



**2019  
Retiree  
Transition HRA  
Guide**

Retiree Transition HRA  
Benefits Available to  
Union Pacific Retirees and  
their Dependents effective  
January 1, 2019



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## GUIDE TO RETIREE TRANSITION HRA

This booklet, or guide, is a covered person’s Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974, as amended (ERISA) - a federal law that governs the operation of employee benefit plans. It describes a covered person’s rights and obligations under the employee welfare benefit plan established by Union Pacific Corporation, provided that the covered person is a participant of the Plan. It is important to understand some of the provisions of this law since they could affect 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. A description of ERISA provisions is found in the ERISA section of this Flex Guide. Union Pacific Corporation reserves the right to change or discontinue this Plan at any time for any reason. Similarly, a participating employer can take such actions with respect to its employees or retirees. This booklet does not create a contract of employment.

## INTRODUCTION

This Retiree Transition HRA Guide (the “Guide”) describes the healthcare benefits available to certain Union Pacific retirees and their Dependents through the Union Pacific Retiree Transition Health Reimbursement Account (“HRA”) Program (“Plan” or “Retiree T-HRA Program”) and reflects the Retiree T-HRA Program provisions effective January 1, 2019. Technically, the Retiree T-HRA Program is part of the Union Pacific Corporation Group Health Plan (“UPC Group Health Plan”), but the Retiree T-HRA Program benefits are offered only to Union Pacific retirees who satisfy the Retiree T-HRA Program’s eligibility requirements (and their Dependents). Consequently, the Retiree T-HRA Program is intended to be a ‘retiree only’ plan described in section 732(a) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) and section 9831(a) of the Internal Revenue Code of 1986, as amended (the “Code”) as a plan that, as of January 1, 2019, has less than 2 participants who are current employees.

The Plan was put into place for retirees who were Union Pacific nonagreement employees that participated in the Union Pacific Corporation Flexible Benefits Program with medical coverage under a UnitedHealthcare or BlueCross/BlueShield of Nebraska medical option that included an HRA or Transition HRA feature and retired after December 31, 2004 with a balance remaining in their HRA or Transition HRA.

As a retiree, you may have other retiree medical coverage under the Union Pacific Retiree Medical Program; however that coverage is not described in this Guide, but is instead described in the 2019 Retiree Medical Guide.

It is important to note that the benefits provided are covered by provisions of ERISA, a federal law which governs the operation of employee benefit plans. ERISA requires that you receive an easily understood description of your benefits (a “Summary Plan Description”). The information about your benefits described in this document, together with the 2019 Retiree Medical Guide, constitute the Summary Plan Description under ERISA.

This document also serves as the official plan document and will help you understand your benefits, as well as your rights under the Plan and ERISA. For more information concerning your ERISA rights, see the ERISA section of this document.

While Union Pacific Corporation (“Company”) intends to continue the Plan indefinitely, it reserves the right to terminate or amend the Plan described in this Guide for any reason. If the Company, acting through its senior human resources officer, or such officer with similar authority, terminates or amends the Plan, benefits under the Plan for retirees will cease or change. The Company may also implement, or increase, required retiree contributions at any time. Similarly, a participating employer can take such actions with respect to its retirees. Reasonable efforts will be made to provide Plan participants with notice of any such change.

Note that the terms “you” and “your” throughout this Guide refer to the retiree and all Dependents covered under the Plan, except where otherwise indicated.

## PLAN PARTICIPATION

### **Eligibility for Benefits at Retirement:**

#### **IF:**

- You participate in the Union Pacific Corporation Flexible Benefits Program with medical coverage under either the UHC HDHP1, UHC HDHP2, BCBS HDHP1, or BCBS HDHP2 option that included a Transition HRA feature immediately before you terminate employment,
- **AND** at the time such coverage under the Flexible Benefits Program ceases when you terminate employment, you (or your surviving Spouse, if your coverage terminates as a result of your death) does not elect to continue such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),
- **AND** you have a balance in your Transition HRA as of the date such coverage ceased,
- **AND** upon termination of employment you are at least age 65, or at least age 55 with 10 years of vesting service (or deemed vesting service\*, as applicable), under a qualified pension plan sponsored by Union Pacific Corporation or any of its subsidiaries participating in the Corporation’s Flexible Benefits Program,
- **AND** you have not waived Retiree HRA benefits,

**THEN** you will be enrolled in the Retiree T-HRA Program. If your termination of employment is the result of your death, your surviving Spouse will be enrolled in the Retiree T-HRA Program if your surviving Spouse was a covered Dependent under the UHC HDHP1, UHC HDHP2, BCBS HDHP1, or BCBS HDHP2 option that included

a Transition HRA feature at the time of your death and 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.

