2026 Employee Flexible Benefits Guide

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

Please read this document carefully to become familiar with your Union Pacific benefits.

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GUIDE TO MANAGEMENT BENEFITS

This booklet contains important information about how your health and welfare benefit plans work. 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 subject to provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA) – a federal law which governs the operation of certain 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 2026 Employee Flexible Benefits Guide, beginning on page 162.

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, 2026. 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 subject to 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 separate attachments describing the UnitedHealthcare (UHC) and BlueCross/BlueShield (BCBS) Medical Care Program options, and information describing the Kaiser Health Maintenance Organizations (HMOs) in which you may be eligible to enroll, constitute the summary plan descriptions under ERISA. These documents, 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 chief 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.

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, 2026.

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 are initially eligible to 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 10 "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 Child 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 HealthEquity, you receive the Union Pacific HSA Contribution ("seed money") 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, full-time salaried, reduced salaried, or full-time hourly person employed by Union Pacific Corporation or Union Pacific Railroad Company (other than a person classified as a co-op or intern) whose terms and conditions of employment are NOT subject to collective bargaining; or
- Any other classification of employees specified by any other Union Pacific affiliate that becomes a participating employer in the Flexible Benefits Program.

Furthermore, 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 Program 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", 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 individual 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 individual is entered, regardless of whether such marriage is recognized in the jurisdiction in which the Employee is domiciled. Such individual ceases to be the Employee's Spouse on the date a decree of divorce, legal separation, or annulment between the Employee and such individual is entered by a court, regardless of whether the effective date of the decree under its terms or applicable state law is subsequent to the decree's entry date.

  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 of the same or opposite sex, one of whom is an Employee, who is:
    - 18 years of age or older;
        - unmarried;
        - the sole domestic partner of the other person and has been so for the immediately preceding 6 months;
        - sharing a primary residence with the other person and has been so sharing for the immediately preceding 6 months; and
        - not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

The domestic partnership may be established by either of the following:

- registering as each other's domestic partner, civil union partner or reciprocal beneficiary with a
- government agency where such registration is available; or
- having a mutually dependent relationship so that each has an insurable
- interest in the life of the other.

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. An individual for whom the Employee is required to enroll in coverage pursuant to a Qualified Medical Child Support Order (QMCSO); or
4. A Disabled Child.
    - 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 learning disability. 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, including a copy of the guidelines for preparing and administering QMCSOs, may be obtained by submitting a ticket to Union Pacific Employee Benefits via the instructions provided in the Benefit Contacts section on page 172.

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.

Healthcare Coverage Level Definitions:

The following definitions apply for purposes of the Medical Care Program, Dental Care Program and Vision Care Program.

- "Employee Only" coverage means coverage provided to the Employee, but not any Dependent of the Employee.
- "Employee + Spouse" coverage means coverage provided to the Employee and the Employee's Spouse, but not the Employee's Child(ren).
- "Employee + Child(ren)" coverage means coverage provided to the Employee and the Employee's Child(ren), but not the Employee's Spouse.
- "Employee + Family" coverage means coverage provided to the Employee, the Employee's Spouse and the Employee's Child(ren).
- "Employee + Dependent(s) Coverage" means any one or more of the following:
    - Employee + Spouse coverage;
    - Employee + Child(ren) coverage; or
    - Employee + Family coverage.

Definitions Related to Domestic Partner Medical, Dental and Vision 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 83, 106, and 81 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

The following healthcare coverage elections are available to an Employee married to another Employee (as such term is defined in either this 2026 Employee Flexible Benefits Guide or the Part-Time Benefits Guide):

1. You and your Employee Spouse each elect Employee Only coverage under the same or different medical, dental and/or vision program options;
2. You or your Employee Spouse elects Employee + Spouse or Employee + 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 Employee + Spouse or Employee + Family coverage;
3. You or your Employee Spouse elects Employee Only medical, dental and/or vision coverage and the other elects Employee + Child(ren) coverage under the same or different medical, dental and/or vision coverage;
4. You or your Employee Spouse elect Employee Only or Employee + Child(ren) medical, dental and/or vision coverage and the other waives such coverage; or
5. Both you and your Employee Spouse waive medical, dental and/or vision coverage.

NOTE: If you are the Dependent of another Employee, and such Employee elects coverage under the Medical, Dental Care and/or Vision Care Program(s) coverage covering you as a Dependent, then you must waive the Medical, Dental and/or Vision coverage for which you receive coverage as a Dependent.

PURCHASING FLEXIBLE BENEFITS

Who Pays for Your Benefits:
You and your Flexible Benefit Program's Employer share the cost of providing benefits for you and your Dependents.

Benefit Type	Cost by Coverage Level	
	Employee Only	**Dependent(s) Level Coverage**
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 Contributions:
Core medical, dental and vision coverage, Domestic Partner medical, dental and vision coverage and all other optional benefits, 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:

- Employee Only Medical
- Employee Only Dental
- Employee Only Vision
- Employee + Dependent(s) Coverage - Medical
- Employee + Dependent(s) Coverage - Dental
- Employee + Dependent(s) Coverage - Vision
- 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:

- All Voluntary Life and AD&D coverages (Employee, Spouse and Child(ren))
- 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

ELIGIBIITY AND ENROLLMENT

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 83, 106, and 81 respectively.

Newly Eligible during the Calendar Year – Initial Election Period and Grace Period:
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 medical, dental and/or vision coverage. If requested documentation is not received within the 45 days, elected coverage for such individual(s) will be cancelled retroactively to its effective date. Your incremental contribution for such coverage, if any, (e.g., difference between Employee Only and Employee + Family coverage) will be refunded and submitted claims for or concerning such individuals will be reprocessed and denied.

If you do not make an affirmative election (including an election to waive coverage) during your 30-day period, you will be defaulted to Core Benefits from the date you became an eligible Employee, unless you notify Employee Benefits and make your elections within the 7-day grace period described below. Core Benefits are described at the beginning of this document on page 6. After the grace period has expired, 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 30-66 and the benefit plan permits enrollment of your Dependents as a result of such Life Event.

If you are a newly eligible Employee and you fail to make a timely, affirmative election (including an election to waive coverage), your enrollment grace period is the 7-day period beginning with the 31st day following the date you become an eligible Employee. 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 the UHC HDHP2 Option or the BCBS

HDHP2 Option, depending on your home address ZIP code, at the same level of coverage 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 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 116.
- Your Dependent Care FSA contribution election must be affirmatively elected in SAP-"My Benefits" for each Calendar Year through the open enrollment process.
- If 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 2026, you must affirmatively elect to do so in SAP-"My Benefits." However, if you have an Employee HSA Contribution election in place for December 2025, your existing election continues in effect unless and until you change it. See the HSA Contribution Program section of this document beginning on page 90 for information regarding how to make your Employee HSA Contribution election.

Generally, each Dependent (i.e., Spouse and/or Child(ren)) you wish to enroll in any coverage offered under the Flexible Benefits Program first must be registered as your Dependent through the SAP-"My Benefits" portal. However, because enrollment for Life and AD&D coverage is performed through a separate website maintained by MetLife, you may enroll your "Spouse" or "Child" (as those terms are defined for purposes of the Life and Accidental Death and Dismemberment Insurance Plan), even if those individuals are not registered through the SAP-"My Benefits" portal.

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 Union Pacific Employee Benefits 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 22.
- 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. 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 an Employee + Dependent(s) Coverage level and an individual listed as your dependent is not eligible, you will continue to be charged at the rate for the enrolled coverage level even if one or more of your dependents is no longer eligible for coverage.
- Each Flexible Benefits Program plan reserves the right to require documentation with respect to any individual you elect to enroll in coverage, including (but not limited to) evidence of the "Life Event", if applicable; evidence that such individual satisfies the plans' definition of a Dependent, and such individual's social security number.

EFFECTIVE DATE OF COVERAGE

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 elections during your initial election period described on page 12 and, if applicable, timely provide any required documents needed to enroll your Dependents. 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 either enroll or waive coverage during this initial election 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 30-66.

- **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 30.

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 30.

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 your initial election period described on page 12 and, if applicable, timely provide any required documents needed to enroll your Dependents. If you are not actively at work when you become an eligible Employee, you will have 30 days (plus the grace period described on page 12) 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 your initial 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 116. 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 30. 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 January1st 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.

ENROLLMENT CHANGES

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 30-66 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 (plus grace period, described on page 12) 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 (plus grace period, described on page 12) 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 (plus grace period, described on page 12) 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 Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

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 for you; however, your Spouse may elect to continue coverage under a Medical Care Program Option. 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.

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 (plus grace period, described below) from the event date. It is the Employee's responsibility to notify Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172 and request a change within this election period 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 contacting Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172. See the "Life Events & Permissible Benefit Changes" section on pages 30-66 of this Flex Guide for more information about Life Events and when it is permissible to make a change to your benefit elections.

Enrollment Change Grace Period:
Once enrolled, if you are eligible to change one or more of your enrollment elections at a time other than an open enrollment period, your enrollment grace period is the 7-day period beginning with the 31st day following the date on which the Life Event occurred or, if the enrollment right is related to Medicaid or SCHIP coverage, beginning with the 61st day following the date on which the applicable event occurred.

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 make a timely election and provide the required supporting documentation to Union Pacific Employee Benefits as described in the "Life Events & Permissible Benefit Changes" table on page 34, 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 (i.e., Employee Only or an Employee + Dependent(s) Coverage level). 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 (i.e., Employee Only or an Employee + Dependent(s) Coverage level).

You must change your address on the UP Employees website SAP - "My Profile", or notify Union Pacific Employee Benefits of your new address within 30 days (plus the grace period described on page 12) following your move. If you fail to make a timely election, 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 coverage level currently elected (i.e., Employee Only or an Employee + Dependent(s) Coverage level) received at your previous 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 coverage level currently elected (i.e., Employee Only or an Employee + Dependent(s) Coverage level) received at your previous 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 30-66 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 election was timely 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 these 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 Dependent Children 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 Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

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 beginning on page 30 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. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid family and medical leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific. For the coverage(s) you elect to continue while on your unpaid leave, 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, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Inspira Financial (Union Pacific's payment administrator) for all other coverages. To arrange for making payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

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 beginning on page 30 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 and HSA Contributions, will continue for the duration of such leave, as long as you continue your required Employee contributions for such coverage. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid family military leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific. 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, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Inspira Financial (Union Pacific's payment administrator) for all other coverages. To arrange for making payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

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 – 30 days or fewer:
If you go on an unpaid leave due to military service for 30 consecutive days or fewer, coverage under Flexible Benefits Program, except Dependent Care FSA and HSA Contributions, will continue for the duration of the military leave as long as you continue your required Employee contributions for such coverage. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid military leave and your Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific. 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 earned in the month your leave begins or ends. For months of your unpaid leave in which such amounts cannot be taken from your pay, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Inspira Financial (Union Pacific's payment administrator) for all other coverage. To arrange for making payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

Unpaid Military Leave – More than 30 days:
Generally speaking, if you go on a leave of absence due to military service for more than 30 consecutive days and such leave does not qualify you for differential pay under the Union Pacific Military Leave Policy ("Military Leave Policy"), your benefits coverage will terminate at the end of the month in which your leave started. Your Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific. 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. In addition, 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 level long-term disability coverages on an after-tax basis. To do so, you must first provide a copy of your orders to Union Pacific Leave Management 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 Dependent Child(ren), 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.

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 by Inspira Financial (Union Pacific's administrator) 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.

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 from the date due.

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 beginning on page 30 of the Flex Guide..

Military Leave with Differential Pay:
If you go on a leave of absence due to military service and such leave qualifies you for differential pay under the Military Leave Policy, you should refer to the "Benefit Coverage for Management Employees on Military Leave" section of the Military Leave Policy for rules governing your benefit options while on such leave of absence. A copy of the Military Leave Policy may be found on the Human Resources page via the UP Employees website www.up.com.

