, therapeutic group and provider-based case management services; • Applied behavioral analysis (ABA) • Psychotherapy, consultation and training session for parents and paraprofessional and resource support to family; and • crisis intervention.	• Personality disorders • Behavior and impulse control disorders • "Z" codes (please call Quantum Health for further explanation) In addition, wilderness therapy (including Outward bound wilderness camping, tall ship programs and other similar activities) is excluded under the Medical Care Program as it is Unproven and not Medically Necessary for the treatment of emotional, addiction, and/or psychological problems including, but not limited to: • Adjustment disorders • Mood disorders • Anxiety disorders • Conduct disorders • Impulse disorders • Social functioning disorders • Substance related disorders; and • Attention-deficit hyperactivity disorder

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders (Continued)	Covered Health Services include enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA)). You are encouraged to contact Quantum Health for referrals to providers and coordination of care. Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorder services and supplies are subject to Deductibles and Coinsurance as presented in the Schedule of Benefits (starting on page 78).	
Nutritional Counseling	Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus, • Coronary artery disease, • Congestive heart failure, • Severe obstructive airway disease, • Gout, • Renal failure, • Phenylketonuria,and • Hyperlipidemias. When nutritional counseling services are billed as a preventive care service, these services will be paid as described under Preventive Care.	Nutritional counseling for: • Weight loss/obesity; • Conditions which have not been shown to be nutritionally related, including (but not limited to) chronic fatigue syndrome; and • hyperactivity. Benefits are limited to three individual sessions during a Covered Person's participation in the Medical Care Program. This limit applies to non-preventive nutritional counseling services only.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Obesity Surgery	See Surgery.	
Organ/Tissue Transplants	Services and supplies for organ or tissue transplants are covered subject to the following limitations. **Donor Charges for Organ/Tissue Transplants:** Donor charges are considered covered expenses ONLY if the recipient is a Covered Person under the Medical Care Program. If the recipient is not a Covered Person, no benefits are payable for donor charges. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service unless the search is made in connection with a transplant procedure arranged by a designated transplant facility. (See **Transplant Management Program** for additional covered benefits for certain qualified transplant procedures, page 118).	
Orthognathic Surgery	See Surgery.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Outpatient Therapy	Short-term outpatient rehabilitation services (including habilitative services) limited to 30 visits per year for the combination of: • Physical Therapy, • Occupational therapy, and • Speech therapy. Rehabilitation services must be provided by a licensed therapy provider, under the direction of a Doctor when required by state law. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. The therapy must be ordered and monitored by a Doctor as part of a Medically Necessary course of treatment for a bodily injury or disease. The therapy must be provided in accordance with a written treatment plan approved by a Doctor. **Speech Therapy.** Benefits for Speech Therapy are available only when the speech impediment or speech dysfunction results from injury, stroke, a congenital anomaly, or if such therapy is considered "habilitative services." Habilitative services are healthcare services that help a Covered Person keep, learn or improve skills and functioning for daily living. Additional visits beyond the 30 visit limit may be available if Medically Necessary.	The Medical Care Program excludes any type of therapy, service, or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Vocational rehabilitation is not covered.
Physical Therapy	See Outpatient Therapy.	
Prescribed Drugs and Medicines	Prescribed drugs and medicines for inpatient services are covered under the medical plan provisions.	
Preventive Care	See Preventive Care under "Health Management Programs" on page 117.	
Prosthetic Devices	Benefits are paid by the Medical Care Program for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to: • Artificial limbs, and • Artificial eyes. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The device must be ordered or provided either by a Doctor, or under a Doctor's direction.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Pulmonary Rehabilitation	See Cardiac and Pulmonary Rehabilitation Therapy.	
RAPL (Radiology, Anesthesiology, Pathology and Lab)	Services performed by radiologists, anesthesiologists, pathologists, and laboratory.	
Reconstructive Surgery	See Surgery.	
Reproductive Services	**Family Planning:** Norplant, diaphragms, IUDs and Depo-Provera are covered under the medical plan provisions. When reproductive services are billed as a preventive care service, these services will be paid as described under Preventive Care.	Oral contraceptives are not covered under this medical program but are covered under the Pharmacy Program (see page 139).
	Infertility: Assisted reproductive technology treatments, including (but not limited to) artificial insemination, GIFT, ZIFT, or in vitro fertilization, are covered expenses. This includes confinement in a Hospital or specialized facility in connection with infertility treatments. Covered infertility treatment services include the following: • In vitro fertilization, • Artifical insemination, • The use of donor ovum and donor sperm related costs, including collection and preparation, • Embryo transfer, • Gamete intrafallopian transfer, • Zygote intrafallopian transfer, • Tubal ovum transfer, • Surgery, and • Injectable-drug-therapy administered within the Doctors office.	Injectable drug therapy that is self-administered is not covered under this medical program but is covered under the Pharmacy Program. (See "Pharmacy") The Medical Care Program will not pay for the cost of donor sperm or egg or any related donor fees.
	Maternity Care: Benefits for pregnancy will be paid at the same level as benefits for any other condition, sickness or injury, unless the services are considered to be preventive services, which are payable at 100% of In-Network covered expenses. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Reproductive Services (Continued)	**Maternity Care:** The Medical Care Program will pay benefits for an inpatient stay for the birth of a child of at least 48 hours for the mother and newborn child following a normal vaginal delivery and 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. For inpatient care (for either the mother or child) which continues beyond the 48/96 hour limits, Prior Authorization must be received as soon as possible.	
	Sterilization: Covered Health Services include vasectomy and tubal ligation.	Reversals are not covered.
Second/Third Opinions	See Surgery.	
Skilled Nursing Facility/ Inpatient Rehabilitation Facility	Skilled Nursing Facility/Inpatient Rehabilitation Facility benefits are payable for room and board charges for up to 45 days of confinement in a Skilled Nursing Facility/Inpatient Rehabilitation Facility if the charges are incurred while you are confined in the Facility and while coverage is in effect. Such confinement must be due to an injury or illness covered by the Medical Care Program.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Skilled Nursing Facility/ Inpatient Rehabilitation Facility (Continued)	The stay must: 1. Be for convalescent care; 2. Start immediately after the end of a Hospital stay that lasted at least 5 days and for which benefits are payable under the Medical Care Program; and 3. Be for the same or related conditions as the Hospital stay.	
Sleep Disorders	See Surgery for sleep apnea surgery. See Laboratory Services for sleep studies.	
Speech Therapy	See Outpatient Therapy.	
Sterilization	See Reproductive Services.	
Substance-Related and Addictive Disorders Treatment Services	Substance-Related and Addictive Disorders Treatment Services include those received on an Inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits for Substance-Related and Addictive Disorders Treatment Services include: • Substance-Related and Addictive Disorders Treatment or chemical dependency evaluations and assessment; • diagnosis; • treatment planning; • detoxification (sub-acute/non-medical); • inpatient services; • Partial Hospitalization/Day Treatment; • Intensive Outpatient Treatment; • services at a Residential Treatment Facility; • referral services; • medication management; • crisis intervention; and • individual, family and group therapeutic services.	Wilderness therapy(including Outward bound wilderness camping, tall ship programs and other similar activities) is excluded under the Medical Care Program as it is Unproven and not Medically Necessary for the treatment of emotional, addiction, and/or psychological problems including, but not limited to: • Adjustment disorders • Mood disorders • Anxiety disorders • Conduct disorders • Impulse disorders • Social functioning disorders • Substance related disorders; and • Attention-deficit hyperactivity disorder

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Substance-Related and Addictive Disorders Treatment Services (Continued)	The Claims Administrator will determine whether an inpatient stay is Medically Necessary. If an inpatient stay is required, it is covered on a Semi-private Room basis; except: • When the Hospital is an all private room Hospital; • When the Hospital's semi-private rooms are filled and only a private room is available; or • When a private room must be used to keep the patient isolated because of the patient's diagnosis. You are encouraged to contact Quantum Health for referrals to providers and coordination of care. Substance-Related and Addictive Disorders services and supplies are subject to Deductibles and Coinsurance as presented in the "Schedule of Benefits (page 78).	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility)	Professional fees for surgical procedures and other medical care related to the surgical procedure received from a Doctor in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, outpatient surgery facility, or birthing center, or via a Doctor house call. Benefits include the facility charge and the charge for required services, supplies, and equipment.	
	Reconstructive Surgery: Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following: • Birth defect, • Sickness, • Surgery to treat a sickness or accidental injury, • Accidental injury, • Reconstructive breast surgery following a mastectomy, and • Reconstructive surgery to remove scar tissue on the neck, face or head if the scar tissue is due to sickness or accidental injury. Note: Replacement of an existing breast implant is a covered expense if the initial breast implant followed mastectomy. **Special Notice Regarding Mastectomies:** If you or your Dependent receives a mastectomy, the covered benefits for the patient will also include coverage for the following, in a manner determined in consultation with the attending Doctor and the patient: • All stages of reconstruction of the breast on which the mastectomy has been performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; • prostheses including mastectomy bras and lymphedema stockings for the arm; • treatment of physical complications in all stages of mastectomy, including lymphedemas; • replacement of an existing breast implant if the initial breast implant followed mastectomy, and • other services required by the Women's Health and Cancer Rights Act of 1998, including breast treatment of complications. Such coverage is subject to annual Deductibles, Coinsurance, and other provisions applicable to the other benefits of the UHC Medical Options.	Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (Continued)	**Assistant Surgeon Services:** Covered expenses for assistant surgeon services are limited to one-fifth (20%) of the amount of covered expenses for the surgeon's charge for the surgery. An assistant surgeon must be a Doctor.	
	Second Surgical Opinion Program: This voluntary program applies when a Doctor recommends that you or a covered Dependent undergo any elective or non- Emergency surgical procedure. You may voluntarily obtain a second surgical opinion for any non-Emergency surgical procedure. The purpose of the second surgical opinion is advisory only. It is the patient's decision whether or not to undergo the surgery. Benefits for the Second Surgical Opinion are subject to the cost sharing features of the Medical Care Program, such as Deductible and Coinsurance. Benefits will be payable for a third opinion on the same basis as benefits for the second opinion. The Doctor who gives the second opinion must: 1) Be qualified to render an opinion on the specific surgical procedure in question, and 2) Examine you in person.	The following are not covered by the Second Surgical Opinion Program: • An opinion on a surgical procedure that would not be covered under the UHC Medical Options; • Any charges in connection with a surgical procedure, if they are payable under other provisions of the UHC Medical Options; and • Surgery that is then performed by the same Doctor who rendered the second surgical opinion. More than two opinions per surgical procedure after the initial recommendation for surgery.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (Continued)	**Obesity Surgery:** Surgical treatment for severe/morbid obesity, as defined by NIH (National Institutes on Health) must meet the following: • Severe Obesity: BMI of 35-40 with co-morbidities; or • Morbid Obesity: BMI of 40 or greater. In addition, the patient's medical history must demonstrate that dietary attempts at weight control have been ineffective, and that there is no specifically correctable cause for obesity (e.g., an endocrine disorder).	Non-surgical treatment of obesity, including morbid obesity, is not covered. **Note:** Abdominoplasty and panniculectomy are not covered, even when recommended as a result of approved obesity surgery services.

	Orthognathic surgery is covered in the following situations:
	• A jaw deformity resulting from facial trauma or cancer; or
	• A skeletal anomaly of either the maxilla or mandible that demonstrates a functional medical impairment such as one of the following:
	  • Inability to incise solid foods; or choking on incompletely masticated solid foods;
	  • Damage to soft tissue during mastication;
	  • Speech impediment determined to be due to the jaw deformity; or
	  • Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.
	• Orthognathic surgery, jaw alignment, and treatment for the Temporo Mandibular Joint as a treatment of obstructive sleep apnea.
		Orthognathic surgery is not covered for the following symptoms:
		• Myofacial, neck, head and shoulder pain,
		• Irritation of head/neck muscles,
		• Popping/clicking of Temporo Mandibular Joint(s),
		• Potential for development or exacerbation of Temporo Mandibular Joint dysfunction,
		• Teeth grinding, and
		• Treatment of malocclusion.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (Continued)	**Gender Dysphoria Surgery:** The Medical Care Program covers genital surgery and surgery to change secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty) and related services when the following eligibility qualifications for surgery are met: • The treatment plan must conform to identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance; • For irreversible surgical interventions, the Covered Person must be age 18 years or older; and • Prior to surgery, the covered person must complete 12 months of successful continuous full time real life experience in the desired gender. Important: Certain Covered Persons will be required to complete continuous hormone therapy prior to surgery. In consultation with the covered person's Physician, this will be determined on a case-by-case basis through the Prior Authorization process. • Augmentation mammoplasty is allowed if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role. The Claims Administrator has specific guidelines regarding Benefits for treatment of Gender Dysphoria (Gender Identity Disorder). Contact Quantum Health at (855) 649-3855for information about these guidelines.	Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics. Voice modification surgery. Facial feminization surgery, including, but not limited to: facial bone reduction, face "lift," facial hair removal, and certain facial plastic procedures.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Therapeutics – Outpatient	Covered Health Services includes therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including: • dialysis (both hemodialysis and peritoneal dialysis), • intravenous chemotherapy, • intravenous infusion, • radiation oncology, • intensity modulated radiation therapy, and • MR-guided focused ultrasound. Benefits include the charges for the facility, related supplies and equipment, and physician services for anesthesiologists, pathologists and radiologists. Covered Health Services also include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when: • Education is required for a disease in which patient self-management is an important component of treatment, and • There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional. Note - dialysis is subject to coordination with Medicare for End Stage Renal Disease.	
Transplants	See Organ/Tissue Transplants.	

ADDITIONAL EXCLUSIONS

The UHC Medical Options do not cover any expenses incurred for services, treatments, items or supplies described in this section, even if either or both of the following are true:

- Such service, treatment, item or supply is recommended or prescribed by a Doctor.
- It is the only available treatment for your condition.

The services, treatments, items, or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in the "Covered Health Services" section beginning on page 85 of this document. Note also the exclusions stated in the "Covered Health Services" section under the column headed "What's Not Covered."

Additional Exclusions	
Type of Service	**What's Not Covered**
Alternative Treatments	• Acupressure, • Aromatherapy, • Hypnotism, • Massage therapy, • Rolfing, and • Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
Comfort or Convenience	• Television; • Telephone; • Beauty/barber service; • Guest service; • Supplies, equipment, and similar incidental services and supplies for personal comfort (i.e., air conditioners, air purifiers and filters, batteries and battery charges, dehumidifiers, humidifiers); • Devices and computers to assist in communication and speech; and • Home remodeling to accommodate a health need, such as (but not limited to) ramps and swimming pools.
Cosmetic Services	• All cosmetic services, except those described under "Covered Health Services" (see page 92)
Dental under the Medical Plans	• Dental care, except as described under "Covered Health Services" (see page 93); • Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums (i.e., extraction, restoration and replacement of teeth, medical or surgical treatments of dental conditions, services to improve dental clinical outcomes); • Dental implants; • Dental braces; • Dental x-rays, supplies and appliances, and all associated expenses, including Hospitalizations and anesthesia. The only exceptions to this are for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic injury, cancer, or cleft palate; in which case, the treatment and required anesthesia to perform the treatment are Covered Health Services; and • Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
Drugs under the Medical Plans	• Prescription drug products for outpatient use that are filled by a prescription order or refill, • Self-injectable medications, • Non-injectable medications provided in a Doctor's office, except as required in an Emergency, • Over-the-counter drugs and treatments, and • Coordination of Benefits as a secondary payment for Prescription Drugs purchased through a non-Union Pacific Health Plan.

Additional Exclusions	
Type of Service	**What's Not Covered**
Experimental, Investigational, or Unproven Services	Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following: • not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; • subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.); or • the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight. Exceptions: • Clinical Trials for which benefits are available as described in the *Covered Health Services* section or • If you are not a participant in a qualifying Clinical Trial as described in the *Covered Health Services* section, and have a sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.
Foot Care	• Except when needed for severe systemic disease, routine foot care (including the cutting or removal of corns and calluses) and nail trimming, cutting, or debriding; • Hygienic and preventive maintenance foot care (i.e., cleaning and soaking the feet, applying skin creams in order to maintain skin tone, other services that are performed when there is not a localized illness, injury or symptom involving the foot); • Treatment of flat feet; • Treatment of sublaxation of the foot; • Shoe orthotics; • Shoes (standard or custom), lifts and wedges; • Shoe inserts; and • Arch supports.

Additional Exclusions	
Type of Service	**What's Not Covered**
Mental Health, Neurobiological Disorders, Autism Spectrum Disorder and Substance-Related and Addictive Disorders Treatment Services	• Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; • Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; • Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder; • Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; • Services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act (or tuition for such services); • Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; • Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. • Transitional Living services
Nutrition	Megavitamin and nutrition based therapy. Except as described under "Covered Health Services" on page 95, enteral feedings and other nutritional and electrolyte supplements (including infant formula and donor breast milk – infant formula available over the counter is always excluded), dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat/cholesterol), oral vitamins, and oral minerals except when the sole source of nutrition. Note: Limited nutritional counseling services are covered as described under "Covered Health Services" on page 100.
Physical Appearance	Cosmetic procedures including, but not limited to: • Pharmacological regimens, nutritional procedures, or treatments; • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures); • Skin abrasion procedures performed as a treatment for acne; • Physical conditioning program (such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation); • Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded; and • Wigs regardless of the reason for the hair loss, except for loss of hair resulting from treatment of a malignancy, hair loss due to alopecia or similar conditions, or permanent loss of hair from an accidental injury.

Additional Exclusions	
Type of Service	**What's Not Covered**

Providers	• Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Doctor or other provider. Services which are self-directed to a freestanding or Hospital-based diagnostic facility. Services (excluding mammography testing) ordered by a Doctor or other provider who is an employee or representative of a free-standing or Hospital- based diagnostic facility, when that Doctor or other provider:
	  • Has not been actively involved in your medical care prior to ordering the service, or
	  • Is not actively involved in your medical care after the service is received.
	• Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child. This includes any service the provider may perform on himself or herself.
	• Services performed by a provider with your same legal residence.
	• Services of a provider or facility beyond the scope of their medical license.

Services provided under Another Plan	Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes (but is not limited to) coverage required by Workers' Compensation, no-fault auto insurance, or similar legislation. If coverage under Workers' Compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness, or mental illness that would have been covered under Worker's Compensation or similar legislation had that coverage been elected. (Note: Medical services, that are Covered Health Services, provided to treat an on-duty injury, where the company is not at fault and no FELA claim will be filed, will be allowed to be paid by the Medical Care Program.) • Health services for treatment of military service related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you. • Health services while on active military duty.
Transplants	• Health services for organ and tissue transplants, except those described under the "Transplant Management Program" section on page 118 of this document. • Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (donor costs for removal are not a Covered Health Service under the Medical Care Program.) • Health services for transplants involving mechanical or animal organs. • Any solid organ transplant that is performed as a treatment for cancer. • Any multiple organ transplants not listed as a Covered Health Service.
Travel	• Health services provided in a foreign country unless required as Emergency health services. • Travel or transportation expenses even though prescribed by a Doctor. Some travel expenses related to covered transplantation services or cancer treatment related services may be reimbursed as described in the "Transplant Management Program" section page 118 of this document.
Vision and Hearing	• Purchase cost of eyeglasses, contact lenses, or hearing aids. (See "Vision Care Program" on page 163 for a description of the vision plan). • Fitting charge for hearing aids, eyeglasses, or contact lenses. • Surgery that is intended to allow you to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, radial keratotomy, laser, and other refractive eye surgery.

Additional Exclusions	
Type of Service	**What's Not Covered**
All Other Exclusions	• Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing; • Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply, or equipment; • Any charges for services, supplies, or equipment advertised by the provider as free; • Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency; • Any charges prohibited by federal anti-kickback or self-referral statutes; • Any charges by a resident in a teaching Hospital where a faculty Doctor did not supervise services; • Any additional charges submitted after payment has been made and your account balance is zero; • Any outpatient facility charge in excess of payable amounts under Medicare. • Appliances for snoring; • Breast reduction surgery, except as described under "Covered Health Services" on page 88; • Charges in excess of eligible expenses or in excess of any specified limitation; • Custodial care or care for the purpose of assisting with the activities of daily living, including (but not limited to) dressing, feeding, bathing, or transferring from a bed to a chair, are not covered . • Domiciliary care; • Growth hormone therapy; • Health services and supplies that do not meet the definition of a Covered Health Service; • Health services received after the date your coverage under the Medical Care Program ends, including health services for medical conditions arising before the date your coverage under the Medical Care Program ends; • Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Medical Care Program; • Health services provided by an Out-of-Network provider for which the annual Deductible and/or Coinsurance are waived; • Health services related to a non-Covered Health Service. When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Medical Care Program would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease or condition and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a cosmetic procedure, that require hospitalization; • Private Duty Nursing; • Non-prescribed disposable medical supplies; • Non-surgical treatment of obesity, including morbid obesity; • Orthognathic surgery, jaw alignment, and treatment for the Temporo Mandibular Joint, except what is described under "Orthognathic Surgery in the "Covered Services" section on page 101;

Additional Exclusions	
Type of Service	**What's Not Covered**

All Other Exclusions (Continued)	• Orthoptic therapy services for the treatment of convergence insufficiency or any other purpose;
	• Orthotic appliances that straighten or re-shape a body part, except as described under Durable Medical Equipment. Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter;
	• Outpatient rehabilitation services, spinal treatment, or supplies including (but not limited to) spinal manipulations by a chiropractor or other Doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring;
	• Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Medical Care Program when:
	  • Related to judicial or administrative proceedings or orders;
	  • Conducted for purposes of medical research; or
	  • Required to obtain or maintain a license of any type;
	• Psycho-surgery;
	• Respite care;
	• Rest cures;
	• Services or supplies received before you become covered under this Medical Care Program; and
	• Speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, a congenital anomaly, or if such therapy is considered "habilitative services." Habilitative services are healthcare services that help a Covered Person keep, learn or improve skills and functioning for daily living.

HEALTH MANAGEMENT PROGRAMS

In addition to the items discussed in the previous section, specific programs are offered to help you manage your health, including Preventive Care, Cancer Resource Services and Transplant Management. These programs are described in more detail in the following pages.

Preventive Care Benefits:
The Medical Care Program supports you and your Dependents in keeping healthy by offering preventive healthcare benefits. Benefits are payable for Covered Health Services for preventive healthcare benefits you receive while you are covered under this Medical Care Program if certain conditions are met.

If you use a Preferred Provider, preventive services described below are payable at 100% of covered expenses. No preventive healthcare benefit is available from an Out-of-Network Provider, unless there are no participating providers available. In that case, it is your responsibility to call Quantum Health to find an alternative Doctor and, if you have made prior arrangements with Quantum Health to use an alternative Doctor, preventive healthcare benefits are payable at 100% of the Reasonable and Customary Amount.

Preventive services are payable at 100% of covered expenses as described below if (a) the services are routine and consistent with the preventive care guidelines of UMR and (b) the services are coded as routine/preventive, rather than with a diagnostic code.

Benefits will be provided for Preventive Services required by the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended, which are defined as:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task force.
2. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration.

3. With respect to women, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration.
4. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Benefits for the Preventive Services outlined above will be paid at 100% in accordance with the Schedule of Benefits on Page 78.

A complete list of preventive services may be found at www.UPMyQHealth.com. You may obtain a copy of this list free of charge by contacting Quantum Health at (855) 649-3855.

Cancer Resource Services:
Quantum Health will arrange for access to certain In-Network providers participating in the Cancer Resource Services (CRS) Program offered under the UHC Medical Options for the provision of oncology services at a Designated Facility. Oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to oncology.

Transplant Management Program:
Access to a network of transplant centers is provided through UMR's Transplant Management Program. The Medical Care Program has specific guidelines regarding benefits for transplant services. Contact Quantum Health at at (855) 649-3855 about these guidelines.

Note: There is no charge for the referral service provided by Transplant Management Program; however, when obtaining services from the Provider to which you are referred, you will be subject to the charges billed by the Provider, in the same manner as any other In-Network Provider (Deductible and Coinsurance will apply.)

For all UHC Medical Options: If you are enrolled in a UHC Medical Option and a Qualified Procedure (listed below) is performed at an In-Network facility, the Covered Health Services provided in connection with the transplant procedure are covered at 85%, after Deductible. In addition, certain travel and accommodation expenses are covered as described below.

Qualified Procedures:
- Heart transplants.
- Lung transplants.
- Heart/Lung transplants.
- Liver transplants.
- Kidney transplants.
- Pancreas transplants.
- Kidney/Pancreas transplants.
- Liver/Kidney transplants.
- Intestinal transplants.
- Liver/Intestinal transplants.
- Bone Marrow (either from you or from a compatible donor) and Peripheral Stem Cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service – please see below.
- Cornea, when performed in a Hospital setting.

Donor costs that are directly related to organ removal are Covered Health Services for which benefits are payable through the organ recipient's coverage under the Medical Care Program.

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a Covered Health Service.

Transportation and Lodging: Quantum Health will assist the patient and family with travel and lodging arrangements when Covered Health Services are received at a designated facility. Expenses for travel and lodging for the transplant recipient and a companion are available under the UHC Medical Options as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or Medically Necessary post-discharge follow-up.
- Eligible expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people. Note: Expenses related to transportation of the patient are subject to the Deductible and Coinsurance amounts.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the designated facility.
- If the patient is a covered Dependent minor Child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $100 per diem rate.

Transplants Not Performed at a Designated Transplant Facility*:* A transplant procedure is not required to be performed at a UMR Designated Transplant Facility for coverage to apply. If a transplant procedure is Medically Necessary but not performed at a UMR Designated Transplant Facility, eligible expenses will be covered as would any other expense covered under the Medical Care Program, subject to In-Network and Out-of-Network Deductibles and Coinsurance. (Note: If a transplant procedure is performed in an Out-of-Network facility, the transportation and lodging provision will not apply.)

CONTACTING QUANTUM HEALTH FOR ASSISTANCE

Quantum Health's Care Coordinators can be reached at (855) 649-3855. Care Coordinators are available from 7:30 a.m. to 9:00 p.m. CT, Monday through Friday (excluding holidays).

UPMYQHEALTH.COM – QUANTUM HEALTH'S MEMBER WEBSITE

The Quantum Health member website, www.UPMyQHealth.com, is your online gateway to a broad range of tools and services.

To register:

- Go to www.UPMyQHealth.com
- Click the "Register" button.
- Enter the information requested.
- Once registered, an email confirmation will be sent to you to verify your account before you log-in for the first time.

The site can save you valuable time. Just a few clicks will take you directly to the information you need, such as:

- Confirm eligibility, specific benefits, Deductible, Coinsurance.
- Review claims status and claims history.
- View exact replicas of your Explanation of Benefits at any time.
- Find an In-Network Doctor or Hospital.
- Estimate Health Care Costs for treatments you are considering.
- Print a temporary Medical ID Card or order a replacement Medical ID Card.

MEDICAL CLAIMS & APPEALS

Internal Claim and Appeal Process:
This section provides information about how and when to file a UHC Medical Option claim for benefits, describes the 4 types of medical claims, and establishes which entity (either Quantum Health or UMR) has the discretionary authority to decide your claim or your appeal of a denied claim.

Union Pacific has delegated to Quantum Health or UMR discretionary decision-making authority with respect to certain types of UHC Medical Option claims and appeals, as set forth below. This means that with respect to the

type of claim or appeal for which Quantum Health or UMR has decision-making authority, Quantum Health or UMR, as applicable, has the exclusive and discretionary authority to find facts, and to interpret and administer the provisions of the Medical Care Program and determine benefits payable under the UHC Medical Options. Any findings, interpretation, or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the finding, interpretation, or determination was arbitrary and capricious. The decisions of Quantum Health or UMR are conclusive and binding, except to the extent a decision is eligible for review under the external review process described below. NOTE: In each section describing the process for deciding the particular type of claim or appeal, the entity with discretionary decision-making authority to decide such claim or appeal (Quantum Health or UMR, as applicable) is identified as the "Claims Administrator." However, regardless of which entity has authority and responsibility to decide your claim or appeal, all Plan benefits are paid through UMR.

Please note that the decisions of Quantum Health or UMR are based only on whether or not the services are Medically Necessary and benefits are available under the Medical Care Program for the proposed treatment, procedure, service or supply.

Decisions will be made in accordance with the terms of the Medical Care Program (including without limitation its provisions limiting benefits to services and supplies that are Medically Necessary), and any applicable internal practices or guidelines that are maintained by Quantum Health or UMR. Quantum Health or UMR also determines whether or not a proposed treatment, procedure, service or supply may be ineligible for benefits based on an applicable Medical Care Program exclusion, including the exclusions for Experimental or Investigational Services or Unproven Services.

Types of Claims and Claims Administrator:

***Post-Service Claims*:** A Post-Service claim is a claim filed for payment of benefits after medical care has been received.

UMR is the Claims Administrator of all Post-Service claims.

UMR is also the Claims Administrator of a requested internal appeal of a denied Post-Service claim if the claim is for medical care provided by an In-Network Provider **and** the appeal requires Clinical Review.

Quantum Health is the Claims Administrator of all other requested internal appeals of denied Post-Service claims.

***Pre-Service Claims*:** A Pre-Service claim is a claim that requires Prior Authorization before receiving medical care, but is not an Urgent Care claim.

UMR is the Claims Administrator of a Pre-Service claim if the claim is for medical care that will be provided by an In-Network Provider **and** the Pre-Service claim requires Clinical Review. UMR is also the Claims Administrator of a requested internal appeal of a denial of such Pre-Service claims.

Quantum Health is the Claims Administrator of all other Pre-Service claims and the requested internal appeal of a denial of such Pre-Service claims.

Urgent Care Claims: An Urgent Care claim is a claim that requires Prior Authorization before receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function, or (in the opinion of a Doctor with knowledge of your medical condition) could cause severe pain. Any claim that a Doctor with knowledge of your medical condition determines is an "Urgent Care claim" as defined herein will be treated as an Urgent Care claim.

UMR is the Claims Administrator of an Urgent Care claim if the claim is for medical care that will be provided by an In-Network Provider **and** the Urgent Care claim requires Clinical Review. UMR is also the Claims Administrator of a requested internal appeal of a denial of such Urgent Care claims.

Quantum Health is the Claims Administrator of all other Urgent Care claims and the requested internal appeal of a denial of such Urgent Care claims.

***Concurrent Care Claims*:** A Concurrent Care claim is a claim to extend an on-going course of treatment that was previously approved for a specific period of time or number of treatments.

UMR is the Claims Administrator of a Concurrent Care claim if the claim is for medical care that will be provided by an In-Network Provider **and** the Concurrent Care claim requires Clinical Review. UMR is also the Claims Administrator of a requested internal appeal of a denial of such Concurrent Care claims.

Quantum Health is the Claims Administrator of all other Concurrent Care claims and the requested internal appeal of a denial of such Concurrent Care claims.

Right to and Payment of Benefits:
Benefits and rights under this Medical Care Program are available only to Covered Persons. Except as required by law, a Covered Person may not assign, in whole or in part, any benefit or right under the Medical Care Program to any person, including but not limited to, a Doctor or other provider, nor are any such benefits and rights subject to garnishment or attachment. However, the Medical Care Program will honor a Covered Person's written authorization to allow direct payment to a Doctor or other provider, so as to permit all or a portion of a payment due for Covered Health Services owed to the Doctor or other provider to be paid directly to the Doctor or provider. An authorization of direct payment is for the convenience of the Covered Person, and shall not be recognized by the Medical Care Program as assigning to the Doctor or other provider the Covered Person's rights to any benefit under the Medical Care Program.

Also, nothing in the above paragraph is intended to prohibit a Covered Person from designating another person (including, in the case of an Urgent Care claim or appeal, a health care professional with knowledge of the Covered Person's medical condition) to serve as the Covered Person's authorized representative with respect to any claim or appeal filed in accordance with Medical Care Program procedures.

Neither UMR nor Quantum Health will reimburse third parties who have purchased or have been assigned benefits by Doctors or other providers.

Filing a Post-Service Claim for Benefits:
If Covered Health Services are received from an In-Network Provider, there is no need to file a claim. The In-Network Provider is responsible for filing claims. Generally, In-Network Providers submit claims within 90 days of the date of service.

UMR pays the In-Network Provider directly. You are responsible for paying Deductibles and/or Coinsurance when a bill is received from the Provider. If an In-Network Provider bills you for any Covered Health Service other than Deductibles and/or Coinsurance, contact Quantum Health, not UMR. Although it is not customary, In-Network Providers may request the Deductible payment at the time services are rendered.

When Covered Health Services are received from an Out-of-Network provider, result from an Emergency, or result from a referral to an Out-of-Network provider, the Covered Person is responsible for filing a claim. You must file the claim in a format that contains all of the information required as described below in the "Required Information" section. Claim forms can be obtained on the Workforce Resources page via the UP Employees website (www.up.com). The Union Pacific group number is 76-414072. The completed claim form, along with your medical documentation, should be submitted to:

UMR
PO Box 30541
Salt Lake City, UT 84130

A Post-Service claim for benefits must be submitted within one year after the date of service. If an Out-of-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you do not file a Post-Service claim with UMR within one year of the date of service, benefits for that health service

will be denied or reduced at the discretion of UMR. This time limit does not apply if you are legally incapacitated. If your Post-Service claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

Filing a Claim for Benefits - Pre-Service Claims and Urgent Claims:
If you have a Pre-Service claim or an Urgent Care claim, you or your Doctor can file your claim verbally by contacting Quantum Health at (855) 649-3855.

Filing a Claim for Benefits - Concurrent Claims:
If an on-going course of treatment was previously approved for a specific period of time or for a number of treatments and your request to extend the treatment is an Urgent Care claim, you or your Doctor must file your claim verbally by contacting Quantum Health at (855) 649-3855. If an on-going course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a non-urgent circumstance, you must file a claim form and submit it to:

Quantum Health
7450 Huntington Park Dr.
Columbus, OH 43235

Required Information:
When filing a claim for benefits, the following information is required:

Post-Service Claims:

1. The Covered Person's name and address;
2. The member and group number stated on your Medical ID Card; and
3. An itemized bill from the provider that includes the following:
   a) Patient diagnosis;
   b) Date(s) of service;
   c) Procedure code(s) and descriptions of service(s) rendered;
   d) Charge for each service rendered;
   e) Provider of service name, address and Tax Identification Number;
   f) The date the Injury or Sickness began; and
   g) A statement indicating either that the Covered Person is or is not enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Pre-Service Claims and Urgent Care Claims:

1. The member and group number stated on your Medical ID Card;
2. Patient diagnosis;
3. Date(s) of service;
4. Procedure code(s) (if available) and descriptions of service(s) to be rendered;
5. Provider of service name and/or ancillary vendor(s); and
6. A statement indicating either that the Covered Person is or is not enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Through the Claims Administrator, a benefit determination will be made as set forth below. Benefits will be paid to you unless either of the following is true:

- The Provider notifies the Claims Administrator that your signature is on file, authorizing direct payments of benefits to that provider; or
- You make a written request for the Out-of-Network provider to be paid directly at the time the claim is submitted.

Non-English Services:
Depending on the county in which you reside, the Claims Administrator may be able to provide you, upon request, with benefit determinations and other notices required to be provided under this internal claim and appeal process in a non- English language. Telephonic oral language services may also be available. Such non-English services shall

be made available by the Claims Administrator in accordance with IRS rules for culturally and linguistically appropriate communications.

Benefit Determinations:
Post-Service Claims: Post-Service claims are those claims that are filed for payment of benefits after medical care has been received. If your Post-Service claim is denied, you will receive a written notice from the Claims Administrator within a reasonable period of time, but not later than 30 days of receipt of the claim as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension for not longer than 15 days, pending your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims: Pre-Service claims are those claims that require Prior Authorization before receiving medical care, but are not Urgent Care claims. If your claim was a Pre-Service claim and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within a reasonable period of time appropriate to the medical circumstances, but not later than15 days of receipt of the claim. If you filed a Pre-Service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the Pre-Service claim was received. If additional information is needed to process the Pre-Service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received and may request a one-time extension for not longer than 15 days, pending your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Urgent Claims: Urgent Care claims are those claims that require Prior Authorization before receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function, or (in the opinion of a Doctor with knowledge of your medical condition) could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be verbal with a written or electronic confirmation to follow within 3 days.

If you filed an Urgent Care claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.
You will be notified of a determination as soon as possible, but not later than 48 hours after the earlier of:

- the Claim Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information if the information is not received within that time.

If you receive the service before waiting for the benefit determination, the claim will be considered a Post-Service claim. The benefit determination and appeals process would follow those for Post-Service claims.

Concurrent Care Claims: If an on-going course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an Urgent Care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment and notify you of its decision within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care claim and decided according to the Urgent Care claims procedures described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to the Post-Service claim or Pre-Service claim procedures described above, whichever applies.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments and the Claims Administrator has determined that such course of treatment will be reduced or terminated, the Claims Administrator will notify you of such determination sufficiently in advance of such reduction or termination to allow you to appeal and obtain a determination regarding your appeal before the course of treatment is reduced or terminated.

If Your Claim is Denied:
If your claim is denied, the Claims Administrator will send you a written notice of denial that will describe the Medical Care Program's review processes, including information regarding how to initiate an appeal. The notice will include information sufficient to identify the claim involved (including the date of service, the Provider, and the claim amount, if applicable). The notice will refer to the part of the Medical Care Program on which the denial is based and explain the reason for denial, including the denial code, if any, and its corresponding meaning, as well as a description of the Claim Administrator's standard, if any, that was used in denying your claim (e.g., if your claim was denied because the services were not Medically Necessary, experimental or unproven, the denial notice will include an explanation of this determination.). If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your claim, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. In addition, the notice will include the following:

- a description of any additional material or information needed to perfect your claim and an explanation of why the material or information is important;
- a statement describing your right to receive, upon request, a copy of the diagnosis code and/or treatment code, and their corresponding meaning. If you request such code(s), the Claims Administrator will provide the code(s) (and its corresponding meaning) to you as soon as practicable following receipt of your request; and
- information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the healthcare reform law to assist you with the internal claims and appeals and external appeal process.

Except as described in the section, "Your Options if the Internal Claim and Appeal Process Is Not Followed" on page 127, you must first exhaust all appeals available to you under the Medical Care Program – both internal and external – before you have a right to bring a civil action under ERISA regarding your denied claim. See the section "Medical Claim Questions and Appeals," immediately below for information regarding your appeal rights.

MEDICAL CLAIM QUESTIONS AND APPEAL PROCESS

This section provides information to help you with the following:

- You have a question or concern about Covered Health Services or your benefits.
- You are notified that a claim has been denied because it has been determined that a treatment, procedure, service or supply is not eligible for benefits under the Medical Care Program and you wish to appeal such determination.

This appeal process will ordinarily apply to determinations as to your eligibility for coverage only if they are part of a claim for actual benefits, which includes Prior Authorization or any other request that you are required to make to obtain full benefits under the Medical Care Program. However, if your coverage is discontinued retroactively for reasons other than the failure to make your contributions on time, you may file an appeal that contests the retroactivity of the termination of coverage. Such an appeal should be filed with the Plan Administrator, not with the Claims Administrator of your claim.

To resolve a question or appeal, just follow these steps:

What To Do First:
If you disagree with the Claim Administrator's initial claim determination, you can appeal that decision. However, before doing so, you may – but are not required to – informally contact Quantum Health at (855) 649-3855 for assistance in resolving your issue. If the Quantum Health Care Coordinator cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. Remember, though, if you are not satisfied with a benefit determination as described in the section, "Medical Claims & Appeals" beginning on page 124 you may appeal it as described below without first informally contacting Quantum Health. If you first informally contact Quantum Health and later wish to request a formal appeal in writing, you should contact Quantum Health and request an appeal.

How to Submit a Claim Decision for Internal Appeal:
If you wish to file an appeal for any denied claim other than a denied Urgent Care claim, you must submit your appeal in writing to Quantum Health at the following address:

Quantum Health
7450 Huntington Park Dr.
Columbus, OH 43235

An appeal of an Urgent Care claim denial can be made via telephone (see "Appeals Determinations – Urgent Care Claims" below).

If the appeal relates to a claim for payment, your request should include:

1. The patient's name and the identification number from the Medical ID Card;
2. The date(s) of medical service(s);
3. The provider's name;
4. The reason you believe the claim should be paid; and
5. Any documentation or other written information to support your request for claim payment.

The appeal process initiated through Quantum Health is known as an "internal appeal" or "internal review." Although all internal appeals must be submitted directly to Quantum Health either in writing (or via telephone when appealing a denied Urgent Care claim), Quantum Health will forward your appeal to UMR for decision, if UMR is the Claims Administrator with authority and responsibility to decide an internal appeal of your denied claim. (See "Types of Claims" beginning on page 120 for an explanation of the claims and appeals for which UMR is the Claims Administrator.)

Internal Appeal Process:
For all internal appeals, regardless of the type of claim denied (i.e., Post-Service, Pre-Service or Urgent Care) you must submit a request for review to Quantum Health within 180 days after you receive the claim denial notice from the Claims Administrator. If a Pre-Service claim or Post-Service claim is denied, there are two levels of internal appeal available. If an Urgent Care claim is denied, there is only one level of internal appeal.

Any internal review on appeal (first level, second level, or Urgent Care claim appeal) will not give deference to the previous claim denials. A qualified individual who was not involved in the decision being appealed, nor a subordinate of the individual who decided the initial claim, will be appointed to decide the appeal. The review will take into account all documents and other information you submit relating to your appeal, regardless of whether such documents or information were submitted or considered in previous claim decisions. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination, nor a subordinate of a healthcare professional involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information.

In deciding whether to appeal a denial or to present additional evidence or testimony, you have the right to review your claim file. Upon request and free of charge, you have the right to reasonable access to and copies of all

documents, records, and other information relevant to your claim for benefits, including the identification of the medical experts consulted regarding your appeal.

Internal Appeal Determinations – Pre-Service and Post-Service Claims:
For Pre-Service and Post-Service claim appeals, you will be provided written or electronic notification of a decision on your appeal as follows:

- For appeals of Pre-Service claims, the first level appeal will be conducted and Quantum Health will notify you of the Claim Administrator's decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for appeal of a denied claim. The second level appeal, if requested, will be conducted and Quantum Health will notify you of the Claim Administrator's decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for review of the first level appeal decision. If your second level appeal is denied, such denial is the Medical Care Program's Final Internal Adverse Benefit Determination, and you can (if eligible) proceed to external review. If your Pre-Service claim is not eligible for external review, you then have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").
- For appeals of Post-Service claims, the first level appeal will be conducted and Quantum Health will notify you of the Claim Administrator's decision within a reasonable period of time, but not later than 30 days from receipt of a request for appeal of a denied claim. The second level appeal, if requested, will be conducted and Quantum Health will notify you of the Claim Administrator's decision within a reasonable period of time, but not later than 30 days from receipt of a request for review of the first level appeal decision. If your second level appeal is denied, such denial is the Medical Care Program's Final Internal Adverse Benefit Determination, and you can (if eligible) proceed to external review. If your Post-Service claim is not eligible for external review, you then have the right to bring a civil action under Section 502(a) of ERISA.

The denial notice of a first level appeal will explain the reason for denial and refer to the part of the Medical Care Program on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the services were not Medically Necessary, experimental or unproven, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal, and will describe the second level appeal procedures.

If you are not satisfied with the first level appeal decision, you must submit a second level appeal in order to preserve your rights to external review or to bring a civil action under ERISA concerning the Medical Care Program's denial of your claim. Your second level appeal request must be submitted to Quantum Health within 60 days from receipt of the first level appeal decision and must specify each and every reason why you believe your claim should be approved. The denial notice from your first level appeal will indicate what information you need to include when making a second level appeal. You may include with your second level appeal information that was not submitted as part of your original claim or first level appeal.

If in response to your second level appeal the Claims Administrator intends to issue a Final Internal Adverse Benefit Determination on the basis of new or additional evidence first considered as part of your second level appeal, or on the basis of a new or different rationale than relied on before, Quantum Health will provide you, free of charge, with the Claim Administrator's description of such new evidence or rationale in advance of the Claim Administrator's determination so that you may have a reasonable opportunity to respond before the final determination is made.

If your second level appeal is denied (i.e., there is a Final Internal Adverse Benefit Determination), the denial notice will describe the Medical Care Program's external review process (if it is available with respect to your appeal) including information regarding how to initiate such an appeal. The notice will include information sufficient to identify the appeal involved (including the date of service, the Provider, and the appeal amount, if applicable). The notice will refer to the part of the Medical Care Program on which the denial is based and explain and discuss the reason for denial, including the denial code, if any, and its corresponding meaning, as well as a description of the

Claim Administrator's standard, if any, that was used in denying your appeal (e.g., if your appeal was denied because the services were not Medically Necessary, experimental or unproven, the denial notice will include an explanation of this determination.) If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. In addition, the notice will include the following:

- a statement describing your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal;
- a statement describing your right to receive, upon request, a copy of the diagnosis code and/or treatment code, and their corresponding meanings. If you request such code(s), Quantum Health will provide the code(s) (and its corresponding meaning) to you as soon as practicable following receipt of your request;
- information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the healthcare reform law to assist you with the internal claims and appeals and external appeal process; and
- a statement regarding your right, if eligible, to request an external review of the Claim Administrator's Final Internal Adverse Benefit Determination and, if external review is unavailable or also results in a denial of your claim, to bring a civil action under Section 502(a) of ERISA.

Internal Appeal Determinations - Urgent Care Claims:
An appeal of a denied Urgent Care claim does not need to be submitted in writing. You or your Doctor should call Quantum Health at (855) 649-3855 as soon as possible. Your Urgent Care claim appeal must specify each and every reason why you believe your claim should be approved. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition. The decision of the Claims Administrator on your Urgent Care claim appeal is the Medical Care Program's Final Internal Adverse Benefit Determination.

If your Urgent Care claim appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Medical Care Program on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the services were not Medically Necessary, experimental or unproven, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal. The denial notice will also describe the Medical Care Program's external review process, which, if you are eligible, includes an expedited process for Urgent Care claims. If you are not eligible for external review, or if your Urgent Care claim appeal is denied on external review, you have the right to bring a civil action under Section 502(a) of ERISA.

Internal Appeal Determinations-Concurrent Care Claims:
An appeal of a denied Concurrent Care claim will be decided according to the Urgent Care claim appeal, Pre-Service claim appeal, or Post-Service claim appeal procedures described above, whichever applies.

Your Options if the Internal Claim and Appeal Process Is Not Followed:
If you believe the Claims Administrator has failed to follow the internal review procedures described above and that failure denies you the opportunity to obtain a decision on the merits of your claim, you may take the following action, without having to exhaust the Medical Care Program's internal claim and appeal process:

- initiate an immediate external review of your claim or appeal using the external review process described below, if your claim is otherwise eligible for review under such external review process; or
- bring a civil action under Section 502(a) of ERISA, if your claim is not otherwise eligible for review under the external review process described below.