\*If you terminate employment after attaining at least age 55, but prior to attaining age 65 and were never a participant in a qualified pension plan sponsored by Union Pacific Corporation or any of its affiliates participating in the Flexible Benefits Program, years of “vesting service” will equal your years of “deemed vesting service,” which is calculated as if you were a participant in the Pension Plan for Salaried Employees of Union Pacific Corporation and Affiliates (“UPC Pension Plan”) and in accordance with the UPC Pension Plan’s vesting rules in effect on the date of your retirement.

#### **Medicare Eligible LTD Participants:**

If you are a Union Pacific employee receiving LTD benefits under the Union Pacific Corporation Short-Term & Long-Term Disability Plan who is Medicare eligible and were enrolled in the UHC HDHP1, UHC HDHP2, BCBS HDHP1, or BCBS HDHP2 option that included a Transition HRA feature immediately before your coverage changed to the UHC PPO or BCBS PPO with Medicare primary, you may participate in the Retiree T-HRA Program if you have a balance in your Transition HRA when you terminate employment and you otherwise meet the Retiree T-HRA Program eligibility requirements.

#### **Waiver of Retiree T-HRA Program Benefits:**

You may waive Retiree T-HRA Program benefits at any time. Your election to waive Retiree T-HRA Program benefits must be made in writing and furnished to Union Pacific HR Services at 1400 Douglas Street, STOP 0320, Omaha, NE 68179. Your election to waive Retiree T-HRA Program benefits is permanent. Once you elect to waive, the remaining balance of your Retiree Transition HRA is forfeited and you will not be reimbursed for any expense submitted after receipt by Union Pacific HR Services of your election to waive Retiree T-HRA Program benefits.

#### **Dependent Coverage:**

An individual who is your “Dependent” as defined in the Plan is eligible for coverage under your Retiree Transition HRA, including any individual who becomes your “Dependent” after you commence participation in the Retiree T-HRA Program.

Claims paid for Dependents who are found to be ineligible for coverage will be the responsibility of the retiree. Plan limitations will also be recalculated and may cause further expense to the retiree.

#### **Dependents:**

For purposes of the Retiree T-HRA Program, the following definitions apply:

- A “Dependent” means the retiree’s Spouse, if not legally separated from the retiree, or a Child.
- A “Spouse” is the person with whom the retiree has entered into a valid marriage in accordance with the law of the jurisdiction in which the marriage between the retiree and such person is entered into, regardless of whether such marriage is recognized in accordance with the law of the jurisdiction in which the retiree is domiciled.
- For purposes of eligibility under the Retiree T-HRA Program, a person who is the retiree’s Spouse is no longer considered a Dependent on the date a decree of divorce or legal separation between the retiree and his/her Spouse is entered by a court.

A Spouse does not include an individual with whom the retiree 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.

- A “Child” is one of the following:
  1. An individual (son, stepson, daughter, or stepdaughter) who is directly related to the retiree by blood, adoption (or placement for adoption), or marriage, or who is a foster child placed with the retiree 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.
    - b) The individual’s principal place of residence is the retiree’s home and the retiree 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 retiree is required to enroll the individual pursuant to a Qualified Medical Child Support Order (QMCSO)
4. A Disabled Child.
  - A "Disabled Child" means an unmarried Child described in paragraph 1. or 2. of the definition of Child above (without regard to the Child's age but otherwise subject to all other applicable eligibility requirements) who is not self-supporting due to physical handicap, mental handicap, or mental retardation. A Child who is not self-supporting must be mainly dependent on the retiree 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 retiree must submit proof to the Plan Administrator, when requested, that the Child meets these conditions.
  - 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" is 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 the Plan to provide any type or form of benefit or option not already provided under the Plan. The QMCSO must specify the name and address of the retiree 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. Additional information, including a copy of guidelines for preparing and administering QMCSOs, may be obtained by calling HR Services (toll free at (877) 275-8747), Monday through Friday from 9:00 AM to 5:00 PM Central Time, excluding holidays.