If your military leave qualifies for differential pay, you will be permitted to continue certain coverages by paying the same monthly Employee contribution amount for the coverage as an active Employee. If your Union Pacific differential pay for a month is insufficient to cover the benefit deductions, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Inspira Financial (Union Pacific's payment administrator) for all other coverages. To arrange to make payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

Unpaid Sabbatical Leave:
If you go on an unpaid sabbatical leave under the Unpaid Sabbatical Program for Management Employees, you are allowed to continue your medical, dental, vision, voluntary life and AD&D, Buy-up level of long-term disability coverage, and domestic partner medical, dental, and/or vision coverage on an after-tax basis. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid sabbatical leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific, For the coverage(s) you elect to continue while on your unpaid leave, 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, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Inspira Financial (Union Pacific's payment administrator) for all other coverages. To arrange to make payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

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 Management 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 are allowed to continue your medical, dental, vision, voluntary life and AD&D, Buy-up level of long-term disability coverage, and domestic partner medical, dental and/or vision coverage on an after-tax basis. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid status assessment leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific, For the coverage(s) you elect to continue while on your unpaid leave, 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, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Inspira Financial (Union Pacific's payment administrator) for all other coverages. To arrange to make payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172. With respect to the above coverages that are discontinued while on unpaid status assessment leave (either at your election or automatically), 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 Management employee is off work for rule or policy violations, you are allowed to continue your medical, dental, vision, voluntary life and AD&D Buy-up level of long-term disability coverage, and domestic partner medical, dental and/or vision coverage on an after-tax basis. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid suspension leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific, For the coverage(s) you elect to continue while on your unpaid leave, 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, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Inspira Financial (Union Pacific's payment administrator) for all other coverages. To arrange to make payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

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 Management 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, except Dependent Care FSA and HSA Contributions, will continue for the duration of such leave, as long as you continue your required Employee contributions for such coverage. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid vacation leave or RULA and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific. 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. For months of your unpaid leave in which such amounts cannot be taken from your pay, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Inspira Financial (Union Pacific's payment administrator) for all other coverages. To arrange to make payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

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 133 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 26 under 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 these 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 Management 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 Dependent Children. 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 is a leave of absence which:

- Is taken 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;
- 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 Employee Benefits within 30 days from the commencement of the leave of absence.

It is the Employee's responsibility to provide notification within 30 days following 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 24.

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 83;
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 (as defined above) 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.

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 from 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 HealthEquity 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.

NOTE: 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 133.

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 Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

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 or Part B (or both)); 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 or Part B (or both));
- The parents become divorced or legally separated; or

- The child stops being eligible for coverage under the Group Health Plan as a "DependentChild."

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 or Part B (or both)), the employer must notify the Plan Administrator of the qualifying event.

When you, your Spouse or Dependent Children become entitled to Medicare Benefits (under Part A or Part B (or both)), you must notify Union Pacific Employee Benefits immediately by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172.

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 Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172. 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 Child, or any person representing any of these individuals can provide this notification. Notification by the Employee, Spouse, or Dependent Child (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 or Part B (or both)), 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: Inspira Financial Health, 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 Child, or any person representing any of these individuals can provide this notice. Notification by the Employee, Spouse, or Dependent Child (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 18months.

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: Inspira Financial Health, 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 Child, 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 or Part B (or both)), 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: Inspira Financial Health, 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 Children, or any person representing any of these individuals can provide this notice. Notification by the Employee, Spouse, or Dependent Children (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 inwriting.
- Divorce or Legal Separation – A copy of the Divorce Decree or Legal Separation document.
- Employee's Medicare Entitlement – A copy of the Employee's Medicarecard.
- 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.

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 Employee Benefits
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:

Inspira Financial Health, Inc.

Attn: Benefit Billing Dept
P.O. Box 953374
St. Louis, MO 63195-3374
(800) 359-3921

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 30-66 for more information).

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

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

Inspira Financial Health, Inc.
Attn: Benefit Billing Dept
P.O. Box 953374
St. Louis, MO 63195-3374
(800) 359-3921

If you have any questions about your current COBRA or USERRA continuation coverage, please contact Inspira Financial COBRA Services at (800) 359-3921. If you have additional benefits questions, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172. 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 Inspira Financial 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 66.

Changes in elections resulting from a Life Event described in the table below must be on account of and correspond with the Life Event. In addition, your election change must be made within 30 days of the Life Event date (plus the 7-day Enrollment Change Grace Period described on page 12.) It is the Employee's responsibility to notify Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172. and to request a change within 30 days (plus 7-day grace period) immediately following a Life Event. 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 Employee Benefits. Changes after the grace period has expired 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 a Craft Professional position to a Management position will be effective on the date of the management 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 116, 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, Union Pacific Employee Benefits is notified of the change and you have made your permissible election change within 30 days (plus the 7-day grace period) following the Life 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.) **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **Required Documentation:** Copy of marriage license must be provided to Union Pacific Employee Benefits within 45 days of the marriage. If children are brought into the marriage, copies of the birth certificates must be provided to Union Pacific Employee Benefits within 45 days of the marriage.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Enroll in coverage: • May enroll yourself or yourself and your Spouse and/or other Dependents in any medical option for which you are eligible. • May enroll in dental and/or vision coverage at any Employee + Dependent(s) Coverage level for which you are eligible. Change existing coverage level: • May change medical coverage from Employee Only coverage to an Employee + Dependent(s) Coverage level under any medical option for which you are eligible; • May change dental and/or vision coverage level from Employee Only coverage to any Employee + Dependent(s) Coverage level for which you are eligible. • May change from an Employee + Dependent(s) Coverage level 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. Drop current coverage: • May drop current medical, dental, and/or vision coverage if Employee and all currently enrolled Dependents are enrolled in the same type of coverage (i.e., medical, dental and/or vision) 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 116 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 by the election change deadline. 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

Election Change Deadline: No later than 30 days following the event date. A 7-day grace period is permitted.

Required Documentation: Copy of divorce or legal separation decree must be provided to Union Pacific Employee Benefits 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 CHILD MEDICAL, DENTAL & VISION	Enroll in coverage: • If Employee's coverage was through Spouse's plan, Employee may enroll in Employee Only coverage or enroll self and any eligible Dependents previously covered under Spouse's plan in Employee + Child(ren) coverage. Change existing coverage level: • If enrolled in Employee + Family coverage, change to Employee + Child(ren) coverage under current medical, dental and/or vison option, covering the Employee and eligible Child(ren). • If Employee is currently enrolled in Employee Only coverage and Child(ren)'s coverage was through Spouse's plan, Employee may change to Employee + Child(ren) coverage under Employee's current medical, dental and/or vision coverage. • May change from an Employee + Dependent(s) Coverage level to Employee Only coverage under Employee's current medical, dental and/or vision option if, following the event the Employee has no eligible covered Dependents. **NOTE:** If you are enrolled in a medical, dental and/or vision option at an Employee + Dependent(s) Coverage level and do not provide notification and required documentation of the divorce or separation as described above, you will continue to be charged at the rate for the Employee + Dependent(s) Coverage level in which you are enrolled prior to the event, even though one or more of your Dependents is no longer eligible for coverage.
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 116 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 by the election change deadline. See the Life and AD&D section for more details.

III. EVENT: Death of Dependent (Death of Spouse and/or Dependent Child) **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **Required Documentation:** Copy of death certificate must be provided to Union Pacific Employee Benefits within 45 days of the death.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Enroll in coverage: • If Employee's coverage was through deceased Spouse's plan, Employee may enroll in Employee Only coverage or enroll self and any eligible Dependent's previously covered under Spouse's plan in Employee + Child(ren) coverage. Change existing coverage level: • If enrolled in Employee + Family coverage and: o Spouse dies, may switch from Employee + Family coverage to Employee + Child(ren) coverage. o Child dies, may switch to Employee + Spouse coverage, if deceased Child was the Employee's only covered Child. • If enrolled in either Employee + Spouse coverage or Employee + Child(ren) coverage and following the event the Employee has no eligible covered Dependents, may switch to Employee Only coverage under the medical, dental and/or vision option in which the Employee is enrolled. **NOTE:** If you are enrolled in a medical, dental and/or vision option at an Employee + Dependent(s) Coverage level and do not provide notification and required documentation of the death as described above, you will continue to be charged at the rate for the Employee + Dependent(s) Coverage level in which you are enrolled prior to the event, even though your Dependent is no longer eligible for 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 116 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 by the election change deadline.

IV. EVENT: Change in Dependent Care Provider **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **Required Documentation:** None required	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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). **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **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 Employee Benefits within 45 days of the event date.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Enroll in coverage: • Medical coverage: o For Dependents added **other than through** birth, adoption, or placement for adoption, may elect to enroll Dependent(s) in Employee + Child(ren) or Employee + Family coverage under current medical plan option. o For Dependents added through birth, adoption, or placement for adoption, may enroll Dependent(s) in Employee + Child(ren) or Employee + Family coverage under any medical plan option in which you are eligible. • Dental and/or vision coverage o May enroll in dental and/or vision coverage at any Employee + Dependent(s) Coverage level for which you are eligible. Change existing coverage level: • May change medical coverage from Employee Only coverage to an Employee + Dependent(s) Coverage level under any medical option for which you are eligible; • May change dental and/or vision coverage level from Employee Only coverage to any Employee + Dependent(s) Coverage level for which you are eligible. • May change from an Employee + Dependent(s) Coverage level to Employee Only coverage under current medical, dental and/or vision option if all eligible Dependents enrolled in current option are enrolled in Spouse's plan. Drop current coverage: • May drop current medical, dental, and/or vision coverage if Employee and all currently enrolled Dependents are enrolled in the same type of coverage (i.e., medical, dental and/or vision) 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 116 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 is 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 by the election change deadline.
V.B. EVENT: Addition of registered Domestic Partner's dependent. (Applicable to Employees eligible for or enrolled in a California HMO medical option.) **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **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 Employee Benefits within 45 days of the event date.	
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Under the California HMO: • if individual added as a dependent of a registered Domestic Partner **other than** through birth, adoption, or placement for adoption, may enroll such registered Domestic Partner's dependent(s) in current California HMO medical option. • if individual added as a dependent of a registered Domestic Partner through birth, adoption, or placement for adoption, may enroll in any California HMO medical option in which you are eligible at any coverage level for which you are eligible. If currently enrolled in a California HMO Employee Only coverage, may change coverage level to Employee + Child(ren) coverage and enroll such registered Domestic Partner's dependent(s).
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). **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **Required Documentation:** None required	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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. 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. 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 or other dependent gains other coverage due to commencement of employment on 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 TerminatesEmployment".
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 Dependent Child, 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. **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **Required Documentation:** Letter from employer must be provided to Union Pacific Employee Benefits within 45 days of the event date.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Employee, Spouse or Dependent Child 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. **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **Required Documentation:** Letter from employer must be provided to Union Pacific Employee Benefits within 45 days of the event.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Payment stopped for Employee, Spouse or Dependent Child: May enroll self, Spouse, and Dependent Child(ren) 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 Dependent Child, 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. **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted **Required Documentation:** COBRA termination letter from employer must be provided to Union Pacific Employee Benefits within 45 days of the event.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	COBRA coverage stopped for Employee, Spouse or Dependent Child(ren): May enroll self, Spouse, and Dependent Child(ren) 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. **Election Change Deadline:** No later than 30 days following the date coverage is lost. A 7-day grace period is permitted. **Required Documentation:** Letter from employer must be provided to Union Pacific Employee Benefits within 45 days of the event.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 116 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. **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **Required Documentation:** Letter from employer must be provided to Union Pacific Employee Benefits within 45 days of the event.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 116 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. **Election Change Deadline:** No later than 30 days following the date coverage is lost. A 7-day grace period is permitted. **Required Documentation:** Letter from Child(ren)'s employer must be provided to Union Pacific Employee Benefits within 45 days of the event.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 116 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 DEPENDENT CHILD BECOMES EMPLOYED OR NEWLY ELIGIBLE FOR COVERAGE	
IX.A. EVENT: Spouse or Dependent Child gains other coverage due to commencement of employment. **Election Change Deadline:** No later than 30 days following the effective date of the new coverage. A 7-day grace period is permitted. **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 Employee Benefits (within 45 days of the effective date) before coverage will be terminated.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	May drop coverage for self, Spouse, or Dependent(s) who become covered by Spouse's or Dependent Child'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 116 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 Dependent Child becomes newly eligible for coverage through employer. **Election Change Deadline:** No later than 30 days following the effective date of the new coverage. A 7-day grace period is permitted. **Required Documentation:** Letter from Spouse's or other Dependent's employer with effective date of Spouse's or other	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	May drop coverage for self, Spouse, or Dependent Child(ren) who become covered by Spouse's or Dependent Child'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 116 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 Dependent Child has an annual open enrollment right under a benefit plan sponsored by Spouse's or other Dependent Child's employer, Spouse or Dependent Child makes an election change under such benefits plan and period of coverage for such benefits plan is not a Calendar Year.

Election Change Deadline: No later than 30 days following the effective date of the new coverage. A 7-day grace period is permitted.

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

EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	May drop corresponding coverage for self, Spouse, or Dependent Children who become covered by Spouse's or Dependent Child's medical, dental, and/or vision plan. May add corresponding coverage for self, Spouse, or Dependent Children who lose coverage under Spouse's or Dependent Child'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 116 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 by the election change deadline.

X. TRANSFER BETWEEN CRAFT PROFESSIONAL AND MANAGEMENT STATUS	
X.A. EVENT: Craft Professional to Management **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **Required Documentation:** Copy of applicable marriage license, signed Domestic Partner Affidavit and Dependent Children's birth certificates must be provided to Union Pacific Employee Benefits within 45 days of the transfer.	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	May enroll self, Spouse, and Dependent Child(ren) in any medical option in which you and the individuals you seek to enroll in coverage are eligible.
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 116 for details.
STD/LTD COVERAGE	Employee eligible for STD and Core LTD coverage after 3 months of continuous service, which includes continuous months of Craft Professional service immediately prior to transfer to Management 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 133 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 by the election change deadline. STD/LTD coverage is effective on the transfer date, provided eligibility requirements have been met.