Before taking such action, however, you may request a written explanation of the failure from the Claims Administrator. **You must submit your request to Quantum Health, regardless of whether Quantum Health is the Claims Administrator with respect to your claim.** Quantum Health will first obtain the Claim Administrator's explanation, if Quantum Health is not the Claims Administrator with respect to the claim or appeal, and then furnish the explanation within 10 days of your request. You may want to obtain such explanation because a request for

immediate review can be rejected if it is determined that the failure was di minimis and unlikely to cause you prejudice or harm. The Claim Administrator's explanation may therefore help you to decide whether to proceed outside the internal review process. If an external reviewer or a court rejects your request for immediate review of your claim on the basis that the violation was di minimis, you have the right to resubmit and pursue the internal appeal of your claim. Quantum Health will notify you of this right within a reasonable time after the external reviewer or court rejects your claim for immediate review, but no later than 10 days following such rejection.

External Review Program:
An external review program is offered in certain circumstances. If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, you may be entitled to request an external review of the Claims Administrator's determination. You may also be entitled to an external review (or, to file a civil action under Section 502(a) of ERISA) if the Claims Administrator fails to follow the internal review procedures described above and that failure denies you the opportunity to obtain a decision on the merits of your claim. If you request such immediate external review and it is rejected, you may be able to resubmit and pursue the internal appeal of your claim. See "Your Options if the Internal Claim and Appeal Process Is Not Followed," above. The external review process is available at no charge to you.

You may request an external review of an adverse benefit determination based upon any of the following:

- the denial of your claim by reason of medical judgment (clinical reasons),
- including the application of the Medical Care Program's exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

You or your representative may request a standard external review by sending a written request to Quantum Health at the address set out in the Final Internal Adverse Determination. **Your request must be sent to Quantum Health regardless of whether Quantum Health or UMR was the Claims Administrator of your internal claim or appeal.** You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received the Final Internal Adverse Determination.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Quantum Health has entered into agreements with three or more IROs that have agreed to perform such reviews.

Standard External Review
A standard external review is comprised of all of the following:

- a preliminary review by Quantum Health of the request;
- a referral of the request by Quantum Health to the IRO; and
- a decision by the IRO.

Within 5 business days after receipt of the request, Quantum Health will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Medical Care Program at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that Quantum Health may process the request.

Within one (1) business day of completing its preliminary review, Quantum Health will issue a notification in writing to you. If your request for external review is complete, but not eligible for external review, the notification will include the reason(s) for its ineligibility and furnish contact information for the Employee Benefits Security Administration. If your request is not complete, the notification will describe the information or materials needed to make your request complete. You must furnish the missing information or materials before the end of the 4 month filing period or within 48 hours following your receipt of the notification, whichever is later. If the request is eligible for external review, Quantum Health will assign an IRO to conduct such review. The IRO has no material affiliation or interest with Quantum Health, UMR or UHC or UBH. Quantum Health will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

Quantum Health will furnish to the IRO documents and information relevant to your claim within five business days of the assignment. If there is information or evidence you or your Doctor wish to submit in support of the request that was not previously provided, you may include this information with the request for external review, and Quantum Health will include it with the documents forwarded to the IRO.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days. Generally speaking, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in making its decision:

- all relevant medical records; the attending health care professional's recommendations;
- reports from appropriate health care professionals and other documents submitted by the Claims Administrator on behalf of the Medical Care Program, by you, or by your treating Provider;
- the terms of the Medical Care Program, including any applicable and lawful review criteria developed and used by the Medical Care Program;
- appropriate practice guidelines, based on evidence-based standards, which may include practice guidelines developed for Federal government, national or professional medical societies, boards and associations; and
- the opinion of the IRO's clinical reviewer(s) based on such available information or documents which such clinical reviewer deems appropriate.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Claims Administrator, which will include the clinical basis for the determination and any other information as required by applicable law.

Upon receipt of a Final External Review Decision reversing the Claims Administrator's determination, the Medical Care Program will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Medical Care Program, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Medical Care Program will not be obligated to provide benefits for the health care service or procedure.

Expedited External Review:
An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination with respect to an Urgent Care claim for which you have filed a request for an internal appeal, and the adverse benefit determination involves a medical condition for which the time frame for completion of the internal appeal process described above for an Urgent Care claim would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a Final Internal Adverse Benefit Determination, if such determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service, procedure or product for which you received Emergency services, but have not been discharged from a facility.

Immediately upon receipt of a request for an expedited external review, Quantum Health will determine whether you meet both of the following:

- you are or were covered under the Medical Care Program at the time the health care service or procedure that is at issue in the request was provided; and
- you have provided all the information and forms required so that Quantum Health may process the request.

After Quantum Health completes the review, Quantum Health will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Quantum Health will assign an IRO in the same manner Quantum Health utilizes to assign standard external reviews to IROs. Quantum Health will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Claims Administrator.

Regardless of whether the external review is a standard external review or expedited external review, if the final independent decision is to approve payment or referral, the Medical Care Program will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Medical Care Program. If the final independent review decision is that payment or referral will not be made, the Medical Care Program will not be obligated to provide benefits for the service or procedure.

You may contact Quantum Health at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

TEMPORARY EXTENSION OF CLAIM AND APPEAL DEADLINES DUE TO COVID-19

The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"). The Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in the sections "Medical Claims & Appeals" and "Medical Claim Questions and Appeal Process" – for you to submit or request any or all of the following:

- an initial claim for benefits;
- an internal appeal (first level, second level or Urgent Care claim appeal) of your denied claim;
- an external review of an adverse benefit determination or Final Internal Adverse Benefit Determination; or
- information needed to perfect an incomplete request for external review.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your right to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in the sections "Medical Claims & Appeals" and "Medical Claim Questions and Appeal Process" - you may have additional time to do so. Please contact Quantum Health at (855) 649-3855 for more information.

COORDINATION OF BENEFITS

Coordination of benefits applies when a covered Employee, a Domestic Partner, or a covered Dependent has health coverage under a UHC Medical Option and one or more Other Plans. One of the plans involved will pay the benefits first; that plan is Primary. The other of the plans involved will pay benefits next; that plan is Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary. Whenever there is more than one plan, the maximum benefit paid is determined by each plan's coordination of benefit rules, but no more than Allowable Expenses charged for that Calendar Year, in any event. When the Union Pacific Corporation Group Health Plan (the "Group Health Plan") is determined to be the Secondary Plan, the total amount of benefits paid in a Calendar Year cannot be more than the Paid Expenses had the Group Health Plan been the Primary Plan.

Example of Coordination of Benefits (e.g., UHC HDHP1 Option):

Assume: a) Deductibles have been met
b) Your HDHP Plan is Secondary

Allowable Expense	$100
Other Plan Benefit at 80%	$ 80
UHC HDHP1 Option – Benefit paid at 85% ($85 less amount paid by other plan - $80 =$5)	$ 5
Total Paid Benefit from Both Plans	$ 85
Employee's Out-of-Pocket Expense	$ 15

How Coordination Works:
When a UHC Medical Option is Primary, it pays its benefits as if the Secondary Plan(s) did not exist.

When a UHC Medical Option is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than the amount the UHC Medical Option would have paid if it were the Primary Plan. Any reductions in benefits will be applied equally to each benefit that would have been paid under the UHC Medical Option.

Which Plan Pays First:
When you, your Dependents, or Domestic Partner (are covered by two or more plans, the following rules apply:

- For you, your plan will pay its benefits first.
- For your Spouse, Domestic Partner or Dependent Child(ren), if he/she is covered as an employee under another plan, that plan would pay benefits first.
- For your Spouse, Domestic Partner or Dependent Child(ren), if he/she is a student of a post-secondary educational institution and covered under another plan through that educational institution, that plan would pay benefits first.
- If your Dependent Child(ren) are covered under plans of both you and your Spouse, the UHC Medical Option will pay its benefits first if your birthday falls earlier in the Calendar Year than your Spouse's birthday. If your Spouse's birthday is earlier in the Calendar Year, your Spouse's plan will pay benefits first. This is called the "Birthday Rule." The year of birth is ignored. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
- If the other plan has a different rule to determine which plans pays benefits first, the Claims Administrator will use that plan's rule in determining which plan pays benefits first.
- For a Dependent Child with separated or divorced parents, benefits will be determined in the following order:
  - The plan of the parent with custody;

- The plan of the Spouse of the parent with custody;
- Finally, the plan of the parent without custody.

However, if a legal decree states that one parent is responsible for healthcare expenses, that parent's plan would pay benefits first.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the Child, the plans covering the Child shall follow the order of benefit determination rules that apply to Dependents of parents who are not separated or divorced.
- If an Employee is laid off or retires and is covered as an active Employee under another plan, the other plan would pay benefits first for the Employee and any Dependents covered. However, if the other plan does not use this rule, it will not apply.
- If none of these rules determines the order of benefits, the plan which has covered a person longer would pay its benefits first.

Right to Exchange Information:
To enforce the Coordination of Benefits provision, Quantum and UMR have the right to give or receive information on your benefits and expenses without your consent. Any claim you submit must have the information that is needed to apply the Coordination of Benefits provision (i.e., proof of other coverage).

The Coordination of Benefits provisions do not apply to pharmacy benefits. Pharmacy benefits will not be coordinated with those of any other health coverage plan.

Glossary

Allowable Expense is the necessary, reasonable and customary expense for healthcare when the expense is covered in whole or in part under at least one of the plans. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is Necessary either in terms of generally accepted medical practice or as defined in the plan.

Alternate Facility is a healthcare facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Healthcare or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Ambulatory Surgical Center is a permanent, licensed public or private facility equipped for surgery that does not provide services or accommodations for overnight care.

Calendar Year is a period that starts on any January 1st and ends on the next December 31st.

Cancer Resource Services (CRS) Program is a program made available under the UHC Medical Options, through UMR, to Employees and Dependents. The Cancer Resource Services Program provides information to Employees or their Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

Claims Administrator is Quantum Health and UMR, which provide certain administration services for the Medical Care Program.

Coinsurance is the percentage of the covered expenses for which benefits are payable under the UHC Medical Options or the Dental Care Program after application of the Deductible and before reaching the Coinsurance Maximum.

Coinsurance Maximum is the maximum amount of annual Coinsurance payments you pay every Calendar Year. If you use both In-Network benefits and Outside Network benefits, two separate Coinsurance Maximums apply. Once you reach the Coinsurance Maximum, benefits for those Covered Health Services that apply to the Coinsurance Maximum are payable at 100% of eligible expenses during the rest of the Calendar Year.

Coinsurance for some Covered Health Services will never apply to the Coinsurance Maximum, and those benefits will never be payable at 100% even when the Coinsurance Maximum is reached.

The following costs will never apply to the Coinsurance Maximum:

- Any charges for non-Covered Health Services.
- Amounts paid toward your Medical Deductible.
- Copayments or Coinsurance for Covered Health Services available by an optional rider.
- Any Coinsurance payments for Covered Health Services that do not apply to the Coinsurance Maximum.
- The amount of any reduced benefits if you do not obtain prior authorization.
- Charges which exceed eligible expenses.

Copayment or Copay is the patient's part of the bill paid at the time of service. Copays are usually flat fees for a particular service, such as for a Doctor's visit.

Covered Health Services are those health services, including services, supplies or pharmaceutical products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this Flex Guide.

- Provided to a Covered Person who meets the Medical Care Program's eligibility requirements, as described under "Eligibility and Effective Date of Coverage" section in this Flex Guide.
- Not otherwise excluded in this Flex Guide.

Deductible is the amount of out-of-pocket expenses that must be paid by you for healthcare services (medical or dental) before the applicable plan begins to pay for all or some of the healthcare services.

Dentist is a person practicing dentistry or oral surgery within the scope of his/her license. It will also include a physician operating within the scope of his/her license when performing any of the Dental Services described in the Dental Care Program.

Doctor is a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if a law applies to this plan which requires that any service performed by a practitioner must be considered on the same basis as if it were performed by a Doctor and that service is within the scope of the practitioner's license.

Emergency is a serious medical condition or symptom resulting from injury, sickness, or mental illness which both:
- Arises suddenly; and
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Gender Dysphoria (Gender Identity Disorder) is a disorder characterized by the following diagnostic criteria:
- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- The disturbance is not concurrent with a physical intersex condition.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The transsexual identity has been present persistently for at least two years.
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

High Deductible Health Plan (HDHP) refers to a High Deductible Health Plan which meets the rules outlined by the Internal Revenue Code in terms of minimum Deductible and maximum out-of-pocket. When the medical option meets the requirements set forth by the IRS, enrolled individuals may be eligible to contribute to a Health Savings Account (HSA).

Hospital is an institution, operated as required by law, which is both of the following:
- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic, and surgical facilities, by or under the supervision of a staff of physicians.
- Has 24-hour nursing services.

A Hospital is not primarily a place for rest, custodial care, or care of the aged and is not a nursing home, convalescent home, or similar institution.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound..

In-Network is using a provider participating in one of the following networks:

- UnitedHealthcare's Preferred Provider Organization (PPO) network for medical services other than Mental Health and Substance-Related and Addictive Disorders Treatment, pharmacy services, or vision care services; or
- United Behavioral Health's network of Mental Health and Substance-Related and Addictive DisordersTreatment providers; or
- OptumRx's network of participating pharmacies for retail or mail order pharmacy services; or
- EyeMed Vision Care's network of participating providers of vision care services and supplies; or
- MetLife's network of PDP dentists.

When a Preferred Provider is used, benefits are paid according to In-Network provisions.

Intensive Outpatient Treatment is a structured outpatient Mental Health and Substance-Related and Addictive Disorders Treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Medical ID Card is the identification card issued to you by your healthcare plan and certifies your eligibility for benefits under the Medical Options. Your plan option's Claims Administrator may issue ID cards in the Employee's name for use by both the Employee and his/her dependent(s).

Medicare refers to Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Section 1394, et seq. and as later amended.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association.*

Mental Health and Substance-Related and Addictive Disorders Treatment is treatment for any sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, and where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a sickness identified in the DSM are considered Mental Health and Substance-Related and Addictive Disorders Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness that is identified in the DSM is considered Mental Health and Substance-Related and Addictive Disorders Treatment.

Detoxification services given prior to, and independent of, a course of psychotherapy or substance abuse treatment are not considered Mental Health and Substance-Related Addictive Disorders Treatment.

Nurse is a registered professional nurse (R.N.).

Other Plans are any of the following types of plans which provide health benefits or services for medical care or treatment: group medical or dental plans, government plans, or no fault coverage.

Out-of-Network, is using a provider who is not participating in the networks provided by the plans as listed below under "Preferred Providers" to obtain medical, vision, or dental services or supplies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Preferred Providers are Doctors, Hospitals, medical facilities, and laboratories that are contracted to participate in one of the networks provided by the plans as follows:

- With respect to medical services or supplies (other than Mental Health and Substance-Related and Addictive Disorders Treatment), UnitedHealthcare's Preferred Provider (PPO) Network.
- With respect to Mental Health and Substance-Related and Addictive Disorders Treatment, a United Behavioral Health contracted provider or otherwise authorized by United Behavioral Health.
- With respect to pharmacy services, a pharmacy that participates in the OptumRx network.
- With respect to vision care, a vision care provider who participates in EyeMed Vision Care's network of vision care providers.
- With respect to dental care, a Dentist who participates in MetLife's Preferred Dental Program.

Preferred Provider Directory is a list of Doctors and Hospitals who are located in your area and with which the following organizations have contracted on behalf of the plan participants to be Preferred Providers and part of the Preferred Provider network: UnitedHealthcare, United Behavioral Health, OptumRx, EyeMed Vision Care, and MetLife Dental. This list will be periodically updated.

Primary Plan is a plan that is primary and is required to pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

Reasonable and Customary Charges are the lowest of:
- The usual charge of the Doctor or other provider for services and supplies; and
- The usual charge of 90% of the Doctors or other providers who have similar training and experience and are in the same geographic area; and
- The actual charge for the services or supplies.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:
- it is established and operated in accordance with applicable state law for Residential Treatment programs;
- it provides a program of treatment under the active participation and direction of a Doctor and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured environment:
    1. room and board;
    2. evaluation and diagnosis;
    3. counseling; and
    4. referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Secondary Plan is a plan under which benefits may be reduced due to benefits payable under Other Plans that are Primary.

Sickness is a physical illness, disease or Pregnancy. The term Sickness as used in this Flex Guide includes Mental Illness and substance abuse disorder, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Nursing Facility is a place that:
- Provides room and board and 24-hour-a-day nursing care by, or under the direction of, a Nurse;
- Is accredited as an Extended Care Facility/Skilled Nursing Facility by the Joint Commission on Accreditation of Hospitals or is recognized as an Extended Care Facility/Skilled Nursing Facility by Medicare; and
- Is not, other than incidentally, a hotel, motel, place for rest, place for custodial care, place for the aged, or place for drug addicts or alcoholics.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorder Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Transplant Management Program is a program made available under the UHC Medical Options to Employees and Dependents. The Transplant Management Program offers access to a network of transplant centers.

Unproven Services are services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening sickness or condition (one which is likely to cause death within one year of the request for treatment), UnitedHealthcare and their Claims Administrator may, at their discretion, determine that an Unproven Service meets the definition of a covered health service for that sickness or condition. For this to take place, UnitedHealthcare and their Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care is services that are received at a medical facility where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate, non-emergency care.

Pharmacy Program

Page

OVERVIEW

The UHC Medical Options include an In-Network Retail Pharmacy, In-Network Mail Order Pharmacy Service, Specialty Pharmacy Service, and Out-of-Network Retail Pharmacy feature. The In-Network Retail Pharmacy, In-Network Mail Order Pharmacy Service, Specialty Pharmacy Service and Out-of-Network Retail Pharmacy feature applies to covered outpatient prescription drugs.

Whomever you elect to cover under a UHC Medical Option is considered a "Covered Person" for purposes of the Pharmacy Program section of this Section of the Flex Guide. You can find the meaning of other capitalized terms found in this Section in the "Pharmacy Program Definitions" on page 160 and the "Glossary" Section on page 133 of the Flex Guide.

The Pharmacy benefits under the UHC Medical Options are provided by OptumRx.

Member Identification (ID) Card - In-Network Pharmacy:
You must either present your Member ID card at the time you obtain your Prescription Drug Product at an In-Network Pharmacy or you must provide the In-Network Pharmacy with identifying information that can be verified by OptumRx. The Union Pacific group number for OptumRx is 01963146. You can access your Member ID card through the MyQHealth website or app. Quantum Health provides care coordination services for the UHC Medical Options, including prescription drug benefits.

If you do not present your Member ID Card or provide verifiable information at an In-Network Pharmacy, you will be required to pay the amount charged by the pharmacy for the Prescription Drug Product at the pharmacy. You may seek reimbursement as described in the "How to File Pharmacy Claims" section on page 155. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility at the time the Prescription Drug Product was dispensed. The amount of the reimbursement will be based on the Prescription Drug Cost, less any HDHP Deductible (if enrolled in a UHC HDHP Option) or Pharmacy Coinsurance Payment that applies.

Limitation on Selection of Pharmacies:
If OptumRx determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, OptumRx may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single In-Network Pharmacy. If you do not make a selection within 31 days of the date you are notified, OptumRx will select a single In-Network Pharmacy for you.

Concurrent Drug Utilization Review:
The Concurrent Drug Utilization Review (CDUR) program screens your prescription for safety and medication use considerations by identifying potentially dangerous drug interactions that may result when two particular Prescription Drug Products are taken at the same time. At the time the prescription is dispensed, an alert of a potential problem is sent electronically to the pharmacy. Once notified of a potential problem, the pharmacist may call the prescribing Doctor or discuss the medication with you and suggest that you speak with your Doctor. This program is used if you use an In-Network Pharmacy.

Additional Information About Your Prescriptions:
Employees can find helpful resources for prescription drugs, such as cost and the usage of a drug, drug interactions and side effects, clinical programs (e.g. supply limits and Prior Authorization requirements), pharmacy locations, cost saving options, and Specialty Pharmacies by visiting the MyQHealth website. To access this site, log onto your account at www.UPMyQHealth.com. You may also call Quantum Health at (855) 649-3855 for assistance.

WHAT'S COVERED

The Plan pays benefits for outpatient Prescription Drug Products given to a Covered Person according to the provisions described below (see "Discretionary Mail Order Program," "Mandatory Mail Order Program," "Specialty Pharmacy Services," and "Pharmacy Benefit Payment Information" sections"). Refer to "What's Not Covered - Exclusions" on page 151 for exclusions.

Prescribed drugs and medicines for inpatient services are covered as medical expenses under the UHC Medical Option provisions. The UHC Medical Option provisions also apply to outpatient prescription drugs that are administered in a Doctor's office or other licensed outpatient setting, unless the drugs are specifically excluded from the UHC Medical Options under "Additional Exclusions" on page 111. These drugs and medicines eligible for payment under the UHC Medical Options' provisions then are not payable under the Pharmacy provisions. Likewise, the drugs and medicines eligible under the Pharmacy provisions then are not payable under the Medical provisions.

Benefits for Outpatient Prescription Drug Products:
Benefits are payable for an outpatient Prescription Drug Product on the OptumRx Prescription Drug List when OptumRx determines that the Prescription Drug Product is, in accordance with OptumRx approved guidelines:

- Prescribed to treat a Covered Health Service (see "Covered Health Services" page 85) or to prevent conception;
- The prescription is not experimental, investigational, or unproven; and
- Determined by OptumRx to be Medically Necessary.

Supply Limits:
Note: Some products are subject to supply limits based on criteria that OptumRx has developed, subject to their periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing online at www.UPMyQHealth.com or by calling Quantum Health at (855) 649-3855 and choosing the pharmacy prompt.

Coverage Authorization:
OptumRx uses a series of reviews when processing certain prescriptions known collectively as "coverage authorization."

Benefits may not be available for the Prescription Drug Product after OptumRx reviews the documentation provided if OptumRx determines that the Prescription Drug Product is not prescribed to treat a Covered Health Service or it is experimental, investigational, or unproven,. You may appeal this determination as described in the "Pharmacy Claim Questions and Appeals" section on page 154.

If you are using an In-Network Retail Pharmacy, your pharmacist will be notified that your Doctor must get approval for the prescription to be covered by calling OptumRx at (877) 559-2955. If you are using the OptumRx Mail Order Pharmacy Service, the pharmacist will call your Doctor to start the approval process. For prescriptions, your Doctor will be asked to provide information to determine if the prescription meets the coverage conditions of your pharmacy benefit. The information your Doctor provides will be reviewed, and coverage will be approved or denied. Letters will be sent to you and your Doctor to explain any denial decision and provide instructions on how to appeal if denied coverage.

If you use an Out-of-Network Retail Pharmacy, coverage authorization still applies and will be reviewed at the time that you submit a claim for reimbursement; otherwise you or your Doctor can check beforehand by calling OptumRx at (877) 559-2955 to ensure that the medications prescribed are in conformance with their coverage authorization. Only approved claims will be reimbursed. Employees will also receive a statement outlining the authorization procedures.

Quantity Level Limits (QLL) /Quantity per Duration (QD):
The QLL program defines the maximum quantity of medication that can be covered for one prescription. The QD program defines the maximum quantity of medication that can be covered in a one-month period. The QLL and QD programs have been developed through research of prevailing medical practices, pharmaceutical safety and the quality of care to the patient. These standards are based upon the manufacturer's package size, dosing indications that are included in the United States Food and Drug Administration (FDA) labeling, and medical literature or guidelines.

If your prescription exceeds the limit and you are using an In-Network Retail Pharmacy or the OptumRx Mail Order Pharmacy Service, your Doctor or pharmacist will be notified of the quantity covered under a single prescription; which is generally, for Retail up to 31 days or mail order up to 90 days. You will have the option to:

- Accept the established quantity limit.
- Pay additional out-of-pocket costs or Pharmacy Coinsurance Payments for amounts that exceed the quantity limit.
- Discuss alternatives with your Doctor before deciding whether to fill the prescription.
- Request coverage authorization for the additional amounts through the coverage review process (when coverage review is available).

If your prescription exceeds the limit and you are using an Out-of-Network Retail Pharmacy, you must file a claim to receive reimbursement and your reimbursement will be limited to the benefit payment based upon the Predominant Reimbursement Rate for the quantity of medication allowed under the QLL and/or QD guidelines.

The QLL and QD limits are subject to change at the discretion of OptumRx. You will be notified in writing if a change is made on a drug you have been prescribed and had filled or filed a claim through the OptumRx system.

Note: Review of Quantity Duration is very similar to Quantity Level Limits; however, Quantity Duration review will also review the timeframe when the refill can be obtained.

To learn more about medication patient safety programs and coverage authorizations through your pharmacy benefit, call Quantum Health at (855) 649-3855 for assistance..

Notification Requirements:
In-Network Pharmacy Notification: When Prescription Drug Products are dispensed at an In-Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying OptumRx.

Out-of-Network Retail Pharmacy Notification: When Prescription Drug Products are dispensed at an Out-of-Network Retail Pharmacy, you or your Doctor must notify OptumRx, as required.

If OptumRx is not notified before the Prescription Drug Product is dispensed, you can ask OptumRx to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from OptumRx as described in the "How to File Pharmacy Claims" section, page 155.

When you submit a claim on this basis, the amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from an In-Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from an Out-of--Network Pharmacy), less any remaining HDHP Deductible (if enrolled in a UHC HDHP Option) and/or your required Pharmacy Coinsurance Payment, if any. The OptumRx contracted pharmacy reimbursement rates (the OptumRx Prescription Drug Cost) will not be available to you at an Out-of-Network Retail Pharmacy.

Pharmacy program benefits begin at the point of service (before a prescription is filled) to provide your pharmacist with important medication and benefit information.

Progression Rx/Step Therapy:
Prescription Drug Products belonging in certain therapeutic classes are subject to step therapy requirements. This means that, in order to receive benefits for such Prescription Drug Product, you will be required to try a lower cost Prescription Drug Product in the same therapeutic class first. You may determine whether a particular Prescription Drug Product is subject to step therapy requirements by visiting MyQHealth at www.UPMyQHealth.com or by calling Quantum Health at (855) 649-3855.

SPECIALTY PHARMACY SERVICES

Certain pharmacy prescriptions are made using special compounds, which are not ordinarily kept in stock and may require advance notice to fill. OptumRx has established a group of Specialty Pharmacies with clinical expertise in dispensing specialty drugs that must be filled through an OptumRx Specialty Pharmacy. Prescriptions obtained through the Specialty Pharmacy are dispensed in 30-day quantities and delivered directly to your home.

Specific drugs that must be dispensed through a Specialty Pharmacy can be found at MyQHealth at www.UPMyQHealth.com. If you have a new prescription for a Prescription Drug Product that must be filled by a Specialty Pharmacy, you must contact the Specialty Pharmacy to process the prescription. If you present a specialty prescription to a retail pharmacy, the retail pharmacy will receive a message from OptumRx that includes a Specialty Pharmacy's phone number.

Once you contact the Specialty Pharmacy, it will provide instructions regarding how to submit the prescription for filling. You will need to furnish payment information before the Specialty Pharmacy fills your prescription.

- You will have access to a Specialty Pharmacy pharmacist who has been trained in dispensing of your drug and is available 24 hours a day, seven days a week, to answer your questions.
- Your prescription will be delivered directly to your home.
- Refills will be coordinated between the Specialty Pharmacy and your Doctor, delivered directly to your home every 30 days.

Specialty drugs not filled by an OptumRx Specialty Pharmacy will not be covered by the Plan.

Benefits for the Specialty Pharmacy drugs are payable, following the "Schedule of Benefits" on page 78 entitled "Prescription Drugs from Retail or Specialty Pharmacy."

Note: A Prescription Order or Refill for a Prescription Drug Product identified as a "Specialty Drug" and required to be filled by a Specialty Pharmacy cannot be written for a 90-day supply and cannot be obtained through the Discretionary Mail Order Pharmacy Program. Specialty Pharmacy prescriptions are dispensed in 30-day quantities.

To contact the Specialty Pharmacy referral line for any questions call Quantum Health at (855) 649-3855. You will be provided contact information for the specific Specialty Pharmacy that specializes in the drug you use. Quantum Health will work with you to establish your contact with the Specialty Pharmacy.

MANDATORY MAIL ORDER PROGRAM

The Mandatory Mail Order (MMO) Program is a program that requires you to use the Mail Order Pharmacy to obtain certain maintenance medications. Maintenance medications are Prescription Drug Products, which are designed to be prescribed as an ongoing therapy. Many maintenance medications can be purchased more conveniently, at a lesser cost to you and the Plan, through the Mail Order Pharmacy. You will be contacted by OptumRx if your medication is required to be filled through the OptumRx Mandatory Mail Order Program.

A Prescription Order or Refill for a Prescription Drug Product that is listed by OptumRx as a Mandatory Mail Order maintenance medication must be written for a 90-day supply. Your Doctor may write a Prescription Order or Refill for up to a 12-month supply for the maintenance medication. To do so, the Prescription Order or Refill must be written for a 90-day supply, with three refills. You will receive reminders when it is time to request a refill for your prescription, which you may do by telephone or online. Once you have requested your refill, your 90-day supply will be dispensed and delivered directly to your home.

For prescriptions being filled for the first time through the Mail Order Pharmacy, you or your Doctor must complete a Mail Order Form. This form can be found at MyQHealth at www.UPMyQHealth.com.

The form can be faxed by you or your Doctor, or you can mail it to:

OptumRx
P.O. Box 2975
Mission, KS 66201
Fax Number: (800) 491-7997

If you have a new Prescription Order or Refill for a Prescription Drug Product listed as a MMO maintenance medication that must be filled by the Mail Order Pharmacy, or if you have an existing Prescription Order or Refill for such a Prescription Drug Product at the time you become enrolled in a UHC Medical Option, you may fill your prescription up to a maximum of two times at a Retail Pharmacy and still receive benefits under the Pharmacy Program. If you fill your

Prescription Order or Refill for a MMO maintenance medication at a Retail Pharmacy, you will receive a letter from OptumRx, indicating that your prescription for the maintenance medication must be filled through the Mail Order Pharmacy after the second fill, and that you must ask your Doctor to write a new prescription for the maintenance medication as a 90-day supply. After the second fill at a Retail Pharmacy, continued use of a Retail Pharmacy for a MMO maintenance medication will no longer be covered under the Pharmacy Program.

Opting Out of Mandatory Mail Order
The MMO program is designed to provide maintenance medications to you at the lowest cost for both you and the Plan. However, because of continually changing market conditions, there are some instances when purchasing through MMO may not be your lowest cost option. If you are able to obtain the medication at a Retail Pharmacy at a lower cost than the Mail Order Pharmacy cost, you can opt out of the Mandatory Mail Order Program by calling Quantum Health at (855) 649-3855. You may then continue to use that Retail Pharmacy to purchase your maintenance medication and the medication will be covered under the Pharmacy Program.

To contact the Mail Order Pharmacy with any questions, call Quantum Health at (855) 649-3855.

DISCRETIONARY MAIL ORDER PROGRAM

A Mail Order Pharmacy Service option is available for your convenience. If you are enrolled in a UHC HDHP Option and you have not yet met your HDHP Deductible, you will pay 100% of the Prescription Drug Cost for the Prescription Drug Product. Refer to "Payment Information - Deductible" on page 145. If you are enrolled in the UHC Non-HDHP PPO, or a UHC HDHP Option and have met your HDHP Deductible, you must pay for the Prescription Drug Product according to the three-tier Coinsurance structure shown in the table for "Mail Order Prescription Drug Products" table on page 151. Payment is made for up to a 90-day supply for each prescription filled by the Mail Order Pharmacy Service. The original prescription must be written for a 90-day supply, plus refills.

For prescriptions being filled for the first time by mail order:

- You or your Doctor must complete a Mail Order Form. This form can be found on the MyQHealth site at www.UPMyQHealth.com. The form can be faxed by you or your Doctor, or you can mail it to:
  OptumRx
  P.O. Box 2975
  Mission, KS 66201
- The prescription should be written for a 90-day supply, plus refills.
- You can contact the Mail Order Pharmacy to find out the cost of the prescription by calling Quantum Health at (855) 649-3855.
- Your payment options for the Mail Order Pharmacy Service are:
  - Payment by credit card or debit card;
  - Payment by check with your order;
  - Payment by ACH transfer or "Tele-check" handled over the telephone (Note: there are no additional fees for this service); or
  - You can submit an order and be billed for the cost of a 90-day prescription up to $100.
- If your Doctor has prescribed a 90-day medication with refills, after the initial prescription is submitted, you can request a refill over the phone or at MyQHealth at www.UPMyQHealth.com.
- When your prescription expires, you will need to request a new prescription from your Doctor. Your prescription may be for up to 12 months. Then a 90-day supply will be delivered directly to your home.

For additional information about your pharmacy benefits, call Quantum Health at (855) 649-3855 or visit MyQHealth at www.UPMyQHealth.com.

PHARMACY BENEFIT PAYMENT INFORMATION

Deductible:
For the UHC HDHP Options: You are responsible for paying the cost of covered pharmacy and covered medical services until the HDHP Deductible is met, before pharmacy benefits are payable under the Plan. (For more information on the HDHP Deductible, see the "Schedule of Benefits" section on page 78 of the Flex Guide.) The In-Network HDHP Deductibles, including family limits, are listed in the following table.

- The amounts you pay for contracted rates with an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Deductible. If an Out-of-Network Retail Pharmacy is used, only the amounts you pay up to the Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Deductible. Prescription Drug Products provided by an Out-of-Network Retail Pharmacy will apply towards the In-Network deductible.
- The amounts you pay for contracted rates with a Preferred Provider for Covered Medical Services are also applied against the HDHP Deductible. If a Non-Preferred Provider is used to receive Covered Medical Services, only the Reasonable and Customary Charges for Covered Medical Services are applied against the HDHP Deductible.

HDHP DEDUCTIBLE	
In-Network	
HDHP1	$3,000 per Covered Person per Calendar Year, not to exceed $6,000 for all Covered Persons in a family.
HDHP2	$4,500 per Covered Person per Calendar Year, not to exceed $9,000 for all Covered Persons in a family.

If you are enrolled in a UHC HDHP Option, after the HDHP Deductible is met, you are responsible for paying the applicable Pharmacy Coinsurance Payment as described below.

For the UHC Non-HDHP PPO Option: No prescription drug Deductible applies. Cost sharing through the Pharmacy Coinsurance Payment, described below, begins with the first prescription.

Pharmacy Coinsurance Payment:
The Pharmacy Coinsurance Payment that you will be required to pay depends on (1) the UHC Medical Option you are covered by, (2) the type of pharmacy that fills the prescription (i.e., Retail Pharmacy, Specialty Pharmacy, Mail Order Pharmacy, or Out-of-Network Retail Pharmacy), and (3) the Tier that the prescription falls in.

For the UHC HDHP1 and UHC HDHP2: After the HDHP Deductible is met, you are responsible for paying the applicable Pharmacy Coinsurance Payment, up to the HDHP Coinsurance Maximum (described in the following Payment Information Schedule), when Prescription Drug Products on the OptumRx Prescription Drug List are obtained from a Retail, Mail Order, or Specialty Pharmacy. The amount you pay for the HDHP Deductible or any non-covered drug product will not be included in calculating the HDHP Coinsurance Maximum. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and the OptumRx contracted rates (the OptumRx Prescription Drug Cost) will not be available to you.

- The amounts you pay for contracted rates with an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Coinsurance Maximum. If an Out-of-Network Retail Pharmacy is used, only the amounts you pay up to the Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Coinsurance Maximum.
- The amounts you pay for contracted rates with a Preferred Provider for Covered Medical Services are also applied against the HDHP Coinsurance Maximum. If a Non-Preferred Provider is used to receive Covered Medical Services, only the Reasonable and Customary Charges for Covered Medical Services are applied against the HDHP Coinsurance Maximum.

For the UHC Non-HDHP PPO: You are responsible for paying the applicable Pharmacy Coinsurance Payment, up to the Coinsurance Maximum (described in the following Payment Information Schedule), when Prescription Drug Products on the OptumRx Prescription Drug List are obtained from a Retail, Mail Order, or Specialty Pharmacy. No prescription drug Deductibles apply. Cost sharing through pharmacy Coinsurance begins with the first prescription. The amount you pay for any non-covered drug product will not be included in calculating the Coinsurance Maximum. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product, and the OptumRx contracted rates (the OptumRx Prescription Drug Cost) will not be available to you.

- The amounts you pay for contracted rates with an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the Coinsurance Maximum. If an Out-of-Network Retail Pharmacy is used, only the amounts you pay up to the Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List are applied against the Coinsurance Maximum.
- The amounts you pay for Covered Medical Services are applied against the same Coinsurance Maximum.

PAYMENT INFORMATION SCHEDULE		
Payment Term	**Description**	**Amounts**
Pharmacy Coinsurance Payment (applies to all UHC Medical Options)	Pharmacy Coinsurance Payments for a Prescription Drug Product at an In-Network Pharmacy are a portion of the Prescription Drug Cost. Pharmacy Coinsurance Payments for a Prescription Drug Product at an Out-of-Network Retail Pharmacy are a portion of the Predominant Reimbursement Rate. Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned a Prescription Drug Product. **NOTE**: The tier status of a Prescription Drug Product can change periodically, generally on January 1st and July 1st, based on the Pharmacy and Therapeutics Committee's periodic tier decisions. When that occurs, your Coinsurance payment may change. If there is a tier change which increases your Coinsurance percentage payment for a medication you have previously filed with OptumRx you will be notified by OptumRx either by letter or by sending information to the pharmacy when the prescription is being processed. In addition you can go to MyQHealth at www.UPMyQHealth.com, or call Quantum Health at (855) 649-3855, for the most up-to-date tier status.	For Prescription Drug Products at an In-Network Pharmacy, you are responsible for paying the lower of: • The applicable Pharmacy Coinsurance Payment; or • The Prescription Drug Cost for that Prescription Drug Product. See the Pharmacy Coinsurance Payment description in the table beginning on page 149.

PAYMENT INFORMATION SCHEDULE		
Payment Term	**Description**	**Amounts**
Coinsurance Maximum (applies to all UHC Medical Options)	The Coinsurance Maximum is the maximum amount you are required to pay for Covered Medical Services and/or Covered Prescription Drug Products on the OptumRx Prescription Drug List in a single Calendar Year. Once you reach the Coinsurance Maximum, you will not be required to pay Coinsurance payments for covered Prescription Drug Products on the OptumRx Prescription Drug List for the remainder of the Calendar Year. Note: For prescriptions purchased at an Out-of-Network Retail Pharmacy, any charges above the Predominant Reimbursement Rate are not considered by the Plan as benefit payments and do not count toward your Coinsurance Maximum.	**In-Network:** HDHP1: combined medical and prescription coinsurance maximum of $2,000 per Covered Person per Calendar Year, not to exceed $4,000 for all Covered Persons in a family. HDHP2: combined medical and prescription coinsurance maximum of $1,500 per Covered Person per Calendar Year, not to exceed $3,000 for all Covered Persons in a family. Non-HDHP PPO: combined medical and prescription coinsurance maximum of $2,750 per Covered Person per Calendar Year, not to exceed $5,500 for all Covered Persons in a family. **Out-of-Network:** Note – Prescription Drug Products provided by a Non-Preferred Provider will apply towards the In-Network Coinsurance Maximum.

Three-Tier Coinsurance: Your Pharmacy Coinsurance Payment under the UHC HDHP Options once the HDHP Deductible has been met or under the UHC Non-HDHP PPO depends on the tier to which the Prescription Drug Product is assigned. Prescription Drug Products are assigned to one of three tiers by OptumRx. Each tier is assigned a Pharmacy Coinsurance flat dollar Copay or percentage, with a minimum and maximum as shown in the next few pages. Tier 3 Prescription Drug Products have the highest Pharmacy Coinsurance Payment percentage and Tier 1 Prescription Drug Products have a flat dollar Copay. The tier assignments change periodically. Tiers indicate how much you will pay for a medication. after you have satisfied any applicable Deductible. You can obtain information regarding which drugs fall into the different tiers by going to MyQHealth at www.UPMyQHealth.com or by calling Quantum Health at (855) 649-3855.

Sometimes your Doctor may prescribe a medication to be "dispensed as written" when a lower tier or lower cost brand or Generic alternative drug is available. As part of your Plan, the pharmacist may discuss with your Doctor whether an alternative drug might be appropriate for you. You and your Doctor make the final decision on your medication, and you can always choose to keep the original prescription at the higher Pharmacy Coinsurance Payment.

Preventive Pharmacy Benefits: Certain Prescription Drug Products that are categorized as preventive care benefits under the Patient Protection and Affordable Care Act (PPACA) are available to members at no charge and are not subject to deductible or coinsurance provisions of the Plan if such Prescription Drug Products are received from an In-

Network Pharmacy. Whether a Prescription Drug Product is available to members at no charge may determined by going to MyQHealth at www.UPMyQHealth.com or by calling Quantum Health at (855) 649-3855 for the most up-to-date status.

Coverage Policies and Guidelines: The Pharmacy and Therapeutics Committee is authorized to make tier placement changes on the Plan's behalf. The Pharmacy and Therapeutics Committee makes the final classification of a FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical, economic and regulatory factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy or administered, relative safety and/or relative efficacy of the Prescription Drug Product, and whether or not supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

OptumRx may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur on January 1st and July 1st. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the Pharmacy and Therapeutics Committee reviews clinical, economic and regulatory factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is determined by the Covered Person and the prescribing Doctor.

When a Generic Becomes Available for a Brand-Name Prescription Drug Product: The tier placement of the Brand-Name Prescription Drug Product may change; and, therefore, your Pharmacy Coinsurance Payment may change. You will pay the Pharmacy Coinsurance Payment applicable for the tier to which the Prescription Drug Product is assigned at the time the Prescription Order or Refill is dispensed. Generic drugs are generally placed in Tier-1; however, this is not always the case (e.g., when a single manufacturer has exclusive marketing rights for a newly available generic drug, the drug may initially be placed on a higher Tier until the period of exclusivity has expired and competition makes the drug more affordable).

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please go to MyQHealth at www.UPMyQHealth.com, or call Quantum Health at (855) 649-3855 for the most up-to-date tier status.

The following table describes Pharmacy Coinsurance Payments and benefits for participants enrolled in a UHC Medical Option, i.e., a UHC HDHP Option or the UHC Non-HDHP PPO.

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits	**UHC Medical Options Your Pharmacy Coinsurance Payment Amount**
In-Network Retail or Specialty Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by an In-Network Retail Pharmacy or a Specialty Pharmacy as written by the provider up to a consecutive 31-day supply (or a 30-day supply if provided by a Specialty Pharmacy) of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. Certain generics may also be dispensed by an In-Network Retail Pharmacy up to a 90-day supply.	Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please go to MyQHealth at www.UPMyQHealth.com or call Quantum Health at (855) 649-3855 to determine tier status. • $10 Copay for a Tier-1 Prescription Drug Product (or cost of drug, if less). • 30% of the Prescription Drug Cost for a Tier-2 Prescription Drug Product. • 40% of the Prescription Drug Cost for a Tier-3 Prescription Drug Product. Each In-Network Retail or Specialty Pharmacy Prescription Order or Refill for Tiers 2 and 3 above is subject to a per-prescription minimum Pharmacy Coinsurance Payment and a per prescription Pharmacy Coinsurance Maximum payment. COVERED AT NO COST (Deductible and Coinsurance do not apply): • Prescription Drug Products that are preventive care under the PPACA. NOT COVERED: • Mandatory Mail Order (MMO) drugs filled at a Retail Pharmacy after the 2-fill transition period; or • Specialty Pharmacy drugs, including self-injectable infertility drugs, filled at a Retail Pharmacy.