**Your Cost for Coverage:**

Participating employers contribute the full cost of coverage under this Plan, based on any unused balance remaining in your Transition HRA at retirement. This means that retirees do not need to make contributions toward the cost of coverage.

WHEN BENEFITS END

Except as provided under "Continuation of Coverage" below, medical benefits provided to you and/or your covered Dependents under the Retiree T-HRA Program described in this document will end as of the last day of the month in which any of the following events occur:

- You are rehired and become eligible for medical benefits as an active employee;
- Your Dependent no longer meets the definition of an eligible dependent ("Dependent");
- The Plan is terminated or amended in a manner that causes your coverage to end;
- You die without a surviving Spouse or Dependents covered by the Plan;
- Your surviving Spouse covered by the Plan dies without any surviving covered Dependents;
- Your Retiree Transition HRA balance is zero; or
- You waive Retiree T-HRA Program benefits.

Notwithstanding the provisions above, 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 1 year after the first day of the Medically Necessary Leave of Absence;
- The date on which the individual attains age 26; or
- The date such individual no longer is an eligible Dependent for a reason other than being on a Medically Necessary Leave of Absence from a post-secondary educational institution.

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

- Commences while the individual is suffering from a serious illness or injury;
- Is medically necessary;
- Results in the individual losing student status at the post-secondary educational institution the individual had been attending; and
- For which the Plan has received written certification by a treating Doctor 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 HR Services within 30 days of the commencement of the leave of absence.

It is the retiree's responsibility to provide notification within 30 days of any other event affecting the eligibility of a covered Dependent or an individual on a Medically Necessary Leave of Absence, such as attainment of age 26, the cessation of a Medically Necessary Leave of Absence, or any other reason that would cause the individual to fail to be a Dependent.

**Continuation of Coverage:**

Your covered Spouse and children who are your covered Dependents immediately prior to your death will not cease to be eligible Dependents solely by reason of your death. Assuming the Plan is not terminated or amended in a manner which causes coverage to end, your surviving covered Spouse will be permitted to continue Retiree T-HRA Program benefits after your death until the earlier of the following:

1. The date your Retiree Transition HRA balance is zero; or
2. Your surviving Spouse's death.

A Child of a deceased retiree who meets the definition of a covered Dependent will continue to be eligible as a Dependent of a surviving covered Spouse. If your surviving Spouse dies with a balance remaining in the Retiree Transition HRA, any remaining covered Dependents will be permitted to continue Retiree T-HRA Program benefits until the earlier of the following:

1. The date the Retiree Transition HRA balance is zero; or
2. 36 months after the end of the month of your surviving Spouse's death.

If, upon the death of the retiree, there is no surviving covered Spouse, any remaining covered Dependents will continue to be eligible for benefits under the Retiree T-HRA Program until the earlier of the following:

1. The date the Retiree HRA balance is zero; or
2. 36 months after the end of the month of your death.

In the event you become divorced or legally separated from your Spouse, your former Spouse may continue Retiree T-HRA Program benefits under a separate Retiree Transition HRA that will be established to pay eligible medical claims of your former Spouse. Coverage under the Spouse's Retiree Transition HRA will begin the first of the month following the month of your divorce or legal separation. The amount available for coverage in the Spouse's Retiree Transition HRA will equal the amount available in your Retiree Transition HRA at the end of the month in which the divorce decree is entered by the court or legal separation occurred. Coverage under the Spouse's Retiree Transition HRA will continue until the earlier of the following:

1. The date the Spouse's Retiree Transition HRA balance is zero, or
2. 36 months after the end of the month in which your divorce decree is entered by the court or legal separation occurred.

In the event your Dependent no longer meets the definition of a Dependent, your Dependent may continue Retiree T-HRA Program benefits under a separate Retiree Transition HRA that will be established to pay eligible medical claims of your Dependent. A separate Dependent Retiree Transition HRA will be established for each Dependent that no longer meets the definition of a Dependent. Coverage under the Dependent's Retiree Transition HRA will begin the first of the month following the month in which your Dependent no longer meets the definition of a Dependent. The amount available for coverage in the Dependent's Retiree Transition HRA will equal the amount available in your Retiree Transition HRA at the end of the month in which your Dependent no longer meets the definition of a Dependent. Coverage under the Dependent's Retiree Transition HRA will continue until the earlier of the following:

1. The date the Dependent's Retiree Transition HRA balance is zero, or
2. 36 months after the end of the month in which your Dependent no longer meets the definition of a Dependent.