X.B. EVENT: Management to Craft Professional **Election Change Deadline:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Management benefits terminate at the end of the month in which Employee terminates Management status.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Management benefits terminate at the end of the month in which Employee terminates Management status.
STD/LTD COVERAGE	Coverage terminates on the date of transfer.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Management benefits terminate at the end of the month in which Employee terminates Management status.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	Management benefits terminate at the end of the month in which Employee terminates Management status.
EFFECTIVE DATE	Employee 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 **Election Change Deadline:** No later than 30 days following the event date. A 7-day grace period is permitted. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 133 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 by the election change deadline. 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 **Election Change Deadline:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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). **Election Change Deadline:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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). **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 and at the same level of coverage 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 any medical, dental and/or vision option for which Employee is eligible, at any coverage level for which Employee is eligible.
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 116 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 annual contribution 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, the Employee may elect to enroll Domestic Partner in Domestic Partner Non-HDHP PPO medical coverage (or California HMO coverage, if eligible), 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. 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. A 7-day grace period is permitted.

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. **Election Change Deadline:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made on an after-tax basis to Inspira Financial. May revoke coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Core life and Core AD&D coverage continues while on leave. Voluntary life and AD&D coverages continue for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke Voluntary life and AD&D coverages.
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. May revoke LTD Buy-Up coverage.
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 you elect to continue and pay for such coverage(s). LTD Buy-Up coverage will end as of the effective date of the leave, unless you elect to continue and pay for such coverage. If the required Employee contributions are not made for a month, coverage is terminated at the end of such month.

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. **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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; at the same coverage level 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 medical, dental and/or vision option for which Employee is eligible, at any coverage level for which Employee is eligible.
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 116 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 annual contribution 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 coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, 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 and coverage terminated during the leave, Employee may elect to enroll Domestic Partner in Domestic Partner non-HDHP medical (or California HMO coverage, if eligible), 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. A 7-day grace period is permitted. 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.) **Election Change Deadline:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made on an after-tax basis to Inspira Financial. May revoke coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Core life and Core AD&D coverage continues while on leave. Voluntary life and AD&D coverages continue for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke Voluntary life and AD&D coverages. 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. May revoke LTD Buy-Up coverage.
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 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 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 you elect to continue and pay for such coverage(s). LTD Buy-Up coverage will end as of the effective date of the leave, unless you elect to continue and pay for such coverage. If the required Employee contributions are not made for a month, coverage is terminated at the end of such month.

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. **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 and at the same level of coverage 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 any medical, dental and/or vision option for which Employee is eligible, at any coverage level for which Employee is eligible.
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 annual contribution 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 coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, 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 and coverage terminated during the leave, Employee may elect to enroll Domestic Partner in Domestic Partner non-HDHP medical (or California HMO coverage, if eligible), 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. A 7-day grace period is permitted. 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 an unpaid Uniformed Services Employment and Re-employment Rights Act (USERRA) leave of more than 30 consecutive days. **Required Notification:** Must notify Union Pacific Employee Benefits 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 CHILD MEDICAL, DENTAL & VISION	May elect to 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. Otherwise, such coverages terminate at the end of the month in which the unpaid leave begins. Election paperwork is provided by Inspira Financial.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Core life and Core AD&D coverage continues while on leave. Voluntary life and AD&D coverages continue for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke Voluntary life and AD&D coverages.
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. May revoke LTD Buy-Up coverage.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage will terminate at the end of the month in which the leave begins.
DOMESTIC PARTNER MEDICAL, DENTAL, VISION	May elect to 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. 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. Unless you elect to continue your coverage(s), coverage terminates at the end of the month in which the unpaid leave begins. Election paperwork is provided by Inspira Financial.
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 you elect to continue and pay for such coverage(s). LTD Buy-Up coverage will end as of the effective date of the leave, unless you elect to continue and pay for such coverage. If you choose to continue one or more coverages and the required Employee contribution for such coverage(s) is not made for a month, coverage is terminated at the end of such month.

XII.D.2. EVENT: Employee returns from an unpaid Uniformed Services Employment and Re-employment Rights Act (USERRA) leave of more than 30 consecutive days. **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 and at the same level of coverage 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 any medical, dental and/or vision option for which Employee is eligible, at any coverage level for which Employee is eligible.
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)	If returning from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled on the same annual contribution 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 coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, 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 and coverage terminated during the leave, Employee may elect to enroll Domestic Partner in Domestic Partner non-HDHP medical (or California HMO coverage, if eligible), 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. A 7-day grace period is permitted.

XII.D.3. EVENT: Employee goes on paid Military leave. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Core life and AD&D coverage continues while on leave. Voluntary life and AD&D coverages continue for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke voluntary life and AD&D coverage.
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. May revoke LTD Buy-Up coverage.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage continues for the duration of the leave as long as pay is sufficient for required Employee contributions to be deducted or, if differential pay is insufficient, required contributions may be continued on an after-tax basis. May revoke coverage.
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 you elect to continue and pay for such coverage(s). LTD Buy-Up coverage will end as of the effective date of the leave unless you elect to continue and pay for such coverage. If the required Employee contributions are not made for a month, coverage is terminated at the end of such month.

XII.D.4. EVENT: Employee returns from paid Military leave. **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 at the same level 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 any medical, dental and/or vision option for which Employee is eligible, at any coverage for which Employee is eligible.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	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 for self, Spouse, or Dependent Child(ren) on the same terms prior to leave. If 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 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 coverage was terminated and employee is returning from leave within the same Calendar Year in which the leave commenced, will be automatically re-enrolled on the same annual contribution 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 coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, 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 and coverage terminated during the leave, Employee may elect to enroll Domestic Partner in Domestic Partner non-HDHP medical (or California HMO coverage, if eligible), 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 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. A 7-day grace period is permitted. STD/LTD coverage is effective as of the return date from the leave.

XII.D.5. EVENT: Employee goes on unpaid Military leave 30 days or fewer. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Core life and Core AD&D coverage continues while on leave. Voluntary life and AD&D coverages continue for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke voluntary life and AD&D coverages.
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. May revoke LTD Buy-Up coverage.
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	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 you elect to continue and pay for such coverage(s). LTD Buy-Up coverage will end as of the effective date of the leave unless you elect to continue and pay for such coverage. If required Employee contributions are not made for a month, coverage is terminated at the end of such month.

XII.D.6. EVENT: Employee returns from unpaid Military leave 30 days or fewer. **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 and at the same level of coverage 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 any medical, dental and/or vision option for which Employee is eligible at any coverage level for which Employee is eligible.
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 annual contribution 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 coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, 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 and coverage terminated during the leave, Employee may elect to enroll Domestic Partner in Domestic Partner non-HDHP medical (or California HMO coverage, if eligible), 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 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. A 7-day grace period is permitted.

XII.E.1. EVENT: Employee goes on unpaid sabbatical. **Required Notification:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made on an after-tax basis to Inspira Financial. May revoke coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Core life and Core AD&D coverage continues while on leave. Voluntary life and AD&D coverages continue for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke Voluntary life and AD&D coverages.
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. May revoke LTD Buy-Up coverage.
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 you elect to continue and pay for such coverage(s). LTD Buy-Up coverage will end as of the effective date of the leave unless you elect to continue and pay for such coverage. If the required Employee contributions are not made for a month, coverage is terminated at the end of such month.

XII.E.2. EVENT: Employee returns from unpaid sabbatical. **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 and at the same level of coverage as 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 any medical, dental and/or vision option for which Employee is eligible, at any coverage level for which Employee is eligible.
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 annual contribution 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 coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, 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 and coverage terminated during the leave, Employee may elect to enroll Domestic Partner in Domestic Partner non-HDHP medical (or California HMO coverage, if eligible), 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 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. A 7-day grace period is permitted. 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 CHILD MEDICAL, DENTAL & VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made on an after-tax basis to Inspira Financial. May revoke coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Core life and Core AD&D coverage continues while on leave. Voluntary life and AD&D coverages continue for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke Voluntary life and AD&D coverages.
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. May revoke LTD Buy-Up coverage.
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 you elect to continue and pay for such coverage(s). LTD Buy-Up coverage will end as of the effective date of the leave, unless you elect to continue and pay for such coverage. If the required Employee contributions are not made for a month, coverage is terminated at the end of such month.

XII.F.2. EVENT: Employee returns from unpaid status assessment leave. **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 and at the same level of coverage as prior to leave. 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 any medical, dental and/or vision option for which Employee is eligible, at any coverage level for which Employee is eligible.
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 annual contribution 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 coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, 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 and coverage terminated during the leave, Employee may elect to enroll Domestic Partner in Domestic Partner non-HDHP medical (or California HMO coverage, if eligible), 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 AD&D elections are effective the first day of the month coinciding with or next following the return date. 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. A 7-day grace period is permitted. 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 CHILD MEDICAL, DENTAL & VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made on an after-tax basis to Inspira Financial. May revoke coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Core life and Core AD&D coverage continues while on leave. Voluntary life and AD&D coverages continue for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke Voluntary life and AD&D coverages.
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. May revoke LTD Buy-Up coverage.
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 you elect to continue and pay for such coverage(s). LTD Buy-Up coverage will end as of the effective date of the leave, unless you elect to continue and pay for such coverage. If the required Employee contributions are not made for a month, coverage is terminated at the end of such month.

XII.G.2. EVENT: Employee returns from unpaid suspension leave. **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 and at the same level of coverage 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 any medical, dental and/or vision option for which Employee is eligible, at any coverage level for which Employee is eligible.
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 annual contribution 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 coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, 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 and coverage terminated during the leave, Employee may elect to enroll Domestic Partner in Domestic Partner non-HDHP medical (or California HMO coverage, if eligible), 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 AD&D elections are effective the first day of the month coinciding with or next following the return date. 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. A 7-day grace period is permitted. 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). **Election Change Deadline:** Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD MEDICAL, DENTAL & VISION	Coverage continues for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke coverage.
LIFE & ACCIDENTAL DEATH & DISMEMBERMENT	Core life and Core AD&D coverage continues while on leave. Voluntary life and AD&D coverages continue for the duration of the leave as long as required Employee contributions for such coverage are made. May revoke voluntary life and AD&D coverages.
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. May revoke LTD Buy-Up coverage.
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	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 you elect to continue and pay for such coverage(s). LTD Buy-Up coverage will end as of the effective date of the leave, unless you elect to continue and pay for such coverage. If required Employee contributions are 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). **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 and at the same level of coverage 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 any medical, dental and/or vision option for which Employee is eligible, at any coverage level for which Employee is eligible.
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 annual contribution 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 coverage terminated during the leave, and Employee returns from leave within the same Calendar Year in which the leave commenced, 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 and coverage terminated during the leave, Employee may elect to enroll Domestic Partner in Domestic Partner non-HDHP medical (or California HMO coverage, if eligible), 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 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. A 7-day grace period is permitted. STD/LTD coverage is effective as of the return date from the leave.

XII.I.1. EVENT: Employee goes on Long-Term Disability. **Election Change Deadline**: Not applicable **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 life and AD&D coverages continue for the duration of the leave as long as required Employee contributions for such coverage are made directly to MetLife. This process is referred to as the "Direct Bill" period. May revoke voluntary life and AD&D coverages.
STD/LTD COVERAGE	Not applicable.
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	Coverage terminates at the end of the month in which LTD 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.I.2. EVENT: Employee returns to work from Long-Term Disability. **Election Change Deadline:** See "Effective Date" section, below. **Required Documentation:** Not applicable	
EMPLOYEE, SPOUSE & DEPENDENT CHILD 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 any medical option for which Employee is eligible, at any coverage level for 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 annual contribution 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. 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 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. A 7-day grace period is permitted. STD/LTD coverage is effective as of the return date from the leave.

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. **Election Change Deadline:** No later than 30 days following the effective date of the new coverage. A 7-day grace period is permitted. **Required Documentation:** An "Affidavit of Domestic Partnership" must be provided to Union Pacific Employee Benefits 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. **Election Change Deadline:** No later than 30 days following the effective date of the new coverage. A 7-day grace period is permitted.	
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). **Election Change Deadline:** No later than 30 days following the effective date of the new coverage. A 7-day grace period is permitted. **Required Documentation:** Letter from Domestic Partner's employer with effective date of change to Domestic Partner's coverage must be provided to Union Pacific Employee Benefits (within 45 days of the effective date of the new	
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. **Election Change Deadline:** No later than 30 days following the date coverage is lost. A 7-day grace period is permitted. **Required Documentation:** Letter from employer must be provided to Union Pacific Employee Benefits 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. **Election Change Deadline:** No later than 30 days following the effective date of the new coverage. A 7-day grace period is permitted. **Required Documentation:** Letter from Domestic Partner's employer with effective date of change to Domestic Partner's coverage must be provided to Union Pacific Employee Benefits (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: General Information

Page

ELIGIBILITY – EMPLOYEE, SPOUSE & DEPENDENT CHILDREN

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 "Definitions" section of this 2026 Employee Flexible Benefits Guide ("Flex Guide") document. The Employee and each person the Employee elects to cover under the Medical Care Program is considered a "Covered Person" for purposes of the Medical Care Program.