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits	**UHC Medical Options Your Pharmacy Coinsurance Payment Amount**
Out-of-Network Retail Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by an Out-of-Network Retail Pharmacy as written by the provider up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. If the Prescription Drug Product is dispensed by an Out-of-Network Retail Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with OptumRx. The Plan will not reimburse you for your HDHP Deductible, Pharmacy Coinsurance Payment, or the difference between the billed cost and the Predominant Reimbursement Rate for that Prescription Drug Product. In addition, the Plan will not reimburse you for any drug not on the Prescription Drug List. **In most cases, you will pay more if you obtain Prescription Drug Products from an Out-of-Network Pharmacy.**	Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please go to MyQHealth at www.UPMyQHealth.com or call Quantum Health at (855) 649-3855 to determine tier status. • $10 Copay for a Tier-1 Prescription Drug Product (or cost of drug, if less). • 30% of the Predominant Reimbursement Rate for a Tier-2 Prescription Drug Product. • 40% of the Predominant Reimbursement Rate for a Tier-3 Prescription Drug Product. Each Out-of-Network Retail Pharmacy Prescription Order or Refill for Tiers 2 and 3 above is subject to a per-prescription minimum Pharmacy Coinsurance Payment and a per prescription Pharmacy Coinsurance Maximum payment. NOT COVERED: • Mandatory Mail Order (MMO) drugs filled at a Retail Pharmacy after the 2-fill transition period; or • Specialty Pharmacy drugs, including self- injectable infertility drugs, filled at a Retail Pharmacy.
Per Prescription Pharmacy Coinsurance Minimums and Maximums from a Retail Pharmacy and Specialty Pharmacy Each Tier 2 and 3 Prescription Order or Refill purchased from a Retail Pharmacy or Specialty Pharmacy is subject to the per prescription Pharmacy Coinsurance Minimum and Pharmacy Coinsurance Maximums described here, unless you have reached the Coinsurance Maximum.	**In-Network and Out-of-Network Retail** **Tier 1 – NA** **Tier 2 - $30 Minimum*/$90 Maximum** **Tier 3 - $60 Minimum*/$150 Maximum** ***or cost of drug, if less**

PRESCRIPTION DRUGS FROM MAIL ORDER PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits	**UHC Medical Options Your Pharmacy Coinsurance Payment Amount**
In-Network Mail Order Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy as written by the provider up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. **Out of Network Mail Order Pharmacy** Prescription Drug Products dispensed by an Out-of-Network Mail Order Pharmacy will not be covered by the Plan	Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please go to MyQHealth at www.UPMyQHealth.com or call Quantum Health at (855) 649-3855 to determine tier status. • $25 for a Tier-1 Prescription Drug Product (or cost of drug, if less). • 25% of the Prescription Drug Cost for a Tier-2 Prescription Drug Product. • 40% of the Prescription Drug Cost for a Tier-3 Prescription Drug Product. Each Mail Order Prescription Order or Refill for Tiers 2 and 3 above is subject to a per-prescription minimum Pharmacy Coinsurance Payment and a per-prescription Maximum Pharmacy Coinsurance Payment. COVERED AT NO COST (Deductible and Coinsurance do not apply): • Prescription Drug Products that are preventive care under the PPACA
Per Prescription Coinsurance Minimums and Maximums from an In-Network Mail Order Pharmacy Each Tier 2 and 3 Prescription Order or Refill purchased through the Mail Order Pharmacy is subject to the per-prescription Pharmacy Coinsurance Minimum and Pharmacy Coinsurance Maximums described here, unless you have reached the Coinsurance Maximum.	**In-Network Mail Order Pharmacy** **Tier 1 – NA** **Tier 2 - $75 Minimum*/$225 Maximum** **Tier 3 - $150 Minimum*/$375 Maximum** ***or cost of drug, if less**

WHAT'S NOT COVERED – EXCLUSIONS

The following exclusions apply to the Pharmacy Program (Note: Some items excluded here may be covered under the Medical Care Program):

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) exceeding the supply limit;
- Prescription Drug Products that are prescribed, dispensed, or intended for use while you are an inpatient (e.g., patient at a Hospital, Skilled Nursing Facility, etc.);
- Medications used for experimental indications and/or dosage regimens determined by OptumRx to be experimental, investigational, or unproven;
- Prescription Drug Products which OptumRx has determined are not Medically Necessary;
- Prescription Drug Products for which the prescription is more than one year old;
- Prescription Drug Products furnished by the local, state, or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state, or federal government (e.g., Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
- Prescription Drug Products that are subject to the Mandatory Mail Order Program when dispensed at a Retail Pharmacy following the two prescription transition period (unless you meet the conditions to opt-out of the MMO program with respect to a specific Prescription Drug Product and have elected to do so);
- Prescription Drug Products that are subject to the Specialty Pharmacy Program when dispensed at a Retail Pharmacy (i.e., not dispensed through a Specialty Pharmacy);
- Prescription Drug Products that are subject to the Progression Rx Step Therapy Program and for which you have not satisfied the program requirements to use a different Prescription Drug Product first;

- Prescription Drug Products for any condition, injury, sickness, or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws (e.g., Federal Employers' Liability Act or "FELA"), whether or not a claim for such benefits is made or payment or benefits are received. (Note: Prescription Drug Products prescribed to treat an on-duty injury, where the company is not at fault and no FELA claim will be filed, will be allowed to be paid by the Plan.);
- Any product dispensed for the purpose of appetite suppression and other weight loss products;
- A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by OptumRx, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. These medications may be covered under the Medical Care Program. This exclusion does not apply to Depo-Provera and other injectable drugs used for contraception;
- Durable Medical Equipment, prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered (see "Prescription Drug Product" definition on page 161). Certain Durable Medical Equipment may be covered under the UHC Medical Options;
- Coordination of benefits on Prescription Drug Products, including Prescription Drug Products on the UHC/OptumRx Prescription Drug List;
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins, unless such general vitamins qualify to be covered as Preventive Care under PPACA;
- Unit dose packaging of Prescription Drug Products;
- Medications used for cosmetic purposes;
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be on the Prescription Drug List;
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken, or destroyed;
- Glucose monitors;
- Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill;
- Drugs available over the counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components which are available in over-the-counter form or equivalent, unless such drugs available over the counter qualify to be covered as Preventive Care under PPACA;
- New Prescription Drug Products and/or new dosage forms that have not yet been reviewed by the Pharmacy and Therapeutics Committee until the date they are reviewed and assigned to a tier.
- Prescription Drug Products to the extent that benefits for such products are provided under this Plan or under any other plan to which the employer sponsors or contributes;
- Injectable drugs that must be administered by a licensed healthcare professional; which, if covered, would be paid under the Medical Plan provisions. This exclusion does not apply to certain insulin or self-administered injectables that are covered by the Plan and can be injected subcutaneously. The list of drugs which are considered "self-administered injectables" is determined by OptumRx. To verify if an injectable drug is considered a self-administered injectable, go to MyQHealth at www.UPMyQHealth.com or call Quantum Health at (855) 649-3855;
- Prescribed devices or supplies of any type, including colostomy supplies or contraceptive devices and supplies (oral contraceptives on the OptumRx Prescription Drug List are covered under the Pharmacy Program);
- Progesterone suppositories; and
- A Prescription Drug Product requested to be filled by the In-Network Mail Order Pharmacy for which an original Prescription Order or Refill is not submitted to the In-Network Mail Order Pharmacy. A Prescription Order or Refill provided to another pharmacy cannot be transferred to the In-Network Mail Order Pharmacy.

HOW TO FILE PHARMACY CLAIMS

For all claims and appeals for Pharmacy Program benefits provided under the UHC Medical Options, Union Pacific has delegated to OptumRx the exclusive and discretionary right to determine facts, interpret and administer the provisions of the Plan, and determine benefits payable under the Pharmacy Program. The decisions of OptumRx are conclusive and binding, except to the extent a decision is eligible for review under the external review process described in the "External Review Program" section below.

Non-English Services:
Depending on the county in which you reside, OptumRx may be able to provide you, upon request, with benefit determinations and other notices required to be provided under this internal claim and appeal process in a non-English language. Telephonic oral language services may also be available. Such non-English services shall be made available by OptumRx in accordance with IRS rules for culturally and linguistically appropriate communications.

Right to and Payment of Benefits:
Benefits and rights under the Pharmacy Program are available only to Covered Persons. Except as required by law, a Covered Person may not assign, in whole or in part, any benefit or right under the Pharmacy Program to any person, including but not limited to, a Doctor, pharmacist or other provider, nor are any such benefits and rights subject to garnishment or attachment. However, the Pharmacy Program will honor a Covered Person's written authorization to allow direct payment to a Doctor, pharmacist or other provider, so as to permit all or a portion of a payment due for a Prescription Drug Product owed to the Doctor, pharmacist or other provider to be paid directly to the Doctor, pharmacist or other provider. An authorization of direct payment is for the convenience of the Covered Person, and shall not be recognized by the Pharmacy Program as assigning to the Doctor, pharmacist or other provider the Covered Person's rights to any benefit under the Pharmacy Program.

Also, nothing in the above paragraph is intended to prohibit a Covered Person from designating another person (including, in the case of an Urgent Care claim or appeal, a health care professional with knowledge of the Covered Person's medical condition) to serve as the Covered Person's authorized representative with respect to any claim or appeal filed in accordance with Pharmacy Program procedures.

OptumRx will not reimburse third parties who have purchased or have been assigned benefits by a Doctor, pharmacist or other provider.

Internal Claim and Appeal Process:
No claim forms are needed if you obtain prescription drugs from an In-Network Retail Pharmacy, Specialty Pharmacy or via the Mail Order Pharmacy Service.

If you obtain prescription drugs from an Out-of-Network Retail Pharmacy, you will need to pay the entire cost of each prescription at the time it is filled. Unless your claim is for urgent care (defined below), you must then submit a claim to OptumRx, within 12 Calendar Months of the date you fill the Prescription Order or Refill.

OptumRx will review your claim. The reimbursement claim form includes instructions on how to complete and where to send the form. To obtain a claim form, go to MyQHealth at www.UPMyQHealth.com or call Quantum Health at (855) 649-3855. You will usually be reimbursed for a covered Prescription Drug Product within 30 days after receipt of your claim form. The completed claim form, along with the prescription receipt, must be sent to:

OptumRx
P.O. Box 29450
Hot Springs, AR 71903

If you have a claim for urgent care, OptumRx will review your claim as an urgent care claim. You, your Doctor, or your pharmacist must submit your urgent care claim by calling OptumRx at (877) 559-2955. An urgent care claim is a claim for care in which the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

- would, in the opinion of a Doctor with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment being requested.

Any claim that a Doctor with knowledge of your medical condition determines is an "urgent care claim" as defined herein will be treated as an urgent care claim.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours of receipt of the claim. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified as soon as possible, but not later than 24 hours after receipt of your claim. In this case you will be notified of the information necessary to complete the claim and you will have 48 hours to provide the information. You will then be notified of the decision as soon as possible, but not later than 48 hours after the earlier of: OptumRx's receipt of the information or the end of the 48 hour period given to provide the information.

For all other claims, a decision regarding your claim will be sent to you within a reasonable period of time, but not later than 30 days of receipt of your claim.

If your claim is denied, OptumRx will send you a written denial notice that will describe the Plan's internal and external review processes, including information regarding how to initiate an appeal. The notice will include information sufficient to identify the claim involved (including the date of service, the Provider, and the claim amount, if applicable). The notice will refer to the part of the Plan on which the denial is based and explain the reason for denial, including the denial code, if any, and its corresponding meaning, as well as a description of Optum Rx's standard, if any, that was used in denying your claim (e.g., if your claim was denied because the prescription drug has not been approved for that use, or is experimental or unproven, the denial notice will include an explanation of this determination). If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your claim, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. In addition, the notice will include the following:

- a description of any additional material or information needed to perfect your claim and an explanation of why such material or information is necessary;
- a statement describing your right to receive, upon request, a copy of the diagnosis code and/or treatment code, and their corresponding meanings. If you request such code(s), OptumRx will provide the code(s) (and its corresponding meaning) to you as soon as practicable following receipt of your request; and
- information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the healthcare reform law to assist you with the internal claims and appeals and external appeal process.

Except as described in the section, "Your Options if the Internal Claim and Appeal Process Is Not Followed" on page 157, you must first exhaust all appeals available to you under the Plan – both internal and external – before you have a right to bring a civil action under ERISA regarding your denied claim. See the section, "Pharmacy Claim Questions and Appeals," immediately below for information regarding your appeal rights.

PHARMACY CLAIM QUESTIONS AND APPEALS

In the event you receive an adverse determination following a request for coverage of a claim, you have the right to appeal the adverse benefit determination to OptumRx in writing within 180 days of receipt of notice of the initial coverage decision. This process is known as an "internal appeal" or "internal review." If a non-urgent care claim is denied, there are two levels of internal appeal to OptumRX. If an urgent care claim is denied, there is only one level of internal appeal.

This appeal process will ordinarily apply to determinations as to your eligibility for Pharmacy Program coverage only if they are part of a claim for actual benefits. However, if your coverage is discontinued retroactively for reasons other than the failure to make your contributions on time, you may file an appeal that contests the retroactivity of the termination of coverage. Such an appeal should be filed with the Plan Administrator, not with OptumRx.

How to Submit a Non-Urgent Care Claim Decision for Internal Review:
To initiate a request for an internal review of a non-urgent care claim denial, you or your Doctor must provide in writing, your name, member ID, Doctor's name and phone number, the prescription drug for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. This information must be mailed to:

OptumRx Attn: Appeals Request
OptumRx c\o Appeals Coordinator CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

Internal Appeal Determinations – Non-Urgent Care Claims:
OptumRx will review your first level appeal, and a decision regarding your appeal will be sent to you within a reasonable period of time, but not later than 30 days of receipt of your written request. If your appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the prescription drug has not been approved for that use, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and at no charge, the information used to review your request for coverage and will describe the second level appeal procedures.

If you are not satisfied with the coverage decision made on the first level appeal, you may make a written request for a second level appeal. Your written request must be made within 90 days of your receipt of notice of the first level appeal decision. You must submit a second level appeal in order to preserve your rights to external review or to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") concerning the Plan's denial of your claim. To initiate a second level appeal, you or your Doctor must provide in writing, your name, member ID, Doctor's name and phone number, the prescription drug for which benefit coverage has been denied, a statement of each and every reason why you believe your claim should be approved, and any additional information that may be relevant to your second level appeal. This information must be mailed to:

OptumRx Attn: Appeals Request
OptumRx c\o Appeals Coordinator CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

Your second level appeal will be reviewed by OptumRx. OptumRx will notify you and your Doctor in writing within a reasonable period of time, but not later than 30 days of receipt of your written request for appeal. The decision of OptumRx made on your second level appeal is the Plan's Final Internal Adverse Benefit Determination.

If, in response to your second level appeal OptumRx intends to issue a Final Internal Adverse Benefit Determination on the basis of new or additional evidence first considered as part of your second level appeal, or on the basis of a new or different rationale than relied on before, OptumRx will provide you, free of charge, with a description of such new evidence or rationale in advance of its determination so that you may have a reasonable opportunity to respond before the final determination is made.

If your second level appeal is denied (i.e., there is a Final Internal Adverse Benefit Determination), the denial notice will describe the Plan's external review process (if it is available with respect to your appeal) including information regarding how to initiate such an appeal. The notice will include information sufficient to identify the appeal involved (including the date of service, the Provider, and the appeal amount, if applicable). The notice will refer to the part of the Plan on which the denial is based and explain and discuss the reason for denial, including the denial code, if any, and its corresponding meaning, as well as a description of OptumRx's standard, if any, that was used in denying your appeal (e.g., if your appeal was denied because the prescription drug has not been approved for that use, or is experimental or unproven, the denial notice will include an explanation of this determination). If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this

fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. In addition, the notice will include the following:

- a statement describing your right to receive, upon request and at no charge, the information relevant to your claim and appeal;
- a statement describing your right to receive, upon request, a copy of the diagnosis code and/or treatment code, and their corresponding meanings. If you request such code(s), OptumRx will provide the code(s) (and its corresponding meaning) to you as soon as practicable following receipt of your request;
- information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the healthcare reform law to assist you with the internal claims and appeals and external appeal process; and
- a statement regarding your right, if eligible, to request an external review of OptumRx's Final Internal Adverse Benefit Determination and, if external review is unavailable or also results in a denial of your claim, to bring a civil action under Section 502(a) of ERISA.

Internal Appeal of Urgent Care Claims:
You have the right to request an urgent appeal of an adverse determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your Doctor may call OptumRx at (888) 403-3398, fax to (877) 239-4565 or write to:

OptumRx Attn: Appeals Request
OptumRx c\o Appeals Coordinator CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

Your appeal of an urgent care claim must identify each and every reason why you believe your claim should be approved. Appeals of urgent care claims are reviewed by OptumRx. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours of receipt of the claim. The decision of OptumRx of an urgent care appeal is the Plan's Final Internal Adverse Benefit Determination.

If your urgent care appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the prescription drug has not been approved for that use, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and at no charge, the information used to review your appeal.

The denial notice will also describe the Plan's external review process, which, if you are eligible, includes an expedited process for urgent care claims. If you are not eligible for external review, or if your urgent claim appeal is denied on external review, you have the right to bring a civil action under Section 502(a) of ERISA.

Pharmacy Internal Appeal Process:
OptumRx will review all first level, second level, and urgent care appeals. Any review on appeal will not give deference to previous claim denials. The person who will perform the internal review of your appeal denial will not be the same person as the person who made the initial decision to deny your claim nor a subordinate of the person who denied your claim. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. If the initial denial is based in whole or in part on a medical judgment, OptumRx will consult with a healthcare professional with appropriate training and experience in the relevant medical field. This healthcare professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination. If OptumRx obtained advice from medical or vocational experts with respect to your claim, these experts will be identified, regardless of whether OptumRx relied on their advice when deciding your claim.

In deciding whether to appeal a denial or to present additional evidence or testimony, you have the right to review your claim file. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim.

Your Options if the Internal Claim and Appeal Process Is Not Followed:
If you believe OptumRx, as applicable, has failed to follow the internal review procedures described above and that failure denies you the opportunity to obtain a decision on the merits of your claim, you may take the following action, without having to exhaust the Plan's internal claim and appeal process:

- initiate an immediate external review of your claim or appeal using the external review process described below, if your claim is otherwise eligible for review under such external review process; or
- bring a civil action under Section 502(a) of ERISA, if your claim is not otherwise eligible for review under the external review process described below.

Before taking such action, however, you may request a written explanation of the failure from OptumRx and OptumRx will furnish such explanation within 10 days of your request. You may want to obtain such explanation because a request for immediate review can be rejected if it is determined that the failure was de minimis and unlikely to cause you prejudice or harm. OptumRx's explanation may therefore help you to decide whether to proceed outside the internal review process. If an external reviewer or a court rejects your request for immediate review of your claim on the basis that the violation was de minimis, you have the right to resubmit and pursue the internal appeal of your claim. OptumRx will notify you of this right within a reasonable time after the external reviewer or court rejects your claim for immediate review, but no later than 10 days following such rejection.

External Review Program:
An external review program is offered in certain circumstances. If, after exhausting your internal appeals, you are not satisfied with the determination made by OptumRx, you may be entitled to request an external review of OptumRx's determination. You may also be entitled to an external review (or, to file a civil action under Section 502(a) of ERISA) if OptumRx fails to follow the internal review procedures described above and that failure denies you the opportunity to obtain a decision on the merits of your claim. If you request such immediate external review and it is rejected, you may be able to resubmit and pursue the internal appeal of your claim. See "Your Options if the Internal Claim and Appeal Process Is Not Followed," above. The external review process is available at no charge to you.

You may request an external review of an adverse benefit determination based upon any of the following:

- the denial of your claim by reason of medical judgment (clinical reasons), including the application of the Plan's exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

You or your representative may request a standard external review by sending a written request to OptumRx at the address set out in its Final Internal Adverse Determination. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your Member ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received OptumRx's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance Member ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). OptumRx has entered into agreements with three or more IROs that have agreed to perform such reviews.

Standard External Review
A standard external review is comprised of all of the following:

- a preliminary review by OptumRx of the request;
- a referral of the request by OptumRx to the IRO; and
- a decision by the IRO.

Within 5 business days after receipt of the request, OptumRx will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the Prescription Drug Product that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that OptumRx may process the request.

Within one (1) business day of completing its preliminary review, OptumRx will issue a notification in writing to you. If your request for external review is complete, but not eligible for external review, the notification will include the reason(s) for its ineligibility and furnish contact information for the Employee Benefits Security Administration. If your request is not complete, the notification will describe the information or materials needed to make your request complete. You must furnish the missing information or materials before the end of the 4 month filing period or within 48 hours following your receipt of the notification, whichever is later. If the request is eligible for external review, OptumRx will assign an IRO to conduct such review. The IRO has no material affiliation or interest with OptumRx. OptumRx will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

OptumRx will furnish to the IRO documents and information relevant to your claim within five business days of the assignment. If there is information or evidence you or your Doctor wish to submit in support of the request that was not previously provided, you may include this information with the request for external review, and OptumRx will include it with the documents forwarded to the IRO.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days. Generally speaking, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in making its decision:

- all relevant medical records;
- the attending health care professional's recommendations;
- reports from appropriate health care professionals and other documents submitted by OptumRx on behalf of the Plan, by you, or by your treating Provider;
- the terms of the Plan, including any applicable and lawful review criteria developed and used by the Plan;
- appropriate practice guidelines, based on evidence-based standards, which may include practice guidelines developed for Federal government, national or professional medical societies, boards and associations; and
- the opinion of the IRO's clinical reviewer(s) based on such available information or documents which such clinical reviewer deems appropriate.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by OptumRx. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and OptumRx, which will include the clinical basis for the determination and any other information as required by applicable law.

Upon receipt of a Final External Review Decision reversing OptumRx's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the Prescription Drug Product.

Expedited External Review:
An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.
You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination with respect to an urgent care claim for which you have filed a request for an internal appeal, and the adverse benefit determination involves a medical condition for which the time frame for completion of the internal appeal process described above for an urgent care claim would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a Final Internal Adverse Benefit Determination, if such determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service, procedure or product for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of a request for an expedited external review, OptumRx will determine whether you meet both of the following:

- you are or were covered under the Plan at the time the health care service or procedure that is at issue in the request was provided; and
- you have provided all the information and forms required so that OptumRx may process the request.

After OptumRx completes the review, OptumRx will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, OptumRx will assign an IRO in the same manner OptumRx utilizes to assign standard external reviews to IROs. OptumRx will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by OptumRx. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to OptumRx.

Regardless of whether the external review is a standard external review or expedited external review, if the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for the Prescription Drug Product in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the Prescription Drug Product.

You may contact Quantum Health at the toll-free number on your Member ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

TEMPORARY EXTENSION OF CLAIM AND APPEAL DEADLINES DUE TO COVID-19

The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"). The Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in the sections "How To File

Pharmacy Claims" and "Pharmacy Claim Questions and Appeals" – for you to submit or request any or all of the following:

- an initial claim for benefits;
- an internal appeal (first level, second level or urgent care appeal) of your denied claim;
- an external review of an adverse benefit determination or Final Internal Adverse Benefit Determination; or
- information needed to perfect an incomplete request for external review.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your right to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in the sections "How To File Pharmacy Claims" and "Pharmacy Claim Questions and Appeals" - you may have additional time to do so. Please contact OptumRx at (877) 559-2955 for more information.

PHARMACY PROGRAM DEFINITIONS

(See also Medical Benefit Definitions in the "Glossary" section, beginning on page 133.)

Brand-Name*:* A Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that OptumRx identifies as a Brand-Name product, based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or Generic based on a number of factors. You should know that all products identified as Brand Name by the manufacturer, pharmacy, or your Doctor may not be classified as Brand Name by the Plan.

Coinsurance Maximum: The maximum amount you are required to pay for Covered Medical Services and/or Covered Prescription Drug Products on the OptumRx Prescription Drug List in a single Calendar Year. For more information, see "Pharmacy Benefit Payment Information", beginning on page 144.

Deductible: The cost of covered pharmacy (and covered medical services) you are responsible for paying before pharmacy benefits (and/or medical benefits) are payable under the Plan. No prescription drug Deductible applies under the Non-HDHP PPO Option. For more information, see "Pharmacy Benefit Payment Information", beginning on page 144.

Generic: A Prescription Drug Product: (1) that is chemically equivalent to a Brand-Name drug or (2) that OptumRx identifies as a Generic product based on available data resources including, but not limited to, Medi- Span, that classify drugs as either brand or Generic based on a number of factors. You should know that all products identified as Generic by the manufacturer, pharmacy, or your Doctor may not be classified as Generic by the Plan.

In-Network Pharmacy*:* A pharmacy that has:

- Entered into an agreement with OptumRx or the OptumRx designee to provide Prescription Drug Products to covered persons;
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products; and
- Been designated by OptumRx as an In-Network Pharmacy.

An In-Network Pharmacy can be a Retail Pharmacy, Specialty Pharmacy, or Mail Order Pharmacy.

Medically Necessary: Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by OptumRx or its designee, within OptumRx's sole discretion. The services must be:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.

- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. OptumRx reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within OptumRx's sole discretion. OptumRx develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services

New Prescription Drug Product*:* A Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by the Prescription Drug List Management Committee.
- December 31st of the following Calendar Year.

Pharmacy Coinsurance Payment:
The portion of the Prescription Drug Cost or Predominant Reimbursement Rate you must pay for a Prescription Order or Refill of a Prescription Drug Product. You are responsible for paying the applicable Pharmacy Coinsurance Payment, up to the Coinsurance Maximum, when Prescription Drug Products on the OptumRx Prescription Drug List are obtained from a Retail Pharmacy, Mail Order Pharmacy or Specialty Pharmacy.

Pharmacy and Therapeutics Committee: The committee that OptumRx designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Predominant Reimbursement Rate: The amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at an Out-of-Network Retail Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at an Out-of-Network Retail Pharmacy includes a dispensing fee and sales tax. OptumRx calculates the Predominant Reimbursement Rate using the OptumRx Prescription Drug Cost that applies for that particular Prescription Drug Product at most In-Network Pharmacies.

Prescription Drug Cost: The rate OptumRx has agreed to pay its In-Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at an In-Network Pharmacy.

Prescription Drug List: A list that identifies those Prescription Drug Products for which benefits are available under the Plan. This list is subject to periodic review and modification by OptumRx (generally on January 1st and July 1st). You may determine to which tier a particular Prescription Drug Product has been assigned at MyQHealth at www.MyQHealth.com or by calling Quantum Health at (855) 649-3855.

Prescription Drug Product*:* A medication, product, or device that has been approved by the FDA and, under federal or state law, can be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the Plan, this definition includes:

- Inhalers (with spacers);
- Insulin;
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood-testing strips - glucose;

    - Urine-testing strips - glucose;
    - Ketone-testing strips and tablets;
    - Lancets and lancet devices.
- Neocate infant formula (if it is the sole source of nutrition).

Prescription Order or Refill: The directive to dispense a Prescription Drug Product issued by a duly licensed healthcare provider whose scope of practice permits issuing such a directive.

Reasonable and Customary Charge: The usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

Vision Care Program

Page

OVERVIEW

The Vision Care Program is a fully insured plan, underwritten by Fidelity Security Life Insurance Company ("FSL") and administered by EyeMed Vision Care, LLC, 4000 Luxottica Place, Mason, OH, 45040. All vision care benefits and coverage described in this Flex Guide are subject to the terms of the Group Policy between FSL and Union Pacific Corporation under which the benefits are provided. If there is any conflict between this Flex Guide and the Group Policy, the Group Policy will govern. Union Pacific has selected EyeMed Vision Care to provide services through a preferred vision provider network and First American Administrators, Inc. ("FAA"), a wholly-owned subsidiary of EyeMed, to administer vision claims. In this capacity, FAA has been granted discretionary authority to make factual findings, to interpret the terms of the Vision Care Program, and to determine entitlement to benefits under the Union Pacific Corporation Group Health Plan ("Plan") in accordance with the terms of the Vision Care Program.

ELIGIBILITY – EMPLOYEE, SPOUSE, AND OTHER DEPENDENTS

You are eligible to participate in Union Pacific's Vision Care Program on the date you become an eligible Employee. You may elect vision coverage for you and your Dependents whether or not you elect medical coverage and regardless of the medical option you elect. For purposes of the Vision Care Program, the terms "Employee", "Spouse", "Dependent" and "Child" are defined in the "Eligibility" section of this Flex Guide (see page 7).

HOW VISION BENEFITS WORK

The Medical Deductible, Coinsurance amounts, and Coinsurance limits under the Medical Options do not apply toward vision care services, nor are the Copayments or optional vision care expenses under this benefit counted toward the Medical Deductible, Coinsurance amount, or Coinsurance Maximum under the Medical Options. Therefore, you are responsible for each applicable Copayment or optional vision care service or supply expense.

EyeMed Vision Care has developed a network of retail locations, licensed optometrists, and ophthalmologists. Participating providers have agreed to discounted fees.

For those Employees who are currently an EyeMed Vision Care member, you may locate a participating provider by following the instructions shown below:

1. Go to the EyeMed Vision Care website at www.eyemedvisioncare.com.
2. Click on the "Members" link.
3. Then click on "Member Login"
4. Type in your User ID/Email Address and password or select an UserID/Email Address and Password, then click on "Login" or "Register" whichever is applicable.
5. Once you have registered and/or logged into the site, click on the "Find Provider" link.

For Employees who are not currently an EyeMed Vision Care member, go to www.eyemedvisioncare.com. Under "Find a Provider" choose "Access Network" on the drop down list. Then enter your ZIP code and click on "Submit".

EyeMed Vision Care is solely responsible for the selection and credentialing of providers in its network. All providers selected by EyeMed Vision Care are independent contractors. Union Pacific and its participating subsidiaries do not guarantee the quality of care provided by these providers.

SCHEDULE OF BENEFITS

SCHEDULE OF BENEFITS: EYEMED VISION CARE NETWORK PROVIDER	
Type of Service	**Member Cost**
Eye Examination (Once every 12 months)	$0 Copay
Retinal Imaging	Up to $39
Contact Lens Fit and Follow Up: Contact lens fit and two follow-up visits once a comprehensive eye examination has been completed Standard (conventional or disposable) * Premium (toric or multifocal) **	 Up to $55 90% of Charge
Standard Plastic Lenses (Once every 12 months): Includes single vision, bifocal, or trifocal lenses Standard progressive (add on to bifocal member cost) Premium progressive Other add-ons and services	 $20 Copay $85 $85 + (80% of Charge) less $120 allowance 80% of Charge
Lens options: UV treatment Standard Anti-reflective coating Tint (solid and gradient) Standard plastic scratch coating Standard polycarbonate (Dependents under age 19) Standard polycarbonate (members age 19 or older) Polarized	 $15 $45 $ 0 $ 0 $ 0 $40 80% of Charge
Frames (One pair every 12 months)	80% of balance over $130 allowance
Additional Pairs of Eyeglasses (lenses and frames)	60% of charge for additional pairs of eyeglasses through EyeMed Vision Care. Call (866) 723-0513 for additional information about these purchases.
Additional Pairs of Contact Lenses	85% of charge for additional pairs of conventional contact lenses through EyeMed Vision Care. Call (866) 723-0513 for additional information about these purchases.
Contact Lenses (Once every 12 months in lieu of eyeglasses): Contact lens allowance covers materials only Conventional Disposable (initial supply of disposable/ planned replacement contact lenses) Medically Necessary ***	 85% of balance over $130 allowance 100% of balance over $130 allowance $0 Copay
*Standard Contact Lens Fitting – Spherical clear contact lenses in conventional wear and planned replacement (examples include, but are not limited to, disposable, frequent replacement, etc.). **Premium Contact Lens Fitting – All lens designs, material, and specialty fittings other than Standard Contact Lenses (examples include toric, multifocal, etc.). *** For purposes of the Vision Care Program, Medically Necessary refers to situations where a vision correction prescription cannot be filled through conventional eyeglasses, determined in accordance with criteria established by EyeMed Vision Care.	
Note: Services must be received from an EyeMed Vision Care provider in order for the Copays to be applicable. Discount is not available on those frames where the manufacturer prohibits a discount. Member is responsible for all applicable taxes.	

SCHEDULE OF BENEFITS: OUT-OF-NETWORK PROVIDER	
Type of Service	**Out-of-Network Allowance ******
Eye Examination (Once every 12 months)	Up to $35
Retinal Imaging	None
Contact Lens Fit and Follow Up: Contact lens fit and follow-up visits once a comprehensive eye examination has been completed	None
Standard Plastic Lenses (Once every 12 months): Single Vision Bifocal Trifocal Standard Progressive Premium Progressive	 Up to $25 Up to $40 Up to $55 Up to $40 Up to $40
Lens Options UV treatment Standard Anti-reflective coating Tint (solid and gradient) Standard plastic scratch coating Standard Polycarbonate (Dependents under age 19) Standard polycarbonate (members age 19 or older) Other add-ons and services	 None None Up to $5 Up to $5 Up to $5 None None
Frames (Once every 12 months)	Up to $63
Contact Lenses (Once every 12 months in lieu of eyeglasses): Conventional Disposable Medically Necessary (with prior approval)*****	 Up to $72 Up to $72 Up to $200
**** Member pays full cost and is reimbursed up to the allowance when an EyeMed claim form is filed ***** For purposes of the Vision Care Program, Medically Necessary refers to situations where a vision correction prescription cannot be filled through conventional eyeglasses, determined in accordance with criteria established by EyeMed Vision Care.	
Note: A discount is not available on those frames where the manufacturer prohibits a discount. The member is responsible for applicable taxes.	

LASER VISION BENEFIT

A member is entitled to a 15% discount or a 5% discount on promotional pricing on LASIK and PRK treatments through the U.S. Laser Network, including pre-operative and post-operative care. However, if the treatment is performed at a LasikPlus Center, which is part of the U.S. Laser Network, and the member elects to obtain pre-operative and post-operative care not from the LasikPlus Center provider, **the other provider may charge additional fees for the pre-operative and post-operative care** for which the member will be responsible, and such fees are not subject to the 15% discount or the 5% discount on promotional pricing.

Accessing the Benefit:

1. To locate the nearest U.S. Laser Network provider, a member must call (877) 552-7376.
2. After the member has located a U.S. Laser Network provider, the member should contact the U.S. Laser Network provider and identify himself or herself as an EyeMed Vision Care member. The member should schedule a consultation with a U.S. Laser Network provider to determine if he or she is a good candidate for laser vision correction.
3. If it is determined that the member is a good candidate for laser vision correction, the member should schedule a treatment date with a U.S. Laser Network provider.
4. To activate the benefit, the member must call the U.S. Laser Network again at (877) 552-7376 with his or her scheduled treatment date.

5. At the time the treatment is scheduled, the member will be responsible to remit an initial refundable deposit to U.S. Laser Network. (If the member should decide not to have the treatment, the deposit will be returned. Otherwise, the deposit will be applied to the total cost of the treatment.)
6. At the time the member remits the deposit, U.S. Laser Network will issue to the member an authorization number confirming the EyeMed Vision Care discount. This authorization number will be sent to the member's U.S. Laser Network provider prior to treatment.
7. On the day of the treatment, it is the responsibility of the member to pay or arrange to pay the balance of the fee.
8. After the treatment, the member should follow all post-operative instructions carefully. In addition, the member is responsible for scheduling any required follow-up visits with a U.S. Laser Network provider to ensure the best results from the laser vision correction.

EXCLUSIONS (NOT COVERED THROUGH THE VISION CARE PROGRAM)

- OptoMap services
- Aniseikonic lenses and tonography
- Medical treatment of eye disease or injury; surgical refraction
- Non-prescription (plano) eyewear
- Protective (safety) eyewear
- Replacement of lost eyewear
- Services not prescribed by an optometrist or ophthalmologist
- Special lens designs or coatings, other than those previously described
- Two pairs of eyeglasses, in lieu of a bifocal
- Visual therapy

OBTAINING VISION BENEFITS

Before visiting a participating EyeMed Vision Care provider location for an eye exam, glasses or contact lenses, it is recommended that members call ahead for an appointment, although some retail locations may have walk-in appointments available. Upon arrival, the Union Pacific group number of 9891003 should be provided to the receptionist or sales associate. If you do not recall the group number, you must indicate that you are a participant in the EyeMed Vision Care Program sponsored by Union Pacific and your Employee ID number should be provided so that eligibility can be verified.

EyeMed Vision Care Customer Service can be reached seven days a week (Monday through Saturday, 7:30 a.m. to 11:00 p.m. and Sunday 11:00 a.m. to 8:00 p.m. Eastern Time) at (866) 723-0513.

The EyeMed Vision Care Program allows members to select the provider of their choice, in or out of the network. EyeMed Vision Care has designed the Plan to deliver quality care, matched with comprehensive benefits, at the most affordable cost, through in-network services. Members have the flexibility to visit an out-of-network provider with a reduction in benefits.

In-Network Benefits:
When vision services are received at a participating EyeMed Vision Care provider location, members are only responsible for the designated Plan Copays and any services or eyewear that exceed any allowances, as well as state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training). Providers verify eligibility and submit claims for reimbursement. The following steps outline how to access the in-network Plan benefit.

1. Locate the nearest EyeMed Vision Care provider. Members may locate EyeMed Vision Care providers nearest them by calling the Customer Care Center at (866) 723-0513 and utilizing the Interactive Voice Response (IVR) system, by speaking with a Customer Service Representative, by referring to their member brochure, or by accessing the Provider Locator Service through the EyeMed Vision Care website at www.eyemedvisioncare.com.
2. Schedule an appointment. Members should identify themselves as having EyeMed Vision Care benefits at this time.

3. Receive services. A member must indicate that he/she is a participant in the EyeMed Vision Care Program sponsored by Union Pacific and your Employee ID number should be provided so that eligibility can be verified. Once eligibility is verified, members may access their benefits.
4. Claims for in-network vision services are processed automatically for you by the EyeMed Vision Care provider. Members are not required to file vision claims, unless the provider is **not** in the EyeMed Vision Care Network.

Out-of-Network Benefits:
EyeMed Vision Care members who choose to use their vision benefits at a non-participating provider location will need to pay for all services and materials at the point of purchase; then submit an out-of-network claim form to FAA/EyeMed Vision Care for reimbursement. Reimbursement for out-of-network claims will be made in accordance with the Out-of-Network Schedule of Benefits on the next few pages.

HOW TO FILE A VISION CLAIM

Filing Process:
Only out-of-network Vision Claims require use of this filing process, outlined here. When using an EyeMed Vision Care provider, your claims are filed automatically on your behalf.

The following steps should be completed prior to submitting an out-of-network claim form:

1. Request an out-of-network claim form.
   Members may obtain the form through the EyeMed Vision Care website at www.eyemedvisioncare.com or by calling the Customer Care Center at (866) 723-0513. The claim form will be mailed directly to the member within 24 hours. Forms can also be e-mailed or faxed. The claim form is also available on the Workforce Resources page via the UP Employees website at:
   http://home.www.uprr.com/emp/ec/forms/index.shtml.
2. Schedule an appointment. Members may make an appointment with the out-of-network provider of their choice.
3. Pay for all services. Members must pay for all services at the point of care and ask the provider for an itemized receipt.
4. Complete the Patient Information portion of your claim form.
5. Complete the Plan Information Portion of the claim form. The Union Pacific group number is 9891003.
6. Complete the Request for Reimbursement portion of the form.
7. Sign the claim form. If the patient is a minor, the parent or legal guardian is required to sign the claim form.
8. Attach itemized receipts from your provider to the claim form.
9. Within one year from the date that the care was provided, the completed claim form, along with the itemized receipts, must be faxed to (866) 293-7373 or mailed to:
   FAA/EyeMed Vision Care
   Attn: OON Claims Processing
   P.O. Box 8504
   Mason, OH, 45040-7111

Time Frames for Processing Claims:

Activity	Time Frame
Plan – Determination of Initial Claim • Initial Review Decision • Extension Period	 30 calendar days 15 calendar days
Plan – Notice of Incomplete Claim	Within time for initial determination, including extension period.
Claimant – Time to Complete Claim	15 Months
Plan – Determination of Claim after receipt of complete information.	Within time for initial determination, including extension period.

All of the vision care services under the Plan are considered post-service claims. If a claim for benefits is denied (in whole or in part), FAA will notify the member in writing of the specific reasons for the denial and of the process for requesting a review of the denial.

VISION CLAIM QUESTIONS AND APPEALS

Appeal of Denied Claims:
A member may request a review of a denied claim. To make this request, the member must send FAA a written letter of appeal no more than 180 calendar days after the date of the denied claim. The written letter of appeal should include the following:

1. The claim number, a copy of the EyeMed Vision Care denial information, or a copy of the FAA Explanation of Benefits;
2. The item of vision coverage that the member feels was misinterpreted or inaccurately applied; and
3. Additional information from the eye care provider that will assist FAA in completing its review of the appeal, such as documents, medical and/or financial records, questions, or comments.

The written letter of appeal should be mailed to the following address:

FAA/EyeMed Vision Care
Attn: Quality Assurance Department 4000
Luxottica Place
Mason, OH 45040

Time Frames for Appealed Claims:

Activity	Time Frame
Claimant – Appeal of Adverse Determination	180 calendar days after the denial
Plan – Decision on Appeal	30 calendar days

FAA will review the appeal for benefits and notify the member in writing of its decision, as well as the reasons for the decision, with reference to specific Plan provisions. FAA has been given final authority to make claims determinations in accordance with the terms of the Vision Care Program. The decisions of FAA are conclusive and binding.

For more information on member rights and how to obtain further review under the Employee Retirement Income Security Act of 1974 (ERISA) as amended, please refer to the ERISA section of this document beginning on page 260.

TEMPORARY EXTENSION OF CERTAIN DEADLINES DUE TO COVID-19

The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"). In response, the Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in the sections "How to File a Vision Claim" and "Vision Claim Questions and Appeals" – for you to submit an initial claim for benefits or request an appeal of a denied claim for benefits.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your rights to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in the sections "How to File a Vision Claim" and "Vision Claim Questions and Appeals," you may have additional time to do so. Please contact EyeMed Vision Care at (866) 723-0513 for more information.

Member Grievance Procedure:
If a member is dissatisfied with the services provided by an EyeMed Vision Care provider, the member should either write to EyeMed Vision Care at the address indicated above or call the EyeMed Vision Care Member Services toll free telephone number at (866) 723-0513. The EyeMed Vision Care Member Services representative will log the

telephone call and attempt to reach a resolution to the issues raised by the member. If a resolution is not able to be reached during the telephone call, the EyeMed Vision Care Member Services representative will document all of the issues or questions raised. EyeMed Vision Care will use its best efforts to contact the member within four business days with an acknowledgement to the issues or questions raised, and will resolve the issue within 30 calendar days. If the member is not satisfied with the resolution, the member may appeal the grievance by using the appeal procedures set forth above.

VISION CARE PROGRAM - DOMESTIC PARTNERS

Overview:
An Employee may elect to enroll the Employee's Domestic Partner for vision coverage. An Employee cannot cover a Domestic Partner if the Employee is legally married to another individual. Moreover, you cannot choose coverage for both a Spouse and a Domestic Partner.

Definition of Domestic Partner:
A "Domestic Partner" of an Employee is an individual who is the same or opposite sex of the Employee and:

- Is age 18 or older;
- Has lived with the Employee for at least six (6) months and whose principle place of residence is with the Employee;
- Has a serious and committed relationship with the Employee;
- Is financially interdependent with the Employee;*
- Is not related to the Employee in any way that would prohibit legal marriage to the Employee;
- Is not the Employee's "Spouse" as defined in the "Eligibility" section on page 7 of this Flex Guide;
- Is not legally married to nor a domestic partner of another individual; and
- Is not otherwise eligible for coverage under the Flexible Benefits Program.

**Financially Interdependent* *means that the Employee and the Domestic Partner share the cost of food and housing. Both the Employee and Domestic Partner do not have to contribute equally or jointly for each of these expenses as long as both are responsible for such costs.*

Eligibility:
You are eligible to enroll your Domestic Partner for vision coverage on the date you become an eligible Employee. Your election to enroll a Domestic Partner in vision coverage is separate and distinct from your vision election under the Vision Care Program for you and your Dependent children, if any. This means vision coverage you may have elected for you and any Dependent child does not cover your Domestic Partner. You may elect vision coverage for your Domestic Partner regardless of whether you elect vision coverage for you and any Dependent child.

When you enroll your Domestic Partner for vision coverage, you are affirming that you have reviewed the Vision Care Program's eligibility terms and the individual meets the above definition of a Domestic Partner. You are also affirming that you will advise Workforce Shared Services about any change in circumstances that affects your Domestic Partner's eligibility for coverage. In the event of fraud or intentional misrepresentation of material fact regarding a Domestic Partner's eligibility for coverage, coverage for such Domestic Partner may be terminated retroactively, and claims paid for an individual found to be ineligible for coverage will be the responsibility of the Employee. Deductibles, Coinsurance and other plan limitations will also be recalculated and may cause further expense to the Employee. The Plan reserves the right to require documentation with respect to the individuals you elect to enroll in coverage, including (but not limited to) evidence that they satisfy the Plan's definition of a Domestic Partner, their social security numbers, and such other information necessary to administer the Vision Care Program.

If your Domestic Partner becomes your Spouse (see definition of a Spouse in the "Eligibility" section on page 7 of this document), he/she will be no longer eligible for Domestic Partner vision coverage. If you wish to continue to provide vision coverage to your former Domestic Partner as your Spouse, you must contact Union Pacific Workforce Shared Services at (877) 275- 8747, within 30 days of the date of your marriage to add the individual as a Dependent.

Effective Dates of Coverage:
Open Enrollment: Elections made during open enrollment are effective January 1st of the following year.

Newly Eligible During a Year: If you become newly eligible during a Calendar Year, your vision election for your Domestic Partner will be effective on the date you become an eligible Employee if you submit your election within the first 30 days following the date you become an eligible Employee. If you do not complete your election during this 30-day period, your Domestic Partner will not receive vision coverage for the Calendar Year unless you are permitted to enroll your Domestic Partner pursuant to a Life Event as described in the "Life Events & Permissible Benefits Changes" section on pages 28-63 of this Flex Guide.

Life Event Changes: Changes in your vision election for your Domestic Partner resulting from a Life Event will be effective on the first day of the month following the event date.

Note: Changes in elections resulting from a Life Event must be made within 30 days following the event. Changes after 30 days can only be made during the next annual open enrollment period for coverage effective January 1st of the following year.

Employee Contributions:
In most cases, a Domestic Partner will not be considered a "Dependent" as defined under the Flexible Benefits Program or the Internal Revenue Code. As a result, your monthly contribution for Domestic Partner vision benefits will be made on an after-tax basis. Your monthly contribution for Domestic Partner vision coverage will begin the next full month of participation following receipt of notification to enroll your Domestic Partner. In addition, federal tax law requires that Union Pacific include in your taxable income the difference, if any, between the fair market value of the Domestic Partner vision coverage and your monthly contribution. The additional amount included in your income is subject to applicable federal, state, and local income tax withholding, as well as Social Security and/or Railroad Retirement tax withholding. Union Pacific will charge you the fair market value for Domestic Partner vision coverage in 2021 so there will not be any additional amount included in your taxable income related to electing this coverage.

Domestic Partner Vision Benefits:
Except as provided in this section, "Vision Care Program-Domestic Partners", a Domestic Partner is eligible for the same vision benefits as an Employee with Vision Care Program Employee Only coverage. For more information, see the "Schedule of Benefits" tables beginning on page 78.

Domestic Partner claims should be submitted using the Domestic Partner's member ID assigned by EyeMed.

When Domestic Partner Vision Coverage Ends:
Vision coverage for your Domestic Partner will end as of the last day of the month in which:

- You terminate employment;
- You cease to be an eligible Employee;
- You cease making any required contribution;
- Your Domestic Partner no longer meets the definition of a Domestic Partner; or
- The Flexible Benefits Program or the Domestic Partner vision benefit option thereunder ends.

A Domestic Partner is not a "qualified beneficiary" and thus, is not eligible to elect COBRA continuation coverage. However, an Employee who elects to continue Vision Care Program coverage under COBRA may also elect to continue Domestic Partner Vision Care Program coverage for a Domestic Partner who was enrolled in Domestic Partner Vision Care Program coverage immediately before the date the Employee's vision coverage ended as a result of the Employee's COBRA qualifying event. The Employee will be entitled to continue Domestic Partner Vision Care Program coverage until the Employee's Vision Care Program COBRA continuation coverage ends.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND OTHER FIDUCIARIES

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan Fiduciaries, including FAA, shall have discretionary authority to make factual findings, interpret and administer the terms of the Plan, and determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan.

Any finding, interpretation, or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the finding, interpretation, or determination was arbitrary and capricious.

Medical Care Program-Domestic Partners

Page

ELIGIBILITY

Domestic Partner PPO Coverage: You are eligible to enroll your Domestic Partner for medical benefits in the Domestic Partner PPO ("Program") on the date you become an eligible Employee. You may enroll your Domestic Partner in coverage regardless of whether you elected coverage for you and any Dependent-Child. Coverage you may have elected for you and your Dependent Child does not cover your Domestic Partner. Your election to enroll a Domestic Partner in the Union Pacific Group Health Plan (the "Group Health Plan") is an election that is separate and distinct from your own Plan election for you and your Dependent children, if any.

Also, if you are eligible for a California HMO Option, the Domestic Partner Non-HDHP PPO is available only if you do not enroll your registered Domestic Partner in a California HMO Option.

If your Domestic Partner becomes your Spouse (see definition of a Spouse in the "Eligibility" section of this Flex Guide on page 7), he/she will no longer be eligible for the Domestic Partner Non-HDHP PPO. However, you may enroll your Spouse under your coverage. If you wish to continue to provide medical benefits to your former Domestic Partner as your Spouse, you must contact Union Pacific Workforce Shared Services within 30 days of the date of your marriage to add the individual as a Dependent.

California HMO Option: Eligibility requirements for enrolling your registered Domestic Partner (and/or dependent(s) of your registered Domestic Partner) are determined under the terms of the California HMO Option in which you are eligible.

COVERAGE OPTIONS

Domestic Partner Non-HDHP PPO Coverage: You are eligible to choose Domestic Partner Non-HDHP PPO coverage for your Domestic Partner. This section describes benefits under the Domestic Partner Non-HDHP PPO coverage. The Domestic Partner Non-HDHP PPO means the UnitedHealthcare (UHC) Non-HDHP PPO if the Employee lives within the UHC "Choice Plus" Network or the BlueCross/BlueShield (BCBS) Non-HDHP PPO if the Employee lives within the BlueCard Network. Therefore, Domestic Partners have either the UHC or the BCBS Non-HDHP PPO available to them, but not both. Under the Domestic Partner Non-HDHP PPO, only the Domestic Partner is eligible to enroll. Children of a Domestic Partner are not eligible for coverage under the Domestic Partner Non-HDHP PPO. (Children of a Domestic Partner are only eligible for coverage under the Plan under a California HMO Option.)