When any one of the above events occurs, you, your Spouse, or Dependent (or any representative of these individuals) must notify the Plan Administrator. This notice must be provided within 60 days following the end of the month in which the event occurred. Failure to provide such notice will result in your Spouse or Dependent not having a separate Retiree Transition HRA. This notice must be provided by calling Union Pacific HR Services at (877) 275-8747. When providing this notice, you must provide your name, Employee ID or Social Security number, a description of the event, and the date the event occurred.

## IF YOU HAVE QUESTIONS

Questions concerning the Plan should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, visit the EBSA website at [www.dol.gov/ebsa](http://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.)

## 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 Plan, you may contact Union Pacific HR Services, 1400 Douglas Street, STOP 0320, Omaha, NE, 68179-0320, or at (877) 275-8747.

## RETIREE TRANSITION HEALTH REIMBURSEMENT ACCOUNTS

Eligible retirees and Dependents may participate in a Retiree Transition Health Reimbursement Account (Retiree Transition HRA).

A Retiree Transition HRA is an account that you may use to pay dental, vision and certain other medical expenses incurred after retirement that are otherwise not reimbursed or reimbursable from any other source. If you do not use all of your Retiree Transition HRA balance during the Calendar Year, any balance remaining is carried over and can be used to pay eligible expenses in a later Calendar Year unless you have waived Retiree T-HRA Program benefits. The Retiree Transition HRA gives you considerable ability to manage your out-of-pocket dental, vision, and medical expenses.

**Note: PayFlex Systems USA ("PayFlex") is the administrator for the Retiree T-HRA Program.**

### **Retiree Transition HRA Components:**

The Retiree Transition HRA is self-insured by Union Pacific. This means that Union Pacific, not an insurance company, pays for covered services that are incurred. Union Pacific has contracted with PayFlex to administer Retiree Transition HRAs. In this capacity, PayFlex has been granted discretionary authority to interpret the terms of the Retiree T-HRA Program and to determine entitlement to benefits in accordance with the terms of the Plan.

Unless you have waived Retiree T-HRA Program benefits, a Retiree Transition HRA will be automatically set up for you if you are eligible to participate in the Union Pacific Retiree T-HRA Program. The initial balance in your Retiree Transition HRA will be the balance in your Transition HRA as of the last day of your coverage under the UHC HDHP1, UHC HDHP2, BCBS HDHP1, or BCBS HDHP2 option that included a Transition HRA feature, except that if you were receiving LTD benefits and enrolled in the UHC PPO or BCBS PPO with Medicare primary, the initial balance in your Retiree Transition HRA will be the balance in your Transition HRA as of the last day of your coverage under the UHC PPO or BCBS PPO.

### **Here's How a Retiree Transition HRA Works:**

Except as provided below, your Retiree Transition HRA can be used to pay the following expenses:

- Any out-of-pocket dental or vision expense that is considered "medical care" under Code section 213(d) incurred by you or your Dependents after your retirement and during 2019 and not reimbursed from any other source; and
- If you are enrolled in the UHC HDHP PPO or BCBS HDHP PPO under the Union Pacific Retiree Medical Program, any out-of-pocket expense for "medical care" under Code section 213(d), excluding amounts paid for long term care services, which is incurred after your retirement and after you have met your 2019 HDHP Deductible and that is not reimbursed from any other source, and
- COBRA premiums incurred after your retirement and during 2019 that are not reimbursed from any other source.



An expense incurred for a medicine or drug (except insulin) cannot be reimbursed by your Retiree Transition HRA unless you have a prescription for such medicine or drug. This requirement applies regardless of whether the medicine or drug is available without a prescription. This means that expenses for over-the-counter medicines or drugs cannot be reimbursed without a prescription, even though the over-the-counter medicine or drug is available without a prescription.