MEDICAL OPTION TYPES: AN OVERVIEW

The Medical Care Program offers Employees and Dependents the following types of medical 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 medical option type is presented below.

Preferred Provider Organization (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 medical option'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.

High Deductible Health Plan (HDHP):
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).

Health Maintenance Organization (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 172, 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 premium through a before-tax payroll deduction under the Flexible Benefits Program. The premium 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. (Note, however, solely with respect to Medicare LTD Employees enrolled in the UHC Non-HDHP PPO there is no network requirement. In-network benefits always apply.)

The UHC HDHP PPO options and the UHC Non-HDHP PPO option are collectively referred to as the "UHC Medical Options." Detailed information regarding the UHC Medical Options is provided in the attached, "2026 UHC Medical Options Attachment" (the 2026 UHC Attachment"), which is incorporated into this Flex Guide by this reference.

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 Highmark BCBS) 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 Highmark BCBS) available to you.

The BCBS HDHP PPO options and the BCBS Non-HDHP PPO option are collectively referred to as the "BCBS Medical Options." Detailed information regarding the BCBS Medical Options is provided in the attached, "2026 BCBS Medical Options Attachment" (the "2026 BCBS Attachment"), which is incorporated into this Flex Guide by this reference.

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. The network available to you depends on your residential ZIP code.

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. 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 offered to eligible Employees who reside in certain geographical areas based on their residential address ZIP code.

The specific healthcare coverage and benefits provided under each UHC Medical Option are governed by the 2026 UHC Attachment. Be sure to consult this document for more detailed information. You may access the 2026 UHC Attachment on the Human Resources page via the UP Employees website (www.up.com). You may also request this document from Quantum Health at no cost to you. Among other things, the 2026 UHC Attachment provides information on the nature of coverage provided, conditions associated with the coverage, 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 or benefits denied to you. If there is a difference between this overview and the information provided in the 2026 UHC Attachment, the 2026 UHC Attachment will govern.

In order to carry out their specific responsibilities under the UHC Medical Options, Quantum Health and UMR have been granted discretionary authority to make factual findings, interpret terms of the UHC Medical Options and determine entitlement to plan benefits in accordance with the terms of these options.

BCBS Medical Options:
The BCBS Medical Options are self-insured arrangements. Union Pacific has contracted with Quantum Health and Highmark BCBS to administer the BlueCard Network and to administer claims and medical management services for medical benefits, mental healthcare benefits, and substance use disorder treatment benefits. 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 and benefits provided under each BCBS Medical Option are governed by the 2026 BCBS Attachment. Be sure to consult this document for more detailed information. You may access the 2026 BCBS Attachment on the Human Resources page via the UP Employees website (www.up.com). You may also request this document from Quantum Health at no cost to you. Among other things, the 2026 BCBS Attachment provides information on the nature of coverage provided, conditions associated with the coverage, 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 or benefits denied to you. If there is a difference between this overview and the information provided in the 2026 BCBS Attachment, the 2026 BCBS Attachment will govern.

In order to carry out their specific responsibilities under the BCBS Medical Options, Quantum Health and Highmark BCBS have been granted discretionary authority to make factual findings, interpret the terms of the BCBS Medical Options and determine entitlement to plan benefits in accordance with the terms of the BCBS Medical Options.

Kaiser Health Maintenance Organizations:

The Health Maintenance Organizations (HMOs) are provided on a fully insured basis. The Kaiser HMOs have discretionary authority to make factual findings, interpret the terms of its option and 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 Human 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 coverage, 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. Note, if you wish to enroll in an HMO, you will be required to enter into an arbitration agreement. The terms of this agreement will be provided to you as part of your HMO enrollment process. 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 this 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.

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. 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.

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 options each administers.

Note: COBRA continuation rights and obligations for the Medical Care Program are explained beginning on page 24 of this 2026 Flex Guide.

LEGAL INFORMATION

Discretionary Authority of Plan Administrator & Other Fiduciaries:

In carrying out their respective responsibilities under the Union Pacific Corporation Group Health Plan ("Plan") and

its self-insured Medical Care Program options, the Plan Administrator and other Plan Fiduciaries including UMR, Quantum Health, OptumRx, and Highmark shall have discretionary authority to make factual findings, interpret the terms of the Plan, and determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan and its self-insured Medical Care Program 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 such finding, interpretation, or determination was arbitrary and capricious.

Third Party 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, Illness, or Injury (each, as defined in the Glossary section of this Flex Guide). 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 a Sickness, 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 Sickness, 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 a Sickness, 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 Sickness, 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 a Sickness, Illness, Injury, or damages, or who is legally responsible for the Sickness, Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, 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 a Sickness, 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 Sickness, 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 Sickness, 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 Sickness, 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 a Sickness, 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 Sickness, 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 a Sickness, 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, Your Dependents, or Your Domestic Partner; 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 Sickness, 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, Dependent, or Domestic Partner will be made in accordance with any assignment of rights made by or on behalf of such Employee, Dependent, or Domestic Partner that is required under a state's Medicaid law. The Plan will not take into account an Employee's, Dependent's, or Domestic Partner'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, Dependent, or Domestic Partner 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, Dependent, or Domestic Partner to such payment for benefits.

Refund for Overpayment of Benefits:

UMR, Highmark and OptumRx, have the right to a refund of any medical, mental health/substance abuse, 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, Highmark, 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, Highmark, or OptumRx may, in addition to other rights they may have, reduce the amount of any future benefits payable under the Plan's self-insured options and under any group benefit plans they issued to your employer by the amount of the refund.

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 Vision Care, 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 THER DEPENDENT CHILDREN

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", "Dependent", "Spouse", and "Child" are defined in the "Definitions" 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.

THE EYEMED NETWORK

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 notguarantee the quality of care provided by these providers.

EyeMed's network of providers includes private practitioners, recognized national retailers (LensCrafters®, Target Optical, and most Pearle Vision locations), as well as regional retailers (America's Best, Eyeglass World, For Eyes Optical, and others). To locate EyeMed Vision Care providers near you, visit www.eyemed.com and choose the **Insight Network.**

You may also call EyeMed's Customer Care Center at 1-844-409-3401. EyeMed's Customer Care Center can be reached Monday through Friday from 6:30 am to 10:00 pm, on Saturdays from 7:00 am until 10:00 pm and on Sundays from 10:00 am to 7:00 pm Central Time.

Online Options
You can also use your in-network benefits to purchase glasses, contacts and prescription sunglasses online. Simply visit glasses.com, contactsdirect.com, lenscrafters.com, targetoptical.com or ray-ban.com to instantly apply your eyewear benefits at checkout.

PLUS Providers
You can choose to visit an in-network PLUS Provider for access to enhanced benefits to help you save even more. At PLUS Providers, you'll receive an additional $50 frame allowance (on top of your base benefits and standard discounts). PLUS Providers are located nationwide and easy to find – just look for them using our Provider Locator at www.eyemed.com.

Using In-Network Providers

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and Union Pacific as the name of your organization. Confirm the provider is an in-network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Plan.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers

If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Schedule of Benefits. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form and attach your itemized receipts. For your convenience, you may submit your claim form in one of the three (3) following options:

1) Online: FAA/EyeMed out-of-network claims can be completed online. To access the out-of-network form or to check the status of a claim, log in to Member Web and navigate to the Claims tab. Remember to upload an itemized paid receipt with your name included.

2) Mail: First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:
FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

3) Email: You may also print a claim form and email it to us at oonclaims@eyemed.com or call the EyeMed's Customer Care Center at 1-844-409-3401.

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 – Maximum 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.

SCHEDULE OF BENEFITS

	In-Network Cost at PLUS Providers	In-Network Cost	Out-of-Network Reimbursement*
Exam Services			
Exam	$0 Copay	$0 Copay	Up to $35
Retinal Imaging	$15 Copay	$15 Copay	$20
Contact Lens Fit and Follow-Up			
Fit and Follow-Up – Standard	Up to $40	Up to $40	Not Covered
Fit and Follow-Up – Premium	10% off retail price	10% off retail price	Not Covered
Frame	20% off balance over $230 allowance	20% off balance over $180 allowance	Up to $63
Standard Plastic Lenses			
Single Vision	$20 Copay	$20 Copay	Up to $25
Bifocal	$20 Copay	$20 Copay	Up to $40
Trifocal	$20 Copay	$20 Copay	Up to $55
Progressive – Standard	$75 Copay	$75 Copay	Up to $40
Progressive – Premium Tier 1	$105 Copay	$105 Copay	Up to $40
Progressive – Premium Tier 2	$115 Copay	$115 Copay	Up to $40
Progressive – Premium Tier 3	$130 Copay	$130 Copay	Up to $40
Progressive – Premium Tier 4	$195 Copay	$195 Copay	Up to $40
Lens Options			
Anti-Reflective Coating – Standard	$45 Copay	$45 Copay	Up to $5
Anti-Reflective Coating – Premium Tier 1	$57 Copay	$57 Copay	Up to $5
Anti-Reflective Coating – Premium Tier 2	$68 Copay	$68 Copay	Up to $5
Anti-Reflective Coating – Premium Tier 3	$85 Copay	$85 Copay	Up to $5
Photochromic – Plastic	$75	$75	Not Covered
Polycarbonate – Standard	$40	$40	Not Covered
Polycarbonate – Standard – Dependent Children < 19 Years	$0 Copay	$0 Copay	Up to $5
Scratch Coating – Standard Plastic	$0	$0	Up to $5
Tint – Solid or Gradient	$0	$0	Up to $5
UV Treatment	$15	$15	Not Covered
All Other Lens Options	20% off retail price	20% off retail price	Not Covered
Contact Lenses**			
Conventional	15% off balance over $180 allowance	15% off balance over $180 allowance	Up to $72
Disposable	100% of balance over $180 allowance	100% of balance over $180 allowance	Up to $72
Medically Necessary	$0 Copay; Paid in Full	$0 Copay; Paid in Full	Up to $200
Other			
Hearing Care from Amplifon Network	Discounts on hearing aids***	Discounts on hearing aids***	Not Covered***
Lasik Or PRK From U.S. Laser Network	15% off retail price or 5% off promotional price	15% off retail price or 5% off promotional price	Not Covered
Frequency (Based on Calendar Year)			
Exam	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months	Once every 12 months
Lenses Or Contact Lenses	Once every 12 months	Once every 12 months	Once every 12 months
Lasik	Once per Lifetime	Once per Lifetime	Once per Lifetime

*You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

**For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.
***Refer to the Medical Care Program for information about hearing aid benefits under that plan.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Additional Discounts

Under the Plan, you may receive benefits for eyeglasses (frame and lenses) or contact lenses as outlined on the Schedule of Benefits. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off additional complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

Medically Necessary Contact Lenses

The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding -10D or +10D in meridian powers
- **Keratoconus** mild/moderate - when keratoconus is present and the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
- **Keratoconus** advanced/ectasia – when keratoconus is present and one or more specified conditions are met
- **Vision Improvement** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

Retinal Imaging

Retinal imaging has been provided as an additional benefit to your vision care benefit. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Please consult with your Provider to determine if you are a candidate for retinal imaging.

Savings on Laser Vision Correction

EyeMed Vision Care, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers savings to you for LASIK and PRK. You are entitled to the following discounts:

$800 off LASIK at Featured Provider Lasik***Plus*** - or - at any other in-network provider you can receive 15% off standard price or 5% off any promotional price.

For additional information or to locate a network provider, visit www.eyemedlasik.com or call **1- 877-5LASER6**. Once you choose your provider, make sure to identify yourself as an EyeMed member to receive your discount and get further member instructions.

Benefit Limitations and Exclusions
Your Vision Care Program contains several limitations and exclusions. Please see your Certificate of Insurance on UP's intranet for a complete list.

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 applicable claim number or a copy of the written denial or a copy of the Explanation of Benefits (EOB), if applicable;
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 162.

Member Complaint Procedure:

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at 1-844-409-3401. to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

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 "Definitions" 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 Employee Benefits 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 "Definitions" 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 Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172, within 30 days of the date of your marriage to change the individual's status from Domestic Partner to Spouse.

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 (plus permitted grace period) following the date you become an eligible Employee. If you do not make a timely election and timely provide proof of your domestic partnership and other required information, 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 30-66 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: No changes to the Domestic Partner vision 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 beginning on page 30 of this Flex Guide for details.