California HMO Option: Alternatively, if you are eligible to enroll in a California HMO, you may enroll an individual that is your registered Domestic Partner (and any dependent(s) of your registered Domestic Partner) in Family coverage along with yourself and your Dependent Child(ren), if any, if such individual(s) are eligible for coverage under the terms of the California HMO. Eligibility requirements, terms and conditions of coverage, and a description of HMO benefits for registered Domestic Partner coverage are described in the information provided by the HMO. Although you must make a separate election to enroll your registered Domestic Partner (and any dependent(s) of your registered Domestic Partner), your registered Domestic Partner (and any dependent(s) of your registered Domestic Partner) will be enrolled in California HMO Family coverage with you (and any of your enrolled Dependent Children).

"California HMO Option" means an HMO offered under the Plan in which an Employee residing in California is eligible to enroll.

No other medical program coverage is available to a Domestic Partner or a Domestic Partner's child .

Note: Domestic Partners will receive an ID card with their own member identification number from either UMR, a subsidiary of UnitedHealthcare, or BlueCross/BlueShield, as applicable for the Non-HDHP PPO, or from Kaiser for a California HMO.

DEFINITIONS

Domestic Partner Non-HDHP PPO Coverage:
For purposes of the Domestic Partner Non-HDHP PPO, the following definition of Domestic Partner applies.

A "**Domestic Partner**" of an Employee is an individual who is the same or the opposite sex of the Employee and:

- Is age 18 or older;
- Has lived with the Employee for at least six months and whose principal place of residence is with the Employee;
- Has a serious and committed relationship with the Employee;
- Is financially interdependent with the Employee;*
- Is not related to the Employee in any way that would prohibit legal marriage to the Employee;
- Is not the Employee's "Spouse" as defined for purposes of the Non-HMO Medical options under Union Pacific's Medical Care Program;
- Is not legally married to nor a Domestic Partner of another individual; and
- Is not otherwise eligible for coverage under the Flexible Benefits Program.

**Financially Interdependent* *means that the Employee and the Domestic Partner share the cost of food and housing. The Employee and Domestic Partner do not have to contribute equally or jointly for each of these expenses as long as both are responsible for such costs.*

An Employee may choose coverage for either a Spouse or a Domestic Partner, but not both. An Employee cannot cover a Domestic Partner if the Employee is legally married to another individual.

When you enroll your Domestic Partner in the Domestic Partner Non-HDHP PPO, you are affirming that you have reviewed the Program's eligibility terms and that the individual meets the above definition of a Domestic Partner. You are also affirming that you will advise Workforce Shared Services about any change in circumstances that affects your Domestic Partner's eligibility for coverage. In the event of fraud or intentional misrepresentation of material fact regarding a Domestic Partner's eligibility for coverage, coverage for such Domestic Partner may be terminated retroactively, and claims paid for an individual found to be ineligible for coverage may be the responsibility of the Employee. Deductibles, Coinsurance, Copays and annual out-of-pocket or other Plan limitations may also be recalculated and may cause further expense to the Employee.

The Plan reserves the right to require documentation with respect to the individuals you elect to enroll in coverage, including (but not limited to) evidence that they satisfy the Plan's definition of a Domestic Partner, their social security numbers, and such other information necessary to administer the Plan.

California HMO Options:
For purposes of the California HMO Options, a registered Domestic Partner is defined pursuant to the plan documents that govern the specific California HMO Option.

A registered Domestic Partner is not your "Spouse" as defined in the "Eligibility" section on page 7 of this Flex Guide. An Employee may choose medical coverage for either a Spouse or a registered Domestic Partner (as such terms are defined in the California HMO plan documents), but not both. An Employee cannot cover a registered Domestic Partner if the Employee is legally married to another individual.

When you enroll your registered Domestic Partner in a California HMO, you are affirming that you have reviewed the Program's eligibility terms and that such individual is eligible for coverage under the terms of the California HMO. You are also affirming that you will advise Workforce Shared Services about any change in circumstances that affects your registered Domestic Partner's eligibility for coverage. In the event of fraud or intentional misrepresentation of material fact regarding a registered Domestic Partner's eligibility for coverage, coverage for such registered Domestic Partner may be terminated retroactively, and claims paid for an individual found to be ineligible for coverage may be the responsibility of the Employee. Deductibles, Coinsurance, Copays and annual out-of-pocket or other Plan limitations may also be recalculated and may cause further expense to the Employee. The plan reserves the right to require documentation with respect to the individuals you elect to enroll in coverage,

including (but not limited to) evidence that they satisfy the plan's definition of a registered Domestic Partner, their social security numbers, and such other information necessary to administer the Plan.

EFFECTIVE DATE OF COVERAGE

Domestic Partner Non-HDHP PPO Coverage:

Open Enrollment: Elections made during open enrollment are effective January 1st of the following year.

Newly Eligible During the Year: If you become newly eligible during the Calendar Year, your medical election for your Domestic Partner will be effective on the date you become an eligible Employee, assuming you complete your election form within 30 days from the date you become an eligible Employee. If you do not complete your election during this 30-day period, your Domestic Partner will not receive medical coverage for the Calendar Year unless you are permitted to enroll your Domestic Partner pursuant to a "Life Event" as described in the "Life Events & Permissible Benefits Changes" on page 62 of this document.

Life Event Changes: Changes in your medical election for your Domestic Partner resulting from a Life Event will be effective on the first day of the month following the event date.

Note: Changes in elections resulting from a Life Event must be made within 30 days following the event. Changes after 30 days can only be made at the next annual open enrollment period for coverage effective January 1st of the following year.

California HMO Options:
You may separately enroll your registered Domestic Partner (and dependent(s) of your registered Domestic Partner) if you elect medical coverage under a California HMO in which you are eligible. See "Eligibility and Effective Date of Coverage" related to medical program coverage in the "Eligibility" section on page 13 of this Flex Guide.

EMPLOYEE CONTRIBUTIONS

Your monthly contribution for Domestic Partner medical coverage (Non-HDHP PPO or, if eligible, California HMO) will be made on an after-tax basis. Your monthly contribution for Domestic Partner medical coverage will begin as soon as administratively practicable following the date your completed elections are received.

In addition, federal tax law requires that Union Pacific include in your taxable income the difference, if any, between the fair market value of the Domestic Partner medical coverage and your monthly contribution. The additional amount included in your income is subject to applicable federal, state, and local income tax withholding, as well as Social Security and/or Railroad Retirement tax withholding.

The following example is designed to illustrate how this difference is calculated:

Fair Market Value of Domestic Partner Medical Coverage/Month*	$1,025.00
Employee After-Tax Monthly Contribution Amount*	$ 315.00
Additional Amount included in Income each Month	$ 710.00

**The amounts shown are for illustrative purposes only and may not reflect the actual fair market value of the coverage or the actual Employee after-tax contribution amount.*

MEDICAL CARE PROGRAM – DOMESTIC PARTNER

UHC Non-HDHP PPO and BCBS Non-HDHP PPO Medical Care Program:
You may enroll your Domestic Partner in the UHC Non-HDHP PPO or in the BCBS Non-HDHP PPO, based upon your residential ZIP code.

If your Domestic Partner is enrolled in the UHC Non-HDHP PPO, then, except as provided in this section, *Medical Care Program – Domestic Partner*, all terms and conditions of the UHC Non-HDHP PPO as described in this 2021 Flex Guide shall apply to such Domestic Partner.

If your Domestic Partner is enrolled in the BCBS Non-HDHP PPO, then, except as provided in this section, *Medical Care Program – Domestic Partner*, all terms and conditions of the BCBS Non-HDHP PPO as described in the *2021 BlueCross/BlueShield Healthcare Benefit Plan Medical Options* shall apply to such Domestic Partner.

The Schedule of Benefits for the UHC Non-HDHP PPO and the BCBS Non-HDHP PPO applicable to Domestic Partner medical coverage is as follows:

2021 SCHEDULE OF BENEFITS **UHC AND BCBS NON-HDHP PPOs** **(DOMESTIC PARTNER MEDICAL COVERAGE)**		
Plan Feature	**In Network**	**Out of Network**
MEDICAL CARE, MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT		
Annual Deductible Individual	$1,250	$2,500
Coinsurance after Deductible Plan pays You pay	85% 15%	65% 35%
Coinsurance Maximum (Annual Limit after Deductible) Individual	$2,750	$5,500
Preventive Care As outlined under "Health Management Programs" page 117 and "Preventive Pharmacy Benefits" page 147.	Paid at 100%	No benefits are paid for a Non-Network Provider
Maximum Lifetime Benefit	Unlimited, except as otherwise indicated in the "Covered Health Services" section, page 85.	

PHARMACY PROGRAM	
Retail	
Annual Deductible	NA
Pharmacy Coinsurance You pay: Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	Up to 31-day Supply* No Deductible $10 Copay 30% 40%
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	No Deductible N/A $30/$90 $60/$150
Mail Order	
PHARMACY PROGRAM	
Annual Deductible	NA

Pharmacy Coinsurance You pay: Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	Up to 90-day Supply No Deductible $25 Copay 25% 40%	
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	 No Deductible N/A $75/$225 $150/$375	
Pharmacy Coinsurance Maximum	Combined Medical and Pharmacy Coinsurance Maximum See "Coinsurance Maximum"	
*Certain generic drugs may be purchased at a Retail Pharmacy for a 90-day supply. **If the actual cost of the drug is less than the stated minimum, the member will pay the actual drug cost.		
OUT-OF-POCKET MAXIMUM		
Annual Deductible and Coinsurance Maximum Individual Family: 2	$4,000	$8,000

Regardless of whether your Domestic Partner is enrolled in the UHC Non-HDHP PPO or the BCBS Non-HDHP PPO, a Domestic Partner may not purchase Conversion Coverage.

California HMO Options:
As an alternative to Domestic Partner Non-HDHP PPO coverage, an Employee living in California may enroll his/her registered Domestic Partner (and any dependent(s) of his/her registered Domestic Partner) in a California HMO available to the Employee. Eligibility requirements, terms and conditions of coverage, and a description of HMO benefits for registered Domestic Partner coverage are described in the information provided by the HMO.

CLAIMS AND REVIEW PROCEDURES

For information regarding how to file benefit claims and appeals, refer to "Medical Claims Appeals" and "Medical Claim Questions and Appeals" in the "Medical Options: United Healthcare" section of this Flex Guide, if the Covered Person resides in the UHC Network area. If the Covered Person resides in the BlueCross/BlueShield Network area, refer to "How to File Medical Claims" and Medical Appeals Procedures" in the *2021 BlueCross/BlueShield Healthcare Benefit Plan Medical Options*.

Legal Information

Page

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR & OTHER FIDUCIARIES

In carrying out their respective responsibilities under the Union Pacific Corporation Medical Care Program (the "Medical Care Program") and the self-insured Medical Care Program Options, the Plan Administrator and other Plan Fiduciaries including UMR, Quantum Health, OptumRx, BlueCross/BlueShield (BCBS), PayFlex, and EyeMed Vision Care shall have discretionary authority to make factual findings and to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan and the Union Pacific Self-Insured Medical Options.

Any finding, 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.

THIRD PARTY LIABILITY/SUBROGATION

Third Party Liability:
The Plan does not cover any expenses for which a third party is responsible as a result of having caused or contributed to a Sickness or Injury. The Plan may nonetheless pay the benefits that would otherwise be payable hereunder, subject to the Plan's rights described below. By filing a claim for benefits under the Plan, the covered person (or that person's legal representative) agrees to these terms.

Right of Subrogation, Reimbursement and Offset:

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation or Federal Employers' Liability Act case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation Federal Employers' Liability Act coverage, other insurance carriers, or third party administrators.

- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.

- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

    - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
    - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
    - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own negligence.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan Administrator has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You or Your Dependents; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

MEDICAID

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

REFUND FOR OVERPAYMENT OF BENEFITS

UMR, BlueCross/BlueShield of Nebraska, EyeMed Vision Care and OptumRx and have the right to a refund of any medical, mental health/substance abuse, vision care or prescription benefits they paid to you if you, your Dependents, or Domestic Partner did not pay for those expenses or if you, your Dependents, or Domestic Partner were reimbursed for any of those expenses by a source other than UMR, BlueCross/BlueShield of Nebraska, EyeMed Vision Care or OptumRx. The refund is the difference between the amount of benefits actually paid and the amount that should have been paid under the terms of the Medical Care Program. In addition, the Plan has a right to a refund of any benefit amount paid in excess of the benefit amount you are entitled to receive under the terms of the Plan.

If you do not promptly refund the required amount, UMR, BlueCross/BlueShield of Nebraska, EyeMed Vision Care or OptumRx may, in addition to other rights they may have, reduce the amount of any future benefits payable under the Union Pacific self-insured Medical Care Program Options and under any group benefit plans they issued to your employer by the amount of the refund.

Health Savings Account Contribution Program

Page

ELIGIBILITY

You are eligible for the Health Savings Account ("HSA") Contribution Program if you:

- Are an Employee enrolled in a medical option ("HDHP Medical Option");
- Have established an HSA with The Bank of New York Mellon, the custodian of BenefitWallet, through the account opening process for Employees ("BenefitWallet HSA"); and
- Are otherwise eligible under federal tax law to contribute to an HSA.

For purposes of the HSA Contribution Program, the terms "Employee" and "Spouse" have the same meanings as defined in the "Eligibility" section of this Flex Guide.

Besides being enrolled in an HDHP, generally, the other HSA eligibility requirements are that you cannot be claimed as another person's tax dependent, you cannot be enrolled in Medicare, and you cannot have any health coverage other than your HDHP coverage, except for certain types of permitted insurance or permitted coverage as described in IRS Publication 969, such as insurance limited to a specific disease. In addition, you may not have coverage under a healthcare FSA which may be used to pay your HDHP Deductible. You should refer to IRS Publication 969 for more information regarding HSA eligibility requirements.

If these eligibility requirements are met, you may make Employee HSA Contributions to your BenefitWallet HSA. In addition, Union Pacific will make a contribution to your BenefitWallet HSA. See the "Contributions" section below for more details. BenefitWallet is the sole HSA provider to whom Union Pacific will forward HSA Contributions.

ENROLLMENT AND EFFECTIVE DATES

If you enroll in a HDHP Medical Option, you will then be given the opportunity to open an HSA with BenefitWallet. You must open an HSA with BenefitWallet in order to receive the Union Pacific HSA Contribution and make Employee HSA Contributions. An HSA must be opened by using the SAP "My Benefits" link, which includes an HSA section. Your account is considered opened when you have selected to agree to the HSA "Terms & Conditions", including the use of the HSA section of the website as an electronic signature*.

*Note: The information collected during the enrollment process will be used by BenefitWallet to fulfill its obligations to establish and maintain a Customer Identification Program ("CIP") pursuant to the USA Patriot Act, the Bank Secrecy Act, the Money Laundering Control Act and all other applicable anti-money laundering laws. Patriot Act screening seeks to match identity on the elements of Name, Social Security Number, Date of Birth and Physical Address. Individuals listing a P.O. Box as their address will have their account opening pended until BenefitWallet can obtain and verify a physical address by two forms of identification. No funds, including Union Pacific HSA Contributions, can be deposited to any Employee's account until the physical address is provided and verified and the account is properly opened.

Enrollment During the Calendar Year

If you enroll in a HDHP Medical Option and are otherwise eligible, but have not previously opened an HSA with BenefitWallet, you may open an account mid-year and indicate the amount of Employee HSA Contributions you wish to make each month. To open your HSA account and make a contribution election, you must log on to SAP "My Benefits" and complete your election(s) in the HSA section.

Your Employee HSA Contribution election must be made prior to the payroll cutoff date of the month in order for your election to be effective on your next regular payroll date.

Enrollment During Open Enrollment

If you wish to contribute to a BenefitWallet HSA for the following Calendar Year, you must enroll in a HDHP Medical Option (or be enrolled by default) during open enrollment.

In order for your Employee HSA Contribution election to be effective beginning with the first payroll in January 2021, you must either make your Employee HSA Contribution election while entering your 2021 Open Enrollment elections in SAP, or if after Open Enrollment has closed, through the HSA Contribution election process within SAP

no later than the January payroll cutoff date. An HSA election made during this time will be deducted beginning with the first payroll in January 2021.

HSA Contribution Election Carryover
A new Employee HSA Contribution election is not required for a subsequent Calendar Year when you re-enroll in a HDHP Medical Option. Thus, if you have an HSA Contribution election in place for December 2020 and do not make a change to this election prior to the January payroll cutoff date, your December 2020 election amount will carryover and be deducted for January 2021.

Effective Date of Changes
Once you have enrolled in a HDHP Medical Option, you may choose to stop or change your existing Employee HSA Contribution election on a monthly basis. Your Employee HSA Contribution election change and revised HSA Employee Contribution salary reduction amount will be effective prospectively. An Employee HSA Contribution election change or revocation must be made prior to the payroll cutoff date of the month in order for such change or revocation to be effective on your next following payroll date. For example, if your Employee HSA Contributions are deducted from pay you receive on the last business day of the month and you make your election prior to the September payroll cutoff date, then your election will be effective with your end of September paycheck. If you make your Employee HSA Contribution election after the September payroll cutoff date, your election will be effective with your end of October paycheck.

To start making Employee HSA Contributions or to change or revoke your existing Employee HSA Contribution election, you must log onto SAP "My Benefits", which includes an HSA section, and complete your election(s).

You will have an opportunity to make a new Employee HSA Contribution election for the next Calendar Year if, during the open enrollment Period for the next Calendar Year, you enroll in a HDHP Medical Option for such Calendar Year.

Regardless of whether you enroll during the Calendar Year or during open enrollment, your Employee HSA Contributions will be deducted from your pay on a before-tax basis.

HOW AN HSA WORKS

Like an IRA, an HSA must be established with a trustee or custodian, such as BenefitWallet. An HSA allows you to pay for most medical expenses on a tax-free basis. Although you may establish an HSA with any qualified HSA trustee or custodian, **you must establish an HSA with BenefitWallet in order to make pre-tax Employee HSA Contributions and receive the Union Pacific HSA Contribution.** For more information regarding HSAs, please contact BenefitWallet at (866) 415-0650 or visit their website at www.mybenefitwallet.com.

Note: Your BenefitWallet HSA is not an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

CONTRIBUTIONS

Contributions to your BenefitWallet HSA under the Health Savings Account Contribution Program may consist of a Union Pacific HSA Contribution and Employee HSA Contributions, should you elect to make Employee HSA Contributions.

You may elect the amount of Employee HSA Contribution, if any, that you make to a BenefitWallet HSA. In addition, if you are eligible to make pre-tax payroll Employee HSA Contributions, Union Pacific will contribute an amount to your BenefitWallet HSA, even if you elect not to make your own Employee HSA Contributions. Your pre-tax payroll Employee HSA Contributions and the Union Pacific HSA Contribution will be deposited into your BenefitWallet HSA.

If your BenefitWallet HSA is closed during the Calendar Year for any reason, your Employee HSA Contribution election is deemed to be revoked. You must open (or re-open) your BenefitWallet HSA before electing to resume Employee HSA Contributions. Furthermore, you must open (or re-open) your BenefitWallet HSA before December 15, 2021 in order to receive the Union Pacific HSA Contribution for which you are eligible, but did not already receive, for the Calendar Year.

There is an annual maximum limit under Federal income tax law that may be contributed to your BenefitWallet HSA and any other HSA you may establish. This limit applies to both your contributions and contributions from any other source, including Union Pacific. For 2021, this maximum limit is $3,600 if you are enrolled in Employee Only HDHP Medical Option coverage and $7,200 if you are enrolled in Family HDHP Medical Option coverage. This maximum contribution limit generally applies only if you satisfy the HSA eligibility requirements for all 12 months during the Calendar Year. These limits may be prorated if you are not HSA eligible for the entire Calendar Year, or if you change your HDHP coverage level during the Calendar Year. You should contact BenefitWallet or your tax or legal advisor if you have questions regarding these limits. If you are or will attain age 55 or older during the Calendar Year, additional "catch-up" contributions are permitted. For 2021, your additional catch-up contribution cannot exceed $1,000.

- Your HSA maximum limit may differ from these limits if you either have no HDHP Medical Option coverage for one or more months in a Calendar Year and/or you have switched between Employee Only and Family HDHP Medical Option coverage during a Calendar Year. You should refer to IRS Publication 969 and/or consult your tax or legal advisor for more information.
- There are special rules for determining the HSA maximum limit when an Employee and Spouse are both eligible to have HSAs. You should refer to IRS Publication 969 and/or consult your tax or legal advisor for more information.
- If you or a family member becomes eligible for Medicare during the Calendar year, you should refer to IRS Publication 969 and/or consult your tax or legal advisor regarding possible effects on your HSA contribution limitations for the year.

Union Pacific HSA Contribution
The amount Union Pacific will deposit in your BenefitWallet HSA as a Union Pacific HSA Contribution depends upon the HDHP Medical Option coverage level for which you enroll. If you enroll in a HDHP Medical Option during open enrollment and open a BenefitWallet HSA, Union Pacific will contribute $900 to your BenefitWallet HSA if you elect Employee Only HDHP coverage and $2,100 if you elect Family HDHP coverage.

If you are hired or first become eligible to enroll in a HDHP Medical Option during the Calendar Year and establish a BenefitWallet HSA, the annual amount deposited in your BenefitWallet HSA based on your coverage level election (Employee Only or Family) for such Calendar Year will be prorated on a monthly basis. This pro- rated amount will be based on the number of **whole** months remaining in the Calendar Year as of the date your HDHP Medical Option coverage is effective. For example, if you are hired on June 22nd and enroll in Employee Only HDHP Medical Option coverage, 6/12 of $900, which is $450, will be deposited in your BenefitWallet HSA for the Calendar Year. This means that if you are hired or first become eligible to enroll in a HDHP Medical Option after December 1, 2021, no Union Pacific HSA Contribution will be made to your BenefitWallet HSA for 2021.

If, as a result of a Life Event during the Calendar Year, you change your level of coverage under a from Employee Only to Family HDHP Medical Option coverage, Union Pacific will make an additional deposit into your BenefitWallet HSA. The amount of this additional Union Pacific HSA Contribution will be the prorated difference between the $2,100 Union Pacific HSA Contribution for Family coverage and the $900 Union Pacific HSA Contribution for Employee Only coverage. For example, if your HDHP Medical Option coverage changes from Employee Only coverage to Family coverage on July 1st, an additional $600 will be deposited in your BenefitWallet HSA. This additional amount is 6/12 of the difference between the $2,100 Union Pacific HSA Contribution for Family coverage and the $900 Union Pacific HSA Contribution for Employee Only coverage, ($2,100 - $900 =$1,200 x 6/12 = $600).

The amount of the Union Pacific HSA Contribution made to your BenefitWallet HSA will not change if, as a result of a Life Event (e.g., a divorce or death), you change your level of coverage under the HDHP Medical Option from Family coverage to Employee Only coverage. However, you should consult with your tax advisor to assure that the amount contributed by Union Pacific and your own HSA Contributions does not exceed the allowable limit.

In order to receive a Union Pacific HSA Contribution for a Calendar Year, your BenefitWallet HSA must be opened during the time you are enrolled in HDHP Medical Option coverage, but no later than the last payroll cutoff date (December 15) of the Calendar Year. Union Pacific HSA Contributions will be deposited in your BenefitWallet HSA as part of a regular payroll cycle that generally is within 45 days of the later of your enrolling in HDHP Medical Option coverage or opening your BenefitWallet HSA. In certain circumstances (e.g., you are hired late in the Calendar Year), your Union Pacific HSA Contribution for 2021 may not be deposited in your BenefitWallet HSA until early 2022. In that case, the amount of the Union Pacific HSA Contribution attributable to 2021 will not be reported on your 2021 Form W-2, but instead will be reported on your 2022 Form W-2. If this should occur, Union Pacific will inform you of the amount you must treat as contributed to your HSA for 2021.

Employee HSA Contributions
If you are enrolled at the same level of HDHP Medical Option coverage (i.e., Employee Only or Family) for the entire Calendar Year, the maximum amount of Employee HSA Contribution you may elect for a Calendar Year is the difference between your applicable annual HSA maximum limit $3,600 if enrolled in Employee Only HDHP Medical Option coverage or $7,200 if enrolled in Family HDHP Medical Option coverage) and the maximum amount Union Pacific could contribute to your BenefitWallet HSA as a Union Pacific HSA Contribution. This means that for 2021, your maximum Employee HSA Contribution cannot exceed $2,700 if you are enrolled in Employee Only HDHP Medical Option coverage for the entire Calendar Year and $5,100 if you are enrolled in Family HDHP Medical Option coverage for the entire Calendar Year. If you are or will attain age 55 or older in 2021 these limits are increased by $1,000 for "catch-up" contributions.

If you initially enroll in Employee Only HDHP Medical Option coverage and as a result of a Life Event change your coverage level during the Calendar Year to Family HDHP Medical Option coverage, your maximum Employee HSA Contribution for the Calendar Year is $5,100, plus the $1,000 "catch-up" contribution if you are or will attain age 55 during the Calendar Year. If you initially enroll in Family HDHP Medical Option coverage and as a result of a Life Event change your coverage level to Employee Only HDHP Medical Option coverage, your maximum Employee HSA Contribution for the Calendar Year for tax purposes will be a prorated amount based on the number of months you were enrolled in the Family coverage and the number of months you were enrolled in Employee Only coverage. This amount may be less than the amount you have contributed. Therefore, you should consult with your tax advisor.

These are maximum Employee HSA Contributions under the HSA Contribution Program. You are responsible for ensuring that your Employee HSA Contributions, combined with the Union Pacific HSA Contribution and any other contributions you make to an HSA do not exceed your legal maximum HSA contribution limit.

IF YOU ARE NO LONGER HSA ELIGIBLE

If during the Calendar Year you are no longer enrolled in a HDHP Medical Option, your Employee HSA Contribution election will terminate at the end of the month in which your HDHP Medical Option coverage terminates. Any Employee HSA Contributions or Union Pacific HSA Contribution made after you are no longer enrolled in HDHP Medical Option coverage will be included in your compensation and are subject to applicable income and employment taxes. Such amounts may also be subject to an additional 6% excise tax, if determined to be an Excess Contribution and not distributed in a timely manner, as discussed below.

In addition, the HSA Contribution Program is not a health plan and as a result, COBRA continuation coverage rights do not apply. This means that although you may have a COBRA right to continue group health plan coverage under a HDHP Medical Option, you cannot make Employee HSA Contributions and you will not receive the Union Pacific HSA Contribution when continuing group health plan coverage under COBRA.

EXCESS CONTRIBUTIONS

If excess contributions are made to your HSA for a Calendar Year, you must withdraw the contributions, along with any earnings associated with the excess contributions, by the due date (including extensions) of your federal tax return or else incur a 6% excise tax. The amount of the excess contributions, along with the associated earnings that are removed in order to avoid the excise tax, are includable in your gross income for income tax purposes. To make

the withdrawal, complete and file an Excess Contribution Form, located on the BenefitWallet member website www.mybenefitwallet.com; or call BenefitWallet Customer Service at (866) 415-0650. BenefitWallet may charge you a fee to process the withdrawal of excess contributions and associated earnings. For more information, consult your legal or tax advisor.

Dental Care Program

Page

OVERVIEW

The Dental Care Program ("Plan") is self-insured by Union Pacific and is administered by Metropolitan Life Insurance Company ("MetLife") through its office in Utica, NY. Union Pacific has contracted with MetLife to administer a Preferred Dental Provider Network and to administer dental claims. In this capacity, MetLife has been granted discretionary authority to interpret the terms of the Dental Care Program and to determine entitlement to Plan benefits in accordance with the terms of the Dental Care Program. For purposes of the Dental Care Program, the term "Employee" has the same meaning as defined in the "Eligibility" section of this Flex Guide (see page 13).

You should also refer to the Eligibility section and the Glossary section of this Flex Guide for the definition of other terms applicable to this Dental Care Program section.

ELIGIBILITY (EMPLOYEE, SPOUSE, AND OTHER DEPENDENTS)

You are eligible to participate in Union Pacific's Dental Care Program on the date you become an eligible Employee. You may elect dental care coverage for you and your Dependents, whether or not you elect medical coverage or regardless of the medical option you elect. See the "Eligibility" section on page 13 of this Flex Guide for the Dental Care Program's definition of Dependents.

Note: COBRA continuation rights and obligations for the Dental Care Program are explained in the "Continuation of Coverage under COBRA" section beginning on page 23 of this Flex Guide.

DENTAL BENEFITS SCHEDULE

The schedule of dental care benefits is shown below. Certain limitations and exclusions may apply. It is important that you refer to the provisions that follow for details about your benefits. You are encouraged to contact MetLife at (888) 777-6806, option 1, or visit their website at www.metlife.com/mybenefits. When prompted for Company Name, type in "Union Pacific Railroad" and you will be directed to the MyBenefits registration screen. Then either register or, if you have already registered, provide your user name and password. MetLife is available to answer questions about coverage or to request a Predetermination of Benefits prior to receiving dental care services other than Emergency treatment, routine oral exams, x-rays, cleaning, or fluoride treatments.

DENTAL EXPENSE BENEFITS			
TYPE OF EXPENSES	**DEDUCTIBLE**	**PLAN'S COINSURANCE**	**BENEFIT MAXIMUMS (AFTER DEDUCTIBLE)**
A) Diagnostic and Preventive Services	None	100%	$2,000/person per Calendar Year for Types A, B, and C combined
B) Basic Services	$50 per person*	80%	
C) Major Services	$50 per person*	50%	
D) Orthodontia	None	50%	$2,000/person per lifetime
E) Temporo Mandibular Joint (TMJ) therapy and/or appliances	$50 per person*	50%	$650/person per lifetime
*There are not separate $50 per person Deductibles for each Service Type (B, C, and E), but instead there is a single $50 per person Deductible for Type B, C, and E Services combined per year. An expense is incurred on the date the dental service is completed. Any expenses that apply toward your Deductible and are incurred during the last three months of the Calendar Year while coverage is in effect will also be applied to your Deductible for the next Calendar Year while coverage is in effect.			
DENTAL CARE PROGRAM BENEFITS			
Benefits are payable for covered dental services performed or prescribed by a Dentist while coverage is in effect. After the Deductible is met for Types B and C and E Services, the Dental Care Program pays benefits for a percentage of the contracted fees, if a Preferred Dentist is used, or a percentage of the Reasonable and Customary Charges as determined by MetLife, if a Non-Preferred Dentist is used.			

When Benefits End:
For information regarding when benefits end, see the "When Coverage Ends" section on page 21 of this Flex Guide.

PREFERRED DENTIST PROGRAM

To receive the greatest benefit and minimize your costs, you may choose to obtain your dental care from a Dentist who participates in MetLife's Preferred Dentist Program (PDP) if available in your location. A PDP Dentist is a general Dentist or specialist who accepts fees that are typically 10% to 35% below "community average" charges as payment in full for services rendered. If you use a Dentist who is not a PDP Dentist, your coverage (i.e., Deductibles and Coinsurance) remains the same. However, the fees you are charged for services by a non-PDP Dentist may be higher than the fees charged by a Dentist participating in the Preferred Dentist Program.

Non-PDP Dentists may bill you for the balance between their charges and what MetLife pays, based on what it has determined to be Reasonable and Customary. This is commonly referred to as balance billing. MetLife's PDP Dentists have agreed to accept the contracted fees as payment in full. However, non-PDP Dentists have not agreed to these contracted fees and may charge an amount that exceeds these fees.

When you visit a PDP Dentist, identify yourself as a member of MetLife's Preferred Dentist Program **by showing your MetLife Identification Card (the Union Pacific group number is 37625) or providing your Employee ID number.**

MetLife is solely responsible for the selection, credentialing, and monitoring of Dentists in its PDP network. All Dentists selected by MetLife are independent contractors. Union Pacific and its participating subsidiaries do not guarantee the quality of care provided by these Dentists.

Reasonable and Customary Charges:
For non-PDP Dentists, Reasonable and Customary Charges are used to determine the benefit payment to be made. The Reasonable and Customary allowance is the lowest of:

- **Dentist's Customary Fee** - The usual fee that the individual Dentist most frequently charges the majority of his or her patients for a service or a supply (profile is updated quarterly); or
- **Reasonable Allowance** - The usual charge of most other Dentists or other providers in the same geographic area for the same or similar services or supplies; or
- **Dentist's Actual Charge** - The actual charge for the services or supplies.

COVERED DENTAL CARE SERVICES

The Plan recommends requesting a Predetermination of Benefits (see page 195) for any potentially costly procedures to ensure that you know what the Plan will cover and what your financial responsibility will be before receiving treatment.

TYPE OF EXPENSES	INCLUDES:
A) Diagnostic and Preventive Services (100% Plan Coinsurance) Diagnostic procedures help the Dentist evaluate the type and extent of necessary treatment. Preventive procedures, such as cleaning and fluoride treatments, are performed during routine examinations. $2,000 maximum benefit per Calendar Year for expense types A, B and C (combined).	• Up to two oral exams per Calendar Year. This coverage limit applies regardless of the type of exam (comprehensive, periodic, problem focused, etc.). • Periodontal cleanings. • Full mouth x-rays once every 60 consecutive months. • Bitewing x-rays once per Calendar Year for adults. • Bitewing x-rays twice per Calendar Year for your Dependents. • Two cleaning and scaling treatments per Calendar Year. • Two topical fluoride treatments per Calendar Year for your Dependents under age 19 only. • Space maintainers for your Dependents under age 19 only. • Laboratory tests and procedures. • Emergency pain relief treatment. • Fissure sealant for your Dependent children under age 19, once every 60 months.

TYPE OF EXPENSES	INCLUDES:
B) Basic Services (80% Plan Coinsurance) $2,000 maximum benefit per Calendar Year for expense types A, B and C (combined).	• Fillings, including amalgam and composite (tooth colored) on all teeth, including molars. • Simple extractions. • Root canal treatment. • Periodontal treatment. • Oral surgery, except for the surgical extraction of impacted wisdom teeth. • Repair or re-cementing of crowns, inlays, onlays, dentures, or bridgework. Crown repairs are covered with a limit of once in 36 months. Also covered are relining and rebasing of dentures at least six months after installation. Only one repair or rebasing may be covered in any 36-consecutive month period. If the Plan pays for a new or replacement denture, it will not cover the repair and rebasing of the old denture. • Injection of antibiotic drugs by the attending Dentist. • Soft tissue grafts to treat periodontal disease of the gums. • Bone grafts to treat periodontal disease. • Debridement service limited to one per lifetime. • Gold Foils are limited to once in seven years. Predetermination of Benefits is recommended, but not required, for bone and skin grafts. See section on "Predetermination of Benefits" on page 195.

C) Major Services
(50% Plan Coinsurance)
$2,000 maximum benefit per Calendar Year for expense types A, B and C (combined).
	• Initial installation of fixed bridgework, including inlays and crowns used as abutments, and partial or removable dentures. Any adjustments that occur six months after installation are also covered provided dental expense benefits are in effect.
	• Bridges and Dentures are limited to one time in seven years.
	• Temporo Mandibular Joint (TMJ) appliance, including installation and adjustments to appliances.
	• Surgical extractions, including impacted wisdom teeth.
	• General anesthesia.
	• The replacement of crowns, inlays, onlays, post and cores, crown buildups, implants and implant prosthetics is covered if the item is at least 7 years old.
	• The replacement of an existing partial or fully removable denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework. The work is covered only if one of the following occurs**:**
	  • Replacement of a removable denture or fixed bridgework is required because you lost one or more teeth after the bridgework or denture was installed.
	  • An existing removable denture or fixed bridgework is at least seven years old and unusable.
	  • A temporary full denture is replaced with one that is permanent because the existing denture cannot be made permanent. Installation must take place within 12 months after the temporary denture was installed.
	  • Addition of teeth to an existing partial removable denture or to bridgework that replaces natural teeth which were removed after the denture or bridgework was installed.
	• Dental implants.
	• Treatment for Bruxism (grinding of teeth) with replacement frequency of once every 24 months.

TYPE OF EXPENSES	INCLUDES:
C) Major Services **(50% Plan Coinsurance)** $2,000 maximum benefit per calendar year for expense types A, B and C (combined)..	Crowns, inlays, onlays, and gold fillings are covered if necessary to restore the structure of decaying teeth as long as the teeth cannot be reconstructed by an amalgam filling. If a tooth can be restored with a material such as amalgam, only the payment that would apply to that procedure will be made toward the charge for another type of restoration chosen by you and your Dentist.
D) Orthodontia (50% Plan Coinsurance) Orthodontia benefits are payable for orthodontic services dealing with teeth irregularities and their correction (often by braces). **$2,000 maximum lifetime limit per person for expense type D.**	• Covered treatment consists of appliance therapy and related diagnostic procedures. Benefits for orthodontic treatment are payable at 50% of the charge (50% of PDP fee, if PDP Dentist, or 50% of Reasonable and Customary fee, if not a PDP Dentist). For claim processing purposes, MetLife considers 20% of the orthodontic covered expense to be incurred at the time of appliance placement. The balance of the Orthodontic Lifetime Maximum ($2,000) will be prorated by the number of months in the treatment plan and paid for monthly over the entire course of treatment regardless of when your provider requires payment. Orthodontic benefits for these months of treatment will be paid automatically provided that the patient is still eligible for coverage, active treatment is still being rendered, and the maximum benefit has not been paid.

EXCLUSIONS

- Any duplicate appliance or prosthetic device.
- Charges by the Dentist for completing dental forms.
- Charges for broken appointments.
- Cosmetic surgery or supplies unless any such surgery or supply is:
  - Otherwise a covered dental service; and
  - Required for reconstructive surgery incidental to, or following surgery that results from a trauma, infection, or disease of the involved part; or
  - Required for reconstructive surgery due to congenital defect or anomaly of a Dependent child that results in a functional defect.
- Expenses and associated expenses incurred for services and supplies for Experimental/Investigational Services. The fact that an Experimental/Investigational Service is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental/ Investigational for the treatment of that particular condition.
- Instruction for oral care, such as hygiene or diet.
- Myofunctional therapy or correction of harmful habits.
- Periodontal splinting.
- Replacement of an orthodontic appliance.
- Replacement of a lost, missing, or stolen crown, bridge, or denture.
- Services or supplies provided before you were covered by the Plan.
- Services not performed by a Dentist, except for cleaning and scaling of teeth, or fluoride treatments, which may be provided by a licensed dental hygienist if supervised and billed by a Dentist.
- Services performed by a denturist.
- Services or supplies which are provided for Occupational Injury or Sickness. An Occupational Injury or Sickness is an injury or sickness that is covered under the Workers' Compensation Act or similar law.
  - For persons for whom coverage under the Workers' Compensation Act or similar law is optional because they could elect it or could have it elected for them, Occupational Injury or Sickness includes any injury or sickness that would have been covered under the Workers' Compensation Act or similar law had that coverage been elected. (Note: Services, that are covered services, provided to treat an on-duty injury, where the company is not at fault and no FELA claim will be filed, will be allowed to be paid by the Plan.)
- Services or supplies that are covered by any employer liability laws.

- Services or supplies that are not otherwise a covered dental service, which any employer is required by law to furnish in whole or in part.
- Services or supplies received through a medical department or similar facility maintained by Union Pacific.
- Services or supplies for which you are not required to pay or for which no charge would have been made if you did not have the Employee or Dependent dental expense benefits.
- Services or supplies provided for dental injuries or illness received as a result of war, declared or undeclared or international armed conflict occurring after coverage under this Plan has become effective.
- Services or supplies received as a result of a dental injury or sickness caused while committing a felony after coverage under this Plan has become effective.
- Services or supplies provided by any other plan that Union Pacific sponsors or contributes to.
- Services or supplies which are not necessary according to generally accepted dental standards or which are not recommended or approved by a Dentist.
- Services or supplies that do not meet generally accepted dental standards.
- Use of decay-preventing materials, except use of fluoride or fissure sealant for Dependents (see "Covered Dental Care Services", Type A on page 191 for details).

No benefits will be payable for expenses you incur after coverage of the Dental Care Program ends. This will apply even if MetLife has predetermined benefits.

DETERMINATION OF DENTAL BENEFITS

See "Dental Benefits Schedule" on page 191.

Additional Proof of Claim:
Please note that MetLife may ask for x-rays and other diagnostic and evaluative materials in order to determine your covered expenses. If you or your Dentist does not provide these items when requested, benefits will be based on available information and a reduction in Plan payments may result.

Alternate Treatment:
Some dental problems can be treated with different types of treatment. Benefits will be based on the materials and method of treatment that cost the least and, according to MetLife, meet generally accepted dental standards. For example, adequate results may be obtained with removable dentures instead of fixed bridgework. If you choose the more expensive treatment, you will be responsible for additional costs associated with your choice.

Predetermination of Benefits:
A feature of the Dental Care Program enables you to know what will be covered before the Dentist does extensive work.

Predetermination of Benefits does not apply to Emergency treatment, routine oral exams, x-rays, cleaning, or fluoride treatments. If a predetermination is desired, the Predetermination of Benefits process is as follows:

1. The Dentist completes a claim form, outlining the procedures and cost.
2. The claim form is then submitted to the MetLife Dental Claims Office. Please note that responses to requests for Predetermination of Benefits that require review by a MetLife consultant may take up to 30 calendar days.
3. The claim is processed, but no payment is made.
4. MetLife will determine benefits before you receive treatment and will send you an Explanation of Benefits with their determination as to what the Plan will pay.

NOTE: MetLife's decision regarding covered services and benefits payable will be final and binding, subject to your right to request a review as described in the section titled "Dental Care Appeal Procedures" on page 187. Predetermination allows you to determine your costs prior to receiving dental services. If the costs you are required to pay are higher than the value that will be derived, alternative courses of treatment should be discussed with your Dentist.

DENTAL CARE CLAIMS AND APPEAL PROCEDURES

"MyBenefits" Online Explanation of Benefits and Claim Status Inquiry:
MetLife has online resources that include information on benefit coverage, PDP Dentist Finder, claim tracking and e-mail alerts. This information can be found on MetLife's website at www.metlife.com/mybenefits.

When prompted for Company Name, type in "Union Pacific Railroad" and you will be directed to Metlife's MyBenefits registration screen. If you have problems accessing the MyBenefits website, please contact the MetLife Internet Support Line at (877) 9MET-WEB ((877) 963-8932) or via e-mail at dental@metnotices.com.

Temporary Extension of Certain Deadlines Due to COVID-19: The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"). In response, the Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in this "Dental Care Claims and Appeal Procedure" section – for you to submit an initial claim for benefits or request an appeal of a denied claim for benefits.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your rights to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in this "Dental Care Claims and Appeal Procedure" section, you may have additional time to do so. Please contact MetLife at (877) 9MET-WEB ((877) 963-8932) for more information.

How to Submit Dental Claims:
Claim forms to file for dental benefits under the Dental Care Program can be obtained directly from the MetLifewebsite at www.metlife.com/mybenefits. The Union Pacific group number is 37625. If you do not have access to
the website you can call MetLife at (888) 777-6806, option 1 to request a claim form. If you use a PDP Dentist, they will submit the claim to MetLife for you.

The address for submitting dental claims is:
MetLife Dental
P.O. Box 981282
El Paso, TX 79998-1282

Post-Service Claims: Post-service claims are those claims that are filed for payment of benefits after dental care has been received. Claim forms must be submitted in accordance with the instructions on the claim form. This will help the claim processing be faster and more accurate. Be sure all questions are answered fully.

After you submit a claim for dental expense benefits, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period of time, but not later than 30 days after the date you submitted your claim, except for situations requiring an extension of time for up to 15 days because of matters beyond the control of the Plan. If MetLife needs such an extension, MetLife will notify you prior to the expiration of the initial 30-day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.

Urgent Care Claims: Urgent care claims are those claims that require notification or approval prior to receiving dental care, where a delay in treatment could seriously jeopardize your life, health, the ability to regain maximum function, or (in the opinion of a Doctor with knowledge of your dental condition) could cause severe pain. If you

have a claim for urgent care, you must contact MetLife by calling (888) 777-6806, option 1. MetLife will notify you of its determination with respect to your urgent care claim (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your claim unless you fail to provide sufficient information. In the case of such a failure, MetLife shall notify you as soon as possible, but not later than 24 hours after receipt of the urgent care claim, of the specific information necessary to complete the claim. You will be given 48 hours to provide the specified information. MetLife will notify you of its benefit determination as soon as possible, but in no case later than 48 hours after its receipt of the specified missing information or the end of the period given you to provide the specified additional information, whichever is earlier.

Claim Denials: If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied, reference the specific Plan provision(s) on which the denial is based, and provide the claim appeal procedures that describe the time limit for filing an appeal and your right to file a lawsuit under section 502(a) of the Employee Retirement Income Security Act ("ERISA") if your appeal is denied. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is required. If the denial is based on dental necessity or an experimental treatment or similar exclusion or limit, the denial notice will include an explanation of this determination. Further, if an internal rule, protocol, guideline, or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline, or other criteria, or indicate that such rule, protocol, guideline, or other criteria was relied upon and that you may request a copy free of charge.

If your claim (either post-service or urgent care) is denied in whole or in part, you may appeal this decision. You must first exhaust all appeals available to you under the Dental Care Program before you have a right to bring a civil action under ERISA regarding your denied claim, regardless of the type of claim (i.e., post-service claim or urgent care claim). Please see the Dental Care Appeal Procedures section below.

Routine Questions About Claim Payments:
If you have any questions about a claim payment, an explanation can be requested from MetLife for dental claims by calling (888) 777-6806, option 1.

Appeal of Post-Service Claims:
If MetLife denies your post-service claim, you may make two appeals of the initial determination. Upon your written request, MetLife will provide you free of charge with copies of documents, records, and other information relevant to your claim. First and second level appeals must be submitted to MetLife at the following address:

MetLife Group Claims Review
P.O. Box 14589
Lexington, KY 40512-4589

Appeals must be in writing and submitted to MetLife within 180 days after your receipt of MetLife's prior determination (i.e., MetLife's claim denial or first level appeal denial, as applicable).

Your appeal must include at least the following information:

- Name of Employee and name of patient, if other than the Employee;
- Name of the Plan;
- Reference to the initial decision;
- Whether the appeal is the first or second appeal of the initial determination; and
- An explanation of each and every reason for which you are appealing the initial determination.

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who

is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a healthcare professional with appropriate training and experience in the field of dentistry involved in the judgment. This healthcare professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination. You may request that MetLife identify for you the healthcare professionals consulted regarding your appeal.