**Note that after-tax medical insurance premiums are considered medical care for purposes of Code section 213(d).**

**Retiree Becoming Medicare Eligible in 2019:**

If you are a Retiree enrolled in the UHC HDHP PPO Program or BCBS HDHP PPO Program in 2019 and you become Medicare eligible in 2019, but did not meet your 2019 HDHP Deductible before becoming Medicare eligible, your Retiree Transition HRA can only be used to pay for dental and vision care expenses. (See the first bullet under “Here’s How a Retiree Transition HRA Works”.)

**Claims and Carryover Provisions:**

A claim for Retiree T-HRA Program benefits must be submitted no later than March 31 of the Calendar Year following the Calendar Year in which the eligible expense is incurred. An eligible expense is incurred when the services are provided and not when you are formally billed, charged or pay for the services. (See “How to File a Claim” below.) Amounts in your Retiree Transition HRA that are not used to pay for eligible expenses incurred in the Calendar Year are carried over and can be used to pay for eligible expenses incurred in the following Calendar Year. Any balance remaining at your death after claims run-out is forfeited, unless you have a Spouse or other Dependent(s) covered by the Retiree Transition HRA. (See “Continuation of Coverage”.)

**Claims:**

You must submit a claim form in order to obtain benefits from your Retiree Transition HRA. Please see “How to File a Claim” below.

If your claim for benefits is denied, you will receive written notice regarding the reason. The notice will point out what (if any) additional information is needed to possibly change the claim denial. The notice also will explain how to have the decision reviewed.

**Filing a Claim for Benefits:** This section provides information about how and when to file a claim. Please note that claim and appeal decisions are based only on whether or not benefits are available under the Plan for the expense. The determination as to whether the pending health service is necessary or appropriate is between you and your Doctor. To receive a reimbursement from your Retiree Transition HRA, you must file a claim form, along with appropriate proof of expenses, and if the expense is for a medicine or drug (other than insulin), a prescription for such medicine or drug. Retiree Transition HRA claims forms are available by calling PayFlex at (844) 729-3539.

Examples of appropriate proof of expenses include:

- An itemized statement showing dental or vision services rendered, dates of such services, and the cost of such services;
- An Explanation of Benefits from any dental or vision plan that is providing coverage for a portion of such expenses you or your Dependent incurred; or
- An Explanation of Benefits from the UHC HDHP PPO or BCBS HDHP PPO in which are you are enrolled for the medical expenses you or your Dependent incurred, and that documents that the expense was incurred after the HDHP Deductible has been satisfied.

In addition, if you are requesting reimbursement of an expense incurred by a Dependent, you must provide proof that such Dependent is enrolled as a Dependent under the Plan during the period in which the Dependent is enrolled as a Dependent under the Plan.

Claims for reimbursement from the Retiree Transition HRA may be filed as eligible expenses are incurred. Reimbursement of eligible expenses will be paid only after the services are rendered, but you may request reimbursement of eligible expenses up to the remaining balance in your Retiree Transition HRA at any time during the Calendar Year and until March 31st of the Calendar Year following the Calendar Year in which the eligible expense is incurred. After a claim is filed, PayFlex will make a benefit determination as set forth in the “Benefit Determinations” section below.

When you file a claim for reimbursement of an expense incurred by a Dependent, you are affirming that the individual incurring the expense meets the definition of “Dependent” under the Plan. The completed claim form, along with your documentation of the eligible expense, must be submitted to:

PayFlex Systems USA, Inc.  
PO Box 981158  
El Paso, TX 79998  
Fax: (855) 703-5305

If your claim is approved, PayFlex will process a payment from your Retiree Transition HRA in an amount equal to the lesser of the following amounts:

- The amount of the eligible expenses approved for reimbursement; or
- The remaining balance in your Retiree Transition HRA.

PayFlex will send this payment to you.

If you have a question concerning your claim, you can contact PayFlex at (844) 729-3539.

**Note: A claim for Retiree T-HRA Program benefits must be submitted no later than March 31st of the Calendar Year following the Calendar Year in which the eligible expense is incurred. An eligible expense is incurred when the services are provided and not when you are formally billed, charged, or pay for the services.**

#### **Benefit Determinations:**

If your claim is denied, you will receive a written notice from PayFlex within a reasonable period of time, but not later than 30 days of receipt of the claim as long as all needed information was provided with the claim. PayFlex will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension for not longer than 15 days, pending your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, PayFlex will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

**If Your Claim is Denied:** If your claim is denied, PayFlex will send you a written notice of denial. The notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your 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 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.