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 2026 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, the Plan does allow an Employee who elects to continue Vision Care Program coverage under COBRA to 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 "Definitions" 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 Employee Benefits within 30 days (plus 7- day grace period) 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) along with yourself and your Dependent Child(ren), if any, in the California HMO at whichever Employee + Dependent(s) coverage level you are eligible, 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 Employee + Dependent(s) 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 Employee Benefits 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 "Definitions" 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 Employee Benefits 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 (plus 7-day grace period) from the date you become an eligible Employee. If you do not make a timely election and timely provide proof of your domestic partnership and other required information, 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" beginning on page 30 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: 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 beginning on page 30 of this Flex Guide for details.

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 Enrollment" related to medical program coverage on page 12 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*	$ 824.00
Employee After-Tax Monthly Contribution Amount*	$ 260.00
Additional Amount included in Income each Month	$ 564.00

**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 the 2026 UHC Attachment 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 *2026 BCBS Attachment* 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:

2026 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	$750	$1,500
Coinsurance after Deductible Plan pays You pay	85% 15%	65% 35%
Coinsurance Maximum (Annual Limit after Deductible) Individual	$2,750	$5,500
Preventive Care See the "Health Management Programs" and "Preventive Pharmacy Benefits" sections in the 2026 UHC Attachment or 2026 BCBS Attachment, as applicable.	Paid at 100%	No benefits are paid for a Non-Network Provider
Maximum Lifetime Benefit	Unlimited, except as otherwise indicated in the 2026 UHC Attachment or 2026 BCBS Attachment, as applicable.	

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

PHARMACY PROGRAM		
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 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		
	In Network	**Out of Network**
Annual Deductible and Coinsurance Maximum Individual	$3,500	$7,000

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 2026 UHC Attachment, 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 *2026 BCBS Attachment*.

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.

UMR, Highmark, 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, Highmark,

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, Highmark, 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 high deductible health plan medical option ("HDHP Medical Option" or "HDHP");
- Have established an HSA with HealthEquity, Inc. ("HealthEquity") through its account opening process for Employees ("HealthEquity 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 Medical Option, 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 HealthEquity HSA. In addition, Union Pacific will make a contribution to your HealthEquity HSA. See the "Contributions" section below for more details. HealthEquity is the sole HSA provider to which Union Pacific will forward HSA contributions.

*Note: HealthEquity is required to collect certain information prior to opening your HSA. The information collected during the enrollment process will be used by HealthEquity 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 HealthEquity 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 AND EFFECTIVE DATES

Enrollment During the Calendar Year

If you enroll in an HDHP Medical Option and are otherwise eligible, but have not previously opened an HSA with HealthEquity, 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.

Effective Date of Changes

Once you have enrolled in an 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 at the end of the month and you make your election prior to the September payroll cutoff date, 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.

NOTE: 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 HealthEquity. 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 HealthEquity in order to make pre-tax Employee HSA Contributions and receive the Union Pacific HSA Contribution.** For more information regarding HSAs, please contact HealthEquity at (877) 750-0934 or visit their website at https://my.healthequity.com.

Note: Your HealthEquity HSA is not an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

CONTRIBUTIONS

Contributions to your HealthEquity 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 HealthEquity HSA. In addition, if you are eligible to make pre-tax payroll Employee HSA Contributions, Union Pacific will contribute an amount to your HealthEquity 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 HealthEquity HSA.

If your HealthEquity 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 HealthEquity HSA before electing to resume Employee HSA Contributions. Furthermore, you must open (or re-open) your HealthEquity HSA before December 15, 2026 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 HealthEquity 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 2026, this maximum limit is $4,400 if you are enrolled in Employee Only HDHP Medical Option coverage and $8,750 if you are enrolled in an Employee + Dependent(s) Coverage 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 HealthEquity 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 2026, 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 the Calendar Year and/or during the Calendar Year you switch your level of HDHP medical Option coverage between Employee Only and an Employee + Dependent(s) Coverage level. 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 maximum amount Union Pacific will deposit in your HealthEquity HSA as a Union Pacific HSA Contribution in 2026 depends upon the HDHP Medical Option coverage level for which you enroll. If you enroll in an HDHP Medical Option, the maximum Union Pacific contribution amount will be as follows:

- Employee Only coverage – $900;
- Employee + Spouse or Employee + Child(ren) coverage – $1,800; or
- Employee + Family coverage – $2,700.

If you are hired or first become eligible to enroll in an HDHP Medical Option during the calendar year and establish a HealthEquity HSA, the annual amount deposited in your HealthEquity HSA based on your coverage level election 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 HealthEquity HSA for the calendar year. This means that if you are hired or first become eligible to enroll in an HDHP Medical Option after December 1, 2026, no Union Pacific HSA Contribution will be made to your HealthEquity HSA for 2026.

In order to receive a Union Pacific HSA Contribution for a calendar year, your HealthEquity HSA must be opened during the time you are enrolled in HDHP Medical Option coverage, but no later than December 15th. Union Pacific HSA Contributions will be deposited in your HealthEquity 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 HealthEquity HSA. In certain circumstances (e.g., you are hired late in the calendar year), your Union Pacific HSA Contribution for 2026 may not be deposited in your HealthEquity HSA until early 2027. In that case, the amount of the Union Pacific HSA Contribution attributable to 2026 will not be reported on your 2026 Form W-2, but instead will be reported on your 2027 Form W-2. If this should occur, Union Pacific will inform you of the amount you must treat as contributed to your HSA for 2026.

Refer below to the "Mid-Year Life Events" section for information regarding a mid-year change of your medical option from Employee-Only to an Employee + Dependent(s) Coverage level, or vice versa.

Employee HSA Contributions
If you are enrolled at the same level of HDHP Medical Option coverage for the entire calendar year, the maximum amount of Employee HSA Contribution you may elect for a calendar year is the difference between annual HSA maximum contribution limit applicable to your level of coverage and the maximum Union Pacific HSA Contribution amount for your level of coverage. This means that for 2026, your maximum Employee HSA Contribution cannot exceed the following amount, assuming you are enrolled at the same coverage level for the entire calendar year:

- Employee Only coverage – $3,500 ($4,400 minus $900);
- Employee + Spouse or Employee + Child(ren) coverage – $6,950 ($8,750 minus $1,800); or
- Employee + Family coverage – $6,050 ($8,750 minus $2,700).

If you are or will attain age 55 or older in 2026 these limits are increased by $1,000 for "catch-up" contributions.

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.

Mid-Year Life Event

If you experience a mid-year "Life Event", as described in the "Life Events & Permissible Benefit Changes" charts in this Flex Guide, you may be able to change your level of medical coverage from Employee Only to an Employee + Dependent(s) Coverage level, or vice versa. In such an event, you should consider your Employee HSA Contribution election, taking into consideration any HSA contributions Union Pacific or your spouse may make to an HSA.

How a Life Event May Affect the Union Pacific HSA Contribution

If, as a result of a Life Event during the calendar year, you change your level of HDHP Medical Option coverage from (i) Employee Only to any Employee + Dependent(s) Coverage level, (ii) Employee + Spouse coverage to Employee + Family coverage or (iii) Employee + Child(ren) coverage to Employee + Family coverage, then Union Pacific will make an additional deposit into your HealthEquity HSA. The amount of this additional Union Pacific HSA Contribution will be the prorated difference between the Union Pacific HSA Contribution amount applicable to your newly elected coverage level and your existing coverage level. For example, if your HDHP Medical Option coverage changes from Employee Only coverage to Employee + Family coverage on July 1st, an additional $900 will be deposited in your HealthEquity HSA. This additional amount is 6/12 of the difference between the $2,700 Union Pacific HSA Contribution for Employee + Family coverage and the $900 Union Pacific HSA Contribution for Employee Only coverage, ($2,700 - $900 =$1,800 x 6/12 = $900).

The amount of the Union Pacific HSA Contribution made to your HealthEquity 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 an Employee + Dependent(s) Coverage level to Employee Only coverage or from one Employee + Dependent(s) Coverage level to another and a lower Union Pacific HSA Contribution amount applies to your newly elected Employee + Dependent Coverage level. However, you should consult with your tax advisor to ensure that the amount contributed by Union Pacific and your own HSA Contributions does not exceed the allowable limit.

How a Life Event May Affect Your Employee HSA Contributions

If you initially enroll in Employee Only HDHP Medical Option coverage and as a result of a Life Event change your HDHP Medical Option coverage level during the Calendar Year to an Employee + Dependent(s) Coverage level, you may be able to increase your maximum Employee HSA Contribution for the Calendar Year. The amount you can contribute may depend on a number of factors, including whether you remain continuously HSA eligible until December 31 of the following Calendar Year. If you make this change during the Calendar Year, please consult with HealthEquity or your tax professional to determine your maximum Employee HSA Contribution amount.

If you initially enroll in an HDHP Medical Option at an Employee + Dependent(s) Coverage level 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 at the Employee + Dependent(s) Coverage level 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 an 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 an 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 HealthEquity member website https://my.healthequity.com; or call HealthEquity Customer Service at (877) 750-0934. HealthEquity 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 "Definitions" section of this Flex Guide (see page 7). Please refer to the glossary section below for the definition of other capitalized terms.

You should also refer to the Eligibility section of this Flex Guide for the definition of other terms applicable to this Dental Care Program section.

ELIGIBILITY (EMPLOYEE, SPOUSE, AND DEPENDENT CHILDREN)

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 "Definitions" section on page 7 of this Flex Guide for the Dental Care Program's definition of "Dependents", including "Spouse" and "Child".

Note: COBRA continuation rights and obligations for the Dental Care Program are explained in the "Continuation of Coverage under COBRA" section beginning on page 24 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.

<table>
<tr><th colspan="4">DENTAL EXPENSE BENEFITS</th></tr>
<tr><th>TYPE OF EXPENSES</th><th>DEDUCTIBLE</th><th>PLAN'S COINSURANCE</th><th>BENEFIT MAXIMUMS (AFTER DEDUCTIBLE)</th></tr>
<tr><td>A) Diagnostic and Preventive Services</td><td>None</td><td>100%</td><td rowspan="3">$2,500/person per Calendar Year for Types A, B, and C combined</td></tr>
<tr><td>B) Basic Services</td><td>$50 per person*</td><td>80%</td></tr>
<tr><td>C) Major Services</td><td>$50 per person*</td><td>50%</td></tr>
<tr><td>D) Orthodontia</td><td>None</td><td>50%</td><td>$2,500/person per lifetime</td></tr>
<tr><td>E) Temporo Mandibular Joint (TMJ) Services</td><td>$50 per person*</td><td>50%</td><td>$650/person per lifetime</td></tr>
<tr><td colspan="4">*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.</td></tr>
<tr><th colspan="4">DENTAL CARE PROGRAM BENEFITS</th></tr>
<tr><td colspan="4">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.</td></tr>
</table>

When Benefits End:
For information regarding when benefits end, see the "When Coverage Ends" section on page 22 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 Plus (PDP Plus) if available in your location. A PDP Plus 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 Plus Dentist, your coverage (i.e., Deductibles and Coinsurance) remains the same. However, the fees you are charged for services by a non-PDP Plus Dentist may be higher than the fees charged by a Dentist participating in PDP Plus.

Non-PDP Plus 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 Plus Dentists have agreed to accept the contracted fees as payment in full. However, non-PDP Plus Dentists have not agreed to these contracted fees and may charge an amount that exceeds these fees.

When you visit a PDP Plus Dentist, identify yourself as a member of MetLife's PDP Plus network **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 Plus 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 Plus 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 101) 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. $2,500 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) $2,500 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 101.
C) Major Services **(50% Plan Coinsurance)** $2,500 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. • 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**:** o Replacement of a removable denture or fixed bridgework is required because you lost one or more teeth after the bridgework or denture was installed. o An existing removable denture or fixed bridgework is at least seven years old and unusable. o 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. o 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. 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.

TYPE OF EXPENSES	INCLUDES:
D) Orthodontia (50% Plan Coinsurance) Orthodontia benefits are payable for orthodontic services dealing with teeth irregularities and their correction (often by braces). **$2,500 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 Plus fee, if PDP Plus Dentist, or 50% of Reasonable and Customary fee, if not a PDP Plus 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 ($2,500) 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.
E) Temporo Mandibular Joint (TMJ) Services (50% Plan Coinsurance) $650 maximum lifetime limit per person	• Temporo Mandibular Joint (TMJ) appliance, including installation and adjustments to appliances.

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", beginning on page 98 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 97.

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 195. 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 Plus 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.

How to Submit Dental Claims:
Claim forms to file for dental benefits under the Dental Care Program can be obtained directly from the MetLife website 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 Plus 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 190will 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 the Primary Plan. Other Plans will pay benefits next; those plans are Secondary Plans. Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than 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 in the relevant UHC or BCBS Medical Care Program Attachments.

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.

GLOSSARY

Allowable Expense, with respect to the Coordination of Dental benefits, means a necessary dental expense which:

- Must be paid by a covered person, and
- is at least partly covered by this Plan and possible another plan that provides benefits to the covered person.

If either this Plan and/or another plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred) such benefits are Allowable Expenses.

If either this Plan and/or another plan provides benefits in the form of services, this Plan will treat the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by such Plan.