MetLife will notify you in writing of its final decision within a reasonable period of time, but not later than 30 days after MetLife's receipt of your written request for review. When the appeal has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

If MetLife denies the claim on appeal, MetLife will send you a written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, and describes the second level appeal procedures. If the denial is based on dental necessity or an experimental treatment or similar exclusion or limit, the denial notice will include an explanation of this determination. If an internal rule, protocol, guideline, or other criterion was relied upon in denying the claim on appeal, the written decision will state the rule, protocol, guideline, or other criteria, or indicate that such rule, protocol, guideline, or other criteria was relied upon, and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records, and other information relevant to your claim.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from MetLife. Your second level appeal request must be submitted in writing to MetLife within 180 days from receipt of the first level appeal decision. The second level appeal will be conducted, and you will be notified by MetLife of the decision in writing within a reasonable period of time, but not later than 30 days after receipt of a request for a second level appeal. When the appeal has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

If your second level appeal is denied, the denial notice will explain the reason for the denial and refer to the part of the Plan on which the denial is based. If an internal rule, protocol, guideline, or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline, or other criteria, or indicate that such rule, protocol, guideline, or other criteria was relied upon, and that you may request a copy free of charge. If the denial is based on dental necessity or an experimental treatment or similar exclusion or limit, the denial notice will include an explanation of this determination. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim and appeal. If your second level appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act, as amended (“ERISA”). You may not file such action unless and until you have first exhausted the claim and appeal process for your post-service claim.

Appeal of Urgent Care Claims:
If MetLife denies your claim for urgent care and you do not receive care, you can request an expedited appeal of your claim denial by phone or in writing. The phone number is (888) 777-6806, option 1, and the address is MetLife Group Claims Review, P.O. Box 14589, Lexington, KY, 40512-4589. MetLife will provide you any necessary information to assist you in your appeal. MetLife will conduct a full and fair review of your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. You may submit information relating to your appeal by telephone, facsimile or another available similarly expeditious method. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a healthcare professional with appropriate training and experience in the field of dentistry involved in the judgment. This healthcare professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination. You may request that MetLife identify for you the healthcare professionals consulted regarding your appeal. You will be

notified of the decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours of your request in writing or by phone with a follow up by written notice.

If your urgent care appeal is denied, the denial notice will explain the reason for the denial and refer to the part of the Plan on which the denial is based. If an internal rule, protocol, guideline, or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline, or other criteria, or indicate that such rule, protocol, guideline, or other criteria was relied upon, and that you may request a copy free of charge. If the denial is based on dental necessity or an experimental treatment or similar exclusion or limit, the denial notice will include an explanation of this determination. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim and appeal. If your urgent care appeal is denied, you have the right to bring a civil action under Section 502(a) of ERISA. You may not file such action unless and until you have first exhausted the claim and appeal process for your urgent care claim.

If your claim for urgent care was denied and you receive the care anyway, you may appeal the denial by following the post-service claim appeal procedures. MetLife will review such appeal in accordance with appeal procedures applicable to appeals of post-service claims.

MetLife has been given final discretionary authority to find facts, interpret the terms of the Dental Care Program and make claim and appeal determinations in accordance with the terms of the Dental Care Program. **The decisions of MetLife are conclusive and binding.** Any finding, interpretation, or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the finding, interpretation, or determination was arbitrary and capricious.

COORDINATION OF DENTAL BENEFITS

Coordination of benefits applies when a covered Employee, covered Dependent, or covered Domestic Partner has dental coverage under this Dental Care Program and one or more Other Plans.

For each claim, one of the plans involved will pay the benefits first; that plan is Primary. Other Plans will pay benefits next; those plans are Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more then the Allowable Expenses charged for that Calendar Year under the Union Pacific Dental Care Program.

For more information concerning how Coordination of Benefits works, see the "Coordination of Benefits" section under the Medical Care Program on page 131.

Coordination of Dental and Medical Benefits:
Also note that depending on which medical option you are enrolled in, certain procedures may be covered (or covered in part) by either your medical option or the Dental Care Program, or by neither of these. In any case, when there is potential that a procedure may be covered by either your medical option or your Dental coverage, it is strongly recommended that a Dental Predetermination of Benefits be requested and that your medical option be contacted to determine if any coverage would be applicable and whether the provider in question is In-Network.

DENTAL CARE PROGRAM - DOMESTIC PARTNERS

Overview:
An Employee may elect to enroll the Employee's Domestic Partner for dental coverage. An Employee cannot cover a Domestic Partner if the Employee is legally married to another individual. Moreover, you cannot choose coverage for both a Spouse and a Domestic Partner.

Definition of Domestic Partner:
A "Domestic Partner" of an Employee is an individual who is the same or opposite sex of the Employee and:

- Is age 18 or older;

- Has lived with the Employee for at least six (6) months and whose principle place of residence is with the Employee;
- Has a serious and committed relationship with the Employee;
- Is financially interdependent with the Employee;*
- Is not related to the Employee in any way that would prohibit legal marriage to the Employee;
- Is not the Employee's "Spouse" as defined in the "Eligibility" section on page 7 of this Flex Guide;
- Is not legally married to nor a domestic partner of another individual; and
- Is not otherwise eligible for coverage under the Flexible Benefits Program.

**Financially Interdependent* *means that the Employee and the Domestic Partner share the cost of food and housing. Both the Employee and Domestic Partner do not have to contribute equally or jointly for each of these expenses as long as both are responsible for such costs.*

Eligibility:
You are eligible to enroll your Domestic Partner for dental coverage on the date you become an eligible Employee. Your election to enroll a Domestic Partner in dental coverage is separate and distinct from your dental election under the Dental Care Program for you and your Dependent children, if any. This means dental coverage you may have elected for you and any Dependent child does not cover your Domestic Partner. You may elect dental coverage for your Domestic Partner regardless of whether you elect dental coverage for you and any Dependent child.

When you enroll your Domestic Partner for dental coverage, you are affirming that you have reviewed the Dental Care Program's eligibility terms and the individual meets the above definition of a Domestic Partner. You are also affirming that you will advise Workforce Shared Services about any change in circumstances that affects your Domestic Partner's eligibility for coverage. In the event of fraud or intentional misrepresentation of material fact regarding a Domestic Partner's eligibility for coverage, coverage for such Domestic Partner may be terminated retroactively, and claims paid for an individual found to be ineligible for coverage will be the responsibility of the Employee. Deductibles, Coinsurance and other plan limitations will also be recalculated and may cause further expense to the Employee. The Plan reserves the right to require documentation with respect to the individuals you elect to enroll in coverage, including (but not limited to) evidence that they satisfy the Plan's definition of a Domestic Partner, their social security numbers, and such other information necessary to administer the Dental Care Program.

If your Domestic Partner becomes your Spouse (see definition of a Spouse in the "Eligibility" section on page 7 of this document), he/she will be no longer eligible for Domestic Partner dental coverage. If you wish to continue to provide dental coverage to your former Domestic Partner as your Spouse, you must contact Union Pacific Workforce Shared Services at (877) 275- 8747, within 30 days of the date of your marriage to add the individual as a Dependent.

Effective Dates of Coverage:
Open Enrollment: Elections made during open enrollment are effective January 1st of the following year.

Newly Eligible During a Year: If you become newly eligible during a Calendar Year, your dental election for your Domestic Partner will be effective on the date you become an eligible Employee if you submit your election within the first 30 days following the date you become an eligible Employee. If you do not complete your election during this 30-day period, your Domestic Partner will not receive dental coverage for the Calendar Year unless you are permitted to enroll your Domestic Partner pursuant to a Life Event as described in the "Life Events & Permissible Benefits Changes" section on pages 28-63 of this Flex Guide.

Life Event Changes: Changes in your dental election for your Domestic Partner resulting from a Life Event will be effective on the first day of the month following the event date.

Note: Changes in elections resulting from a Life Event must be made within 30 days following the event. Changes after 30 days can only be made during the next annual open enrollment period for coverage effective January 1st of the following year.

Employee Contributions:
In most cases, a Domestic Partner will not be considered a "Dependent" as defined under the Flexible Benefits Program or the Internal Revenue Code. As a result, your monthly contribution for Domestic Partner dental benefits will be made on an after-tax basis. Your monthly contribution for Domestic Partner dental coverage will begin the next full month of participation following receipt of notification to enroll your Domestic Partner. In addition, federal tax law requires that Union Pacific include in your taxable income the difference, if any, between the fair market value of the Domestic Partner dental coverage and your monthly contribution. The additional amount included in your income is subject to applicable federal, state, and local income tax withholding, as well as Social Security and/or Railroad Retirement tax withholding. Union Pacific will charge you the fair market value for Domestic Partner dental coverage in 2021 so there will not be any additional amount included in your taxable income related to electing this coverage.

Domestic Partner Dental Benefits:
Except as provided in this section, "Dental Care Program-Domestic Partners", all terms and conditions of the Dental Care Program as described in this Flexible Benefits Guide shall apply to a Domestic Partner as if the Domestic Partner were an Employee with Dental Care Program Employee Only coverage.

Domestic Partner claims should not be submitted using the Employee's name and social security number. Domestic Partner claims must be submitted using the Employee's ID Number preceded by the numbers "99", which is the ID number assigned to Domestic Partners by MetLife. For example, if your Employee ID is 1234567, the Domestic Partner must use "991234567".

When Domestic Partner Dental Coverage End:
Dental coverage for your Domestic Partner will end as of the last day of the month in which:

- You terminate employment;
- You cease to be an eligible Employee;
- You cease making any required contribution;
- Your Domestic Partner no longer meets the definition of a Domestic Partner; or
- The Flexible Benefits Program or the Domestic Partner dental benefit option thereunder ends.

A Domestic Partner is not a "qualified beneficiary" and thus, is not eligible to elect COBRA continuation coverage. However, an Employee who elects to continue Dental Care Program coverage under COBRA may also elect to continue Domestic Partner Dental Care Program coverage for a Domestic Partner who was enrolled in Domestic Partner Dental Care Program coverage immediately before the date the Employee's dental coverage ended as a result of the Employee's COBRA qualifying event. The Employee will be entitled to continue Domestic Partner Dental Care Program coverage until the Employee's Dental Care Program COBRA continuation coverage ends.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND OTHER FIDUCIARIES

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan Fiduciaries, including MetLife, shall have discretionary authority to interpret the terms of the Plan and to determine facts and eligibility for entitlement to Plan benefits in accordance with the terms of the Plan.

Any finding, interpretation, or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the finding, interpretation, or determination was arbitrary and capricious.

MEDICAID

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

payment of benefits under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to such Employee or Dependent to such payment for benefits.

REFUND FOR OVERPAYMENT OF BENEFITS

MetLife has the right to a refund of any dental benefits it paid to you or on your behalf if you, your Dependents, or your Domestic Partner did not pay for those expenses, or if you, your Dependents, or your Domestic Partner were reimbursed for any of those expenses by a source other than MetLife. The refund is the difference between the amount of benefits actually paid and the amount that should have been paid under the terms of the Dental Care Program. In addition, MetLife has a right to a refund of any amount paid to you or on your behalf that exceeds the amount of any benefit you, your Dependents, or your Domestic Partner are entitled to receive under the terms of the Dental Care Program or any benefits paid while you and/or persons you identified as your Dependent or Domestic Partner were not eligible for benefits under the Dental Care Program.

If you do not promptly refund the required amount and in addition to other rights they may have, MetLife may reduce the amount of any future benefits payable under the Plan and under any group benefits plan they issued to your employer by the amount of the refund.

Dependent Care Flexible Spending Account

Page

ELIGIBILITY AND ENROLLMENT

Eligibility:
You are eligible to participate in the Dependent Care Flexible Spending Account ("Dependent Care FSA") if you are an eligible Employee. For purposes of the Dependent Care FSA, the terms "Employee" and "Spouse" are defined in the Eligibility section of this Flex Guide.

For purposes of the Dependent Care FSA, an "Eligible Dependent" is defined, below:

Dependent Care FSA Eligible Dependents:
The dependent care services described in the section "Eligible Dependent Care Expenses" will be reimbursed only if they are provided for an Eligible Dependent. For purposes of the Dependent Care FSA, an Eligible Dependent is an individual who is:

- Under the age of 13 and is your qualifying child as defined in Internal Revenue Code Section 152 (or if you are a divorced or separated parent, a child who is in your legal custody, even if you cannot claim a dependency exemption for such child);
- Your Spouse who is physically or mentally incapable of caring for himself/herself and who has the same principal place of abode as you for more than one-half of the year; or
- An individual who is physically or mentally incapable of caring for himself/herself and who has the same principal place of abode as you for more than one-half of the year, and either:
  - Is your dependent for federal income tax purposes; or
  - Would be your dependent for such purpose, except that:
    - Such individual earned more than the federal exemption amount for the Calendar Year;
    - Such individual filed a joint federal income tax return; or
    - You (or your Spouse if filing jointly) could be claimed as someone else's dependent under federal tax law.

Effective Dates:
If you wish to contribute to the Dependent Care FSA for the following Calendar Year, you must enroll during open enrollment indicating the annual contribution amount you wish to make for the following Calendar Year. An election at open enrollment to contribute to the Dependent Care FSA applies only to the following Calendar Year. **A new election is required for each subsequent year.**

If you become newly eligible during a Calendar Year, your Dependent Care FSA election will be effective on the first of the month following the date you become an eligible Employee, provided you submit your election within 30 days from the date you become an eligible Employee. Your contributions will be deducted on a before-tax basis and will begin as soon as practicable following your elections. If you do not complete your election within 30 days of the date you become an eligible Employee, you will not be able to enroll in the Dependent Care FSA until the next open enrollment period to become effective January 1st of the following Calendar Year.

Once you are covered, you have the opportunity to change coverage during the open enrollment period held in the fall of each year for the next Calendar Year. Any change will become effective January 1st of the following Calendar Year.

You may also have the opportunity to change your election under the Dependent Care FSA during a Calendar Year if you experience a Life Event (as described on pages 28-63 of this Flex Guide in the "Life Events & Permissible Benefits Changes" section of this Flex Guide) during the Calendar Year.

Enrollment:
When you enroll you will be required to indicate the annual amount you wish to contribute on a before-tax basis. In most instances, your annual contribution will be deducted in equal installments each pay period over the course of the Calendar Year.

It is very important that you estimate your dependent care expenses carefully because the Dependent Care FSA requires that you forfeit any unused amount remaining after reimbursement is made of all eligible expenses incurred during the Calendar Year. Note: The amount you elect to contribute to a Dependent Care FSA does not automatically renew or "roll over" to the subsequent year. IRS rules require a new election for each year.

HOW THE DEPENDENT CARE FSA WORKS

The Dependent Care FSA permits you to pay for eligible dependent care expenses on a "before-tax" basis. This can mean tax savings for you because your payroll-based contributions to the Dependent Care FSA are deducted before federal income, Social Security, Railroad Retirement, and, in most cases, state and local taxes (if applicable) are taken. When applicable taxes are applied against your pay, they are computed on a lower base, thus lowering your tax liability. The amount credited in your Dependent Care FSA is then available for reimbursement to cover eligible expenses as they are incurred during the Calendar Year.

For example, assume you have incurred $5,000 of eligible expenses during the Calendar Year and you elected to contribute $5,000 to the Dependent Care FSA. The expenses are reimbursable from the Dependent Care FSA. Without it, you would pay for these expenses with money that has already been, or will be, recognized for tax purposes.

The following example is designed to illustrate how the Dependent Care FSA can work for you. Note that your tax savings will be reduced by any unused Dependent Care FSA balance that remains after reimbursement of all eligible expenses incurred during the Calendar Year. See the section "Make Sure You Understand the 'Use It or Lose It' Rule" below for more information.

	Without FSA	With FSA
Income	$ 55,000	$ 55,000
FSA Election	$ 0	$ 5,000
Taxable Income	$ 55,000	$ 50,000
Tax (30%)*	$ 16,500	$ 15,000
Tax Savings	$ 0	$ 1,500

** The tax percentage shown represents a hypothetical example of all applicable taxes and is for illustrative purposes only. Your situation will vary depending on your actual tax liability.*

As Social Security and/or Railroad Retirement taxes are not withheld on your contributions to the Dependent Care FSA, it is possible that your future Social Security and/or Railroad Retirement benefits would be reduced.

IMPORTANT FSA RULES

Before You Enroll:
There is no doubt that the Dependent Care FSA can provide you with significant savings when it comes to paying for eligible dependent care expenses. Before you enroll, there are a few other things to consider, which will allow you to use the account to your best advantage.

Be Aware Your Contribution Amount is Fixed for the Calendar Year:
The annual contribution election you make for dependent care stays in effect until December 31st of each Calendar Year. The amount you elect to contribute to your Dependent Care FSA cannot be changed during the year, except for the limited circumstances set forth in the "Life Events & Permissible Benefits Changes" section on pages 28-63 of this Flex Guide.

NOTE: Changes are not allowed for Life Events reported more than 30 days following the event date for the same Calendar Year. This means if a Life Event is not timely reported, you are not allowed to change your Dependent Care FSA election until the subsequent annual open enrollment period for coverage effective January 1st of the following year.

Make Sure You Understand the 'Use It or Lose It' Rule:
Remember, the tax savings you receive by participating in the Dependent Care FSA will be offset by the amount of your forfeited Dependent Care FSA balance, if any. Forfeited amounts are allocated to pay the expenses of administering the Dependent Care FSA.

Dependent care expenses incurred during the period of the Calendar Year in which you have coverage are eligible for reimbursement if filed for reimbursement by the March 31 of the following Calendar Year. Coverage extends to the end of the month in which you cease to be an Employee. See the section "Termination of Coverage" below for more information. Dependent care expenses are incurred when eligible dependent care services are provided and not when you are formally billed, charged, or pay for the dependent care services.

> Any part of an account balance remaining at the end of the period of coverage in a Calendar Year (e.g.: the end of the month in which you terminate employment or December 31 of the year) cannot be carried forward and is forfeited. However, you will have until March 31st of the following Calendar Year to file claims for eligible expenses incurred during that period of coverage.

Before deciding how much to contribute to the Dependent Care FSA, you should carefully estimate your projected annual expenses.

OVERVIEW

Contribution Minimum/Maximum:
If you are single, you may contribute up to $5,000 to the Dependent Care FSA. If you are married and file a joint return, you may contribute up to $5,000, but if your Spouse also contributes to a Dependent Care FSA through his/her employer, your combined Calendar Year contribution cannot exceed $5,000. If you are married and file separate returns, you may only contribute up to $2,500. The minimum amount you may contribute is $300 per year. However, non-taxable benefit payments from your Dependent Care FSA cannot exceed the lesser of your annual pay or your Spouse's earned income, so you should limit your contributions accordingly.

Generally, working parents may use a Dependent Care FSA where making arrangements for dependent care is required in order to enable the parent(s) to work (or actively look for work). Generally, if your Spouse is unemployed or employed in a non-paying capacity, you will not be able to contribute to a Dependent Care FSA. However, if your non-working Spouse is either incapable of caring for himself/herself, or is a Full-Time Student for at least some part of each of five calendar months during the Calendar Year, he/she will be treated as having earned income for the months in which he/she is incapable of caring for himself/herself or is a Full-Time Student. Such Spouse's earned income is considered to be $500 per month if you have two or more Eligible Dependents and $250 per month if you have one Eligible Dependent.

Before contributing to a Dependent Care FSA, you should consider that you might save even more if you use the federal tax credit instead.

If your tax rate is higher than the applicable tax credit percentage, you will generally improve your tax position by using the Dependent Care FSA, rather than the tax credit. If your tax rate is lower than the applicable tax credit percentage, you generally will be better off taking full advantage of the tax credit.

You are required to furnish the tax identification number(s) or Social Security Number(s) of your dependent care provider(s) when you make a claim from the Dependent Care FSA and on your federal income tax return. Failure to show this information on your tax return will, in most cases, make you ineligible to receive a tax credit or benefits from the Dependent Care FSA.

Eligible Dependent Care Expenses:
Your Dependent Care FSA may be used to pay for most expenses for the care of your Eligible Dependents so you (and your Spouse) can work. During any period your Spouse is incapable of caring for himself/herself or is a Full-Time Student, he/she will be treated as working.

Please keep in mind that the Dependent Care FSA cannot be used for medical expenses. Before using a Dependent Care FSA, you may want to refer to IRS Publication 503, "Child and Dependent Care Expenses." Please be aware, however, that Publication 503 is intended to help taxpayers determine whether their expenses qualify for the dependent care tax credit. It is not intended to explain what expenses may be eligible for reimbursement under

the Dependent Care FSA. Therefore, some statements contained in Publication 503 are not correct as applied to a Dependent Care FSA.

Eligible expenses are only for care provided at your home unless such care is for your Eligible Dependent under age 13 or for another Eligible Dependent who spends at least eight hours a day in your home. Eligible expenses include:

- Care of an Eligible Dependent, including such items as:
  - General supervision
  - Day care centers (including related food charges and administration of medicine; i.e., prescriptions, if such expenses cannot be separated from the cost of childcare)
  - Nursery school
  - Summer day camp (if not primarily for educational purposes)
  - Household services (when part of dependent care) such as:
    - Cooking
    - Cleaning
    - General housekeeping

Exclusions:
The Dependent Care FSA cannot be used for:

- "Babysitting" other than during work hours.
- Care or services given by:
  - Your child(ren) under age 19; or
  - Anyone you (or your Spouse) could claim as a legal dependent for federal income tax purposes.
- Expenses covered by any medical plan.
- Expenses claimed as a tax credit on your federal income tax return.
- Expenses for food, clothing, overnight camp, or entertainment.
- Education for an Eligible Dependent who is in Kindergarten or a higher grade.
- Expenses for dependent care so that you or your Spouse can perform volunteer work.
- Expenses for dependent care so that your ex-Spouse can work.
- Expenses for dependent care so that your Domestic Partner can work.

Termination of Coverage:
If you cease to be an Employee who is participating in the Dependent Care FSA during a Calendar Year, you may obtain reimbursement for dependent care expenses incurred through the end of the calendar month in which you cease to be an Employee. You have until March 31st of the following Calendar Year to file claims for eligible expenses incurred during the previous year. Unused amounts are forfeited to pay for plan expenses.

Coverage under the Union Pacific Child Development Center:
Union Pacific sponsors the Union Pacific Child Development Center in which eligible Union Pacific Employees may enroll their children for childcare. Coverage under the Union Pacific Child Development Center is considered coverage under the Union Pacific Dependent Care Assistance Program for any Employee eligible to participate in the Child Development Center who participates in the Dependent Care FSA. For more information, go to the Workforce Resources page on the UP Employees website (www.up.com).

REIMBURSEMENT (HOW TO FILE A CLAIM)

Expenses for dependent care may be reimbursed only after the services are rendered. This means, for example, if your dependent care provider requires payment before the dependent care services are rendered, you pay for the services in advance and then must wait to obtain reimbursement for such expenses until after the dependent care services are rendered. You may request at any time during the Calendar Year reimbursement of such incurred expenses **up to the amount in your Dependent Care FSA at the time reimbursement is requested**. If you have not already contributed the full amount you elected to your Dependent Care FSA, eligible unpaid claims will be held pending future account contributions.

Claims must be submitted to PayFlex Systems USA, Inc., Attn: Benefit Billing PO Box 953374 St. Louis, MO 63195, or via fax at (402) 231-4310. Claims may also be submitted to PayFlex via their Express Claim Service at

www.payflex.com. If you have a question concerning your claim, you can contact PayFlex at 844-PAYFLEX (844-729-3539). Your claim must include the following:

- An FSA Claim Form; and
- Appropriate proof of expenses.

The FSA claim form is available on the Workforce Resources Forms page via the UP Employees website www.up.com. Please carefully review the directions for completing and submitting the form.

For reimbursement of dependent care expenses, appropriate proof of expense is an itemized statement or invoice from your dependent care provider that includes:

- Day care provider's name and tax ID number or social security number;
- Dates of service; and
- Amount paid to day care provider.

All reimbursements will go to you and may not be paid directly to the provider of service. Reimbursements will be deposited directly to the banking account that you set up through PayFlex for direct deposit or a check will be mailed to you if you do not have direct deposit through PayFlex. To set up direct deposit through PayFlex, log on to www.payflex.com click on the "Forms" link, then click on "Direct Deposit Authorization From" and follow the instructions, you can also find the form here: http://home.www.uprr.com/emp/ec/attachments/payflex_dcfsa.pdf If you have any questions about the PayFlex direct deposit process, you may call PayFlex at 844-PAYFLEX (844-729-3539).

Any balance remaining in your account on December 31st of the Calendar Year cannot be carried forward to reimburse eligible expenses incurred in the following Calendar Year and will be forfeited. However, you have until March 31st of the following Calendar Year to file claims for eligible expenses incurred during the previous year. Any check you've received from PayFlex that remains uncashed after September 30th of the year following the Calendar Year in which the expense was incurred will be forfeited.

If your claim is denied, you will receive a written notice from PayFlex within 30 days of receipt of the claim as long as all needed information was provided with the claim. PayFlex will notify you within this 30-day period if additional information is needed to process the claim, and PayFlex may request a one-time extension not longer than 15 days, pending your claim until all information is received. If the extension is needed because you failed to submit all information necessary to decide your claim, the notice will describe the information needed and you will have 45 days from the receipt of the notice to provide the needed information.

A denial notice will explain the reason for the denial and reference specific plan provisions on which the denial is based. The notice will describe any additional material or information needed to perfect your claim and an explanation of why the material or information is important and provide the claim appeal procedures.

APPEAL PROCEDURES

If you have a question or concern about a benefit determination, you may informally contact a PayFlex Customer Service representative at 844-PAYFLEX (844-729-3539) before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction, you may request a formal appeal as described below. If you wish to request a formal appeal of a denied claim, you must submit an appeal in writing to:

PayFlex Systems USA, Inc.
Attn: Benefit Billing Dept
P.O. Box 953374
St. Louis, MO 68195

This written appeal must include your name, a description of the claim determination that you are appealing, the reason you believe the claim should be paid, and any written information to support your appeal. You may include information that was not submitted as part of your original claim. You should also include a copy of your claim form and supporting documentation.

Your first appeal request must be submitted in writing to PayFlex within 180 days after you receive the claim denial notice.

The first level appeal will be conducted, and you will be notified by PayFlex of the decision in writing within 30 days from receipt of a request for appeal of a denied claim. If your appeal is denied, the denial notice will explain the reason(s) for the denial and refer to the part of the plan on which the denial is based. The notice will describe your right to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to your claim and appeal and will describe the second level appeal procedures.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Plan Administrator (or delegate). Your second level appeal request must be submitted in writing within 60 days from receipt of the first level appeal denial. This written appeal must include your name, a description of the claim determination that you are appealing, the reason you believe the claim should be paid, and any written information to support your appeal. Your second level appeal request must be sent to:

Union Pacific WR Benefits
Attn: Dependent Care Flexible Spending Account Appeals
1400 Douglas Street, Stop 0320
Omaha, NE 68179-0320

You may include with your appeal information that was not submitted as part of your original claim or first level appeal. The second level appeal will be conducted, and you will be notified by the Plan Administrator (or delegate) of the decision in writing within 30 days from receipt of a request for a second level appeal. The decision of the Plan Administrator (or delegate) on your second level appeal is final and binding. If your second level appeal is denied, the denial notice will explain the reason for the denial and refer to the part of the plan on which the denial is based. The notice will describe your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim and appeal.

Any review on appeal (either first or second level) will not give deference to previous claim denials. Any review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in previous claim decisions. As part of any appeal, you will have the right to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. The person who will review an appeal will not be the same person as the person who denied the claim that you are appealing, nor a subordinate of the person who denied your claim.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND OTHER FIDUCIARIES

In carrying out their respective responsibilities under the Flexible Benefits Program, including the Dependent Care FSA, the Plan Administrator and other plan fiduciaries, including PayFlex, shall have discretionary authority to make factual findings, to interpret the terms of the Flexible Benefits Program, and to determine eligibility for and entitlement to Flexible Benefits Program benefits in accordance with the terms of the Flexible Benefits Program, including the Dependent Care FSA.

Any finding, interpretation, or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the finding, interpretation, or determination was arbitrary and capricious.

Life and Accidental Death & Dismemberment (AD&D) Insurance Plan

Page

OVERVIEW

The Union Pacific Corporation Nonagreement Life Insurance Plan (generally referred to in this section as the "Life and Accidental Death & Dismemberment (AD&D) Insurance Plan" or the "Plan") is insured and administered by Metropolitan Life Insurance Company ("Metropolitan Life"), 200 Park Avenue, New York, New York 10166. All Life and AD&D coverage and benefits described in this Flex Guide are subject to the terms of the Group Policy between Metropolitan Life and Union Pacific Corporation (including your Certificate of Insurance issued under such Group Policy) under which the benefits are provided. If there is any conflict between this section of the Flex Guide and the Group Policy, the Group Policy will govern. For purposes of the Life and AD&D Insurance Plan, the terms "Employee", "Spouse", "Child", "Domestic Partner" and "Dependent" are defined in the "Definitions" section on page 7 of this Flex Guide.

You should also refer to the "Eligibility" section on page 13 of this Flex Guide for additional information applicable to this Life and AD&D Insurance Plan section.

COST, EVIDENCE OF INSURABILITY & OTHER REQUIREMENTS

Cost:
Core Employee Life and Core Employee AD&D coverage are provided by Union Pacific to an Employee at no cost to the Employee. The cost of Voluntary Employee Life and Voluntary AD&D Insurance coverage is paid for by the Employee. In addition, the cost of Voluntary Spouse/Child(ren) Life and Voluntary AD&D Insurance coverage is also paid for by the Employee.

Evidence of Insurability:
Voluntary Employee Life Insurance coverage and Voluntary Spouse Life Insurance coverage at certain levels require a submission of evidence of insurability at the time the Employee elects such coverage. The submitted evidence of insurability for the insured individual must be satisfactory to Metropolitan Life before the coverage will become effective. If satisfactory evidence of insurability is not provided, the coverage amount will be capped at the maximum amount of coverage that is not subject to the evidence of insurability requirement. Details on how to provide evidence of insurability may be obtained by calling Metropolitan Life at (866) 659-1377 or (800) 855-2880 TTY for hearing impaired.

If Metropolitan Life determines that the evidence is satisfactory, the Voluntary Life Insurance amount requiring such evidence will become effective the date stated in writing by Metropolitan Life, provided the Employee is actively at work on such date. If the Employee is not actively at work on the date an amount of insurance would otherwise take effect, that amount of insurance will take effect on the day the Employee resumes active work.

Voluntary Employee Life Insurance and Evidence of Insurability:
Upon Initial Eligibility
If an Employee elects Voluntary Employee Life Insurance coverage when first eligible for Life Insurance coverage, evidence of insurability will be required in order to receive Voluntary Employee Life coverage in excess of $500,000.

During Open Enrollment
If an Employee does not elect Voluntary Employee Life Insurance coverage when first eligible and instead initially elects Voluntary Employee Life Insurance coverage during open enrollment, evidence of insurability will be required in order to receive such coverage in an amount exceeding the lesser of:

- 2 times the Employee's Basic Annual Earnings; or
- $500,000

If, during open enrollment, an Employee elects to increase his current Voluntary Employee Life Insurance coverage, evidence of insurability will be required in order to increase such coverage by an amount that exceeds 2 times the Employee's Basic Annual Earnings.

As a Result of a Qualifying Life Event (see "Life Events & Permissible Benefits Changes" section on pages 28-63)
If an Employee did not elect Voluntary Employee Life Insurance coverage when first eligible and instead initially elects Voluntary Employee Life Insurance coverage as a result of a qualifying Life Event, evidence of insurability will be required in order to receive Voluntary Employee Life Insurance coverage in an amount exceeding the lesser of:

- 3 times the Employee's Basic Annual Earnings, or
- $500,000

If, as a result of a qualifying Life Event, an Employee elects to increase his current Voluntary Employee Life Insurance coverage, evidence of insurability will be required if the: elected amount of coverage will exceed the lesser of:

- 3 times the Employee's Basic Annual Earnings, or
- $500,000

Voluntary Spouse Life Insurance and Evidence of Insurability:

Upon Initial Eligibility.
If an Employee elects Voluntary Spouse Life Insurance coverage when the Employee is first eligible for Life Insurance coverage, evidence of insurability will be required in order to receive Voluntary Spouse Life Insurance coverage in an amount exceeding $100,000.

During Open Enrollment.
If an Employee does not elect Voluntary Spouse Life Insurance coverage when first eligible and instead initially elects Voluntary Spouse Life Insurance coverage during open enrollment, evidence of insurability will be required in order to receive such coverage in an amount exceeding $100,000.

If, during open enrollment, an Employee elects to increase his current Voluntary Spouse Life Insurance coverage, evidence of insurability will be required in order to increase such coverage by an amount that exceeds 1 times the Employee's Basic Annual Earnings.

As a result of a Qualifying Life Event (see "Life Events & Permissible Benefits Changes" section on pages 28-63.
If an Employee did not elect Voluntary Spouse Life Insurance coverage when first eligible and instead initially elects Voluntary Spouse Life Insurance coverage as a result of a qualifying Life Event, evidence of insurability will be required in order to receive such coverage in an amount exceeding $100,000.

If, as a result of a qualifying Life Event, an Employee elects to increase his current Voluntary Spouse Life Insurance coverage, evidence of insurability will be required if the elected amount of coverage will exceed $100,000.

Additional Requirements Applicable to Dependent(s) (Spouse and Child(ren)) Insurance Coverage:
On the date Dependent(s) insurance is scheduled to take effect, the Dependent(s) must not be:

- confined at home under a Physician's care;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If the Dependent(s) do(es) not meet these requirements on such date, insurance for the Dependent(s) will take effect on the date the Dependent(s) no longer is/are:

- confined;
- receiving or applying to receive disability benefits from any source; or
- hospitalized.

SUMMARY OF LIFE AND AD&D INSURANCE BENEFITS

The following Schedule of Benefits provides a summary of the amount of insurance offered ("Amount of Insurance") through the types of coverage available under the Life and AD&D Insurance Plan. Should the explanation of benefits described in this Summary differ from the terms of the group insurance contract through which Life and AD&D Insurance Plan benefits are provided, the group insurance contract will supersede the Schedule.

SCHEDULE OF BENEFITS	
Core Coverage (Company Paid)	
Type of Coverage	**Full Amount of Insurance**
Core Employee Life*	1x Basic Annual Earnings ($10,000 Minimum/$50,000 Maximum)
Core Employee Accidental Death & Dismemberment	1x Basic Annual Earnings ($10,000 Minimum/$50,000 Maximum)
Optional Benefits (Employee Paid)	
Type of Coverage	**Full Amount of Insurance (based on Employee Election)**
Voluntary Employee Life*	From 1x to 8x Basic Annual Earnings
Voluntary Employee AD&D	From 1x to 8x Basic Annual Earnings
Voluntary Spouse Life	From .5x to 4x Basic Annual Earnings (Maximum: lesser of 50% of Employee's Core and Voluntary Life combined or $500,000)
Voluntary Child(ren) Life	Either $5,000 or $10,000 per Child regardless of the number of Children covered
Voluntary Spouse and Child(ren) AD&D+†	(a) For Spouse: 50% of Employee's Voluntary AD&D, (b) Per Child: 15% of Employee's Voluntary AD&D
Voluntary Spouse Only AD&D+†	60% of Employee's Voluntary AD&D
Voluntary Child(ren) Only AD&D+†	20% of Employee's Voluntary AD&D per Child regardless of the number of Children covered

*Maximum amount for combined Core and Voluntary Employee Life is $3,000,000.
+ In all cases, maximum coverage amounts for Spouse AD&D and Child AD&D are $250,000 and $25,000 per Child, respectively.
†Collectively, Voluntary Spouse and Child(ren) AD&D, Voluntary Spouse Only AD&D and Voluntary Child(ren) Only AD&D are referred to as "Voluntary Dependent AD&D Coverages."

NOTES:

- All benefit amounts are rounded to the next higher $1,000 if they are not a multiple of $1,000.
- Basic Annual Earnings means your annualized base pay determined as of July 31st of the prior year, excluding overtime and other extra pay. Changing from a full-time salaried employee to a reduced salaried employee (or vice versa) after such date does not affect this determination. If you are paid on an hourly basis, your Basic Annual Earnings are calculated by taking the standard hours for your position and multiplying it by your hourly rate as of July 31st of the prior year, which is then annualized, excluding overtime and extra pay. If you are an executive and as of July 31st of the prior year your monthly salary was reduced due to a temporary reduction in salary as determined by Union Pacific in response to significant changes in business requirements, such reduction is disregarded when determining your regular rate of pay.
- If you are currently covered by any of these coverage options, your pay as of each July 31st will be used to determine the level of coverage(s) available effective the following January 1st.
- If you become covered by any of these coverage options during a Calendar Year other than January 1st, your annualized pay at the time your coverage begins will be used to determine the level of coverage(s) available. If you are an executive and at the time your coverage begins your monthly salary was reduced due to a temporary reduction in salary as determined by Union Pacific in response to significant changes in business requirements, such reduction is disregarded when determining your regular rate of pay. Once you are covered, your pay as of the next July 31st will be used to determine the level of coverage(s) available effective the following January 1st.
- The amount of coverage you elect for yourself and your Spouse and/or your Child(ren) ("Dependent(s)") will not change during the Calendar Year even if your pay changes.

LIFE INSURANCE COVERAGE AND BENEFITS

Coverage:
If you die while covered under one or more of the life insurance or AD&D options, the Plan will pay the amount of benefit in effect for you at the time of your death. If your Dependent dies while covered under one or more of the Life Insurance or AD&D options, the Plan will pay the amount of benefit in effect for the Dependent at the time of the Dependent's death.

YOUR BENEFICIARY

Your "Beneficiary" is the person or persons you choose to receive any benefits payable under the Life and AD&D Insurance Plan because of your death. To review your Beneficiary designation currently on file, please call (866) 659-1377. You may also visit the Metropolitan Life website at www.metlife.com/mybenefits to name or change your beneficiary.

You may designate a Beneficiary in your application or enrollment form provided by Metropolitan Life Insurance Company or online at www.metlife.com/mybenefits. You may change your Beneficiary at any time. To do so, you must send a signed and dated, written form provided by Metropolitan Life Insurance Company to MetLife Recordkeeping Center, PO Box 14401, Lexington, KY 40512-4401 within 30 days of the date you sign the form or you may also visit the Metropolitan Life website at www.metlife.com/mybenefits to name or change your beneficiary. To request a form, contact Metropolitan Life Insurance Company at (866) 659-1377. You do not need the consent of the Beneficiary to make a change. The change will take effect on the date the form is signed, but it will not apply to any amount paid by Metropolitan Life Insurance until Metropolitan Life Insurance receives and approves the timely submitted form.

More than One Beneficiary:
If you name more than one Beneficiary and the Beneficiary form does not specify their shares, they will share equally.

Death of a Beneficiary:
If a beneficiary dies before you, that Beneficiary's interest will end. It will be shared equally by any remaining Beneficiaries unless the Beneficiary form states other division of shares.

No Beneficiary at Your Death:
If there is a Beneficiary for the insurance, it is payable to that Beneficiary. Any amount of insurance for which there is no Beneficiary at your death, Metropolitan Life Insurance may determine one or more of the following who survive you to be your Beneficiary:

- Your surviving Spouse;
- Your surviving Child(ren);
- Your surviving parents;
- Your surviving siblings; or
- Your estate.

If a Beneficiary or payee is a minor or incompetent to receive payment, Metropolitan Life will pay that person's guardian. Any payment made in good faith will discharge the Plan's liability to the extent of such payment.

BENEFICIARY OF YOUR DEPENDENTS

With respect to life insurance for your Dependents, Metropolitan Life may pay you as the Beneficiary if alive. If you are not alive, Metropolitan Life may determine the Beneficiary to be one or more of the following who survive you:

- Your Spouse;
- Your Child(ren);
- Your parent(s);
- Your sibling(s); or
- Your estate.

Any payment made in good faith will discharge the Plan's liability to the extent of such payment.

If both you and any Dependent die within a 24 hour period, Metropolitan Life will pay the Dependent's Life Insurance to the Beneficiary receiving payment of your Life Insurance or Metropolitan Life may pay your estate. If a Beneficiary or a payee is a minor or incompetent to receive payment, Metropolitan Life will pay that person's guardian.

Payment of Benefits:
The amount of Life and AD&D benefits in effect for you and/or your Dependent upon your death and/or your Dependent's death will be based upon the amount of Life and AD&D benefits in effect for you and/or your Dependent at the time of death.

Unless the Beneficiary requests payment by check, when it is stated that Metropolitan Life will pay benefits in "one sum" or a "single sum", Metropolitan Life may pay the full benefit amount:

- by check;
- by establishing an account that earns interest and provides the Beneficiary with immediate access to the full benefit amount; or
- by any other method that provides the Beneficiary with immediate access to the full benefit amount.

Other modes of payment may be available upon request. For details, call (800) 638-6420.

Accelerated Benefit Option:
The Accelerated Benefit Option applies to Employee and Voluntary Spouse Life Insurance coverages only. The Accelerated Benefit Option is available should you or your Spouse, as applicable, become terminally ill with a life expectancy of six months or less. A portion of the eligible life insurance benefits, which would otherwise be payable at death, will be paid in advance to you while you or your Spouse, as applicable, is still living, assuming you decide to elect this option. Metropolitan Life will provide you with the proceeds in one lump sum unless you or your legal representative selects another payment form.

The life insurance benefits not paid in advance during your lifetime or the lifetime of your Spouse, as applicable, will remain with Metropolitan Life until the applicable person's death, at which time the remaining benefit will be paid to you or your Beneficiary.

Requirements for Payment of an Accelerated Benefit Option:
In order for your or your Spouse's Life Insurance benefit to be Accelerated Benefit Option eligible:

- the insurance benefit option being accelerated must equal or exceed $20,000;
- the insurance benefit option being accelerated must not have been assigned; and
- Metropolitan Life must receive proof that you or your Spouse, as applicable, is terminally ill ("Proof of Terminal Illness"), which will require:
  - a completed accelerated benefit claim form; and
  - a signed Physician's certification with supporting documentation that you or your Spouse, as applicable, are terminally ill.

The maximum amount available under the Accelerated Benefit Option is 80% of both your Core Employee Life and your Voluntary Employee Life benefit. Also, if you only have Core Employee Life coverage, the Accelerated Benefit Option is limited to $40,000. If you have Voluntary Employee Life coverage, the maximum Accelerated Benefit amount available is $500,000. The maximum Accelerated Benefit Option amount for Voluntary Spouse Life Insurance coverage is 80% of the Voluntary Spouse Life Insurance coverage, not to exceed $250,000.

For questions regarding the Accelerated Benefit Option, call (800) 638-6420 or (800) 855-2880 TTY for hearing impaired.

ESTATE RESOLUTION SERVICES

If you have Voluntary Employee Life Insurance coverage, the following Estate Resolution Services are provided at no additional cost. If you are eligible to receive these Estate Resolution Services and you or your Spouse (for the Will Preparation Service) or you or a Beneficiary (for the Probate Service) would like more information regarding these services, please call (800) 821-6400.

Will Preparation Service:
If you have Voluntary Employee Life Insurance coverage, a Will Preparation Service will be made available to you

through a Metropolitan Life affiliate (the "Affiliate"). This service will be made available at no cost to you. The service enables you to have a will prepared for you and your Spouse free of charge by attorneys designated by the Affiliate. If you have a will prepared by an attorney not designated by the Affiliate, you must pay for the attorney's services directly. Once proof of payment is received, you will be reimbursed for the attorney's services in an amount equal to the lesser of the amount you paid for the attorney's services and the amount customarily reimbursed for such services by the Affiliate.

Probate Service:
If you die while having Voluntary Employee Life Insurance coverage, a probate benefit will be made available to your estate, through an Affiliate.

The probate service benefit provides for certain probate services to be made available upon your death, free of charge by attorneys designated by the Affiliate. If probate services are provided by an attorney not designated by the Affiliate, your estate must pay for those attorney's services directly. Once proof of such payment is received, your estate will be reimbursed for the attorney's services in an amount equal to the lesser of the amount your estate paid for the attorney's services and the amount customarily reimbursed for such services by the Affiliate.

This Benefit will be provided at no cost to you and will end on the date your Group Voluntary Life Insurance coverage ends.

FUNERAL DISCOUNT AND PLANNING SERVICES

Employees have access to Funeral Discount and Planning Services through an affiliate of Metropolitan Life. This service will be made available at no cost, for Employees, spouses and extended family members (children, parents, grandparents and great-grandparents). Callers will have access to counselors as well as discounts on funeral services through the largest network of funeral homes and cemetery providers in the United States. Services include discounts of up to 10% off funeral, cremation, and cemetery services provided through a Dignity Memorial funeral home (not yet available in some states), unlimited access to Dignity's comprehensive end-of-life planning tool and resource library, professional funeral consultants to help you make confident decisions, planning services to help make final wishes easier to manage and Bereavement Travel Services to assist with time-sensitive travel arrangements to be with loved ones (when services are provided through a Dignity Memorial location).

ACCIDENTAL DEATH & DISMEMBERMENT

Benefits:
If you or a Dependent sustains an accidental injury that is the Direct and Sole Cause of a Covered Loss described in the table below, Proof of the accidental injury and Covered Loss must be sent to Metropolitan Life. When such Proof is received, Metropolitan Life will review the claim and, if approved, will pay the insurance in effect on the date of the injury.

Direct and Sole Cause means the Covered Loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes.

Metropolitan Life will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

Presumption of Death:
You and/or a Dependent will be presumed to have died as a result of an accidental injury if:

- the aircraft or other vehicle in which you and/or a Dependent were traveling disappears, sinks, or is wrecked; and
- the body of the person who has disappeared is not found within 1 year of:
  - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a Common Carrier; or
  - the date the person is reported missing to the authorities, if traveling in any other aircraft or other vehicle.

COVERED LOSSES AND BENEFIT AMOUNTS	
The amount payable depends on the type of Covered Loss.	
LOSS OF OR BY REASON OF	**PERCENT OF YOUR AMOUNT OF**
Life	100%
Loss of a hand permanently severed at or above the wrist but below the elbow	50%
Loss of a foot permanently severed at or above the ankle but below the knee	50%
Loss of an arm permanently severed at or above the elbow	75%
Loss of a leg permanently severed at or above the knee	75%
Loss of sight in one eye	50%
Loss of any combination of hand, foot, or sight of one eye, as defined above	100%
Loss of the thumb and index finger of same hand	25%
Loss of Speech and Hearing	100%
Loss of speech or loss of hearing	50%
Paralysis of both arms and both legs	100%
Paralysis of both legs	75%
Paralysis of the arm and leg on either side of the body	50%
Paralysis of one arm or leg	25%
Brain Damage	100%
Coma	1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 100 months

Definitions for Covered Losses and Benefit Amounts:
Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

Loss of speech means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.

Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.

Loss of thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

Exclusions:
Not every loss is a "Covered Loss" which will result in the payment of a benefit. Metropolitan Life will not pay benefits under this section for any loss caused or contributed to by:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the armed forces of any country or international authority. However, service in reserve forces

does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;

6. any incident related to:
   - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
   - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
   - travel in an aircraft or device used:
     - for testing or experimental purposes;
     - by or for any military authority; or
     - for travel or designed for travel beyond the earth's atmosphere;
7. committing or attempting to commit a felony;
8. the voluntary intake or use by any means of:
   - any drug, medication or sedative, unless it is:
     - taken or used as prescribed by a Physician; or
     - an "over the counter" drug, medication or sedative taken as directed;
   - alcohol in combination with any drug, medication, or sedative; or
   - poison, gas, or fumes; or
9. war, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

Exclusion for Intoxication
Metropolitan Life will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

Common Disaster
If you and your Spouse are injured in the same accident and die within 365 days as a result of injuries in such accident, the Full Amount that Metropolitan Life will pay for your Spouse's loss of life will be increased to equal the Full Amount payable for your loss of life.

Benefit Payment:
For loss of your life, Metropolitan Life will pay benefits to your Beneficiary.

For any other loss sustained by you, or for any loss sustained by a Dependent, Metropolitan Life will pay benefits to you.

If you or a Dependent sustain more than one Covered Loss due to an accidental injury, the amount Metropolitan Life will pay, on behalf of any such injured person, will not exceed the Full Amount of Insurance.

Metropolitan Life will pay benefits in one sum. Other modes of payment may be available upon request. For details call Metropolitan Life's toll free number (800) 638-6420.

If both you and any Dependent die within a 24 hour period, Metropolitan Life will pay the Dependent's Accidental Death and Dismemberment Insurance to the Beneficiary receiving payment of your Accidental Death and Dismemberment Insurance including payment of any Additional Benefits, or Metropolitan Life may pay your estate. If a Beneficiary is a minor or is incompetent to receive payment, Metropolitan Life will pay that person's guardian.

Additional AD&D Benefits:
An additional benefit, over and above the coverage elected, may be payable for a Covered Loss under certain

circumstances. Any such benefit is payable in addition to any other AD&D benefits payable under this coverage. A list of additional benefits and conditions is provided below.

For Core Employee AD&D, Voluntary Employee AD&D and Voluntary Dependent AD&D Coverages:

I. Additional Benefit-Seat Belt Use: If you or a Dependent die as a result of an accidental injury, Metropolitan Life will pay this additional Seat Belt Use benefit if:

1. Metropolitan Life pays a benefit for loss of life under the ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. Metropolitan Life receives Proof that the deceased person:
   - was in an accident while driving or riding as a passenger in a Passenger Car;
   - was wearing a Seat Belt which was properly fastened at the time of the accident; and
   - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened. A copy of such certification must be submitted to Metropolitan Life with the claim for benefits.

Benefit Amount

The Seat Belt Use benefit is an additional benefit equal to 10% of the Full Amount of Insurance. However, the amount Metropolitan Life will pay for this benefit will not be less than $1,000 or more than $25,000.

Benefit Payment

For loss of your life, Metropolitan Life will pay benefits to your Beneficiary. For loss of a Dependent's life, Metropolitan Life will pay benefits to you.

II. Additional Benefit-Air Bag Use: If you or a Dependent die as a result of an accidental injury, Metropolitan Life will pay an additional benefit if:

1. Metropolitan Life pays a benefit for loss of life under the ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. Metropolitan Life receives Proof that the deceased person:
   - was in an accident while driving or riding as a passenger in a Passenger Car equipped with an Air Bag(s);
   - was riding in a seat protected by an Air Bag;
   - was wearing a Seat Belt which was properly fastened at the time of the accident; and
   - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened and that the Passenger Car in which the deceased was traveling was equipped with Air Bags. A copy of such certification must be submitted to Metropolitan Life with the claim for benefits.

Benefit Amount

The Air Bag Use Benefit is an additional benefit equal to 10% of Full Amount of Insurance otherwise payable according to the Schedule of Benefits. However, the amount Metropolitan Life will pay for this benefit will not be less than $1,000 or more than $25,000.

Benefit Payment

For loss of your life, Metropolitan Life will pay benefits to your Beneficiary. For a loss of a Dependent's life, Metropolitan Life will pay benefits to you.

The following terms are defined for purposes of the additional benefit applicable to Seat Belt Use and Air Bag Use:

Passenger Car means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

Seat Belt means any restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

The term includes any child restraint device that meets the requirements of state law.

Air Bag means an inflatable restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

III. Additional Benefit-Common Carrier: If you or a Dependent dies as a result of an accidental injury, Metropolitan Life will pay this additional benefit if:

1. Metropolitan Life pays a benefit for loss of life under the ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. Metropolitan Life receives Proof that the injury resulting in the deceased's death occurred while traveling in a Common Carrier.

Benefit Amount

The Common Carrier Benefit is an amount equal to the Full Amount of Insurance.

Benefit Payment

For loss of your life, Metropolitan Life will pay benefits to your Beneficiary. For a loss of a Dependent's life, Metropolitan Life will pay benefits to you.

Common Carrier, for purposes of the additional benefit applicable to a Common Carrier, means a government regulated entity that is in the business of transporting fare paying passengers. The term does not include:

- chartered or other privately arranged transportation;
- taxis; or
- limousines.

For Voluntary Employee AD&D and Voluntary Dependent AD&D Coverages:

I. Additional Benefit- Child Care: If you or your Spouse die as a result of an accidental injury, Metropolitan Life will pay this additional Child Care benefit if:

1. Metropolitan Life pays a benefit for loss of life under the ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. Metropolitan Life receives Proof that:
   - on the date of your death a Child was enrolled in a Child Care Center; or
   - within 12 months after the date of your death a Child was enrolled in a Child Care Center.

Child Care Center means a facility that:

- is operated and licensed according to the law of the jurisdiction where it is located; and provides care and supervision for children in a group setting on a regularly scheduled and daily basis.

Benefit Amount

For each Child who qualifies for this benefit, Metropolitan Life will pay an amount equal to the Child Care Center charges incurred for a period of up to 1 consecutive year, not to exceed:

- an annual maximum of $5,000; and
- an overall maximum of 12% of the Full Amount of Insurance.

In the event that both you and your Spouse die such that each death would cause a payment to be made for a Child under this Additional Benefit, the following rules apply:

- the annual maximum will be 2 times the amount stated above;
- the overall maximum will be equal to the stated percentage applied to the sum of the Full Amounts of Insurance for both you and your Spouse; and
- in no event will the amount paid under all Child Care benefits exceed the amount of Child Care charges incurred.

Metropolitan Life will not pay for Child Care Center charges incurred after the date a Child attains age 12.

Metropolitan Life may require Proof of the Child's continued enrollment in a Child Care Center during the period for which a benefit is claimed.

Benefit Payment
Metropolitan Life will pay this benefit quarterly when it receives Proof that Child Care Center charges have been paid. Payment will be made to the person who pays such charges on behalf of the Child. If this benefit is in effect on the date you die and there is no Child who could qualify for it, Metropolitan Life will pay $1,000 to your Beneficiary in one sum.

II. Additional Benefit-Child Education: If you or your Spouse die as a result of an accidental injury, Metropolitan Life will pay this additional Child Education benefit if:

1. Metropolitan Life pays a benefit for loss of life under the ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. Metropolitan Life receives Proof that on the date of your death a Child was:
   - enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or
   - at the 12th grade level and, within one year after the date of your death, enrolls as a full-time student in an accredited college, university or vocational school.

Benefit Amount
For each Child who qualifies for this benefit, Metropolitan Life will pay an amount equal to the tuition charges incurred for a period of up to 1 consecutive academic year, not to exceed:

- an academic year maximum of $10,000; and
- an overall maximum of 20% of the Full Amount of Insurance.

In the event that both you and your Spouse die such that each death would cause a payment to be made for a Child under this Additional Benefit, the following rules apply:

- the academic year maximum will be 2 times the amount stated above;
- the overall maximum will be equal to the stated percentage applied to the sum of the Full Amounts of Insurance for both you and your Spouse; and
- in no event will the amount paid under all Child Education benefits exceed the amount of tuition incurred.

Metropolitan Life may require Proof of the Child's continued enrollment as a full-time student during the period for which a benefit is claimed.

Benefit Payment
Metropolitan Life will pay this benefit semi-annually when it receives Proof that tuition charges have been paid. Payment will be made to the person who pays such charges on behalf of the Child. If this benefit is in effect on the date you die and there is no Child who could qualify for it, Metropolitan Life will pay $1,000 to your Beneficiary in one sum.

III. Additional Benefit-Hospital Confinement: Subject to the provisions of the ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE, Metropolitan Life will pay this additional benefit if:

1. Metropolitan Life receives Proof that you or a Dependent are confined in a Hospital as a result of an accidental injury which is the direct result of such confinement independent of other causes; and
2. this benefit is in effect on the date of the injury.

Benefit Amount
Metropolitan Life will pay an amount for each full month of Hospital Confinement equal to the lesser of:

- 1% of the Full Amount of Insurance; and
- $1,000.

Metropolitan Life will pay this benefit on a monthly basis beginning on the 8th day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a pro-rata basis for any partial month of confinement.

Metropolitan Life will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

Benefit Payment
Benefit payments will be made monthly. Payment will be made to you.

For Voluntary Employee AD&D Coverage:
Additional Benefit-Spouse Education: If you die as a result of an accidental injury, Metropolitan Life will pay this additional Spouse Education benefit if:

1. Metropolitan Life pays a benefit for loss of life under the ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. Metropolitan Life receives Proof that:
   - on the date of your death, your Spouse was enrolled as a full-time student in an accredited school; or
   - within 12 months after the date of your death, your Spouse enrolls as a full-time student in an accredited school.

Benefit Amount
Metropolitan Life will pay an amount equal to the tuition charges incurred for a period of up to 1 academic year, not to exceed:

- an academic year maximum of $5,000; and
- an overall maximum of 5% of the Full Amount of Insurance.

Metropolitan Life may require Proof of the Spouse's continued enrollment as a full-time student during the period for which a benefit is claimed.

Benefit Payment
Metropolitan Life will pay this benefit semi-annually when Metropolitan Life receives Proof that tuition charges have been paid. Payment will be made to the Spouse. If this benefit is in effect on the date you die and there is no Spouse who could qualify for it, Metropolitan Life will pay $1,000 to your Beneficiary in one sum.

CLAIM AND APPEAL INFORMATION

General Procedures for Presenting Claims for Benefits:
For all Life and AD&D Insurance Plan claims and appeals, Metropolitan Life Insurance Company has been delegated the exclusive and discretionary right to determine facts and interpret and administer the provisions of the 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. The decisions of Metropolitan Life are conclusive and binding.

Note: The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"). In response, the Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in this "Claim and Appeal Information" section – for you to submit an initial claim for benefits or request an appeal of a denied claim for benefits.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your rights to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in this "Claim and Appeal Information" section, you may have additional time to do so. Please contact Metropolitan Life at (800) 638-6420 (or (800) 855-2880 TTY for hearing impaired) for more information.

Claim forms to file for life and accidental death and dismemberment benefits under the Life and AD&D Insurance Plan ("Benefits") can be obtained from Metropolitan Life by calling at (800) 638-6420 or (800) 855-2880 TTY for hearing impaired or accessed via their website at www.metlife.com/mybenefits. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

The claim form (and any required Proof) should be returned to Metropolitan Life for processing to the address indicated on the claim form.

When the claim has been processed, you or your Beneficiary will be notified of the Benefits paid. The Benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time Metropolitan Life makes payment. If any Benefits have been denied, you or your Beneficiary will receive a written explanation.

Routine Questions:
If there is any question about a claim payment, an explanation can be requested from Metropolitan Life by calling at (800) 638-6420 or (800) 855-2880 TTY.

Specific Claim Procedures for Life Insurance Benefits:
Notice of the death of an insured person should be given as soon as reasonably possible after the death. The claim form will be sent to the Beneficiary or Beneficiaries of record.

When Metropolitan Life receives the claim form and Proof, it will review the claim and, if the claim is approved, will pay benefits subject to the terms and provisions of your Certificate of Insurance and the Group Policy. The Benefit Amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time Metropolitan Life makes payment.

Specific Claim Procedures for Accidental Death and Dismemberment Benefits:
Notice of a Covered Loss should be given to Metropolitan Life as soon as is reasonably possible but in any case within 20 days of the Covered Loss. The claim form will be sent to you or the Beneficiary or Beneficiaries of record.

The claim form should be completed and sent along with Proof of the Covered Loss to Metropolitan Life as instructed on the claim form. If you or the Beneficiaries have not received a claim form within 15 days of giving notice of the claim, Proof may be sent using any form sufficient to provide Metropolitan Life with the required Proof.

The claimant must give Metropolitan Life Proof no later than 90 days after the date of the Covered Loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice or Proof are given as soon as is reasonably possible.

When Metropolitan Life receives the claim form and Proof, it will review the claim and, if the claim is approved, will pay benefits subject to the terms and provisions of your Certificate of Insurance and the Group Policy. The Benefit Amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time Metropolitan Life makes payment.

Time Limit on Legal Actions:
A legal action on a claim may only be brought against Metropolitan Life during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

Determination of Benefits-Life and AD&D Claims:
Initial Determination:
After Metropolitan Life receives your claim for Benefits, Metropolitan Life will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date Metropolitan Life received your claim, unless Metropolitan Life notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If Metropolitan Life denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because Metropolitan Life did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.

The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal. You must first exhaust all appeals available to you under the Life and Accidental Death & Dismemberment (AD&D) Insurance Plan (except any voluntary appeal procedures offered by the Plan) before you have a right to bring a civil action under ERISA regarding your denied claim. See the section, "Appealing the Initial Determination" immediately below for information regarding your appeal rights.

Appealing the Initial Determination:
In the event a claim has been denied in whole or in part, you or, if applicable, your Beneficiary can request a review of your claim by Metropolitan Life. This request for review must be in writing and sent within 60 days after you or, if applicable, your Beneficiary received notice of denial of the claim to Group Insurance Claims Review at the address of Metropolitan Life's office which processed the claim. When requesting a review, please state the reason you or, if applicable, your Beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your Beneficiary deem appropriate. Upon your written request, Metropolitan Life will provide you free of charge with copies of relevant documents, records and other information.

Metropolitan Life will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your Beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date Metropolitan Life received your request for review, unless Metropolitan Life notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If Metropolitan Life denies the claim on appeal, Metropolitan Life will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Metropolitan Life's decision on your appeal is final and binding. Upon written request, Metropolitan Life will provide you free of charge with copies of documents, records and other information relevant to your claim. If your appeal is denied, you have a right to file an action under Section 502(a) of ERISA.

Incontestability: Statements Made by You:
Any statement made by you will be considered a representation and not a warranty. Metropolitan Life will not use such statement to avoid life and accidental death and dismemberment insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a written application or enrollment form;
2. You have signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to you or your Beneficiary.

Metropolitan Life will not use your statements which relate to insurability to contest life insurance after it has been in force for 2 years during your life. In addition, Metropolitan Life will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during your life, unless the statement is fraudulent.

Misstatement of Age:
If your or your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, Metropolitan Life will adjust the benefits and/or premiums.

CONVERSION TO A PERSONAL POLICY

Application for a Personal Policy:
If you or one of your Dependents ceases to be insured for life insurance coverage for one of the reasons stated below, you can convert all or part of the life insurance coverage, which then ends, to an individual whole life insurance contract. AD&D amounts are not eligible for the conversion option. **Evidence of insurability is not required for conversion to a personal policy.** The reasons are:

1. Your employment ends for any reason or you otherwise lose eligibility.
2. All term life insurance of the Life and AD&D Insurance Plan ends by amendment or otherwise; but, on the date it ends, you must have been insured for five continuous years for that insurance.

NOTE: The life insurance available under the Life and AD&D Insurance Plan is term coverage. The term coverage under the Plan cannot be converted to an individual term policy under the conversion option.

To convert your existing Employee, Spouse, or Child Life Insurance coverage into a personal policy, you should contact Metropolitan Life Insurance at (877) 275-6387 (1-877-ASKMET7)

Availability:
If you or a Dependent opt to convert as stated above, Metropolitan Life must receive a completed conversion application form within the Application Period described below.

1. If written notice of the option to convert is given within 15 days before or after the date life insurance for you or a Dependent, as applicable, ends, the Application Period begins on the date that such life insurance ends and expires 31 days after such date.
2. If written notice of the option to convert is given more than 15 days after the date life insurance for you or your Dependent, as applicable, ends, the Application Period begins on the date such life insurance ends and expires 15 days from the date of such notice.

In no event will the Application Period exceed 91 days from the date life insurance ends.

Individual Contract Rules:
The individual contract must conform to the following:

Amount: If the life insurance under the Life and AD&D Insurance Plan ends by amendment or otherwise for you or a Dependent, as applicable, the maximum amount of insurance you may elect for the new policy is the lesser of the following:

1. The total amount of the life insurance then ending under the Life and AD&D Insurance Plan reduced by the amount of group life insurance for you or your Dependent, as applicable, under any group policy within 31 days after the date insurance under the Life and AD&D Insurance Plan ends; or
2. $10,000.

If your or your Dependent's life insurance ends due to an organizational restructuring, the maximum amount of insurance that may be elected for the new policy is the amount of life insurance that ends under the Life and AD&D Insurance Plan less the amount of life insurance for you or your Dependent, as applicable, under any group policy within 31 days after the date insurance under the Life and AD&D Insurance Plan ends.

If your or your Dependent's life insurance ends for any other reason, the maximum amount of insurance that may be elected for the new policy is the amount of the applicable life insurance that ends under the Life and AD&D Insurance Plan.

Form: Any form of a life insurance contract that:

1. Conforms to Title VII of the Civil Rights Act of 1964, as amended, having no distinction based on sex; and
2. Is one that Metropolitan Life usually issues at the age and amount for which applied.

This does not include term insurance or a contract with an accidental death and dismemberment benefit, an accelerated benefit option, a waiver of premium benefit or any other rider or additional benefit.

Premium: Based on Metropolitan Life's rate as it applies to the form and amount and to your class of risk and age at the time.

Effective Date: On the 32nd day after the date the applicable life insurance under the Life and AD&D Insurance Plan ends.

If you Die During the Application Period:
If you or your Dependent, as applicable, dies within 31 days after the life insurance ends, proof of your death must be sent to Metropolitan Life. When Metropolitan Life receives such proof with the claim, Metropolitan Life will review the claim and if Metropolitan Life approves it will pay the Beneficiary. The amount Metropolitan Life will pay is the amount you were entitled to convert.

The amount you were entitled to convert will not be paid as insurance under both a new individual conversion policy and the Life and AD&D Insurance Plan.

PORTING ELIGIBLE LIFE AND AD&D INSURANCE

With the exception of Core Employee Life and Core Employee AD&D coverage, all life and AD&D coverage for you and your Dependents is portability eligible in the event such coverage is lost for one of the reasons listed in your Certificate of Insurance. "Porting" is a process in which you choose to continue such coverage under another group policy offered by Metropolitan Life Insurance Company. **Evidence of insurability is not required to port.**

Availability:
For you or a former Dependent to Port, Metropolitan Life must receive a completed written application within the Application Period described below.

1. If written notice of the option to Port is given within 15 days before or after the date insurance for you or a Dependent, as applicable, ends, the Application Period begins on the date such insurance ends and expires 31 days after that date.
2. If written notice of the option to Port is given more than 15 days after but within 91 days of the date insurance for you or your Dependent, as applicable, ends, the Application Period begins on the date such insurance ends and expires 45 days after the date of the notice.

In no event will the Application Period exceed 91 days from the date life insurance ends.

Additional information and details regarding Porting can be found in your Certificate of Insurance.

GENERAL PROVISIONS

Assignment:
Your Life Insurance and AD&D rights and benefits under the Group Policy may be assigned. You may assign your Life Insurance rights and benefits as a gift or as a viatical assignment, and you may also assign your AD&D rights and benefits as a gift. See the Group Policy for more information regarding how to assign your Life and AD&D benefits.

Previous Employment with Union Pacific:
If you were employed by Union Pacific with life insurance coverage under the Life and Accidental Death & Dismemberment Insurance Plan when your employment ended and are re-hired by Union Pacific within 2 years after such employment ending, you will not be eligible for life insurance under the Life and Accidental Death & Dismemberment Insurance Plan unless you surrender:

- any individual policy of life insurance to which you converted when your employment ended; and
- any certificate of insurance continued as ported insurance when such employment ended.

The cash value, if any, of such surrendered insurance will be paid to you.

Suicide:
For Voluntary Life
If you commit suicide within 2 years from the date Life Insurance for you takes effect, Metropolitan Life will not pay such insurance and their liability will be limited to returning to your Beneficiary any premiums previously paid by you.

If you commit suicide within 2 years from the date an increase in your life insurance takes effect, Metropolitan Life will pay to the Beneficiary the amount of insurance in effect on the day before the increase. Any premium you paid for the increase will be returned to the Beneficiary.

For Dependent Life
If a Dependent commits suicide within 2 years from the date life insurance for such Dependent takes effect, Metropolitan Life will not pay such insurance and their liability will be limited to returning to the Beneficiary any premiums previously paid by you.

If a Dependent commits suicide within 2 years from the date an increase in life insurance for such Dependent takes effect, Metropolitan Life will pay to the Beneficiary the amount of insurance in effect on the day before the increase. Any premium you paid for the increase will be returned to the Beneficiary.

Physical Exams:
If a claim is submitted for insurance benefits other than Life Insurance benefits, Metropolitan Life will have the right to ask the insured to be examined by a Physician(s) of its choice as often as is reasonably necessary to process the claim. Metropolitan Life will pay the cost of such exam.

Autopsy:
Metropolitan Life has the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons it is requesting the autopsy.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND OTHER PLAN FIDUCIARIES

In carrying out their respective responsibilities under the Life and AD&D Insurance Plan, the Plan Administrator and other Plan fiduciaries, including Metropolitan Life Insurance Company, shall have discretionary authority to make factual findings, interpret the terms of the Plan, and to determine eligibility for and entitlement to Life and AD&D Insurance Plan benefits in accordance with the terms of the Plan.

Any finding, 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.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES:

There are state-specific requirements that may change the provisions described in this Flex Guide. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of your Group Insurance Certificate. Metropolitan Life has a website that describes these state-specific requirements. You may access the website at www.metlife.com/mybenefits.

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Metropolitan Life at (866) 659-1377.

Short-Term & Long-Term Disability

Page

OVERVIEW

Purpose:
The Union Pacific Corporation Short-Term & Long-Term Disability Plan (the "STD/LTD Plan") provides continued income for you if illness or injury prevents you from working.

Applicable STD/LTD Plan Terms:
The capitalized terms used in this section of the Flex Guide are defined in the "Definition" section beginning on page 256.

Except as provided in the following paragraph, the terms of the STD/LTD Plan described herein apply to Employees Actively at Work on January 1, 2021. For such Employees, except as otherwise provided in the STD/LTD Plan, the Short-Term Disability ("STD") and the Long-Term Disability ("LTD") determination processes are administered by Metropolitan Life Insurance Company ("MetLife") and, with respect to STD only, the Senior Manager - Employee Assistance Program and Peer Support of the Union Pacific Railroad Company ("Senior Manager"), acting as agents of the Plan.

Applicants for STD or LTD benefits are required to cooperate with MetLife and the Senior Manager as they perform this function for the STD/LTD Plan in order to receive benefits. The STD component of the plan is self-insured by Union Pacific and the LTD component of the plan is fully insured by MetLife. The plan is administered by MetLife and the Senior Manager, except as otherwise specified in the plan. The LTD benefits insured by MetLife are subject to the terms of the Group Policy between MetLife and Union Pacific Corporation (including your Certificate of Insurance issued under such Group Policy) under which the benefits are provided. With respect to LTD benefits, if there is any conflict between this section of the Flex Guide and the Group Policy, the Group Policy will govern.

If you are an Employee Actively at Work on or after January 1, 2021, but have a "recurring Disability" as described on page 233 of this Flex Guide such that the recurring Disability is treated as beginning prior to January 1, 2008, the terms of the STD/LTD Plan in effect on the date such Disability initially began determines your plan benefits with respect to such Disability. If you have a claim resulting from a recurring Disability as described in the previous sentence, you must follow the claims and appeals procedures described in the "Claims and Appeals (Pre-2008 Disability)" section on page 245. In addition, those claim and appeal procedures must be used by an Employee to obtain STD/LTD benefits when the Employee's STD period begins prior to January 1, 2008. The STD and LTD Disability determination processes described in the "Claims and Appeals (Pre-2008 Disability)" section are administered by Union Pacific Health & Medical Services and the Senior Manager, acting as agents of the STD/LTD Plan. Applicants for STD or LTD benefits who file claims in accordance with such claim and appeal procedures are required to cooperate with Union Pacific Health & Medical Services and the Senior Manager as they perform this function for the Plan in order to receive benefits. These Pre-2008 Disability benefits are self-insured by Union Pacific.

General Requirements:
Medical Evidence: The STD/LTD Plan requires objective medical evidence from your attending Physician or from a Plan- appointed Physician and may request additional Medical Information to support your claim for Short-Term or Long-Term benefits throughout your Disability.

The STD/LTD Plan will review the Medical Information to ensure that you are receiving Appropriate Care and Treatment from a Physician. Failure to cooperate in Appropriate Care and Treatment from a Physician will result in a cessation of benefits.

Return-to-Work Program: The Return-to-Work Program focuses on vocational rehabilitation and identifying the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation also can lead to a new occupation or employer that is better suited to your condition and makes the most of your abilities.

You are automatically eligible to participate in the Return-to-Work Program, and services are provided at no cost to you. The goal is to focus on your abilities — what you can do versus what you can't — in an effort to return you to work sooner than expected.

The case management specialist handling your claim will coordinate your Return-to-Work services, which may include:

- **Vocational Analysis –** Assessment and counseling to help determine how your skills and abilities can be applied to a new or modified job with Union Pacific or any other employer.
- **Labor Market Surveys –** Studies to find jobs available in your locale that would use your abilities.
- **Retraining Programs –** Programs to facilitate return to your previous job, or to train you for a new job.
- **On-Site Job Analysis –** Analysis to determine what modifications may be made to maximize your employment opportunities.
- **Job Modifications/Accommodations –** Identify changes in your job or accommodations to help you perform the previous job for consideration by Union Pacific, or a similar vocation.
- **Training in Job Seeking Skills –** Provides special training to identify abilities, set goals, develop resumes and polish interviewing techniques, as well as other career search assistance.

Failure to cooperate in a STD/LTD Plan-approved Return-to-Work program will result in a cessation of benefits.

Administrative Reminder:
Health and Medical Services Review: Certain jobs and/or medical conditions have safety sensitive concerns as they relate to your continuing work or a return to work after a period of Disability. While MetLife (or the Senior Manager, with respect to STD claims as a result of substance abuse) has exclusive discretion and authority to determine whether you are Disabled under the STD/LTD Plan, if your Disability claim relates to a job or medical condition that includes safety sensitive concerns, Union Pacific Health and Medical Services, or the Senior Manager, as delegated by Union Pacific Health and Medical Services in accordance with its guidelines – will determine whether you may return to work. When making this 'return to work' determination, Health and Medical Services and the Senior Manager are acting on behalf of Union Pacific, and not on behalf of the Plan. This means this determination is independent from any determination of Disability made by MetLife (or the Senior Manager) with respect to the STD/LTD Plan.

SHORT-TERM DISABILITY

Purpose:
Short-Term Disability (STD) provides continued income to Employees temporarily unable to perform the essential functions of their regular jobs due to sickness or accident as determined by the STD/LTD Plan. To qualify for STD benefits, your Physician must certify that you are unable to perform the essential functions of your regular job during the period for which STD benefits are claimed and must indicate the length of time that this condition has been occurring and is expected to last if requested by the STD/LTD Plan.

Cost:
Short-Term Disability coverage is provided by Union Pacific to its Employees at no cost to the Employee.

Eligibility:
You are eligible for Short-Term Disability coverage once you have been an Employee for three continuous months. If you are an agreement employee with at least three months continuous service and you transfer to a nonagreement position, you are immediately eligible for STD coverage.

The three month period is completed on the same day of the month in the third month following the date of hire, or if the same day of the month does not exist, the last day of the third month following the date of hire.

For example:

- If your date of hire is January 6, 2021, your STD eligibility effective date is April 6,2021.
- If your date of hire is January 30, 2021, your STD eligibility effective date is April 30,2021.
- If your date of hire is January 31, 2021, your STD eligibility effective date is April 30, 2021 (because there are only 30 days in April).

STD benefits are payable so long as you have satisfied the STD eligibility requirements before your illness begins or accidental injury occurs. Benefits are payable beginning the first Day of absence due to illness or injury.

Qualifications:
To qualify for benefits, if you either are going to miss more or have already missed more than four consecutive Days, including your non-working Days, due to illness or accidental injury, you must:

1) report the absence to your supervisor, and
2) initiate a claim by contacting:
   a) Union Pacific EAP at (800) 779-1212, if your absence is for a substance abuse condition;
   b) BOTH Union Pacific EAP at (800) 779-1212 and MetLife at (888) 608-6665 if your absence is for a behavioral health condition*; or
   c) MetLife at (888) 608-6665 if your absence is for a condition other than substance abuse or behavioral health).

You must take these actions while you are covered by the STD/LTD Plan and prior to the earlier of:

1. The date you are notified your employment is being terminated; or
2. Your date of termination of employment.

*Note –You must contact both MetLife and the Union Pacific EAP if you are absent from work due to a behavioral health condition because while MetLife is responsible for determining whether you are eligible for STD benefits due to such condition, the Union Pacific EAP will provide you with information regarding behavioral health services available under other Union Pacific sponsored benefit plans, and upon request will also provide you with a referral service to behavioral health providers.

If your claim is not a substance abuse or behavioral health claim, you may also choose to initiate a claim with MetLife by visiting their website at www.metlife.com/mybenefits. When prompted for Company Name, type in "Union Pacific Railroad" and you will be directed to the MyBenefits registration screen. Then either register or, if you have already registered, indicate your user name and password.

In addition, to qualify for benefits, you are required to provide Medical Information if requested by the STD/LTD Plan to ensure that you are receiving Appropriate Care and Treatment from a Physician.

Furthermore, to qualify for STD benefits, if requested by the STD/LTD Plan your Physician must certify that you are unable to perform the essential functions of your regular job during the period for which STD benefits are claimed and must indicate the length of time that this condition has been occurring and is expected to last. The STD/LTD Plan will review your Physician's certification and determine whether benefits will be paid based upon objective Medical Information and the requirements of your job. You will be asked to periodically submit documentation to MetLife (or the Senior Manager, with respect to a STD claim due to substance abuse) that provides proof of your continuing Disability. If Medical Information necessary to decide your STD claim is not received by MetLife or Senior Manager, as applicable, within 14 calendar days of the date your claim was initiated, your claim will be denied, unless MetLife or Senior Manager, as applicable, in its discretion, elects to extend the time period for making its determination. For more information, see the section, "Claims & Appeals (other than pre-2008 Disability)" on page 241.

Examples of consecutive non-working Days:

- Consecutive scheduled work Days during which you are absent – all of the consecutive scheduled work Days during which you are absent count as non-working Days;
- Consecutive scheduled work Days during which you are absent, *split* by a weekend or equivalent Day(s) – all of the work Days during which you are absent *and* the weekend/equivalent Day(s) count as non-working Days; and
- Consecutive scheduled work Days during which you are absent, followed by a weekend or equivalent Day(s), followed by your return to work on your next scheduled work Day – only the consecutive scheduled work Days during which you are absent count as non-working Days (the weekend or equivalent Day(s) do(es) not count as non-working Day(s)).

STD Administrative Reminders:

1. STD benefits are not payable until MetLife or Senior Manager, as applicable, has certified your claim, so to minimize the chance for an interruption in pay it is important that you and your treating provider(s) reply promptly and supply all requested information to MetLife or Senior Manager, as applicable.
2. If you delay contacting the Union Pacific EAP or MetLife, as applicable, to initiate a claim when either you will be or you are absent due to illness, STD benefits may be lost. Retroactive STD benefits are available for a maximum of eight Days prior to the day you initiate your claim. If your first Day off work is more than eight Days prior to the day you initiate your claim, the initial Day(s) of your absence that are more than eight Days prior to the date you initiate your claim will not be considered a Day on which you are Disabled. MetLife has discretionary authority to waive this requirement when circumstances dictate (e.g., Employee cannot call because he/she is incapacitated).

Vacation:

An Employee continues to accrue vacation days while on STD leave. Once an Employee has begun STD benefits, he/she cannot claim vacation days until after the Employee's STD absence has ended. Employees are allowed to claim vacation immediately following an STD absence instead of reporting to work on their first scheduled day back, if their supervisor has approved the vacation day(s).

If an Employee commences STD leave and returns to work in the same Calendar Year, but so late in the year that he/she does not have a reasonable opportunity (as determined by Union Pacific) to use his/her remaining unused vacation, the Employee will be allowed to carryover up to 5 days of unused vacation and unused vacation in excess of 5 days will be paid out in January of the following Calendar year.

If an Employee commences and remains on STD leave through the end of the Calendar Year, but without having started LTD benefits, the Employee will be able to carryover up to 5 days of unused vacation from the Calendar Year in which the STD leave commenced. Unused vacation in excess of 5 days will be paid out if he/she did not have a reasonable opportunity (as determined by Union Pacific) to use remaining unused vacation. Unused vacation paid out will be paid in January of the following Calendar year.

STD Benefits:

After the three-month eligibility requirement is satisfied, your level of benefit for a given Calendar Year for each condition that results in your Disability is determined by the continuous years of service that you will attain during that Calendar Year, subject to rules for recurring disabilities. (See the table below.) For example, if an Employee will reach his/her five- year anniversary during 2021, the STD benefit amount for which he/she is eligible increases effective January 1, 2021, to 13 Weeks at 100% of Regular Rate of Pay, followed by 13 Weeks at 75% of Regular Rate of Pay. If you return to work with Union Pacific and as an Employee become Disabled again because of an entirely unrelated condition, and the criteria in the "Qualifications" section are met, the Disability is treated as a new period of Disability and STD benefits start again according to the "STD Benefit Amount Table" shown below. If you terminate your employment, and are rehired, your length of service is calculated from your most recent hire date.

STD Benefit Amount		
Length of Service	**100% of Regular Rate of Pay**	**75% of Regular Rate of Pay**
Less than 3 months	None	None
3 months and <5 years	9 Weeks	9 Weeks
5 years and <10 years	13 Weeks	13 Weeks
10 years or more	18 Weeks	8 Weeks

Regular Rate of Pay:

Your regular rate of pay is your monthly salary amount in effect as of the date of the Disability that led to you being placed on STD. If you are an executive and your Disability begins during a month when your monthly salary is reduced due to a Temporary Reduction in Salary for Executives, such reduction is disregarded when determining your regular rate of pay. If your Disability begins while you are on a Union Pacific approved leave of absence (military leave, family military leave, FMLA, unpaid sabbatical, unpaid status assessment leave, unpaid suspension

leave, unpaid vacation, or RULA), your regular rate of pay is your monthly salary amount in effect immediately preceding the date of Disability. The regular rate of pay is adjusted for any merit increase effective during the period of Disability. The regular rate of pay does not include bonuses or overtime. If you are paid on an hourly basis, your salary is calculated by taking the standard hours for your position and multiplying it by your hourly rate. If you are receiving a geographic supplement payment, that payment continues unaffected while you are on STD. This means that you will continue to receive 100% of your geographic supplement, even if your STD benefit is 75% of your regular rate of pay.

The amount of your STD benefits will be reduced by any Other Income Replacement Benefits directly payable to you from any other State, Federal, Railroad Retirement Board, or other income benefit program. If you have a Qualified Domestic Relations Order (QDRO), garnishment, or other reduction to a source of Other Income Replacement Benefit, the offset to the STD benefit is calculated based on the full amount of the Other Income Replacement Benefit before such a reduction.

You must apply for Railroad Retirement Board (RRB), Social Security, or Workers Compensation benefits under applicable laws, and you must promptly notify MetLife of award amounts as you receive them or are notified that you will receive them to continue receiving STD benefits. Your Disability benefits under the STD/LTD Plan will be reduced by the amount of RRB sickness benefits you receive or are entitled to receive. Your Disability benefits will be reduced by the amount estimated that you are eligible to receive under the RRB sickness benefit program. When approval or denial of your RRB sickness benefit is received, notify MetLife immediately. If you fail to apply for RRB sickness benefits, your Disability benefits will be reduced by such estimated RRB sickness benefit amount.

Note: The process to apply for RRB sickness benefits is separate from the process to apply for a RRB disability annuity. Employees are responsible for promptly initiating these processes with the RRB. The RRB can be reached at (877) 772-5772 or local office contact information is available at www.rrb.gov.

If you begin receiving benefits from a Union Pacific sponsored pension plan, your STD benefits will be reduced by any Union Pacific sponsored pension plan benefit (before reduction for any QDRO) if and when you actually begin receiving the pension benefits.

RRB Sickness Benefits:
A RRB sickness benefit application form must be filed with the RRB within the first 10 days of your illness/injury. An application is considered filed on the day it is received by the RRB. Call the RRB Help Line at (877) 772-5772 for information about how to apply for benefits. Information is also available on the RRB website at www.rrb.gov. Failure to apply for RRB sickness benefits for which you are eligible will result in your STD benefit being reduced without you receiving the daily RRB sickness benefit to make up for the reduction. The RRB reviews the maximum daily sickness benefit amount annually.

Recurring Disabilities:
If you return to Active Work with Union Pacific and as an Employee become Disabled again because of the same or related condition on or before the 180th day of your return to Active Work, and the criteria in the "Qualifications" section are met, your Disability is treated as one continuous Disability. As a result, the STD benefits that were in effect at the time you initially began receiving STD benefits for this Disability will apply. You will be eligible for any of those remaining benefits and those benefits (if any) will resume immediately. You cannot claim vacation days following the date of your Disability recurrence until after the date your STD absence has ended.

If you return to Active Work with Union Pacific and as an Employee become Disabled again because of the same or related condition on or before the 180th day of your return to Active Work, and if such a recurrence bridges over a Calendar Year end, the STD benefit available for the recurrence is limited to whatever remains of those STD benefits for which you were eligible when the Disability began. If you later qualify for LTD benefits following such recurrence, your LTD benefit will be your LTD election in effect at the start of your initial STD period. This means that even if you are Actively at Work on or after January 1, 2021, if such recurrence bridges over January 1, 2021, your STD/LTD benefit would be limited to those benefits in effect at the start of your initial STD.

If you return to Active Work with Union Pacific and as an Employee become Disabled again because of the same or related condition *after* 180 days of returning to Active Work, and the criteria in the "Qualifications" section are met,

your Disability is treated as a new period of Disability and STD benefits start again according to the "STD Benefit Amount Table" shown above.

If you exhaust your STD benefits and return to Active Work, and then you later become Disabled as a result of the same or related condition before having earned additional Weeks of STD benefits, you should call MetLife at (888) 777- 6806, option 2. MetLife will then send you the necessary forms for LTD benefits since your STD benefits have already been exhausted at commencement of the most recent Disability absence.

STD Periods That Continue Through Year End:
If a new Calendar Year begins while you are receiving STD benefits, you will be limited to those STD benefits for which you were eligible when the Disability began.

STD Benefits End When:
Benefits will continue until the earliest of the following occurs:

- You are able to perform the essential functions of your regular job, whether or not you return to work.
- You exhaust the STD benefits for which you are eligible based on your years of service.
- You are not receiving Appropriate Care and Treatment as defined by the STD/LTD Plan.
- You fail to cooperate in a STD/LTD Plan-approved rehabilitation program.
- You or your Physician fails to provide acceptable, objective proof of your continuing Disability when requested by the STD/LTD Plan.
- You die.
- Your employment with Union Pacific Corporation or any of its affiliates is terminated because you engaged in any conduct, either before or while receiving STD benefits that would have resulted in such termination had you remained actively employed as determined by Union Pacific.

Exclusions:
STD benefits will not be paid for any period of Disability resulting from treatment for or caused by any of the following:

- Cosmetic surgery or treatment primarily to change appearance;
- (Note: STD benefits will be paid for a period of Disability resulting from cosmetic surgery following cancer surgery, severe burns or skin grafting.)
- Reversal of sterilization;
- Liposuction;
- War, whether declared or undeclared, or act of war, insurrection, rebellion, or terrorist act;
- Active participation in a riot;
- To the extent permitted by law, intentionally self-inflicted injury;
- To the extent permitted by law, attempted suicide; or
- Commission of or attempt to commit a felony.

Termination of Coverage:
STD coverage ends on your last day of employment as an Employee.

LONG-TERM DISABILITY

Purpose:
Long-Term Disability (LTD) provides continued income for extended periods of Disability. Generally speaking, you are considered to be Disabled if you are unable to engage in your Own Job for up to 12 months after the date you are placed on LTD and thereafter, if you are unable to engage in Any Work. See the definition of "Disability" or "Disabled" for more details.

Cost:
LTD coverage at the Core level is provided by Union Pacific to Employees at no cost to the Employee. The cost of Buy-up LTD coverage beyond the Core level is paid for by the Employee on an after-tax basis. Therefore, the

portion of the LTD benefit received that is attributable to the Company-paid Core benefit is taxable to the recipient and the portion of LTD benefit received that is attributable to the Buy-up coverage, if any, is not taxable to the recipient.

Eligibility:
Newly Eligible during the Calendar Year: If you are an Employee, you are eligible to receive LTD coverage after completion of three months of continuous service as an Employee. For the remainder of the year in which you first become eligible, you will have Core LTD coverage.

Service Prior to Becoming an Employee: If you become an Employee and were continuously employed as:

- an agreement employee for at least three months immediately prior to you becoming an Employee; or
- an intern or in a part-time hourly position for at least three months immediately prior to you becoming an Employee,

then you are eligible to elect the Buy-Up LTD coverage immediately upon becoming an Employee. The Buy-up coverage is subject to the Pre-existing Condition rules (see page 239). If you do not elect the Buy-up LTD coverage, you will receive Core LTD coverage.

Open Enrollment: You may elect to change your LTD coverage during open enrollment for a Calendar Year following the Calendar Year in which you first become eligible for LTD coverage. Any time you elect to change your coverage from the Core level to the Buy-up level, the election is subject to the Pre-existing Condition rules (see the next few pages: page 239).

Life Event Changes: You are not allowed to change your LTD election as a result of any Life Events.

LTD Benefits:

Core	50% of Core Predisability Earnings; limited to a maximum monthly benefit of $10,000
Buy-up	62% of Buy-up Predisability Earnings; limited to a maximum monthly benefit of $30,000

"Core Predisability Earnings" are equal to the greater of the gross salary or wages you were earning as of your last day at work before your Disability began or the gross salary or wages you were earning as of July 31st immediately preceding the date your Disability began. Your Core Predisability Earnings are determined on a monthly basis. If you are an executive and your monthly salary is reduced due to a Temporary Reduction in Salary for Executives for one or both the months used to determine your Core Predisability Earnings, such reduction is disregarded when determining your Core Predisability Earnings for such month(s).

Core Predisability Earnings do not include:

- Commissions;
- awards and bonuses;
- overtime pay;
- the grant, award, sale, conversion and/or exercise of shares of stock or stock options;
- Union Pacific's contributions on your behalf to any deferred compensation arrangement or pension plan (e.g. matching contribution to a thrift plan);
- UP HSA Contributions (i.e., "Seed Money"); or
- any other compensation you receive as a result of your employment with Union Pacific.

If you are Disabled and have received an LTD monthly benefit at the Core level for 12 months, your Core Predisability Earnings will be adjusted only for the purposes of determining whether you continue to be Disabled and for calculating the Work Incentive described later in this section of the Flex Guide, if any. The STD/LTD Plan will make the initial adjustment as follows:

- The plan will add to your Core Predisability Earnings an amount equal to the product of your Core Predisability Earnings times the lesser of:
  - 7%; or
  - The annual rate of increase in the Consumer Product Index for the prior calendar year.

Annually, thereafter, your adjusted Core Predisability Earnings will be increased as calculated by the method set forth above but substituting your adjusted Core Predisability Earnings from the prior year for your Core Predisability Earnings. This adjustment is not a cost-of-living benefit.

"Buy-up Predisability Earnings" are equal to the sum of:

- the gross salary or wages you were earning as of your last day at work before your Disability began or the gross salary or wages you were earning as of July 31st immediately preceding the date your Disability began, whichever is greater; (Note: If you are an executive and your monthly salary is reduced due to a Temporary Reduction in Salary for Executives for one or both the months used to determine your Buy-Up Predisability Earnings, such reduction is disregarded when determining your Buy-Up Predisability Earings for such month(s).)
- plus your commissions and any performance bonus, such as Executive Incentive Compensation ("EIC") and Management Incentive Plan ("MIP") bonuses, earned in the past 12 months that are then pro-rated over a 12-month period.
- In the event the bonus cycle changes, Buy-up Predisability Earnings will include the bonus earned in the last 12 months of the last bonus cycle.

Example:

Disability Date: April 19, 2021

Gross Salary as of April 18, 2021: $ 70,000 Gross Salary as of July 31, 2020: $ 67,500	April 18, 2021 Gross Salary is greater than the Gross Salary as of July 31, 2020	$ 70,000
MIP Bonus earned in Past 12 Months: $ 4,800 (MIP Bonus Pro-Rated over 12 Months: $ 400)	plus MIP Bonus Pro-Rated over 12 Months	$ 400
	Total Buy-up Predisability Earnings	$ 70,400

If you are paid on an hourly basis, your Buy-up Predisability Earnings are calculated by taking the standard hours for your position and multiplying it by your hourly rate, plus performance bonuses, such as EIC and MIP bonuses, earned in the past 12 months that are then pro-rated over a 12-month period.

Buy-up Predisability Earnings do not include:

- overtime pay;
- awards and bonuses (other than EIC and MIP, as applicable);
- the grant, award, sale, conversion and/or exercise of shares of stock or stock options;
- Union Pacific's contributions on your behalf to any deferred compensation arrangement or pension plan (e.g. matching contribution to a thrift plan);
- UP HSA Contributions (i.e., "Seed Money"); or
- Any other compensation you receive as a result of your employment with Union Pacific.

If you are Disabled and have received an LTD monthly benefit at the Buy-up level for 12 months, your Buy-up Predisability Earnings also will be adjusted. This adjustment is made as described above in the description of Core Predisability Earnings and only for the purposes of determining whether you continue to be Disabled and for calculating the Work Incentive, if any.

Core Predisability Earnings and Buy-up Predisability Earnings do not include geographic supplement payments. If you are receiving a geographic supplement payment, that payment ceases when you are placed on LTD.

How to Apply for LTD Benefits:
In order to receive LTD benefits you must complete the necessary forms provided in the LTD Claim Packet and return them to MetLife. You must provide the completed LTD forms while you are covered by the STD/LTD Plan and prior to the earlier of:

1. The date you are notified that your employment is being terminated; or
2. Your date of termination of employment.

MetLife will send you the LTD Claim Packet approximately one month prior to your anticipated LTD commencement date, or you can request the LTD Claim Packet by calling MetLife at (888) 777-6806, option 2. You should complete and return the LTD Claim Packet prior to exhausting your STD benefits. Medical evidence of Appropriate Care and Treatment will be required from your attending Physician. The STD/LTD Plan may also require an examination(s) by a STD/LTD Plan-appointed Physician. You assume the cost for providing Medical Information from your attending Physician. The cost of an examination by a plan-appointed Physician will be assumed by the STD/LTD Plan.