The term does not include:

- expenses for services performed because of an Occupational Injury or Sickness;
- any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more plans compute their benefit payments on the basis of reasonable and customary fees;
- any amount of expenses in excess of the higher negotiated fee for a service, if two or more plans compute their benefit payments on the basis of negotiated fees; and
- any amount of benefits that thisPlan does not pay because the covered person fails to comply with this Plan's managed care or utilization review provisions, these include provisions requiring;
    - second surgical opinions;
    - pre-certification of services;
    - use of providers in a plan's network of providers; or
    - any other similar provisions.

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

Coinsurance is the portion of the covered expenses under the Dental Care Program paid by members after the Deductible is met.

Deductible is the amount of out-of-pocket expenses that a member must pay for dental services each Calendar Year before the Plan begins to pay for all or some of the dental 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.

Emergency is a serious medical condition or symptom resulting from injury or sickness 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.

Experimental, Investigational is any service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition.

Illness means a bodily disorder, disease or physical sickness. 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.

In-Network is using a provider participating in MetLife's network of PDP Plus dentists.

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

Out-of-Network is using a provider who is not participating in MetLife's Preferred Dentist Program Plus (PDP Plus) network provided by the dental program as listed to obtain dental services or supplies.

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.

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

DENTAL CARE PROGRAM - DOMESTIC PARTNER

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 "Definitions" 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.*

Other capitalized terms are defined in the Glossary section found above.

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 Employee Benefits 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 "Definitions" 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 Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172, 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 (plus 7-day grace period) following the date you become an eligible Employee. If you do not make a timely election and timely provide proof of your domestic partnership and other required information, 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 30-66 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: 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 beginning on page 30 of this Flex Guide for details.

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 2026 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 (plus 7-day grace period) 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 make a timely election and timely provide required information, 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 unless you experience a mid-year "Life Event" which permits you to enroll before open enrollment. (See Mid-Year Life Event below.)

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.

Mid-Year Life Event
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 30-66 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 dependent care 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 $7,500 of eligible expenses during the calendar year and you elected to contribute $7,500 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	$ 70,000	$ 70,000
FSA Election	$ 0	$ 7,500
Taxable Income	$ 70,000	$ 62,500
Tax (30%)*	$ 21,000	$ 18,750
Tax Savings	$ 0	$ 2,250

* *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 will 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 generally 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 30-66 of this Flex Guide.

NOTE: Changes are not allowed for Life Events reported more than 30 days (plus 7-day grace period) 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.

Before deciding how much to contribute to the Dependent Care FSA, you should carefully estimate your projected annual expenses.

> Any part of an account balance remaining at the end of the period of coverage in the 2026 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 31, 2027 to file claims for eligible expenses incurred during that period of coverage.

OVERVIEW

Contribution Minimum/Maximum:
If you are single, you may contribute up to $7,500 to the Dependent Care FSA. If you are married and file a joint return, you may contribute up to $7,500, but if your Spouse also contributes to a Dependent Care FSA through his/her employer, your combined calendar year contribution cannot exceed $7,500. If you are married and file separate returns, you may only contribute up to $3,750. 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 child and dependent care 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 child and dependent care expenses qualify for a 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 Human 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 Inspira Financial, PO Box 2495, Omaha, NE 68103, or via fax at (888) 238-3539. Claims may also be submitted to Inspira Financial via their Express Claim Service at www.inspirafiancial.com. If you have a question concerning your claim, you can contact Inspira Financial at (888) 678-8242 (TTY: 711). Your claim must include the following:

- An FSA Claim Form; and
- Appropriate proof of expenses

The FSA claim form is available on the Human 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 Inspira Financial for direct deposit or a check will be mailed to you if you do not have direct deposit through Inspira Financial. To set up direct deposit through Inspira Financial, log on to www.inspirafinancial.com click on the "Forms" link, then click on "Direct Deposit Authorization Form" and follow the instructions. If you have any questions about the Inspira Financial direct deposit process, you may call Inspira Financial at (800) 284-4885.

Any balance remaining in your account on December 31st of the 2026 calendar year cannot be carried forward to reimburse eligible expenses incurred in the 2027 calendar year and will be forfeited. However, you have until March 31, 2027 to file claims for eligible expenses incurred during the 2026 calendar year.

If your claim is denied, you will receive a written notice from Inspira Financial within 30 days of receipt of the claim as long as all needed information was provided with the claim. Inspira Financial will notify you within this 30-day period if additional information is needed to process the claim, and Inspira Financial 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 an Inspira Financial Customer Service representative at (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:

Inspira Financial Health, Inc.
P.O. Box 8396
Omaha, NE 68108-0396

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 Inspira Financial within 180 days after you receive the claim denial notice.

The first level appeal will be conducted, and you will be notified by Inspira Financial 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 Employee 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 Inspira Financial, 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

OVERVIEW

The Union Pacific Corporation Management 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 and Enrollment" section on page 12 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/her 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 30-66)
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/her 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/her 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 30-66.
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/her 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 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. 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.

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. To request a form, contact Metropolitan Life Insurance Company at (866) 659-1377. Alternatively, you may visit the Metropolitan Life website at www.metlife.com/mybenefits or call (866) 659-1377 to review, name, or change your Beneficiary. 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 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 you 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 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 make factual findings, interpret the terms of the Plan, and 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 finding, interpretation or determination was arbitrary and capricious. The decisions of Metropolitan Life are conclusive and binding.

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 you 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 you 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 you 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 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 finding, 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" or "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 7.

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, 2026. 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"), acting as agent of the Plan.

If you are an Employee Actively at Work on or after January 1, 2026, but have a "recurring Disability" as described on page 143 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 148. In addition, those claims 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, acting as agent of the STD/LTD Plan. Applicants for STD or LTD benefits who file claims in accordance with such claims and appeal procedures are required to cooperate with Union Pacific Health & Medical Services as it performs this function for the Plan in order to receive benefits. These Pre-2008 Disability benefits are self-insured by Union Pacific.

Applicants for STD or LTD benefits are required to cooperate with MetLife 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, 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.

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 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 will make a separate determination regarding whether you may return to work. When making this 'return to work' determination, Health and Medical Services is 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 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 a Craft Professional employee with at least three months continuous service and you transfer to a Management 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, 2026, your STD eligibility effective date is April 6, 2026.
- If your date of hire is January 30, 2026, your STD eligibility effective date is April 30, 2026.
- If your date of hire is January 31, 2026, your STD eligibility effective date is April 30, 2026 (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 MetLife at (888) 608-6665.

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.

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 that provides proof of your continuing Disability. If Medical Information necessary to decide your STD claim is not received by MetLife within 14 calendar days of the date your claim was initiated, your claim will be denied, unless MetLife, 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 145.

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 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.
2. If you delay contacting MetLife 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 ten- year anniversary during 2026, the STD benefit amount for which he/she is eligible increases effective January 1, 2026, 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 <10 years	9 Weeks	9 Weeks
10 years or more	13 Weeks	13 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 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 https://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, tax withholding or other deduction) if and when you actually begin receiving the pension benefits. You must promptly notify MetLife if you begin receiving pension plan benefits and furnish MetLife with your benefit amount.

RRB Sickness Benefits:
An 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 https://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, 2026, if such recurrence bridges over January 1, 2026, 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 gender dysphoria surgery/treatment or 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:
- a Craft Professional 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 143). 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 (page 143).

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	60% of Buy-up Predisability Earnings; limited to a maximum monthly benefit of $25,000

"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.

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, pension plan or

other compensation plan (e.g., matching contribution to a thrift plan or stock purchase 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;
- 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, 2026

Gross Salary as of April 18, 2026: $ 70,000 Gross Salary as of July 31, 2025: $ 67,500	April 18, 2026 Gross Salary is greater than the Gross Salary as of July 31, 2025	$ 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, pension plan or other compensation plan (e.g., matching contribution to a thrift plan or employee stock purchase 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 https://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, tax withholding or other deduction) if and when you actually begin receiving the pension benefits. You must promptly notify MetLife if you begin receiving pension plan benefits and furnish MetLife with your benefit amount.

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, 2026, 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 2025 open enrollment (occurring in 2024) and then increased your LTD coverage by electing the Buy-up level during the 2026 open enrollment (occurring in 2025). If you incur a Disability during 2025 that extends into 2026, 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 2026.

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 immediate 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:

- 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.

- 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 135 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 141 of this Flex Guide. 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 and LTD Claims:
If you are claiming STD or 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 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 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 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 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 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 MetLife 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, MetLife, or another person making the benefit determination (at MetLife'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.

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, you should contact Union Pacific Health & Medical Services by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172. 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:
If your LTD claim is that you are Disabled for any reason, 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 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 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 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 HR 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 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 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 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.

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, 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, Core employee life coverage continues while Core AD&D coverage terminates. You may continue medical, dental, vision, voluntary employee life and/or accidental death & disability ("AD&D"), voluntary spouse life and/or AD&D, and voluntary child life and/or AD&D coverage by making the required after- tax premium contributions. You may also continue Domestic Partner medical, dental and/or vision coverage for your Domestic Partner. Union Pacific Employee Benefits 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. (Note that eligibility for Medicare is a Life Event that permits the change to the Non-HDHP PPO option.) See the "Life Events & Permissible Benefits Changes" section on pages 30-66 of this Flex Guide for details.

See the 2026 UHC Attachment (if eligible for the UHC Medical Options) or the 2026 BCBS Attachment (if eligible for the BCBS Medical Options) for Non-HDHP option provisions.

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 beginning on page 30-66 of this Flex Guide 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 make a timely 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, 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 as you have in the current Calendar Year.

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 the 2026 UHC Attachment 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 2026 BCBS Attachment shall apply to your coverage.

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, Medicare-eligible LTD participants who elect coverage in a Medicare Prescription Drug Plan under Part D are no longer eligible for coverage under the Union Pacific Group Health Plan (including and not limited to medical and prescription drug benefits). In addition, medical coverage for your Spouse and Dependents also ends upon your enrollment in Medicare Part D coverage.

Finally, if you are a Medicare-eligible LTD participant and your Spouse or a covered Dependent elects coverage in a Medicare Prescription Drug Plan under Part D, coverage under the Union Pacific Group Health Plan (including and not limited to medical and prescription drug benefits) for such Spouse and/or covered Dependent will end.

In order to avoid paying additional expenses pertaining to reprocessed claims, it is essential that you provide applicable Medicare card(s) or other eligibility documentation as soon as possible following the Medicare eligibility date by submitting a ticket to Union Pacific Employee Benefits via the instructions found in the Benefit Contacts section on page 172.

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:

2026 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**
MEDICAL CARE, MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT			
Annual Deductible Employee Only Employee + Dependent(s) Coverage Per Person Annual Maximum	 $750 $750 $1,500	 $1,500 $1,500 $3,000	 $750 $750 $1,500
Coinsurance after Deductible Plan pays You pay	 85% 15%	 65% 35%	 85% 15%
Coinsurance Maximum (Annual Limit after Deductible) Employee Only Employee + Dependent(s) Coverage Per Person Annual Maximum	 $2,750 $2,750 $5,500	 $5,500 $5,500 $11,000	 $2,750 $2,750 $5,500
Preventive Care See the "Health Management Programs" and "Preventive Pharmacy Benefits" sections in the 2026 UHC Attachment or 2026 BCBS Attachment, as applicable.	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 2026 UHC Attachment or 2026 BCBS Attachment, as applicable.		

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% Note – if your Specialty Pharmacy medication is filled under the "SmartFill Program: • 15-day supply cost = ½ a 30-day supply • 90-day supply cost = 3x a 30-day supply		
Pharmacy Coinsurance Minimums/Maximums per Script Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	No Deductible N/A $30/$90 $60/$150 Note – if your Specialty Pharmacy medication is filled under the "SmartFill Program: • 15-day Min/Max = ½ the amounts above • 90-day Min/Max = 3x the amounts above		
PHARMACY PROGRAM			
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 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 Employee Only Family: 2+Persons	In-Network $3,500 $7,000	Out-of-Network $7,000 $14,000	UHC No Network $3,500 $7,000

Medicare Eligibility and Medical/Pharmacy Benefit Coverage:

If you are receiving LTD benefits and are Medicare eligible, you must furnish a copy of your Medicare card to Union Pacific Employee Benefits.

It is likely that you will become eligible for Medicare while receiving LTD benefits. When you become Medicare eligible, you must furnish a copy of your Medicare card to Union Pacific Employee Benefits immediately.

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. When your medical coverage is changed to the Non-HDHP PPO option, Medicare will become your primary coverage and your Union Pacific medical plan coverage will be secondary.

If you do not provide your Medicare card to WSS and change your coverage to the Non-HDHP PPO on a timely basis, any incorrectly processed claims will be reprocessed and premiums adjusted upon your notification to WSS.

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, **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, **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 24 of this Flex Guide.

If you, your Spouse or Dependent Children become entitled to Medicare Benefits (under Part A, Part B (or both), or Part D), you must notify Union Pacific Employee Benefits immediately by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172. If you do not notify Union Pacific in a timely manner, any incorrectly processed claims will be reprocessed.