If you qualify, LTD benefits can begin only upon exhaustion of your STD benefits. In no instance will exhaustion of STD benefits guarantee LTD benefit eligibility. LTD benefits will continue until you cease to be Disabled (or your benefits are terminated for another reason; see "When LTD Benefits End" below), exhaust the LTD benefits for which you are eligible ("Maximum Benefit Duration"), or die (whichever occurs first). The Maximum Benefit Duration for which you are eligible is the later of your normal retirement age, as defined by the Social Security Administration on the date your Disability begins, or the Maximum Benefit Duration described in the below table, based on the date you become Disabled:

Age on Disability Date	Maximum LTD Benefit Duration
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

If you have exhausted your STD benefits and returned to work, and then you later become Disabled on or before the 180th day of your return to work as a result of the same or related condition and before having earned additional Weeks of STD benefits, you should call MetLife at (888) 777-6806, option 2. MetLife will then send you the necessary forms for LTD benefits since your STD benefits have already been exhausted at commencement of the most recent Disability absence.

Offsets to Your Benefit:
Your LTD benefits will be reduced (or offset) by any Other Income Replacement Benefits. If you have a Qualified Domestic Relations Order (QDRO), garnishment, or other reduction to a source of Other Income Replacement Benefit, the offset to the LTD benefit is calculated based on the full amount of the Other Income Replacement Benefit before such a reduction.

You must apply for RRB, Social Security, or Workers Compensation benefits under applicable laws and you must promptly notify MetLife of award amounts as you receive them or are notified that you will receive them to continue receiving LTD benefits.

Note: The process to apply for an RRB disability annuity is separate from the process to apply for RRB sickness benefits. Employees are responsible for promptly initiating these processes with the RRB. The RRB can be reached at (877) 772-5772 or local office contact information is available at www.rrb.gov.

If you begin receiving benefits from a Union Pacific sponsored pension plan, your LTD benefits will be reduced by any Union Pacific sponsored pension plan benefit (before reduction for any QDRO) if and when you actually begin receiving the pension benefits.

When LTD Benefits End:
Benefits will continue until the earliest of the following occurs:

- You are determined to be no longer Disabled under the STD/LTD Plan.
- You have received the maximum benefits available for your condition as specified in the "Benefit Limits" section below.
- You return to work in such a capacity that you earn enough to no longer be deemed Disabled.
- You or your Physician fails to provide acceptable objective proof of your continuing Disability when requested by the STD/LTD Plan.
- You are not receiving Appropriate Care and Treatment as defined by the STD/LTD Plan and as determined by the plan.
- You fail to have a medical examination with a STD/LTD Plan-appointed Physician as requested by the Plan.
- You fail to cooperate in a STD/LTD Plan-approved Rehabilitation Program.
- You exhaust the LTD benefits for which you are eligible based on your age when your STD benefit started.
- You die.

Benefits are payable through the date you cease eligibility for LTD benefits. Any partial-month of LTD benefits will be paid on a pro rata basis.

Benefit Limits:
If Disability is due to a Neuromuscular, Musculoskeletal, or Soft Tissue Disorder, LTD benefits are limited to a lifetime maximum equal to the lesser of: 24 months or the Maximum Benefit Duration.

If Disability is caused by a Mental or Nervous Disorder or Disease, LTD benefits are limited to a lifetime maximum of 12 months unless the Employee is continuously confined to a hospital or mental health facility when the 12 month limit is reached, in which case LTD benefits can exceed the 12 month lifetime maximum. However, in these instances of continuous confinement, benefits cease upon discharge from the hospital or mental health facility.

For purposes of this provision, mental health facility means a facility licensed in the jurisdiction in which it is located to provide care and treatment for a Mental or Nervous Disorder or Disease. Such facility must provide care on a 24 hour a day basis under the supervision of a staff of Physicians, and must provide a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.
This limitation will not apply to Disability resulting from:

- Schizophrenia;
- Dementia; or
- Organic Brain Disease.

If Disability is caused by Chronic Fatigue Syndrome or a related condition, LTD benefits are limited to a lifetime maximum equal to the lesser of 24 months or the Maximum Benefit Duration.

If Disability is caused by alcohol, drug or substance abuse or addiction, LTD benefits are limited to one period of Disability during your lifetime. During your Disability you will be required to participate in an alcohol, drug or substance abuse or addiction recovery program recommended by a Physician.

Disability payment for alcohol, drug or substance abuse or addiction will end at the earliest of:

- The date you receive 24 months of benefit payments;
- The date you cease or refuse to participate in the recovery program referred to above;
- The date you exhaust the LTD benefits for which you are eligible based on your age when your Disability benefits started; or
- The date you complete such recovery program.

Exceptions:
LTD benefits will not be payable if Disability results from:

- War, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;
- Your active participation in a riot;
- To the extent permitted by law, intentionally self-inflicted injury;
- To the extent permitted by law, attempted suicide;
- Commission of or attempt to commit a felony; or
- Pre-existing Conditions.

Pre-existing Conditions:
No benefits are payable under LTD in connection with a Pre-existing Condition unless the Employee has been Actively at Work for a 12-consecutive month period after the date LTD coverage took effect. If an Employee elects the Buy-up LTD coverage, benefits at the Buy-up level for a Pre-existing Condition will only be payable if the Employee has been Actively at Work for 12-consecutive months after the Buy-up coverage is effective. If the Employee becomes Disabled and has not met this 12-month requirement, the LTD benefit paid will be based on the prior (lower) benefit coverage, if any. Disabilities that result from a condition that is not a Pre-existing Condition are payable at the increased benefit coverage election amount.

Recovery:
In the case of a Disability for which an Employee may have a right of recovery against Union Pacific, benefits will be provided subject to the provisions hereinafter set forth. The STD/LTD Plan does not intend that benefits provided by the plan will duplicate, in whole or in part, any amount otherwise recovered from Union Pacific. Accordingly, benefits provided under the STD/LTD Plan will be offset against any recovery the Employee may have against Union Pacific.

Recurring Disability:
If you become Disabled again because of the same or related condition for which you previously received LTD benefits, the STD/LTD Plan will treat such Disability as a part of your prior claim (i.e., a recurring Disability), and you will be immediately evaluated for LTD without first completing another period on STD if:

- You were continuously an Employee under the LTD Program between your prior claim and your recurring Disability; and
- Your recurring Disability occurs within 180 days of the end of your prior claim.

This means that even if you are Actively at Work on or after January 1, 2021, if you have a recurring Disability, your LTD benefit is limited to that which was in effect at the start of your initial LTD period.

You cannot claim vacation days following the date of your Disability recurrence until you return from your period of LTD leave.

Disability Periods That Bridge Calendar Years:
The LTD benefit level election in effect on the date your Disability occurs is the benefit level that you will receive upon approval for LTD benefits. As an example, assume that you elected the Core LTD benefit level during the 2020 open enrollment (occurring in 2019) and then increased your LTD coverage by electing the Buy-up level during the 2021 open enrollment (occurring in 2020). If you incur a Disability during 2020 that extends into 2021, the LTD benefit you will receive as a result of this Disability will be based on your Core LTD benefit level election. The Buy-up benefit level election will apply to a Disability first occurring in 2021.

Rehabilitation Programs:
Rehabilitation Program Incentive: While you are Disabled, you may be required to participate in a rehabilitation program at the STD/LTD Plan's discretion. Your monthly LTD benefit, before reduction for Other Income Replacement Benefits, is increased by 10% when you participate in a rehabilitation program approved by MetLife.

The case management specialist handling your claim will begin the rehabilitation process and may refer you to professional rehabilitation staff, including registered nurses (R.N.) and vocational rehabilitation coordinators.

Rehabilitation specialists will contact you and will coordinate with your medical carrier and/or attending physician for a broad understanding of your diagnosis, prognosis and expected return-to-work date.

In some cases, the services of independent vocational rehabilitation specialists may be used. Vendor selection is determined by MetLife and is based on your Physician's evaluation and recommendations; your individual vocational needs; and the vendor's credentials, specialty, reputation and experience. You and your Physician still remain in control of the direction of your medical treatment.

Monthly benefit payments will cease on the date you refuse to participate in a rehabilitation program in which MetLife determines you are able to participate.

Moving Expense Incentive: If you participate in the Rehabilitation Program while you are Disabled, MetLife may reimburse you for expenses you incur in order to move to a new residence recommended as part of such Rehabilitation Program. If you accept relocation as part of a Rehabilitation Program, moving expenses approved by MetLife in advance will be reimbursed. You will not be reimbursed for moving expenses if they were incurred for services provided by a member of your immediately family or someone living in your residence. You must provide satisfactory proof to MetLife that you incurred the charges.

Indexing of Predisability Earnings: While you are Disabled, you are encouraged to return to work. If you work while you are Disabled and receiving LTD benefits, your LTD benefits will be adjusted as follows:

- Your monthly LTD benefit will be increased by your Rehabilitation Program incentive, if any; and
- Reduced by Other Income Replacement Benefits.

Your LTD monthly benefit as adjusted above will not be reduced by the amount you earn from working, except to the extent that such adjusted LTD monthly benefit plus, the amount you earn from working and the income you receive from Other Income Replacement Benefits exceeds 100% of your Core Predisability Earnings (or, if applicable, your Buy-up Predisability Earnings). After the first 24 months on LTD, your LTD monthly benefits will be reduced by 50% of the amount you earn from working while Disabled.

Family Care Incentive: If, during the first 24 months you receive LTD benefits, you work or participate in a Rehabilitation Program approved by MetLife, you will be reimbursed for eligible family care expenses up to $400 per month for each eligible family member.

The following are eligible family care expenses:

1. care for your or your spouse's child, legally adopted child, or child for whom you or your spouse is legal guardian and who is:
   - living with you as part of your household;
   - dependent on your for support, and
   - under age 13.

The child care must be provided by a licensed child care provider who may not be a member of your immediate family or living in your residence.

2. care for your family member who is:
   - living with you as part of your household;
   - chiefly dependent on you for support; and
   - incapable of independent living, regardless of age, as a result of mental or physical handicap.

The care provider may not be provided by a member of your immediate family.

Eligible family care expenses do not include expenses for which you are eligible for reimbursement under any other group plan or from any other source. You must provide satisfactory proof to MetLife that you incurred the charges.

Annual Review:
Employees receiving LTD benefits will be reviewed on at least an annual basis and must cooperate fully in the review process. Failure to do so will result in cessation of benefits.

The annual review will consist of all or part of the following:

1. Appropriate Care and Treatment plan review.
2. Work capabilities and/or functional capacity evaluation, and/or transferable skills analysis, and/or a vocational plan.
3. Earnings update as determined by review of complete tax returns and/or other appropriate documentation. Exceptions from the annual review process will be granted at the discretion of the STD/LTD Plan.

Termination of Coverage:
Coverage under the LTD component of the STD/LTD Plan ends when you cease to be an Employee.

CLAIMS AND APPEALS (OTHER THAN PRE-2008 DISABILITY)

Filing Your STD/LTD Claim:
To file a claim for STD benefits you must follow the steps described in the "Qualifications" section on page 231 of this document. You must provide objective Medical Information necessary to decide your STD claim within 14 days of the date you file your claim for STD benefits.

To file a claim for LTD benefits, you must complete an application form and provide other information as described in the "How to Apply for LTD Benefits" section on page 236 of this document. Your LTD application form must be sent to:

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

If you fail to file your claim for STD benefits and/or LTD benefits within 90 days following the first day for which STD benefits and/or LTD benefits could be claimed for a continuous period of Disability, STD benefits and/or LTD benefits are not payable for such claim.

STD Claim for Disability - Substance Abuse:
If your STD claim is that you are Disabled as a result of substance abuse, MetLife will forward your claim to the Senior Manager - Employee Assistance Program and Peer Support of the Union Pacific Railroad Company ("Senior Manager"). The Senior Manager will review your claim to determine whether you are Disabled as a result of substance abuse. If such claim is denied by the Senior Manager, you will be provided written notification of the Senior Manager's decision within a reasonable period of time, but not later than 45 days following MetLife's receipt of your claim. (This notification will be provided to you by MetLife on behalf of the Senior Manager.) The Senior Manager may extend this period for up to 30 days if the Senior Manager determines that an extension is necessary because of matters beyond the control of the STD/LTD Plan. You will be notified prior to the end of the initial 45-day period of the circumstances requiring the extension and the date by which the STD/LTD Plan expects to make a decision. The Senior Manager may further extend this period for up to an additional 30 days if the Senior Manager determines that a further extension is necessary because of matters beyond the control of the plan. You will be notified prior to the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the STD/LTD Plan expects to make a decision.

Any notice of extension will explain the standards on which entitlement to the STD/LTD Plan benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You will have 45 days from the date you are notified of the extension to provide the additional information. If the Senior Manager determines the reason for the extension is your failure to provide Medical Information necessary to decide your claim, you will be notified of this fact, and the time period for the plan to make its decision regarding your claim is suspended (i.e., tolled) from the date such notification is sent to you until the earlier of: a) the date on which you respond to the STD/LTD Plan's request for additional information; or b) the date established by the plan for furnishing such information. The 30 day extension period within which the plan must make its decision will then begin to run from the earlier of: a) the date on which you respond to the plan's request for additional information (regardless of whether you provide all of the requested information); or b) the date established by the STD/LTD Plan for furnishing such information.

LTD Claims and STD Claim for Disability - Other than Substance Abuse:
If your STD claim is that you are Disabled for reason(s) other than substance abuse or if you are claiming LTD benefits for any reason, MetLife will review your claim. If your claim is denied, MetLife will provide you with written notification of the decision within a reasonable period of time, but not later than 45 days following receipt of your claim. MetLife may extend this period for up to 30 days if MetLife determines that an extension is necessary because of matters beyond the control of the STD/LTD Plan. You will be notified prior to the end of the initial 45-day period of the circumstances requiring the extension and the date by which the plan expects to make a decision. MetLife may further extend this period for up to an additional 30 days if MetLife determines that a further extension is necessary because of matters beyond the control of the STD/LTD Plan. You will be notified prior to the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the plan expects to make a decision.

Any notice of extension will explain the standards on which entitlement to the STD/LTD Plan benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You will have 45 days from the date you are notified of the extension to provide the additional information. If MetLife determines the reason for the extension is your failure to provide Medical Information necessary to decide your claim, you will be notified of this fact, and the time period for the plan to make its decision regarding your claim is suspended (i.e., tolled) from the date such notification is sent to you until the earlier of: a) the date on which you respond to the plan's request for additional information; or b) the date established by the plan for furnishing such information. The 30 day extension period within which the STD/LTD Plan must make its decision will then begin to run from the earlier of: a) the date on which you respond to the plan's request for additional information (regardless of whether you provide all of the requested information); or b) the date established by the plan for furnishing such information.

Periodic Review:
The STD/LTD Plan may periodically review your condition to determine whether you continue to be Disabled under the plan. You will be required to provide objective Medical Information and such other information as requested by the plan. You must cooperate fully in the review process. Failure to do so will result in cessation of STD/LTD Plan benefits. If the plan determines as a result of its review that you are no longer Disabled (or if you fail to cooperate in the review process), the plan will provide you with written notification of its determination. You may request an appeal of this determination. (See STD Request for Review or LTD Request for Review, below.)

Denial of Claim or Cessation of Disability:
If your claim is denied, or the STD/LTD Plan determines that you are no longer Disabled, the notice advising of the denial shall specify the reason or reasons for the denial and make specific reference to pertinent plan provisions on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your claim, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. The notice will also include, to the extent applicable, an explanation regarding why the STD/LTD Plan disagreed with (1) the views of medical and/or vocational experts treating you, (2) the views of medical and/or vocational experts whose advice was obtained on behalf the plan in connection with the review of your claim, and (3) a disability determination regarding you made by the Railroad Retirement Board/Social Security Administration. In addition, the notice will also describe any additional material or information necessary for you to perfect your claim, explaining why such material or information is needed, and shall advise you of the procedures for review of the denial.

For both STD and LTD benefit claims, you must first exhaust all appeals available to you under the STD/LTD Plan before you have a right to bring a civil action under ERISA regarding your denied claim.

Termination of Benefits at End of Specified Period:
If the STD/LTD Plan determines you are Disabled for a fixed or specific period, and at the end of such period you wish to extend plan benefits, you must provide objective Medical Information and such other information as requested by the plan. Your request to extend plan benefits in this situation will be treated as a new claim and will be decided within the applicable time periods described above.

STD Request for Review:
STD First Level Appeals: If your STD claim is denied, or if you disagree with a determination made by the Senior Manager or MetLife regarding your benefits under the STD/LTD Plan, you may request a First Level Appeal review. Your request for a First Level Appeal review must be in writing and made within 180 days of your receipt of the written notice from MetLife regarding your claim. Your request for review must be sent to:

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

You may request and receive free of charge a copy of all documents, records, and other information relevant to your claim. When requesting a review, state the reasons for your position and submit all data, questions, or comments you deem appropriate. This first level appeal will be conducted by an Appeal Physician, who is a MetLife physician who was not involved in the original determination regarding your claim and also is not a subordinate of the Senior Manager or the MetLife personnel involved in your original claim determination. The Appeal Physician will not give any deference to the initial denial of your claim. The Appeal Physician will review your First Level Appeal request and take into account all documents and other information submitted by you relating to your claim, regardless of whether the documents or other information was considered by the Senior Manager or MetLife when deciding your initial claim. If the decision on your First Level Appeal is based on a medical judgment, the Appeal Physician will consult with a healthcare professional with appropriate training and experience, if the Appeal Physician determines, in his/her sole discretion, that he/she does not already possess such training and experience. If the Appeal Physician consults with a healthcare professional, such healthcare professional will not have been consulted with respect to your initial claim or the subordinate of a healthcare professional consulted with respect to your initial claim.

Before the Appeal Physician issues a denial of your disability claim on appeal based upon any new or additional evidence considered or relied upon, or generated by the STD/LTD Plan, the Appeal Physician, or another person making the benefit determination (at the Appeal Physician's direction) in connection with the claim, you will be provided a copy of such evidence free of charge. The evidence will be provided to you as soon as possible, but sufficiently in advance of the date on which the notice of the adverse benefit determination is required, in order to provide you with an opportunity to respond to the new evidence.

The Appeal Physician will send you written notice of the decision within a reasonable period of time, but no later than 45 days following receipt of your request for review. The Appeal Physician may extend this period for an additional 45 days if the Appeal Physician determines that special circumstances require an extension of time to process the claim. You will be notified prior to the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Appeal Physician expects to make a decision regarding your appeal.

STD Second Level Appeals: If your STD First Level Appeal is denied, you may request a review of the determination by MetLife. Your request for an STD Second Level Appeal review must be in writing and made within 30 days of your receipt of the written notice from MetLife regarding your STD First Level Appeal. Your request for review must be sent to:

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

You may request and receive free of charge a copy of all documents, records, and other information relevant to your claim. When requesting a review, state any and all reasons for your position and submit all data, questions, or comments you deem appropriate. MetLife will not give any deference to the previous claim and appeal denials. The MetLife representative performing the second review will be an individual who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the matter under review.

MetLife will review your Second Level Appeal request and take into account all documents and other information submitted by you relating to your appeal, regardless of whether the documents or other information was considered in previous claim and appeal decisions by the Senior Manager or MetLife when deciding your initial claim or First Level Appeal. If the decision on your Second Level Appeal is based on a medical judgment, MetLife will consult

with a healthcare professional with appropriate training and experience. If MetLife consults with a healthcare professional, such healthcare professional will not have been consulted with respect to your initial claim or First Level Appeal or the subordinate of a healthcare professional consulted with respect to your initial claim or First Level Appeal.

Before Metropolitan Life issues a denial of your disability claim on appeal based upon any new or additional evidence considered or relied upon, or generated by the STD/LTD Plan, Metropolitan Life, or another person making the benefit determination (at Metropolitan Life's direction) in connection with the claim;, you will be provided a copy of such evidence free of charge. The evidence will be provided to you as soon as possible, but sufficiently in advance of the date on which the notice of the adverse benefit determination is required, in order to provide you with an opportunity to respond to the new evidence.

MetLife will send you written notice of the decision within a reasonable period of time, but no later than 45 days following receipt of your request for review. MetLife may extend this period for an additional 45 days if MetLife determines that special circumstances require an extension of time to process the appeal. You will be notified prior to the end of the initial 45-day period of the circumstances requiring the extension and the date by which the STD/LTD Plan expects to make a decision. The decision of MetLife on your Second Level Appeal is final and binding.

LTD Request for Review:
LTD Appeals: If your LTD Disability claim is denied, or if you disagree with a determination made by MetLife regarding your LTD benefits under the STD/LTD Plan, you may request an LTD Appeal review. Your request for an LTD Appeal review must be in writing and made within 180 days of your receipt of the written notice from MetLife regarding your LTD claim. Your request for review must be sent to:

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

You may request and receive free of charge a copy of all documents, records, and other information relevant to your claim. When requesting a review, state any and all reasons for your position and submit all data, questions, or comments you deem appropriate. This LTD appeal will be conducted by MetLife through an Appeal Physician, who is a MetLife physician who was not involved in the original determination regarding your claim and also is not a subordinate of the MetLife personnel involved in your original claim determination. The Appeal Physician will not give any deference to the initial denial of your claim. The Appeal Physician will review your LTD Appeal request and take into account all documents and other information submitted by you relating to your claim, regardless of whether the documents or other information was considered by MetLife when deciding your initial claim. If the decision on your LTD Appeal is based on a medical judgment, the Appeal Physician will consult with a healthcare professional with appropriate training and experience, if the Appeal Physician determines, in his/her sole discretion, that he/she does not already possess such training and experience. If the Appeal Physician consults with a healthcare professional, such healthcare professional will not have been consulted with respect to your initial claim or the subordinate of a healthcare professional consulted with respect to your initial claim.

Before the Appeal Physician issues a denial of your disability claim on appeal based upon any new or additional evidence considered or relied upon, or generated by the STD/LTD Plan, the Appeal Physician, or another person making the benefit determination (at the Appeal Physician's direction) in connection with the claim, you will be provided a copy of such evidence free of charge. The evidence will be provided to you as soon as possible, but sufficiently in advance of the date on which the notice of the adverse benefit determination is required, in order to provide you with an opportunity to respond to the new evidence.

The Appeal Physician will send you written notice of the decision within a reasonable period of time, but no later than 45 days following receipt of your request for review. The Appeal Physician may extend this period for an additional 45 days if the Appeal Physician determines that special circumstances require an extension of time to process the claim.

You will be notified prior to the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Appeal Physician expects to make a decision regarding your appeal. The decision of MetLife on your LTD appeal is final and binding.

For All Appeals:
If your STD First Level Appeal, STD Second Level Appeal, or LTD Appeal is denied, the notice shall specify the reason or reasons for the denial and make specific reference to pertinent STD/LTD Plan provisions on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. The notice will also include, to the extent applicable, an explanation regarding why the plan disagreed with (1) the views of medical and/or vocational experts treating you, (2) the views of medical and/or vocational experts whose advice was obtained on behalf the STD/LTD Plan in connection with the review of your claim, and (3) a disability determination regarding you made by the Railroad Retirement Board/Social Security Administration. In addition, the notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. The notice will inform you of the medical or vocational expert(s) whose advice was obtained on behalf of the plan. If your STD Second Level Appeal or LTD Appeal is denied, you have a right to file an action under Section 502(a) of ERISA.

Temporary Extension of Certain Deadlines Due to COVID-19: The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"). In response, the Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in this "Claims and Appeals (Other Than Pre-2008 Disability)" section – for you to submit an initial claim for benefits or request an appeal of a denied claim for benefits.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your rights to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in this "Claims and Appeals (Other Than Pre-2008 Disability)" section, you may have additional time to do so. Please contact MetLife at (888) 608-6665 for more information.

For All Claims and Appeals:
Please note that if a period of time for making a decision is extended by the STD/LTD Plan to permit you to submit information necessary to make a determination, the period the plan has to make a decision does not begin to elapse until you have provided the information.

Time Limit on Legal Actions:
A legal action on a claim may only be brought against MetLife during a certain period. This period begins 60 days after the date the proof of your continuing Disability is filed with MetLife and ends 3 years after the date the proof is required to be filed with MetLife.

CLAIMS AND APPEALS (PRE-2008 DISABILITY)

Recommencing Pre-2008 LTD Benefits as a Result of a Recurring Disability:
In order to recommence your Pre-2008 LTD benefits as a result of a recurring Disability described on page 233, you should contact Union Pacific Health & Medical Services at (877) 275-8747. In the event you are required to complete an application in order to recommence your benefits, you must mail the application to:

Union Pacific Health & Medical Services
Attn: Pre-2008 LTD
1400 Douglas St. Stop 0350
Omaha, NE 68179

You must contact Union Pacific Health & Medical Services and request that your LTD benefits recommence while you are covered by the STD/LTD Plan and prior to the earlier of:

1. The date you are notified your employment is being terminated; or
2. Your date of termination of employment.

Medical evidence of Appropriate Care and Treatment will be required from your attending physician. The STD/LTD Plan may also require an examination(s) by a plan-appointed Physician. You assume the cost for providing Medical Information from your attending physician. The cost of an examination by a plan-appointed Physician will be assumed by the STD/LTD Plan.

If you fail to file your claim for LTD benefits within 90 days following the first day for which LTD benefits could be claimed for a continuous period of Disability, LTD benefits are not payable for such claim.

Claim for Disability - Substance Abuse:
If your LTD claim is that you are Disabled as a result of substance abuse, Union Pacific Health & Medical Services will forward your claim to the Senior Manager-Employee Assistance Program and Peer Support of the Union Pacific Railroad Company ("Senior Manager"). The Senior Manager will review your claim to determine whether you are Disabled as a result of substance abuse. If such claim is denied by the Senior Manager, you will be provided written notification of the Senior Manager's decision within a reasonable period of time, but not later than 45 days following Union Pacific Health & Medical Services receipt of your claim. (This notification will be provided to you by Union Pacific Health & Medical Services on behalf of the Senior Manager.) The Senior Manager may extend this period for up to 30 days if the Senior Manager determines that an extension is necessary because of matters beyond the control of the STD/LTD Plan. You will be notified prior to the end of the initial 45-day period of the circumstances requiring the extension and the date by which the plan expects to make a decision. The Senior Manager may further extend this period for up to an additional 30 days if the Senior Manager determines that a further extension is necessary because of matters beyond the control of the plan. You will be notified prior to the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the STD/LTD Plan expects to make a decision.

Any notice of extension will explain the standards on which entitlement to the STD/LTD Plan benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You will have 45 days from the date you are notified of the extension to provide the additional information. If the Senior Manager determines the reason for the extension is your failure to provide Medical Information necessary to decide your claim, you will be notified of this fact, and the time period for the plan to make its decision regarding your claim is suspended (i.e., tolled) from the date such notification is sent to you until the earlier of: a) the date on which you respond to the plan's request for additional information; or b) the date established by the plan for furnishing such information. The 30 day extension period within which the STD/LTD Plan must make its decision will then begin to run from the earlier of: a) the date on which you respond to the plan's request for additional information (regardless of whether you provide all of the requested information); or b) the date established by the STD/LTD Plan for furnishing such information.

Claim for Disability - Other than Substance Abuse:
If your LTD claim is that you are Disabled for reason(s) other than substance abuse, Union Pacific Health & Medical Services will review your claim. If your LTD claim is denied, Union Pacific Health & Medical Services will provide you with written notification of the decision within a reasonable period of time, but not later than 45 days following receipt of your claim. Union Pacific Health & Medical Services may extend this period for up to 30 days if Union Pacific Health & Medical Services determines that an extension is necessary because of matters beyond the control of the STD/LTD Plan. You will be notified prior to the end of the initial 45-day period of the circumstances requiring the extension and the date by which the plan expects to make a decision. Union Pacific Health & Medical Services may further extend this period for up to an additional 30 days if Union Pacific Health & Medical Services determines that a further extension is necessary because of matters beyond the control of the STD/LTD Plan. You will be notified prior to the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the plan expects to make a decision.

Any notice of extension will explain the standards on which entitlement to the STD/LTD Plan benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

You will have 45 days from the date you are notified of the extension to provide the additional information. If Union Pacific Health & Medical Services determines the reason for the extension is your failure to provide Medical Information necessary to decide your claim, you will be notified of this fact, and the time period for the plan to make its decision regarding your claim is suspended (i.e., tolled) from the date such notification is sent to you until the earlier of: a) the date on which you respond to the plan's request for additional information; or b) the date established by the STD/LTD Plan for furnishing such information. The 30 day extension period within which the plan must make its decision will then begin to run from the earlier of: a) the date on which you respond to the plan's request for additional information (regardless of whether you provide all of the requested information); or b) the date established by the plan for furnishing such information.

Periodic Review:
The STD/LTD Plan may periodically review your condition to determine whether you continue to be Disabled under the plan. You will be required to provide objective Medical Information and such other information as requested by the plan. You must cooperate fully in the review process. Failure to do so will result in cessation of plan benefits. If the STD/LTD Plan determines as a result of its review that you are no longer Disabled (or if you fail to cooperate in the review process), the plan will provide you with written notification of its determination. You may request an appeal of this determination (See LTD Request for Review, below.)

Denial of Claim or Cessation of Disability:
If your claim is denied, or the STD/LTD Plan determines that you are no longer Disabled, the notice advising of the denial shall specify the reason or reasons for the denial and make specific reference to pertinent STD/LTD Plan provisions on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your claim, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. The notice will also include, to the extent applicable, an explanation regarding why the plan disagreed with (1) the views of medical and/or vocational experts treating you, (2) the views of medical and/or vocational experts whose advice was obtained on behalf the plan in connection with the review of your claim, and (3) a disability determination regarding you made by the Railroad Retirement Board/Social Security Administration. In addition, the notice will describe any additional material or information necessary for you to perfect your claim, explaining why such material or information is needed, and shall advise you of the procedures for review of the denial.

For both STD and LTD benefit claims, you must first exhaust all appeals available to you under the STD/LTD Plan before you have a right to bring a civil action under ERISA regarding your denied claim.

Termination of Benefits at End of Specified Period:
If the STD/LTD Plan determines you are Disabled for a fixed or specific period, and at the end of such period you wish to extend plan benefits, you must provide objective Medical Information and such other information as requested by the plan. Your request to extend plan benefits in this situation will be treated as a new claim and will be decided within the applicable time periods described above.

LTD Request for Review:
First Level Appeals: If your LTD Disability claim is denied, or if you disagree with a determination made by the Senior Manager or Union Pacific Health & Medical Services regarding your LTD benefits under the STD/LTD Plan, you may request a First Level Appeal review. Your request for a First Level Appeal review must be in writing and made within 180 days of your receipt of the written notice from Union Pacific Health & Medical Services regarding your claim. Your request for review must be sent to:

Union Pacific Health & Medical Services
Attn: Pre-2008 LTD
1400 Douglas St. Stop 0350
Omaha, NE 68179

You may request and receive free of charge a copy of all documents, records, and other information relevant to your claim. When requesting a review, state any and all reasons for your position and submit all data, questions, or comments you deem appropriate. This first level appeal will be conducted by an individual in the Union Pacific Health and Medical Services who was not involved in the original determination regarding your claim and also is not a subordinate of the Senior Manager or the Union Pacific Health & Medical Services personnel involved in your

original claim determination. The reviewer will not give any deference to the initial denial of your claim. The reviewer will review your First Level Appeal request and take into account all documents and other information submitted by you relating to your claim, regardless of whether the documents or other information was considered by the Senior Manager or Union Pacific Health & Medical Services when deciding your initial claim. If the decision on your First Level Appeal is based on a medical judgment, the reviewer will consult with a healthcare professional with appropriate training and experience, if the reviewer determines, in his/her sole discretion, that he/she does not already possess such training and experience. If the reviewer consults with a healthcare professional, such healthcare professional will not have been consulted with respect to your initial claim or the subordinate of a healthcare professional consulted with respect to your initial claim.

Before the reviewer issues a denial of your disability claim on appeal based upon any new or additional evidence considered or relied upon, or generated by the STD/LTD Plan, such reviewer, or another person making the benefit determination (at the reviewer's direction) in connection with the claim, you will be provided a copy of such evidence free of charge. The evidence will be provided to you as soon as possible, but sufficiently in advance of the date on which the notice of the adverse benefit determination is required, in order to provide you with an opportunity to respond to the new evidence.

The reviewer will send you written notice of the decision within a reasonable period of time, but no later than 45 days following receipt of your request for review. The reviewer may extend this period for an additional 45 days if the reviewer determines that special circumstances require an extension of time to process the claim. You will be notified prior to the end of the initial 45-day period of the circumstances requiring the extension and the date by which the reviewer expects to make a decision regarding your appeal.

Second Level Appeals: If your First Level Appeal is denied, you may request a review of the determination by the Plan Administrator (or delegate). Your request for a Second Level Appeal review must be in writing and made within 30 days of your receipt of the written notice from Union Pacific Health & Medical Services regarding your First Level Appeal. Your request for review must be sent to:

Union Pacific WR Benefits
Attn: STD/LTD Appeals
1400 Douglas Street Stop 0320
Omaha, NE 68179-0320

You may request and receive free of charge a copy of all documents, records, and other information relevant to your claim. When requesting a review, state any and all reasons for your position and submit all data, questions, or comments you deem appropriate. The Plan Administrator (or delegate) will not give any deference to the Senior Manager's or Union Pacific Health & Medical Services' initial denial of your claim or Union Pacific Health & Medical Services' denial of your First Level Appeal. The Plan Administrator (or delegate) will review your Second Level Appeal request and take into account all documents and other information submitted by you relating to your appeal, regardless of whether the documents or other information was considered by the Senior Manager or Union Pacific Health & Medical Services when deciding your initial claim or First Level Appeal. If the decision on your Second Level Appeal is based on a medical judgment, the Plan Administrator (or delegate) will consult with a healthcare professional with appropriate training and experience. If the Plan Administrator (or delegate) consults with a healthcare professional, such healthcare professional will not have been consulted with respect to your initial claim or First Level Appeal, or the subordinate of a healthcare professional consulted with respect to your initial claim or First Level Appeal.

Before the Plan Administrator (or delegate) issues a denial of your disability claim on appeal based upon any new or additional evidence considered or relied upon, or generated by the plan, the Plan Administrator (or delegate), or another person making the benefit determination (at the Plan Administrator's (or delegate's) direction) in connection with the claim, you will be provided a copy of such evidence free of charge. The evidence will be provided to you as soon as possible, but sufficiently in advance of the date on which the notice of the adverse benefit determination is required, in order to provide you with an opportunity to respond to the new evidence.

The Plan Administrator (or delegate) will send you written notice of the decision within a reasonable period of time, but no later than 45 days following receipt of your request for review. The Plan Administrator (or delegate) may extend this period for an additional 45 days if the Plan Administrator (or delegate) determines that special

circumstances require an extension of time to process the appeal. You will be notified prior to the end of the initial 45-day period of the circumstances requiring the extension and the date by which the STD/LTD Plan expects to make a decision. The decision of the Plan Administrator (or delegate) on your Second Level Appeal is final and binding.

If your appeal (either First or Second Level) is denied, the notice shall specify the reason or reasons for the denial and make specific reference to pertinent STD/LTD Plan provisions on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. The notice will also include, to the extent applicable, an explanation regarding why the plan disagreed with (1) the views of medical and/or vocational experts treating you, (2) the views of medical and/or vocational experts whose advice was obtained on behalf the plan in connection with the review of your claim, and (3) a disability determination regarding you made by the Railroad Retirement Board/Social Security Administration. In addition, the notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. The notice will inform you of the medical or vocational expert(s) whose advice was obtained on behalf of the STD/LTD Plan. If your Second Level Appeal is denied, you have a right to file an action under Section 502(a) of ERISA.

Temporary Extension of Certain Deadlines Due to COVID-19: The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"). In response, the Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in this "Claims and Appeals (Pre-2008 Disability)" section – for you to submit an initial claim for benefits or request an appeal of a denied claim for benefits.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your rights to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in this "Claims and Appeals (Pre-2008 Disability)" section, you may have additional time to do so. Please contact Union Pacific Health and Medical Services at (877) 275-8747 for more information.

For all Claims and Appeals:
Please note that if a period of time for making a decision is extended by the STD/LTD Plan to permit you to submit information necessary to make a determination, the period the plan has to make a decision does not begin to elapse until you have provided the information.

Pre-2008 Disability Defined Terms:
For purposes of this section, "Claims and Appeals (Pre-2008 Disability)," the following terms are defined as follows:

Appropriate Care and Treatment: Medical care and treatment that meet all of the following:

- It is received from a Licensed Care Provider whose medical training and clinical experience are suitable for treating the specific Disability;
- It is necessary to meet basic health needs and is of demonstrable medical value;
- It is consistent in type, frequency, and duration of treatment with relevant guidelines of national medical, research, and healthcare coverage organizations and governmental agencies;
- It is consistent with the diagnosis of the condition; and
- Its purpose is maximizing medical improvement and return to work.

- ***Licensed Care Provider:*** An individual providing treatment that is within the limits of his/her medical license and who:
- Is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- A licensed psychologist (Ph.D. or Psy.D.) whose primary practice is treating patients.

- ***Medical Information:*** Medical information from your Licensed Care Provider consists of any information requested by the STD/LTD Plan and in all situations should include at a minimum the following:
- Your diagnosis;
- Prognosis;
- Treatment plan and duration;
- Functional limitations; and
- Anticipated return to work date.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries:
In carrying out their respective responsibilities under the STD/LTD Plan, the Plan Administrator, MetLife, the Senior Manager, Union Pacific Health & Medical Services (with respect to pre-2008 Disability claims and appeals) and other plan fiduciaries shall have discretionary authority to make factual findings and to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the STD/LTD Plan. Any finding, interpretation or determination made pursuant to such discretionary authority shall be given full force and effort unless it can be shown that the interpretation or determination was arbitrary and capricious.

OTHER BENEFITS

Upon commencement of LTD benefits, participation in the UP Flexible Benefits Program and eligibility for Core coverage or any other employee benefit ceases except as noted below.

While receiving LTD benefits, you may continue medical, dental, vision, employee Core or voluntary life and/or accidental death & disability ("AD&D"), voluntary spouse life and/or AD&D, and voluntary child life and AD&D coverage by making the required after-tax premium contributions. You may also continue Domestic Partner medical and/or dental coverage for your Domestic Partner. Union Pacific Workforce Shared Services can provide you with more information about these benefits while on LTD. Benefits may be continued as described below:

Medical Coverage:
The medical coverage option in effect at the time LTD benefits begin will continue in effect for the remainder of the Calendar Year, unless you are a Medicare-eligible LTD participant required to change to a Non-HDHP PPO option, as described below. Once you are enrolled in a medical plan option, you cannot change your coverage during the Calendar Year unless you experience a Life Event that permits a change in the medical plan option. See the "Life Events & Permissible Benefits Changes" section on pages 28-63 of this document for details.

If a Domestic Partner medical election is in effect when LTD benefits begin, no changes to the Domestic Partner medical election will be permitted during the Calendar Year unless you experience a Life Event for which changes are allowed. See the "Life Events & Permissible Benefits Changes" section on page 62 of this document for details.

Except as described below with respect to Medicare-eligible LTD participants, during the fall of each Calendar Year you will be given the opportunity to enroll in medical coverage for the subsequent Calendar Year. Your enrollment must be completed during the open enrollment period. If you do not enroll, you will be defaulted to the same medical benefits in the new Calendar Year as you are receiving in the current Calendar Year, except that if you have medical coverage in the current Calendar Year and your medical coverage option is no longer available in the new Calendar Year, you will be defaulted to coverage in either the UHC HDHP2 Option or the BCBS HDHP2 Option depending on your home address, at the same level of coverage (i.e., Employee Only or Family) as you have in the current Calendar Year.

Medicare-eligible LTD participants are required to change their medical option to the UHC Non-HDHP PPO, with Medicare as the primary coverage and the UHC Non-HDHP PPO as secondary coverage, or to the BCBS Non-HDHP PPO, if your home address ZIP code is outside the UHC network area, with Medicare as the primary coverage and the BCBS Non-HDHP PPO as secondary coverage. In addition, if you are a Medicare-eligible LTD participant, your medical coverage is affected if you, your Spouse, or Dependent enroll in Medicare Prescription Drug Coverage under Medicare Part D. (See the "Important Medicare Part D Coverage Note" on page 253).

If your coverage is changed to the UHC Non-HDHP PPO, the terms and conditions of the UHC Non-HDHP PPO Option as described in this Flexible Benefits Guide shall apply to your coverage, except that Medicare-eligible LTD participants and their Dependents enrolled in the UHC Non-HDHP PPO do not have a Network requirement. This means the UHC Non-HDHP PPO's cost sharing features (i.e., Deductible, Coinsurance and Coinsurance Maximum) are applied the same, regardless of whether your provider is a UHC Network Provider. If your coverage is changed to the BCBS Non-HDHP PPO, the terms and conditions of the BCBS Non-HDHP PPO as described in the BlueCross/Blue Shield Summary Plan Description shall apply to your coverage.

Recovery of Overpayments:
The STD/LTD Plan has the right to recover overpayments of STD or LTD benefits paid by the plan (e.g., if such benefits exceed the difference between your LTD benefit minus any offset for Other Income Replacement Benefits). The plan may recover this amount either through your direct repayment or through a reduction to future STD or LTD benefits until the recovery is satisfied. For example, if you initially receive your full LTD benefit paid by MetLife and you later have your RRB disability annuity approved retroactive to your first day of LTD, then you would be in an overpaid status when MetLife recalculates your benefit to reflect the approval of the RRB disability annuity and you are required to repay MetLife for any overpayment amount.

The STD/LTD Plan's right to recover overpayments of STD or LTD benefits from Other Income Replacement Benefits comes first (prior to any claim by any other party against the Other Income Replacement Benefits) even if you have not been fully compensated for your Disability and even if the recovery you receive is described as being other than to compensate you on account of Disability (for example, pain and suffering or emotional distress). The plan shall automatically have a lien against Other Income Replacement Benefits, and you will be required when you submit a claim to sign a "Reimbursement Agreement" acknowledging the STD/LTD Plan's right to funds obtained from any recovery you receive. In addition, the plan is not responsible for any share of attorney fees incurred in pursuing or obtaining any Other Income Replacement Benefits**.**

Subrogation:
To the extent you are entitled to receive any recovery from a third party who caused or contributed to your Disability by intentional act or negligence, the third party's insurer or any other source (for example, funds that may be recovered in a lawsuit, a settlement, an arbitration, or a payment from the third party's insurance company, or uninsured/underinsured motorist coverage) and if you do not seek recovery from such third party, the STD/LTD Plan may proceed in your name against the third party. This right is not dependent upon the third party admitting responsibility, and is not dependent upon the execution of an agreement by you (or your legal representative) to the right of recovery.

By filing a claim under the STD/LTD Plan, you are accepting the terms of this subrogation provision. You must immediately give written notice to MetLife if you pursue a recovery from a responsible third party. You must do nothing to prejudice a right of recovery, such as accept a settlement that is less than the reasonable value of the claim. The plan is not responsible for any share of attorney fees incurred in pursuing or obtaining any recovery or settlement.

The Schedule of Benefits for the UHC and the BCBS Non-HDHP PPO Options is set forth below:

2021 SCHEDULE OF BENEFITS UHC AND BCBS NON-HDHP PPOs FOR MEDICARE ELIGIBLE LTD PARTICIPANTS			
	BCBS		UHC
Plan Feature	**In Network**	**Out of Network**	**No Network Requirement**
MEDICAL CARE, MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT			
Annual Deductible Employee Only Family: 2+ Persons	 $1,250 $2,500	 $2,500 $5,000	 $1,250 $2,500
Coinsurance after Deductible Plan pays You pay	 85% 15%	 65% 35%	 85% 15%
Coinsurance Maximum (Annual Limit after Deductible) Employee Only Family: 2+ Persons	 $2,750 $5,500	 $5,500 $11,000	 $2,750 $5,500
Preventive Care As outlined under "Health Management Programs" page 117 and "Preventive Pharmacy Benefits" page 147.	Paid at 100%	No benefits are paid for a Non-Network Provider	Paid at 100%
Maximum Lifetime Benefit	Unlimited, except as otherwise indicated in the "Covered Health Services" section, page 85.		

PHARMACY PROGRAM	
Retail	
Annual Deductible	NA
Pharmacy Coinsurance You pay: Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	Up to 31-day Supply* No Deductible $10 Copay 30% 40%
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	 No Deductible N/A $30/$90 $60/$150
Mail Order	
Annual Deductible	NA
Pharmacy Coinsurance You pay: Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	Up to 90-day Supply No Deductible $25 Copay 25% 40%

PHARMACY PROGRAM			
Pharmacy Coinsurance Minimums/Maximums per Script**			
Tier 1 - Generic	No Deductible		
Tier 2 - Preferred	N/A		
Tier 3 - Non-Preferred	$75/$225		
	$150/$375		
Pharmacy Coinsurance Maximum	Combined Medical and Pharmacy Coinsurance Maximum See "Coinsurance Maximum"		
*Certain generic drugs may be purchased at a Retail Pharmacy for a 90-day supply. **If the actual cost of the drug is less than the stated minimum, the member will pay the actual drug cost.			
OUT-OF-POCKET MAXIMUM			
Annual Deductible and Coinsurance Maximum			
Employee Only	$4,000	$8,000	$4,000
Family: 2+Persons	$8,000	$16,000	$8,000

If you are receiving LTD benefits and are Medicare eligible, you must furnish a copy of your Medicare card to Union Pacific Workforce Shared Services. Generally, your coverage under the UHC Non-HDHP PPO or the BCBS Non-HDHP PPO will be effective the first day of the month coinciding with or next following your Medicare eligibility date. However, if you are Medicare eligible (for a reason other than End Stage Renal Disease) and you have received LTD benefits for less than six months, your coverage under the UHC Non-HDHP PPO or the BCBS Non-HDHP PPO will not be effective until the first day of the month following your sixth month of LTD benefits. If you are Medicare eligible as a result of End Stage Renal Disease ("ESRD"), your coverage under the UHC Non-HDHP PPO or the BCBS Non-HDHP PPO will not be effective until the first day of the month following the 30th month of your Medicare eligibility.

Important Medicare Part D Coverage Note: If you (1) are Medicare eligible (for a reason other than End Stage Renal Disease), (2) receive LTD benefits for 6 months or more, and (3) elect coverage in a Medicare Prescription Drug Plan under Part D, then your medical coverage under the Union Pacific Corporation Group Health Plan (including and not limited to medical, mental health/substance abuse, and prescription drug benefits) and the medical coverage for your Spouse and Dependents will end on the last day of the month in which the Plan is notified by the Centers for Medicare and Medicaid Services of your enrollment in Medicare Part D. If you are Medicare eligible (for a reason other than End Stage Renal Disease) and receive LTD benefits for 6 months or more, and your Spouse or a covered Dependent elects coverage in a Medicare Prescription Drug Plan under Part D, medical coverage under the Union Pacific Corporation Group Health Plan (including and not limited to medical, mental health/substance abuse, and prescription drug benefits) for such Spouse or Dependent will end on the last day of the month in which the Plan is notified by the Centers for Medicare and Medicaid Services of such Spouse's or Dependent's enrollment in Medicare Part D.

If you (1) are Medicare eligible as a result of End Stage Renal Disease ("ESRD") and have been eligible for Medicare for at least 30 months due to the ESRD and (2) elect coverage in a Medicare Prescription Drug Plan under Part D, then your medical coverage under the Union Pacific Corporation Group Health Plan (including and not limited to medical, mental health/substance abuse, and prescription drug benefits) and the medical coverage for your Spouse and Dependents will end on the last day of the month in which the STD/LTD Plan is notified by the Centers for Medicare and Medicaid Services of your enrollment in Medicare Part D. If you are Medicare eligible as a result of ESRD and have been eligible for Medicare for at least 30 months due to the ESRD, and your Spouse or a covered Dependent elects coverage in a Medicare Prescription Drug Plan under Part D, medical coverage under the Union Pacific Corporation Group Health Plan (including and not limited to medical, mental health/substance abuse, and prescription drug benefits) for such Spouse or Dependent will end on the last day of the month in which the Plan is notified by the Centers for Medicare and Medicaid Services of such Spouse's or Dependent's enrollment in Medicare Part D.

You, your Spouse, and other Dependents may have rights to continue certain benefits under COBRA. These rights are explained in detail in the "Continuation of Coverage under COBRA" section on page 23 of this document. Unless you are a Medicare eligible LTD participant, if you have elected coverage at your current location, you may elect a new medical coverage option if you relocate while on LTD and:

- Your current medical coverage option is not available at your new location; or
- You are eligible at your new location for a medical coverage option not otherwise available in your old location.

You must notify Union Pacific Workforce Shared Services of your new address within 30 days following your relocation. If you are eligible to make an election and you fail to do so, your medical coverage will be as follows:

- If your current medical option is available in the new location, you will receive the same medical coverage option as you received at your old location at the same level of coverage (i.e., Employee Only or Family) received at your old location; or
- If your current medical option is **not** available in the new location, you will be defaulted to either the UHC HDHP2 Option or the BCBS HDHP2 Option, depending upon the home address ZIP code of your new residence at the same level of coverage (i.e., Employee Only or Family) received at the old location; or
- If you previously waived coverage at the old location, you will not receive coverage at the new location unless you experience another Life Event as described in the "Life Events & Permissible Benefits Changes" section on pages 28-63 of this document that would allow you to enroll in coverage.

Your new medical election (or default coverage if you fail to make a new election) will be effective on the first of the month coinciding with or next following your notification to Union Pacific Workforce Shared Services of your new address, if notification is received within 30 days of the event. Any after-tax contributions for your new election will begin the month following the receipt of your completed election form. If you fail to make an election, any after-tax contributions for your default coverage will begin the month following the month in which your 30-day election period ends.

Health Savings Account (HSA) Contribution Program:
You are ineligible to make Employee HSA Contributions during the time you are receiving LTD benefits.

If you are receiving LTD benefits at the beginning of the Calendar Year, are enrolled in a Union Pacific HDHP option and would otherwise be eligible for the HSA Contribution Program if not receiving LTD benefits, Union Pacific will contribute the Union Pacific HSA Contribution, also referred to as "Seed Money", based on your HDHP coverage level election (Employee Only or Family).

If you begin receiving LTD benefits during the Calendar Year, are enrolled in a Union Pacific HDHP option and would otherwise be eligible for the HSA Contribution Program if not receiving LTD benefits, Union Pacific will contribute the Union Pacific HSA Contribution, also referred to as "Seed Money", based on your HDHP coverage level election (Employee Only or Family) unless the Union Pacific HSA Contribution for such Calendar Year has already been contributed on your behalf prior to your commencement of LTD benefits.

Dental Coverage:
The dental coverage option in effect at the time LTD benefits begin will continue in effect for the remainder of the Calendar Year. Once you are enrolled in the dental plan, you cannot change your coverage during the Calendar Year unless you experience a Life Event that permits a change in the dental plan option. See the "Life Events & Permissible Benefits Changes" section on pages 28-63 of this document for details.

If a Domestic Partner dental election is in effect when LTD benefits begin, no changes to the Domestic Partner dental election will be permitted during the Calendar Year unless you experience a Life Event for which changes are allowed. See the "Life Events & Permissible Benefits Changes" section on pages 28-63 of this document for details.

During the fall of each Calendar Year, you will be given the opportunity to enroll in dental coverage for the subsequent Calendar Year. If you do not enroll during the open enrollment period, you will be defaulted to the same dental coverage option in the new Calendar Year as you are receiving in the current Calendar Year.

Vision Coverage:
The vision coverage option in effect at the time LTD benefits begin will continue in effect for the remainder of the Calendar Year. Once you are enrolled in the vision plan, you cannot change your coverage during the Calendar Year unless you experience a Life Event that permits a change in the vision plan option. See the "Life Events & Permissible Benefits Changes" section on pages 28-63 of this document for details.

During the fall of each Calendar Year, you will be given the opportunity to enroll in vision coverage for the subsequent Calendar Year. If you do not enroll during the open enrollment period, you will be defaulted to the same vision coverage option in the new Calendar Year as you are receiving in the current Calendar Year.

Employee Life, Spouse Life, and Child Life and AD&D Insurance:
Union Pacific will continue to pay for Core Employee Life Insurance coverage for the duration of your Disability absence. If you elected Voluntary Employee Life and AD&D Insurance, Voluntary Spouse Life and AD&D Insurance, and/or Voluntary Child(ren) Life and AD&D Insurance coverage as an active Employee, you may continue the coverage(s) while on LTD at active Employee rates, payable with after-tax dollars. Premium notices will be issued by MetLife and payments must be made directly to MetLife to continue this coverage.

Return to Work:
If an LTD recipient returns to work in a position eligible for the Flexible Benefits Program, benefits the Employee elected to continue while on LTD will continue for the remainder of the Calendar Year. The benefits that terminated (either automatically or at the Employee's election) at the commencement of LTD benefits will not be available for the remainder of the Calendar Year in which the Employee returns to work, except as follows:

- **Core Life/Core AD&D:** The Employee will continue enrollment in Core Life and will be reenrolled in Core AD&D coverage.
- **Dependent Care Flexible Spending Account:** If the Employee returns to work in the same Calendar Year in which the LTD leave began, the Employee may re-enroll in the Dependent Care Flexible Spending Account on the same terms prior to the commencement of LTD benefits. If the Employee returns to work in a Calendar Year subsequent to the Calendar Year in which the LTD leave began, the Employee may elect to participate in the Dependent Care Flexible Spending Account.
- **HSA Contributions:** If the Employee returns to work and is enrolled in a UHC HDHP option, the Employee may elect to make Employee HSA Contributions.

Retirement Plan:
If you are an active participant in the Pension Plan for Salaried Employees of Union Pacific Corporation and Affiliates ("Pension Plan") when you become Disabled, you may continue to receive compensation and service credit while Disabled. Any compensation and service credited under the Pension Plan is determined in accordance with the terms of the Pension Plan.

If you qualify for LTD benefits and have an account in a Union Pacific Thrift Plan, you may request a distribution of the entire balance of your thrift plan account(s).

If you have a participant loan from the Union Pacific Thrift Plan that is repaid to the Thrift Plan via payroll deduction, this payroll deduction will stop when you begin LTD benefits. **You must contact Vanguard, the Thrift Plan Trustee, at (800) 523-1188 to arrange for direct repayment of your loan to Vanguard.**

Vacation:
If you become Disabled and begin receiving LTD benefits, you will be paid for unused and accrued vacation in accordance with state payroll regulations.

DEFINITIONS - STD/LTD

Actively at Work or Active Work: You are performing all of the usual and customary duties of your job. You will be deemed "Actively at Work" during weekends (or regularly scheduled non-work days) or approved vacations, holidays, or business closures if you were Actively at Work on the last scheduled work day preceding such time off provided you are not Disabled. If you are on a Union Pacific approved leave of absence (military leave, family military leave, FMLA, unpaid sabbatical, unpaid status assessment leave, unpaid suspension leave, unpaid vacation or required unpaid leave of absence ("RULA")), you will be considered "Actively at Work" during such leave provided you are not Disabled.

Any Work: Work for any employer in your Local Economy at any gainful occupation for which you are reasonably qualified taking into account your training, education and experience.

Appropriate Care and Treatment: Medical care and treatment that is:

- Given by a Physician whose medical training and clinical specialty are appropriate for treating your Disability;
- Consistent in type, frequency, and duration of treatment with relevant guidelines of national medical, research, healthcare coverage organizations and governmental agencies;
- Consistent with a Physician's diagnosis of your Disability; and
- Intended to maximize your medical and functional improvement.

Day: A "day" for purposes of STD is a calendar day. Each scheduled work day that a person is absent due to injury or illness counts as a STD benefit day. Likewise, each weekend, or equivalent day between scheduled work days, counts as an STD benefit day if you are absent due to accidental injury or illness on the day immediately before and immediately after the weekend equivalent period.

Disability or Disabled means:

- for purposes of Short-Term Disability, the inability to perform your Own Job due to illness or accidental injury; and
- for purposes of Long-Term Disability:
  - You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment;
  - You are unable to earn:
    - During the period you are receiving STD benefits and the next 12 months of sickness or accidental injury, more than 80% of Your Core Predisability Earnings; or, if applicable, your Buy-up Predisability Earnings at your Own Job; and
    - After such period, more than 70% of your Core Predisability Earnings; or, if applicable, your Buy-up Predisability Earnings from Any Work.
  - For purposes of determining whether a Disability is the direct result of an accidental injury, the Disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

If you no longer meet the definition of Disabled and do not return to work with Union Pacific, your employment and associated benefits will cease. If your occupation requires a license, the fact that you lose your license for any reason will not, in itself, constitute Disability.

Employee means (1) an active non-agreement, full-time salaried, reduced salaried, or full-time hourly person (other than any person classified as a coop or intern) employed by Union Pacific Corporation or Union Pacific Railroad Company or (2) any other classification of employees specified by any other Union Pacific affiliate that becomes a participating employer in the Flexible Benefits Program.

The term "Employee" shall not include a person who is classified by Union Pacific Corporation, Union Pacific Railroad or any other Union Pacific affiliate that becomes a participating employer in the Flexible Benefits Program (individually, "Flexible Benefits Program Employer") as an independent contractor or a person who is not treated by a Flexible Benefits Program Employer as an employee for purposes of withholding federal employment taxes,

regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding. If an individual is engaged in an independent contractor or similar capacity and is subsequently classified by a Flexible Benefit Plan Employer, a governmental body or the judiciary as an Employee, such person, for purposes of the Flexible Benefits Program, shall be deemed to be an Employee from the actual (and not effective) date of such classification by a Flexible Benefits Program Employer or the date as of which such classification by the governmental body or judiciary is final and not appealable. Additionally, the term "Employee" excludes any person who, as to the United States, is a non-resident alien with no U.S. source income from a Flexible Benefits Program Employer.

Local Economy: The geographic area within which you reside; and which offers suitable employment opportunities within a reasonable travel distance. If you move on or after the date you become Disabled, the STD/LTD Plan may consider both your former and current residence to be your Local Economy.

Medical Information: Medical information from your Physician consists of any information requested by the STD/LTD Plan and in all situations should include at a minimum the following:

- Your diagnosis;
- Prognosis;
- Treatment plan and duration;
- Functional limitations; and
- Anticipated return to work date.

Mental or Nervous Disorder or Disease: A medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders as of the date of your Disability. A condition may be classified as a "Mental or Nervous Disorder or Disease" regardless of its cause.

Neuromuscular, Musculoskeletal, or Soft Tissue Disorder: includes, but not limited to, to, any disease or disorder of the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles, unless the Disability has objective evidence of:

- Myelopathies;
- Myopathies.
- Radiculopathies;
- Seropositive Arthritis;
- Spinal Tumors, malignancy, or Vascular Malformations; or
- Traumatic Spinal Cord Necrosis

Myelopathies means disease of the spinal cord supported by objective clinical findings of spinal cord pathology.

Myopathies means disease of skeletal muscle supported by clinical, histological, biochemical and/or electrodiagnostic findings.

Radiculopathies means disease of the peripheral nerve roots supported by objective clinical findings of nerve pathology.

Seropositive Arthritis means an inflammatory disease of the joints supported by clinical findings of arthritis plus positive serological tests for connective tissue disease.

Spinal means components of the bony spine or spinal cord.

Traumatic Spinal Cord Necrosis means injury or disease of the spinal cord resulting from traumatic injury with resultant paralysis.

Tumor(s) means abnormal growths which may be malignant or benign.

Vascular Malformations means abnormal development of blood vessels.

Other Income Replacement Benefits: Your STD or LTD benefits will be reduced (or offset) by other income, including:

- any disability or retirement benefits that you, your Spouse or children receive or are eligible to receive as a result of your disability or retirement, under any of the following:
    - Railroad Retirement Board benefits (including retirement, sickness, and disability annuity benefits).
    - Social Security benefits.
    - State or public employee retirement or disability plan benefits.
    - Pension or disability benefits from a plan of any other nation or political subdivision thereof.
    - Any income received for disability or retirement under a Union Pacific-sponsored pension plan.
- Any income received from disability under:
    - A group insurance policy to which Union Pacific Corporation has made a contribution, such as:
        - Benefits for loss of time from work due to disability.
        - Installment payments for permanent total disability.
    - A no-fault auto law for loss of income, excluding supplemental disability benefits.
    - A government compulsory benefit plan or program which provides payments for loss of time on the job as a result of a disability, whether such payment is made directly by the plan or program, or through a third party.
    - A self-funded plan sponsored by Union Pacific Corporation, if Union Pacific contributes towards it or makes payroll deductions to it.
    - Any sick pay or other salary continuation that Union Pacific Corporation pays to you.
    - Workers compensation or a similar law which provides periodic benefits.
    - Occupational disease laws.
    - Laws providing for maritime maintenance and cure.
    - Unemployment insurance laws or programs.
- Any income that you receive from working while Disabled to the extent that such income reduces the amount of your monthly benefit.
- Any award or settlement you receive for loss of income as a result of claims against a third party.

Own Job: The essential functions you regularly perform for Union Pacific that provide your primary source of income.

Physician:

- A person licensed to practice medicine in the jurisdiction where such services are performed; or
- Any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the STD/LTD Plan. Each such person must be licensed in the jurisdiction where the service is performed and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- Any member of your immediate family, including your and/or your Spouse's parents, children (natural, step or adopted), siblings, grandparents, or grandchildren.

Pre-existing Condition: An injury or illness for which the employee in the three months prior to either the effective date of coverage under the STD/LTD Plan; or, with respect to the Buy-up coverage available under the plan, in the three months prior to the effective date of the Buy-up coverage:

1) Received medical treatment, consultation, care or services;
2) Took prescription medications or had medications prescribed; or
3) Had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care, or treatment.

Rehabilitation Program: means an approved program coordinated by MetLife that includes:

- return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience, and past earnings;
- on site job analysis;
- job modification/accommodation;
- vocational assessment;
- short-term skills enhancement;
- vocational training; or
- restorative therapies to improve functional capacity to return to work.

Temporary Reduction in Salary for Executives: A temporary reduction in the monthly salary of an executive during a period determined by Union Pacific in response to significant changes in business requirements.

Week: A "week" for purposes of STD consists of seven (7) consecutive calendar days.

Employee Retirement Income Security Act of 1974 (ERISA)

Page

INTRODUCTION

This Employee Flexible Benefits Guide ("Flex Guide") describes certain Union Pacific health and welfare benefits available to you. It includes information about who is covered, the kinds of benefits provided, limitations or restrictions you should know about, and how to claim benefits. Many benefits are covered by provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA), a federal law which governs the operation of employee benefit plans. It is important to understand some of the provisions of this law since the provisions could affect you. This section helps you use your benefits and understand your rights under ERISA and the plans governed by ERISA, and is applicable to the benefits described in this Flex Guide that are covered by ERISA.

Summary Plan Descriptions:
ERISA requires that you receive easily understood descriptions of your benefits, called summary plan descriptions. With the exception of the Union Pacific Corporation Group Health Plan, the information about your employee benefit plans that are subject to ERISA and described in this document constitutes the summary plan descriptions under ERISA. The information about the Union Pacific Corporation Group Health Plan described in this document, together with the information on the BCBS HDHP and PPO Medical Options and the various HMOs in which you are eligible to enroll, constitutes the summary plan description under ERISA for the Union Pacific Corporation Group Health Plan.

Plan Sponsorship:
The plans' coverage is sponsored by:

Union Pacific Corporation
1400 Douglas Street, Stop 0330
Omaha, NE 68179

The plans are extended to eligible employees of participating Union Pacific subsidiaries. A complete list of these subsidiaries, including their addresses, employer identification numbers, and the plans in which their employees participate, is available in the Union Pacific Workforce Resources Department in Omaha, Nebraska, and may be obtained upon written request.

Plan Administrator:
The Plan Administrator of the Union Pacific health and welfare benefit plans covered by ERISA is the Executive Vice President & Chief Human Resources Officer, Union Pacific Railroad Company. The Plan Administrator administers the plans and makes decisions about how plan provisions apply in specific cases. To contact the Plan Administrator, forward your correspondence to:

Executive Vice President Human Resources
Union Pacific Railroad Company
1400 Douglas Street, Stop 0330
Omaha, NE 68179
(402) 544-5000

The Workforce Resources Department provides administrative services, answers questions, and generally acts as the Plan Administrator's representative in handling day-to-day matters involving plan participants. Feel free to contact Union Pacific Workforce Shared Services at (877) 275-8747, with any questions.

YOUR ERISA RIGHTS

As a participant in a benefit plan that is subject to ERISA, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

1. Examine, without charge, in the Workforce Resources Department in Omaha or at your company headquarters if copies are kept there, all documents governing the plans, including insurance contracts and a copy of the latest annual reports (Form 5500 Series) filed by the plans with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of the documents governing the operation of the plans, including insurance contracts, copies of the latest annual reports (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for copies.

3. 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.

Continue Group Health Plan Coverage:
You may continue health care coverage for yourself, your Spouse or Dependents if there is a loss of coverage under an applicable plan as a result of a qualifying event. You, your Spouse or your Dependents may have to pay for such coverage. Review the terms of the applicable plan and any other documents governing the plan on the rules regarding your COBRA continuation coverage rights.

Maternity and Newborn Infant Coverage:
For those medical program options that provide maternity or newborn infant coverage, those plans 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 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 provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Certain Mastectomy Coverage:
For those medical program options that cover mastectomies, if you or your Dependent receives a mastectomy, the covered benefits for the patient will also include 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;
- Prostheses; and
- Treatment of physical complications in all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage is subject to annual Deductibles, Coinsurance and Copay provisions, and other provisions that are applicable to the other benefits of the medical program option.

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 employee benefit plan. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the plans or exercising rights under ERISA.

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

Under ERISA, there are steps you can take to enforce your rights. For example, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days of a request, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you as much as $110 per day until you receive the materials, unless they were not sent due to reasons beyond the Plan Administrator's control. To ensure your request was not lost in the mail, you should call the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. However, before filing a lawsuit you must first exhaust all appeals required by the plan. Please refer to each benefit section regarding claims and appeals. If it should happen that plan fiduciaries misuse a plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or 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 your plan, you should contact the Workforce Resources Department. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, 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, 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 Employee Benefits Security Administration toll free at 866/444/3272 or by visiting EBSA's website at www.dol.gov/ebsa.

Claiming Your Benefits:
You generally must file a claim if you are eligible for a benefit from any Union Pacific plan. Often, there are time limits for sending claim forms, so be sure of each plan's deadlines. You could lose benefits if you delay filing. You should refer to each benefit section regarding the filing of claims.

How You Can Appeal:
If your claim is denied, you have the right to appeal for those benefit programs covered by ERISA. You may also submit in writing reasons why you think your claim should not be denied. Please refer to each benefit section regarding how you can appeal.

Besides having the right to appeal, you or your authorized representative can examine any plan documents (except legally privileged information) related to your claim.

Serving Legal Process:
If you or your beneficiaries choose to take legal action against any of the plans over terms of the plans, legal process should be served on:

Executive Vice President & Chief Human Resources Officer,
Union Pacific Railroad Company
1400 Douglas Street, Stop 0330
Omaha, NE 68179
(402) 544-5000

Future of the Plans:
While Union Pacific intends to continue these plans indefinitely, it reserves the right to terminate or amend any or all of the benefit plans for any reason. If the Company terminates or amends a welfare plan, benefits under the plan for active employees and/or retirees would cease or change. The Company may also increase the required employee or retiree contributions at any time. Similarly, a participating employer can take such actions with respect to its employees or retirees. Every effort will be made to provide plan participants with reasonable notice of any such change.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries:
In carrying out their respective responsibilities under the plans, the Plan Administrator and other plan fiduciaries shall have discretionary authority to make factual findings, to interpret the terms of the plans, and to determine entitlements to benefits in accordance with the terms of the plans. Any finding, interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the finding, interpretation or determination was arbitrary and capricious.

The Plan Administrator may designate other persons to carry out such of her responsibilities under the plans for the operation and administration of the plans as she deems advisable and delegate to the persons designated such of her powers as she deems necessary to carry out such responsibilities. Any designation and delegation shall be subject to such terms and conditions as the Plan Administrator deems necessary or proper. Any action or determination made or taken in carrying out responsibilities under the plans by the persons so designated by the Plan Administrator shall have the same force and effect for all purposes as if such action or determination had been made or taken by the Plan Administrator.

IMPORTANT PLAN INFORMATION

The following chart lists the employer identification, policy and plan numbers for all Union Pacific benefit plans subject to ERISA. It also lists plan years, the twelve-month period for which Union Pacific maintains financial records for each plan. Technically, the plans listed on the chart are known as welfare plans.

The Employer Identification Number (EIN) assigned by the IRS to Union Pacific Corporation as the Plan Sponsor is 13-2626465.

PLAN NAME	PLAN NO.	INSURANCE CARRIER, ADMINISTRATOR OR TRUSTEE	CONTRACT OR POLICY NO.	PLAN YEAR	CONTRIBUTION SOURCES
Union Pacific Corporation Group Health Plan (A) Medical Benefits **(1) UHC Medical Options** (a) Medical & Mental Health/ Substance Abuse (b) Pharmacy	502 Group Health Plan	UMR 115 W Wausau Ave Wausau, WI 54401 Quantum Health 7450 Huntington Park Drive Columbus, OH 43235 OptumRx 11000 Optum Circle Eden Prairie, MN 55344		1/1 - 12/31	Employees & Employers
(2) BlueCross/Blue Shield Medical Options (a) Medical & Mental Health/ Substance Abuse (b) Pharmacy	502 Group Health Plan	BlueCross/BlueShield Fifth Avenue Place 120 Fifth Avenue Pittsburgh, PA 15222- 3099 Quantum Health 7450 Huntington Park Drive Columbus, OH 43235 OptumRx 11000 Optum Circle Eden Prairie, MN 55344		1/1 - 12/31	Employees & Employers

PLAN NAME	PLAN NO.	INSURANCE CARRIER, ADMINISTRATOR OR TRUSTEE	CONTRACT OR POLICY NO.	PLAN YEAR	CONTRIBUTION SOURCES
Union Pacific Corporation Group Health Plan (A) Medical Benefits **(3) HMO Medical Options** (a) Medical, Pharmacy & Mental Health/ Substance Abuse	502 Group Health Plan	Kaiser Foundation Health Plan, Inc. Northern California Region One Kaiser Plaza Oakland, CA 94612 Kaiser Foundation Health Plan, Inc. Southern California Region One Kaiser Plaza Oakland, CA 94612 Kaiser Foundation Health Plan, Inc. Colorado Region 10350 E. Dakota Avenue Denver, CO 80231-1314 Kaiser Foundation Health Plan, Inc. Northwest Region 500 NE Multnomah Suite 100 Portland, OR 97232	35219 - Medical 123413 - Medical 725 - Medical 8457-001 - Medical	1/1 - 12/31	Employees & Employers
(B) Dental Benefits		Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166	37625 - Dental	1/1 - 12/31	Employees & Employers
(C) Vision Benefits		EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040	9891003 - Vision (Active Population) 9891011 - Vision (COBRA)	1/1 - 12/31	Employees & Employers
Union Pacific Corporation Short and Long-Term Disability Plan	504 Disability Plan	Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 For pre-2008 disability claims: Union Pacific Health & Medical Services Attn: Pre-2008 LTD 1400 Douglas Street STOP 0350 Omaha, NE 68179	93503-1-G - Disability	1/1 - 12/31	Employees & Employers
Union Pacific Corporation Nonagreement Life Insurance Plan	555 Life Insurance Plan	Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166	93503-1-G - Life & AD&D	1/1 - 12/31	Employees & Employers

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Page

INTRODUCTION

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) and regulations thereunder require health plans to protect the privacy of an individual's healthcare information. The HIPAA privacy rules and this section apply to the Medical Care Program, Pharmacy Program, Dental Care Program, and Vision Care Program under the Union Pacific Corporation Group Health Plan (the "Group Health Plan") which are described in this Flexible Benefits Guide. The privacy rules restrict the disclosure of Protected Health Information to Union Pacific Corporation and its affiliated companies ("Union Pacific"). Union Pacific may use or disclose Protected Health Information it receives from the Group Health Plan only as provided in this Health Insurance Portability and Accountability Act of 1996 (HIPAA) section.

ENTITIES RESPONSIBLE FOR HIPAA COMPLIANCE

The Group Health Plan's HMOs and the insurance carrier for the Vision Care Program under the Group Health Plan are responsible for complying with HIPAA's privacy rules with respect to the Protected Health Information they create, maintain, or receive. These benefit programs are "fully insured". The HMOs and the Vision Care Program insurance carrier are identified in the Important Plan Information in the "ERISA" and "Benefit Contacts" sections. If you are enrolled in an HMO or the Vision Care Program under the Group Health Plan, please see the Privacy Notice provided by the HMO or the Vision Care Program insurer for more information about their obligations and your rights under the HIPAA privacy rules.

For benefits that are self-insured by Union Pacific, the Group Health Plan is responsible for complying with HIPAA's privacy rules with respect to the Protected Health Information that the Group Health Plan creates, maintains, or receives. The self-insured benefits under the Group Health Plan offered to Employees and their Dependents consist of the Dental Care Program, the UHC Medical Options and the BlueCross/BlueShield Medical Options.

AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

The Group Health Plan, with respect to the benefits under the Group Health Plan that are self-insured by Union Pacific, has adopted a Notice of Privacy Practices ("Notice") which is available upon request to participants in the Group Health Plan. To request a copy of this Notice, contact Union Pacific Workforce Shared Services:

Union Pacific Workforce Shared
Services
1400 Douglas Street, Stop 0320
Omaha, NE 68179-0320
(877) 275-8747 or (402) 544-4000

If you wish to receive the Notice of Privacy Practices adopted for the Vision Care Program under the Group Health Plan, contact the insurance carrier of that benefit. If you are enrolled in an HMO, contact the HMO to request a copy of the HMO's Notice of Privacy Practices.

Except as otherwise provided, the remainder of this HIPAA section applies only to the self-insured benefits under the Group Health Plan. For the remainder of this HIPAA section, the Group Health Plan is referred to as the "Plan."

PERMITTED AND REQUIRED USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan may disclose Protected Health Information to Union Pacific only if one of the following applies:

1. The Plan receives proper written authorization from the participant or the participant's representative. The authorization must specifically authorize the use or disclosure. A proper authorization form is required for uses by or disclosure to Union Pacific if the use or disclosure does not meet the condition described in Paragraphs 2, 3, or 4 below;
2. The Plan discloses information to Union Pacific that is, for purposes of HIPAA's privacy rule, enrollment or disenrollment information;

3. The Plan provides Union Pacific with Protected Health Information in the form of Summary Health Information for the purposes of obtaining premium bids, or determining whether to modify, amend or terminate the Plan; provided, however, that such Protected Health Information used for 'underwriting purposes' (as defined in the HIPAA regulations) shall not include Protected Health Information that is 'genetic information' (as defined in the HIPAA regulations); or
4. The Plan receives a signed certification from Union Pacific that the plan documents restrict the use and disclosure of the Protected Health Information as required by the HIPAA regulations on privacy and confidentiality, and Union Pacific agrees to comply with the restrictions, and the information has been requested to carry out administrative functions (i.e., payment or health care operations functions) which Union Pacific performs for the Plan, and the uses and disclosures of Protected Health Information by Union Pacific will be restricted to plan administration functions performed by Union Pacific on behalf of the Plan in accordance with the Plan document.

Conditions of Disclosure:
Union Pacific agrees that with respect to Protected Health Information disclosed to Union Pacific by the Plan, other than enrollment/disenrollment information and Summary Health Information, or disclosed pursuant to a valid HIPAA authorization, Union Pacific shall:

a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.
b. Ensure that any agents to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to Union Pacific with respect to Protected Health Information.
c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan, program or arrangement of Union Pacific.
d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
e. Make available to a Plan participant who requests access, the Plan participant's Protected Health Information in accordance with the HIPAA regulations.
f. Make available to a Plan participant who requests an amendment, the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with the HIPAA regulations.
g. Make available to a Plan participant who requests an accounting of disclosures of the participant's Protected Health Information, the information required to provide an accounting of disclosures in accordance with the HIPAA regulations.
h. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA regulations.
i. If feasible, return or destroy all Protected Health Information received from the Plan that Union Pacific still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
j. Ensure that the adequate separation between the Plan and Union Pacific required in the HIPAA regulations is satisfied.

Adequate Separation between Plan and Plan Sponsor:
Union Pacific shall only allow access to Protected Health Information to employees whose duties include performing administrative functions on behalf of the Plan and are in the following categories:

- Assistant Vice President Talent Management, Union Pacific Railroad Company
- Executive Vice President & Chief Human Resources Officer, Union Pacific Railroad Company
- Union Pacific Workforce Resources Services
- Union Pacific Workforce Resources Benefits Group
- Union Pacific Workforce Resources Compensation Group
- Union Pacific Workforce Resources Information Systems Group
- Union Pacific Payroll Group
- Union Pacific Audit Group

These employees shall only have access to and use Protected Health Information to the extent necessary to perform the Plan administrative functions that Union Pacific performs for the Plan. In the event that any of these employees do not comply with the provisions of this paragraph, the employee shall be subject to disciplinary action by Union Pacific for non-compliance pursuant to Union Pacific's employee discipline and termination procedures.

Reports of Non-Compliance:
If you suspect an improper use or disclosure of Protected Health Information, you may report the occurrence to the Plan's Privacy Office:

Union Pacific Workforce Shared
Services
Attn: HIPAA Privacy
1400 Douglas Street, Stop 0320
Omaha, NE 68179-0320
(877) 275-8747 or (402) 544-4000

DEFINITIONS

For purposes of this HIPAA section, the following terms shall have the meaning set forth below:

"Protected Health Information" means "individually identifiable health information" that is maintained or transmitted by the Plan. Protected Health Information does not include individually identifiable health information in employment records held by Union Pacific. "Individually identifiable health information" is information, including demographic information, that is collected from an individual and created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare services to an individual; or the past, present, or future payment for the provision of healthcare services to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information includes information of persons who are living and persons who have been deceased for 50 years or less. The following components of an individual's information are considered Protected Health Information:

a. Names;
b. Street address, city, county, precinct, ZIP code;
c. Dates directly related to a participant, including birth date, health facility admission and discharge date, and date of death;
d. Telephone numbers, fax numbers, and electronic mail addresses;
e. Social security numbers;
f. Medical record numbers;
g. Health plan beneficiary numbers;
h. Account numbers;
i. Certificate/license numbers;
j. Vehicle identifiers and serial numbers, including license plate numbers;
k. Device identifiers and serial numbers;
l. Web universal resource locators (URLs);
m. Internet Protocol (IP) address numbers;
n. Biometric identifiers, including finger and voice prints;
o. Full face photographic images and any comparable images; and
p. Any other unique identifying number, characteristic, or code.

"Summary Health Information" means information that may be individually identifiable health information, and:

a. Summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
b. From which the applicable information described in the HIPAA regulations has been deleted, except that the geographic information need only be aggregated to the level of a five-digit ZIP code.

Benefit Contacts

Quantum Health – for UHC and BCBS Medical Options (including OptumRx pharmacy benefits)

- Care Coordinator/Customer Service..……(855) 649-3855
- Website - MyQHealth……..……www.UPMyQHealth.com

Union Pacific WR Services — 9:00 a.m. to 5:00 p.m. (CT)
Toll-Free ..... (877) 275-8747
UP Network 8-544-4000
Fax Number ..... (402) 233-2736
Email Address .....HRSC@up.com
Mailing Address .....1400 Douglas Street, Stop 0320, Omaha, NE 68179

- All General Nonagreement or Retirement Benefit Questions
- Educational Assistance
- Dependent Care Flexible Spending Account
- Pension
- Service Awards/Retirement Awards

BenefitWallet Health Savings Account (HSA) Contributions

- Website:
  FAQs, HSA calculator, check account balance/transaction information.....www.mybenefitwallet.com
- Customer Service ..... (866) 415-0650

Health Maintenance Organization (HMO)

- Kaiser Colorado..... (800) 632-9700
- Kaiser Northwest..... (800) 813-2000
- Kaiser Northern California ..... (800) 464-4000
- Kaiser Southern California ..... (800) 464-4000

Vision Care (EyeMed)

- Website/Provider
  Directory.....www.eyemed.com
- Member Services..... (866) 723-0513
  Questions or help locating a participating provider, Contract #9891003 (Active population); #9891011 (COBRA)

Dental Care Benefits (Metropolitan Life)

- Website/Provider
  Directory.....www.metlife.com/dental
- Member only website .....www.metlife.com/mybenefits
- Member Services..... (888) 777-6806
  option 1, Locate a participating provider, questions about dental benefits or claims, Group #37625

Dependent Care Flexible Spending Account (PayFlex)

- Website.....www.payflex.com
  Set up direct deposit, access account balance/information, submit claims online.
- Customer Service 844-PAYFLEX (844-729-3539)
- Fax number for submitting claims..... (855) 703-5305

Life Insurance (Metropolitan Life)

- Website.....www.metlife.com/mybenefits
  Enroll in benefits, update dependents and beneficiaries.
- Member Services..... (866) 659-1377

Short and Long-Term Disability, claims beginning on or after 1/1/2008 (Metropolitan Life):

- Website.....www.metlife.com/mybenefits
  Submit claims online, check claim status.
- Customer Service ..... (888) 777-6806
  option 2

Medical Plan Summaries

Page

Self-Insured Medical Options

Health Maintenance Organizations (HMOs)

2021 SCHEDULE OF BENEFITS						
BLUE CROSS / BLUE SHIELD	**BCBS HDHP1**		**BCBS HDHP2**		**BCBS Non-HDHP PPO**	
Plan Feature	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
HEALTHCARE						
Annual Deductible Employee Only Family: 2+ Persons	$3,000 $6,000	$6,000 $12,000	$4,500 $9,000	$9,000 $18,000	$1,250 $2,500	$2,500 $5,000
Health Savings Account: Maximum Company Contributions (including Seed Money)+* Employee Only Family: 2+ Persons	$900 $2,100		$900 $2,100		N/A	
Annual Deductible "Gap" Employee Only Family: 2+ Persons	$2,100 $3,900	$5,100 $9,900	$3,600 $6,900	$ 8,100 $15,900	N/A	
Medical Coinsurance After Deductible Plan pays You pay	85% 15%	65% 35%	85% 15%	65% 35%	85% 15%	65% 35%
Coinsurance Maximum (Annual Limit after Deductible) Employee Only Family: 2+ Persons	$2,000 $4,000	$4,000 $8,000	$1,500 $3,000	$3,000 $6,000	$2,750 $5,500	$5,500 $11,000
Preventive Care (As outlined under "Health Management Programs" page 117 and "Preventive Pharmacy Benefits", page 147.)	Paid at 100%	No benefits are paid for an Out-of-Network Provider	Paid at 100%	No benefits are paid for an Out-of-Network Provider	Paid at 100%	No benefits are paid for an Out-of-Network Provider
Maximum Lifetime Benefit	Unlimited, except as otherwise indicated in the "Covered Services" section beginning on page 85.					

+A Health Savings Account (HSA) is not an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, amended (ERISA).
*The HSA contributions reflected in this Schedule of Benefits are intended only to illustrate how amounts contributed to an HSA may be used to offset HDHP Deductibles. These amounts would apply for a full-year participant who receives the maximum annual Union Pacific HSA contribution.

PHARMACY PROGRAM			
BLUE CROSS / BLUE SHIELD	**BCBS HDHP1**	**BCBS HDHP2**	**BCBS Non-HDHP PPO**
Retail			
Annual Deductible	Combined Medical and Pharmacy Deductible See "Deductible"	Combined Medical and Pharmacy Deductible See "Deductible"	N/A
Pharmacy Coinsurance You pay: Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	Up to 31-day Supply* After the Deductible $10 Copay 30% 40%	Up to the 31-day Supply* After the Deductible $10 Copay 30% 40%	Up to 31-day Supply* No Deductible $10 Copay 30% 40%
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	After the Deductible N/A $30/$90 $60/$150	After the Deductible N/A $30/$90 $60/$150	No Deductible N/A $30/$90 $60/$150
Mail Order			
Annual Deductible	Combined Medical and Pharmacy Deductible See "Deductible"	Combined Medical and Pharmacy Deductible See "Deductible"	N/A
Pharmacy Coinsurance You pay: Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	Up to 90-day Supply After the Deductible $25 Copay 25% 40%	Up to 90-day Supply After the Deductible $25 Copay 25% 40%	Up to 90-day Supply No Deductible $25 Copay 25% 40%
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	After the Deductible N/A $75/$225 $150/$375	After the Deductible N/A $75/$225 $150/$375	No Deductible N/A $75/$225 $150/$375
Pharmacy Coinsurance Maximum	Combined Medical and Pharmacy Coinsurance Maximum See "Coinsurance Maximum"		

*Certain Generic drugs may be purchased at a Retail Pharmacy for a supply up to 90-days.
**If the actual cost of the drug is less than the stated minimum, the member will pay the actual drug cost.

OUT-OF-POCKET MAXIMUM						
Annual Deductible and Coinsurance Maximum	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Employee Only	$5,000	$10,000	$6,000	$12,000	$4,000	$8,000
Family: 2 +Persons	$10,000	$20,000	$12,000	$24,000	$8,000	$16,000

KAISER PERMANENTE®

UNION PACIFIC CORPORATION

Effective Dates: 01/01/2021 - 12/31/2021

Colorado
HMO
Non-Grandfathered
Group Number(s): #00725

General Information	
Website	www.kp.org
Member Services Number	303-338-3800 or toll free 1-800-632-9700
Member Services Weekday Hours	8:00am to 6:00pm
Member Services Weekend Hours	Closed on weekends
Annual Deductible: Individual/Family	Not applicable
Annual Out-of-Pocket Max: Individual/Family	$2,000 Individual / $4,500 Family
Office Visits (Outpatient)	
Primary Care	$25 copay and all office administered injectables/infusions subject to a 20% coinsurance which applies to the annual out-of-pocket maximum
Specialty Care	$35 copay and all office administered injectables/infusions subject to a 20% coinsurance which applies to the annual out-of-pocket maximum
Preventive Care	100% covered
Scheduled Prenatal Visits and 1st Postpartum Visit	100% covered
Well-Baby Care (23 months or younger)	100% covered
Vision Exam - Optometrist	$25 copay; $150 hardware benefit every 24 months
Vision Exam - Ophthalmologist	$35 copay
Physical, Occupational, Speech Therapy	$25 copay to a maximum of 20 visits per calendar year
Outpatient/Ambulatory Surgery	$150 copay
Lab and X-Ray	
Laboratory	100% covered
X-Ray	100% covered for diagnostic x-rays and $35 copay for therapeutic x-rays
MRI/CT/PET/Nuclear Medicine	$100 copay
Emergency Care	
Ambulance (Ground or Air)	20% coinsurance up to $500 per trip
Emergency Room	$100 copay per admission
Urgent Care	$50 copay
Hospital Care (Inpatient)	
Inpatient	$300 copay per admission
Delivery and Inpatient Baby Care	$300 copay per admission

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the applicable EOC, or to the Disclosure Form for California, or to the Member Handbook for Hawaii.

KAISER PERMANENTE®

UNION PACIFIC CORPORATION

Effective Dates: 01/01/2021 - 12/31/2021

Colorado
HMO
Non-Grandfathered
Group Number(s): #00725

Mental Health and Chemical Dependency	
Mental Health Outpatient (Individual)	$25 copay
Mental Health Outpatient (Group)	$12 copay
Mental Health Inpatient	$300 copay per admission
Chemical Dependency Outpatient (Individual)	$25 copay
Chemical Dependency Outpatient (Group)	$12 copay
Chemical Dependency Inpatient	$300 copay per admission
Prescription Drugs	
Pharmacy/Retail: Generic	$15 copay and 80% covered self-injectables up to $250 out-of-pocket max per drug per fill
Pharmacy/Retail: Brand	$25 copay and 80% covered self-injectables up to $250 out-of-pocket max per drug per fill
Pharmacy/Retail: Day Supply	30 days
Mail Order - Generic	$30 copay and 80% covered self-injectables up to $250 out-of-pocket max per drug per fill
Mail Order - Brand	$50 copay and 80% covered self-injectables up to $250 out-of-pocket max per drug per fill
Mail Order - Day Supply	90 days
Other	
Skilled Nursing Facility (SNF)	100% covered; limit 100 days
Infertility Services	50% coinsurance
Hospice Care	100% covered
Home Health Care	100% covered
Durable Medical Equipment (DME)	80% covered
Chiropractic Care	Not covered

Notes

Bariatric Surgery – 70% covered; must be medically necessary

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the applicable EOC, or to the Disclosure Form for California, or to the Member Handbook for Hawaii.

KAISER PERMANENTE®

Union Pacific – HMO

Effective Dates: January 01, 2021 – December 31, 2021

Northwest
Traditional HMO
Group Number(s): 08457
Subgroup(s): 001,007

General Information	
Website	www.kp.org
Member Services Number	1-800-813-2000 1-503-813-2000 in the Portland metropolitan area
Member Services Weekday Hours	8:00 a.m. to 6:00 p.m.
Member Services Weekend Hours	Not applicable
Annual Deductible: Individual/Family	$0 individual/$0 family
Annual Out-of-Pocket Max: Individual/Family	$1250 individual/$2500 family
Office Visits (Outpatient)	
Primary Care	$25 Copay
Specialty Care	$25 Copay
Preventive Care	100% Covered
Scheduled Prenatal Visits and 1st Postpartum Visit	100% Covered
Well-Baby Care (23 months or younger)	100% Covered
Vision Exam - Optometrist	$25 Copay
Vision Exam - Ophthalmologist	$25 Copay
Physical, Occupational, Speech Therapy	$25 Copay per visit; limited to 20 visits per therapy per calendar year
Outpatient/Ambulatory Surgery	$100 Copay; 100% covered if preventive care
Lab and X-Ray	
Laboratory	100% Covered
X-Ray	100% Covered
MRI/CT/PET/Nuclear Medicine	100% Covered
Emergency Care	
Ambulance (Ground or Air)	$75 Copay
Emergency Room	$100 Copay; waived if admitted
Urgent Care Benefits	$25 Copay
Hospital Care (Inpatient)	
Inpatient	$250 Copay per admit
Delivery and Inpatient Baby Care	$250 Copay per admit

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the applicable EOC, or to the Disclosure Form for California, or to the Member Handbook for Hawaii.

KAISER PERMANENTE®

Union Pacific – HMO

Effective Dates: January 01, 2021 – December 31, 2021

Northwest
Traditional HMO
Group Number(s): 08457
Subgroup(s): 001,007

Mental Health and Chemical Dependency	
Mental Health Outpatient (Individual)	$25 Copay
Mental Health Outpatient (Group)	$12 Copay
Mental Health Inpatient	$250 Copay per admit
Chemical Dependency Outpatient (Individual)	$25 Copay
Chemical Dependency Outpatient (Group)	$12 Copay
Chemical Dependency Inpatient	$250 Copay per admit
Prescription Drugs	
Pharmacy/Retail: Generic	$15 Copay 30 day supply formulary drugs
Pharmacy/Retail: Brand	$30 Copay 30 day supply formulary drugs
Pharmacy/Retail: Day Supply	30 day supply
Mail Order - Generic	$30 Copay 90 day supply maintenance formulary drugs
Mail Order - Brand	$60 Copay 90 day supply maintenance formulary drugs
Mail Order - Day Supply	90 day supply
Other	
Skilled Nursing Facility (SNF)	100% Covered limited to 100 days per year
Infertility Services	50% Covered; diagnosis and treatment
Hospice Care	100% Covered for patient diagnosed with life expectancy of six months or less
Home Health Care	100% Covered for homebound patient in the service area upon physician referral; limited to 130 days per calendar year
Durable Medical Equipment (DME)	80% Covered Medicare criteria apply
Chiropractic Care	Not covered
Notes	

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the applicable EOC, or to the Disclosure Form for California, or to the Member Handbook for Hawaii.

Proposed Benefit Summary

KAISER PERMANENTE®

Customer Name: **Union Pacific**
Customer ID: **35219 Northern California**

Principal Benefits for
Kaiser Permanente Traditional HMO Plan (1/1/21—12/31/21)

Accumulation Period

The Accumulation Period for this plan is 1/1/21 through 12/31/21 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$25 per visit
Most Physician Specialist Visits	$25 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$25 per visit
Most physical, occupational, and speech therapy	$25 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$150 per procedure
Allergy injections (including allergy serum)	$3 per injection visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$250 per admission

Emergency Health Coverage	You Pay
Emergency Department visits	$100 per visit

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	$50 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply
Most generic refills through our mail-order service	$20 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	$25 for up to a 30-day supply
Most brand-name refills through our mail-order service	$50 for up to a 100-day supply

(continues)

Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$250 per admission
Individual outpatient mental health evaluation and treatment	$25 per visit
Group outpatient mental health treatment	$12 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$250 per admission
Individual outpatient substance use disorder evaluation and treatment	$25 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Covered Services for diagnosis and treatment of infertility	$25 per visit
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Proposed Benefit Summary

KAISER PERMANENTE®

Customer Name: **Union Pacific**
Customer ID: **123413 Southern California**

Principal Benefits for
Kaiser Permanente Traditional HMO Plan (1/1/21—12/31/21)

Accumulation Period

The Accumulation Period for this plan is 1/1/21 through 12/31/21 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$25 per visit
Most Physician Specialist Visits	$25 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$25 per visit
Most physical, occupational, and speech therapy	$25 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$150 per procedure
Allergy injections (including allergy serum)	$3 per injection visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$250 per admission

Emergency Health Coverage	You Pay
Emergency Department visits	$100 per visit

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	$50 per trip

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Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply
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Most brand-name refills through our mail-order service	$50 for up to a 100-day supply

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Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$250 per admission
Individual outpatient mental health evaluation and treatment	$25 per visit
Group outpatient mental health treatment	$12 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$250 per admission
Individual outpatient substance use disorder evaluation and treatment	$25 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Covered Services for diagnosis and treatment of infertility	$25 per visit
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).