Change of Address

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 Employee Benefits 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 option as you received at your old location at the same coverage level currently elected (i.e., Employee Only or an Employee + Dependent(s) Coverage level) 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 coverage level currently elected (i.e., Employee Only or an Employee + Dependent(s) Coverage level) 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 30-66 of this Flex Guide 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 Employee Benefits 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.

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 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 30-66 of this Flex Guide 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 30-66 of this Flex Guide 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 30-66 of this Flex Guide for details.

If a Domestic Partner vision election is in effect when LTD benefits begin, no changes to the Domestic Partner vision 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 30-66 of this Flex Guide 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.

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:

- 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:

- An active full-time salaried, reduced salaried, or full-time hourly person employed by Union Pacific Corporation or Union Pacific Railroad Company and whose terms and conditions of employment are NOT subject to collective bargaining (other than any person classified as a coop or intern) or
- Any other classification of employees specified by any other Union Pacific affiliate that becomes a participating employer in the Flexible Benefits Program.

Furthermore, 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.

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 Flex Guide constitutes the summary plan descriptions under ERISA. The information about the Union Pacific Corporation Group Health Plan described in this Flex Guide, together with 2026 UHC Attachment, 2026 BCBS Attachment and the information on 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 0320
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 Human 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 Senior Vice President & Chief HR 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:

Senior Vice President & Chief HR Officer, Union Pacific Railroad Company
1400 Douglas Street, Stop 350
Omaha, NE 68179
(402) 544-5000

The Human 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 Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 172, 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 Human 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 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 Human 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. 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:

Senior Vice President & Chief HR Officer, Union Pacific Railroad Company
1400 Douglas Street, Stop 350
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, interpret the terms of the plans, and 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 and 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: Medical Benefits					
UHC Medical Options					
Medical & Mental Health/Substance Abuse	502 Group Health Plan	UMR 115 W Wausau Ave Wausau, WI 54401 Quantum Health 5240 Blazer Parkway Dublin, OH 43017	76-414072	1/1 – 12/31	Employee & Employers
Pharmacy	502 Group Health Plan	OptumRX 11000 Optum Circle Eden Prairie, MN 55344	76-414072	1/1 – 12/31	Employee & Employers
BlueCross/BlueShield Medical Options					
Medical & Mental Health/Substance Abuse	502 Group Health Plan	Highmark BCBS Fifth Avenue Place 120 Fifth Avenue Pittsburgh, PA 15222-3099 Quantum Health 5240 Blazer Parkway Dublin, OH 43017		1/1 – 12/31	Employee & Employers
Pharmacy	502 Group Health Plan	OptumRX 11000 Optum Circle Eden Prairie, MN 55344	76-414072	1/1 – 12/31	Employee & Employers
HMO Medical Options					
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 123413 725 8457	1/1 – 12/31	Employee & Employers

Union Pacific Corporation Group Health Plan: Other Benefits					
Dental Benefits		Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166	37625	1/1 – 12/31	Employee & Employers
Vision Benefits		EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040	9891003-Active 9891011-COBRA 1029447-Domestic Partner	1/1 – 12/31	Employee & Employers
Union Pacific 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	Employee & Employers
Union Pacific Management 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	Employee & 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 Flex 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 Employee Benefits:

Union Pacific Employee Benefits
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:

- Senior Vice President & Chief HR Officer, Union Pacific Railroad Company
- Vice President HR, Union Pacific Railroad Company
- Union Pacific Employee Benefits 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 Employee Benefits
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) available Monday-Friday, 7:30 a.m. to 9:00 p.m. CST

- Care Coordinator/Customer Service…….. (855) 649-3855
- Website Quantum Health……. www.upquantumhealth.com
  - Request Medical ID cards, answer claim/billing/benefit questions, find in-network providers, manage a health condition, save money on out-of-pocket costs, understand how to get the most out of your benefits

Union Pacific Employee Benefits

To submit a ticket:

- Employees with access to the UP network can submit a ticket by navigating to the Human Resources webpage and clicking "Create a ticket for Human Resources"
  - https://home.www.uprr.com/emp/it/oss/secure/tckt/tckt_dtl.cfm?action=add&sys_id=WR
- Employees without access to the UP network can submit a ticket by navigating to UP.com and selecting Employees > Additional Resources > Create a Ticket for HR

Union Pacific Human Resources — 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 Management or Retirement Benefit Questions
- Educational Assistance
- Dependent Care Flexible Spending Account
- Pension
- Service Awards/Retirement Awards

Caregiver Support (Family First)

- Website ……..https://www.family-first.com/union-pacific
- Member Services ……877-585-7090
  - Available 8am – 8pm ET

Dental Care Benefits (Metropolitan Life)

- Website/Provider Directory..... www.metlife.com/dental
- Member Services..... (888) 777-6806 option 1
  - Locate a participating provider, questions about dental benefits or claims, Group #37625

Dependent Care Flexible Spending Account (Inspira Financial)

- Website……www.inspirafinancial.com
  - Set up direct deposit, access account balance/information, submit claims online
- Customer Service ..... (844) 729-3539
- Fax number for submitting claims..... (402) 231-4310

Diabetes, High Blood Pressure and Weight Management (Dario)

- Website..... https://about.dariohealth.com/union-pacific
- Member Services..... (833) 708-3061

Employee Assistance Program (Personal Assistance Services)

- Member Services (Available 24/7)……800-779-1212
- Website……www.paseap.com
  - Live Chat Available M-F 9am – 5pm CT

- Email……..……..……client.sercies@pas.eap.com
- Text 341-451-5727 to connect with a PAS counselor M-F 9am – 5pm CT

Fertility and Family Building; Menopause & Midlife Health (Maven)
- Website..... www.mavenclinic.com
- Email Address……..... support@mavenclinic.com

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

Health Savings Account (HSA) Contributions (HealthEquity)
- Website……..……https://my.healthequity.com/ClientLogin.aspx
  - FAQs, HSA calculator, check account balance/transaction information
- Customer Service .....(877) 750-1445

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

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); #1029447 (Domestic Partner)

Voluntary Benefits and Employee Discounts (Coresteam)
- Website…… https://unionpacific.corestream.com/
- Member Services……..……402-519-6033
- Email……..…….upsupport@corestream.com

Medical Plan Summaries

Page

2026 SCHEDULE OF BENEFITS						
HEALTHCARE						
	UHC HDHP1		**UHC HDHP2**		**UHC Non-HDHP PPO**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network****
Annual Deductible						
Employee Only	$3,400	$6,800	$4,900	$9,800	$750	$1,500
Employee + Dependent(s) Coverage						
- Per Person	$3,400	$6,800	$4,900	$9,800	$750	$1,500
- Annual Maximum	$6,800	$13,600	$9,800	$19,600	$1,500	$3,000
HSA+* Maximum Company Contributions						
Employee Only	$900		$900		N/A	
Employee + Spouse	$1,800		$1,800		N/A	
Employee + Child(ren)	$1,800		$1,800		N/A	
Employee + Family	$2,700		$2,700		N/A	
Medical Coinsurance After Deductible						
Plan Pays	85%	65%	85%	65%	85%	65%
Employee Pays	15%	35%	15%	35%	15%	35%
Coinsurance Maximum (Annual Limit after Deductible)						
Employee Only	$2,000	$4,000	$1,500	$3,000	$2,750	$5,500
Employee + Dependent(s) Coverage						
- Per Person	$2,000	$4,000	$1,500	$3,000	$2,750	$5,500
- Annual Maximum	$4,000	$8,000	$3,000	$6,000	$5,500	$11,000
Preventive Care (As outlined under "Health Management Programs" and "Preventive Pharmacy Benefits")	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 17 of the 2026 UHC Medical Options Attachment.					

+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						
	UHC HDHP1		**UHC HDHP2**		**UHC Non-HDHP PPO**	
RETAIL						
Annual Deductible	Combined Medical and Pharmacy Deductible See "Deductible"		Combined Medical and Pharmacy Deductible See "Deductible"		N/A	
Pharmacy Coinsurance	Up to 31-day Supply*					
You Pay	After the Deductible		After the Deductible		No Deductible	
Tier 1 – Generic	$10 Copay		$10 Copay		$10 Copay	
Tier 2 – Preferred	30%		30%		30%	
Tier 3 – Non-Preferred	40%		40%		40%	
Pharmacy Coinsurance Minimums/Maximums per Script**	After the Deductible		After the Deductible		No Deductible	
Tier 1 – Generic	N/A		N/A		N/A	
Tier 2 – Preferred	$30/$90		$30/$90		$30/$90	
Tier 3 – Non-Preferred	$60/$150		$60/$150		$60/$150	
MAIL ORDER						
Annual Deductible	Combined Medical and Pharmacy Deductible See "Deductible"		Combined Medical and Pharmacy Deductible See "Deductible"		N/A	
Pharmacy Coinsurance	Up to 90-day Supply					
You Pay:	After the Deductible		After the Deductible		No Deductible	
Tier 1 – Generic	$25 Copay		$25 Copay		$25 Copay	
Tier 2 – Preferred	25%		25%		25%	
Tier 3 – Non-Preferred	40%		40%		40%	
Pharmacy Coinsurance Minimums/Maximums per Script**	After the Deductible		After the Deductible		No Deductible	
Tier 1 – Generic	N/A		N/A		N/A	
Tier 2 – Preferred	$75/$225		$75/$225		$75/$225	
Tier 3 – Non-Preferred	$150/$375		$150/$375		$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	$5,400	$10,800	$6,400	$12,800	$3,500	$7,000
Employee + Dependent(s) Coverage:						
- Per Person	$5,400	$10,800	$6,400	$12,800	$3,500	$7,000
- Annual Maximum	$10,800	$21,600	$12,800	$25,600	$7,000	$14,000

2026 SCHEDULE OF BENEFITS						
HEALTHCARE						
	BCBS HDHP1		**BCBS HDHP2**		**BCBS Non-HDHP PPO**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
ANNUAL DEDUCTIBLE						
EMPLOYEE ONLY	$3,400	$6,800	$4,900	$9,800	$750	$1,500
EMPLOYEE + DEPENDENT(S) COVERAGE						
- PER PERSON	$3,400	$6,800	$4,900	$9,800	$750	$1,500
- ANNUAL MAXIMUM	$6,800	$13,600	$9,800	$19,600	$1,500	$3,000
HSA[+]* MAXIMUM COMPANY CONTRIBUTIONS						
EMPLOYEE ONLY	$900		$900		N/A	
EMPLOYEE + SPOUSE	$1,800		$1,800		N/A	
EMPLOYEE + CHILD(REN)	$1,800		$1,800		N/A	
EMPLOYEE + FAMILY	$2,700		$2,700		N/A	
MEDICAL COINSURANCE AFTER DEDUCTIBLE						
PLAN PAYS	85%	65%	85%	65%	85%	65%
EMPLOYEE PAYS	15%	35%	15%	35%	15%	35%
COINSURANCE MAXIMUM (ANNUAL LIMIT AFTER DEDUCTIBLE)						
EMPLOYEE ONLY	$2,000	$4,000	$1,500	$3,000	$2,750	$5,500
EMPLOYEE + DEPENDENT(S) COVERAGE						
- PER PERSON	$2,000	$4,000	$1,500	$3,000	$2,750	$5,500
- ANNUAL MAXIMUM	$4,000	$8,000	$3,000	$6,000	$5,500	$11,000
PREVENTIVE CARE (AS OUTLINED UNDER "HEALTH MANAGEMENT PROGRAMS" AND "PREVENTIVE PHARMACY BENEFITS")	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 20 of the 2026 BCBS Medical Options Attachment.					

[+]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						
	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	Up to 31-day Supply*					
YOU PAY	After the Deductible		After the Deductible		No Deductible	
TIER 1 – GENERIC	$10 Copay		$10 Copay		$10 Copay	
TIER 2 – PREFERRED	30%		30%		30%	
TIER 3 – NON-PREFERRED	40%		40%		40%	
PHARMACY COINSURANCE MINIMUMS/MAXIMUMS PER SCRIPT**	After the Deductible		After the Deductible		No Deductible	
TIER 1 – GENERIC	N/A		N/A		N/A	
TIER 2 – PREFERRED	$30/$90		$30/$90		$30/$90	
TIER 3 – NON-PREFERRED	$60/$150		$60/$150		$60/$150	
MAIL ORDER						
ANNUAL DEDUCTIBLE	Combined Medical and Pharmacy Deductible See "Deductible"		Combined Medical and Pharmacy Deductible See "Deductible"		N/A	
PHARMACY COINSURANCE	Up to 90-day Supply					
YOU PAY:	After the Deductible		After the Deductible		No Deductible	
TIER 1 – GENERIC	$25 Copay		$25 Copay		$25 Copay	
TIER 2 – PREFERRED	25%		25%		25%	
TIER 3 – NON-PREFERRED	40%		40%		40%	
PHARMACY COINSURANCE MINIMUMS/MAXIMUMS PER SCRIPT**	After the Deductible		After the Deductible		No Deductible	
TIER 1 – GENERIC	N/A		N/A		N/A	
TIER 2 – PREFERRED	$75/$225		$75/$225		$75/$225	
TIER 3 – NON-PREFERRED	$150/$375		$150/$375		$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	$5,400	$10,800	$6,400	$12,800	$3,500	$7,000
EMPLOYEE + DEPENDENTS(S) COVERAGE						
- PER PERSON	$5,400	$10,800	$6,400	$12,800	$3,500	$7,000
- ANNUAL MAXIMUM	$10,800	$21,600	$12,800	$25,600	$7,000	$14,000

KAISER PERMANENTE®

Union Pacific Corporation

	Colorado 00725 Proposed 01/01/2026 Plan Type: DHMO STD $750/$20 MS (Alternate)
Annual Deductible	
Individual / Family	$750 Individual / $1,500 Family (Embedded)
Maximum Out-Of-Pocket	
Individual / Family	$3,400 Individual / $6,800 Family (Embedded)
Accumulation Period	Calendar Year
Grandfathered Status	Non-Grandfathered
Hospital Inpatient	
Services rendered while hospitalized	20% Coinsurance after Plan Deductible
Maternity Inpatient	20% Coinsurance after Plan Deductible
Outpatient	
Primary Care	$20 per visit (Plan Deductible does not apply)
Urgent Care	$30 per visit (Plan Deductible does not apply)
Specialist	$30 per visit (Plan Deductible does not apply)
Well-child & Preventive Care visits	No Charge (Plan Deductible does not apply)
Routine prenatal care	20% Coinsurance after Plan Deductible
Outpatient surgery	20% Coinsurance after Plan Deductible
Therapies (PT/OT/ST)	$20 per visit after Plan Deductible limited to 30 visits per therapy per accumulation period
X-rays and Lab tests	X-ray $10 per encounter after Plan Deductible; Lab $10 per encounter after Plan Deductible
Advanced Imaging (CT / MRI / PET)	20% Coinsurance after Plan Deductible
Ambulance services	$150 per trip after Plan Deductible
Emergency department visits	20% Coinsurance after Plan Deductible
Outpatient Prescription Drugs	
Generic Drugs	$10 Copay Retail (Plan Deductible does not apply), $20 Copay Mail Order (Plan Deductible does not apply)
Brand Drugs	$30 Copay Retail (Plan Deductible does not apply), $60 Copay Mail Order (Plan Deductible does not apply)
Non-preferred Brand Drugs	$60 Copay Retail (Plan Deductible does not apply), $120 Copay Mail Order (Plan Deductible does not apply)
Specialty Drugs	20% Coinsurance up to a maximum of $250 (Plan Deductible does not apply)
Pharmacy Deductible	This Plan does not have a drug deductible
Days Supply	Retail Plan Pharmacy: up to a 30-day supply, Mail Order Plan Pharmacy: up to a 90-day supply
Mental Health Services	
Inpatient psychiatric care	20% Coinsurance after Plan Deductible
Outpatient individual therapy visits	$20 per visit (Plan Deductible does not apply)
Outpatient group therapy visits	$10 per visit (Plan Deductible does not apply)
Substance Use Services	
Inpatient detoxification	20% Coinsurance after Plan Deductible
Outpatient individual therapy visits	$20 per visit (Plan Deductible does not apply)
Outpatient group therapy visits	$10 per visit (Plan Deductible does not apply)

Infertility Services	
Covered services related to the treatment of infertility	Cost share is determined by place of service. Includes IVF, GIFT & ZIFT. Includes Infertility drugs at applicable Pharmacy Cost Shares
Additional Benefits	
Base Durable Medical Equipment	20% Coinsurance (Plan Deductible does not apply)
Skilled Nursing Facility	20% Coinsurance after Plan Deductible limited to 100 days per accumulation period
Home Health	No Charge (Plan Deductible does not apply) limited to 120 visits per accumulation period
Hospice Care	No Charge (Plan Deductible does not apply) (Unlimited Visits)
Vision Exam	$20 per visit (Plan Deductible does not apply)
Riders	
Vision Hardware	Not Included
Hearing aids	$1000 allowance / 1 device per ear / every 36 months (Plan Deductible does not apply) and Pediatric 20% Coinsurance / 1 device per ear / every 60 months after Plan Deductible
Chiropractic	$20 per visit / 20 visit limit per accumulation period (Plan Deductible does not apply)
Acupuncture	$20 per visit / 20 visit limit per accumulation period (Plan Deductible does not apply)
Bariatric surgery	20% Coinsurance after Plan Deductible
Dental	Not Included
Custom Benefits	

KAISER PERMANENTE®

Union Pacific Corporation

	Northwest 08457 Proposed 01/01/2026 Plan Type: DHMO STD $750/$20 MS (Alternate)
Annual Deductible	
Individual / Family	$750 Individual / $1,500 Family (Embedded)
Maximum Out-Of-Pocket	
Individual / Family	$3,400 Individual / $6,800 Family (Embedded)
Accumulation Period	Calendar Year
Grandfathered Status	Non-Grandfathered
Hospital Inpatient	
Services rendered while hospitalized	20% Coinsurance after Plan Deductible
Maternity Inpatient	20% Coinsurance after Plan Deductible
Outpatient	
Primary Care	$20 per visit (Plan Deductible does not apply)*
Urgent Care	$30 per visit (Plan Deductible does not apply)
Specialist	$30 per visit (Plan Deductible does not apply)
Well-child & Preventive Care visits	No Charge (Plan Deductible does not apply)
Routine prenatal care	No Charge (Plan Deductible does not apply)
Outpatient surgery	20% Coinsurance after Plan Deductible
Therapies (PT/OT/ST)	$30 per visit after Plan Deductible limited to 30 visits per therapy per accumulation period
X-rays and Lab tests	X-ray $10 per encounter after Plan Deductible; Lab $10 per encounter after Plan Deductible
Advanced Imaging (CT / MRI / PET)	20% Coinsurance after Plan Deductible
Ambulance services	$150 per trip after Plan Deductible
Emergency department visits	20% Coinsurance after Plan Deductible
Outpatient Prescription Drugs	
Generic Drugs	$10 Copay Retail (Plan Deductible does not apply), $20 Copay Mail Order (Plan Deductible does not apply)
Brand Drugs	$30 Copay Retail (Plan Deductible does not apply), $60 Copay Mail Order (Plan Deductible does not apply)
Non-preferred Brand Drugs	$60 Copay Retail (Plan Deductible does not apply), $120 Copay Mail Order (Plan Deductible does not apply)
Specialty Drugs	20% Coinsurance up to a maximum of $250 (Plan Deductible does not apply)
Pharmacy Deductible	This Plan does not have a drug deductible
Days Supply	Retail Plan Pharmacy: up to a 30-day supply, Mail Order Plan Pharmacy: up to a 90-day supply
Mental Health Services	
Inpatient psychiatric care	20% Coinsurance after Plan Deductible
Outpatient individual therapy visits	$20 per visit (Plan Deductible does not apply)*
Outpatient group therapy visits	$10 per visit (Plan Deductible does not apply)*
Substance Use Services	
Inpatient detoxification	20% Coinsurance after Plan Deductible
Outpatient individual therapy visits	$20 per visit (Plan Deductible does not apply)*
Outpatient group therapy visits	$10 per visit (Plan Deductible does not apply)*

Infertility Services	
Covered services related to the treatment of infertility	50% Coinsurance after Plan Deductible. Excludes IVF, GIFT & ZIFT. Includes Infertility drugs
Additional Benefits	
Base Durable Medical Equipment	20% Coinsurance after Plan Deductible
Skilled Nursing Facility	20% Coinsurance after Plan Deductible limited to 100 days per accumulation period
Home Health	No Charge (Plan Deductible does not apply) limited to 130 visits per accumulation period
Hospice Care	No Charge (Plan Deductible does not apply) (Unlimited Visits)
Vision Exam	$30 per visit (Plan Deductible does not apply)
Riders	
Vision Hardware	Not Included
Hearing aids	(OR) $1000 allowance / 1 device per ear / every 36 months (Plan Deductible does not apply) and Pediatric 20% Coinsurance / 1 device per ear / every 36 months (Plan Deductible does not apply) / (WA) 20% Coinsurance / 1 device per ear / every 36 months (Plan Deductible does not apply)
Chiropractic	$20 per visit / 20 visit limit per accumulation period (Plan Deductible does not apply)
Acupuncture	$20 per visit / 20 visit limit per accumulation period (Plan Deductible does not apply)
Bariatric surgery	20% Coinsurance after Plan Deductible
Dental	Not Included
Custom Benefits	
	Kaiser Foundation Health Plan of the Northwest (KFHP-NW) is licensed as a Health Care Service Contractor in Oregon and Washington. *Per Senate Bill 1529 (OR only): Primary care visit – No charge or $5 copay (not subject to Deductible) for first 3 visits per year. First 3 visits are any combination of primary care non-specialty medical Services, mental health outpatient Services, naturopathic medicine visits, Substance Use Disorder outpatient Services, or telemedicine Services.

KAISER PERMANENTE®

Union Pacific Corporation	Northern & Southern California 35219 & 123413 Proposed 01/01/2026 Plan Type: DHMO STD $750/$20 MS (Alternate)
Annual Deductible	
Individual / Family	$750 Individual / $1,500 Family (Embedded)
Maximum Out-Of-Pocket	
Individual / Family	$3,400 Individual / $6,800 Family (Embedded)
Accumulation Period	Calendar Year
Grandfathered Status	Non-Grandfathered
Hospital Inpatient	
Services rendered while hospitalized	20% Coinsurance after Plan Deductible
Maternity Inpatient	20% Coinsurance after Plan Deductible
Outpatient	
Primary Care	$20 per visit (Plan Deductible does not apply)
Urgent Care	$20 per visit (Plan Deductible does not apply)
Specialist	$30 per visit (Plan Deductible does not apply)
Well-child & Preventive Care visits	No Charge (Plan Deductible does not apply)
Routine prenatal care	No Charge (Plan Deductible does not apply)
Outpatient surgery	20% Coinsurance after Plan Deductible
Therapies (PT/OT/ST)	$20 per visit after Plan Deductible (Unlimited Visits)
X-rays and Lab tests	X-ray $10 per encounter after Plan Deductible; Lab $10 per encounter after Plan Deductible
Advanced Imaging (CT / MRI / PET)	20% Coinsurance after Plan Deductible up to a maximum of $150
Ambulance services	$150 per trip after Plan Deductible
Emergency department visits	20% Coinsurance after Plan Deductible
Outpatient Prescription Drugs	
Generic Drugs	$10 Copay Retail (Plan Deductible does not apply), $20 Copay Mail Order (Plan Deductible does not apply)
Brand Drugs	$30 Copay Retail (Plan Deductible does not apply), $60 Copay Mail Order (Plan Deductible does not apply)
Non-preferred Brand Drugs	$30 Copay Retail (Plan Deductible does not apply), $60 Copay Mail Order (Plan Deductible does not apply); when approved through the formulary exception process
Specialty Drugs	20% Coinsurance up to a maximum of $250 (Plan Deductible does not apply)
Pharmacy Deductible	This Plan does not have a drug deductible
Days Supply	Retail Plan Pharmacy: up to a 30-day supply, Mail Order Plan Pharmacy: up to a 100-day supply
Mental Health Services	
Inpatient psychiatric care	20% Coinsurance after Plan Deductible
Outpatient individual therapy visits	$20 per visit (Plan Deductible does not apply)
Outpatient group therapy visits	$10 per visit (Plan Deductible does not apply)
Substance Use Services	
Inpatient detoxification	20% Coinsurance after Plan Deductible
Outpatient individual therapy visits	$20 per visit (Plan Deductible does not apply)
Outpatient group therapy visits	$10 per visit (Plan Deductible does not apply)

Infertility Services	
Covered services related to the treatment of infertility	Cost share is determined by place of service. Includes IVF, GIFT & ZIFT. Includes Infertility drugs at applicable Pharmacy Cost Shares
Additional Benefits	
Base Durable Medical Equipment	20% Coinsurance (Plan Deductible does not apply)
Skilled Nursing Facility	20% Coinsurance after Plan Deductible limited to 100 days per benefit period
Home Health	No Charge (Plan Deductible does not apply) limited to 120 visits per accumulation period
Hospice Care	No Charge (Plan Deductible does not apply) (Unlimited Visits)
Vision Exam	No Charge (Plan Deductible does not apply)
Riders	
Vision Hardware	Not Included
Hearing aids	$1000 allowance / 1 device per ear / every 36 months (Plan Deductible does not apply)
Chiropractic	$20 per visit / 20 visit limit per accumulation period (Plan Deductible does not apply)
Acupuncture	$20 per visit / 20 visit limit per accumulation period (Plan Deductible does not apply)
Bariatric surgery	20% Coinsurance after Plan Deductible
Dental	Not Included
Custom Benefits	