#### **Questions and Appeals:**

This section provides information to help you with the following:

- You have a question or concern about your Retiree T-HRA Program benefits.
- You are notified that a claim has been denied and you wish to appeal such determination.

To resolve a question or appeal, follow these steps:

**What To Do First:** You may informally contact PayFlex Customer Service at (800) 284-4885 before requesting a formal appeal. If the PayFlex Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in “How to File a Claim”, you may appeal it as described below without first informally contacting PayFlex Customer Service. If you first informally contact PayFlex Customer Service and later wish to request a formal appeal in writing, you must contact PayFlex Customer Service to request an appeal.

**How to Appeal a Claim Decision:** If you disagree with a claim determination after following the above steps, you can contact PayFlex in writing to formally request an appeal. All appeal requests must be sent to:

PayFlex Systems USA, Inc.  
PO Box 981158  
El Paso, TX 79998  
Fax: (855) 703-5305

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 to PayFlex within 180 days after you receive the claim denial.

**First Level Appeals:** Any review on your first level appeal will not give deference to the previous claim denial. A qualified individual who was neither involved in the decision being appealed nor a subordinate of the individual who decided the initial claim will be appointed to decide the appeal. The review will take into account all documents and other information you submit relating to your appeal, regardless of whether such documents or information was submitted or considered in the previous claim decision. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

The first level appeal will be conducted and you will be notified by PayFlex in writing of its decision within a reasonable period of time, but not later than 30 days from receipt of a request for appeal of a denied claim. If your first level appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. 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, including the information you need to include if you want to make a second level appeal.

**Second Level Appeals:** If your first level appeal is denied, 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 your receipt of the first level appeal decision and must specify each and every reason why you believe your claim should be approved. Your second level appeal request must be sent to:

Union Pacific HR Benefits  
Attn: Retiree Transition HRA Appeals  
1400 Douglas Street, Stop 0320  
Omaha, NE 68179-0320

You may include with your second level appeal information that was not submitted as part of your original claim or first level appeal. Any review on your second level appeal will not give deference to the previous claim denials. The Plan Administrator (or delegate) will review your second level appeal request and take into account all documents and other information you submit relating to your appeal, regardless of whether such documents or information was submitted or considered in the previous claim and appeal decisions. 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 for benefits.

The Plan Administrator (or delegate) will notify you in writing of its decision regarding your second level appeal within a reasonable period of time, but not later than 30 days from receipt of your request for review of the first 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 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. In addition, you have the right to bring a civil action under Section 502(a) of ERISA if your second level appeal is denied.

#### DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND OTHER FIDUCIARIES

In carrying out their respective responsibilities under the Plan, the Plan Administrator (or delegate) and other plan fiduciaries including PayFlex, shall have discretionary authority to determine facts, make factual findings and interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan.

Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

## THIRD PARTY LIABILITY/SUBROGATION

### **Third Party Liability:**

The Plan does not cover any expenses for which a third party is responsible as a result of having caused or contributed to a sickness or injury. The Plan may nonetheless pay the benefits that would otherwise be payable hereunder and then recover its payments from out of the funds the covered person receives through any award from or settlement with the third party, the third party's insurer or any other source (e.g., uninsured/underinsured motorist coverage). By filing a claim for benefits under the Plan, the covered person (or that person's legal representative) is agreeing to promptly pay back to the Plan out of any such funds recovered from the third party, the third party's insurer or any other source (for example, funds recovered in a lawsuit, a settlement, an arbitration or a payment from the third party's insurance company, or uninsured/underinsured motorist coverage) the claims paid by the Plan.

### **Subrogation:**

To the extent that a covered person is entitled to receive any recovery from a third party who caused or contributed to a sickness or injury by intentional act or negligence, the third party's insurer or any other source (for example, funds recovered in a lawsuit, a settlement, an arbitration or a payment from the third party's insurance company, or uninsured/underinsured motorist coverage), the Plan has a right to funds obtained as a result of that recovery to the extent of the claims it has paid. This right comes first (prior to any claim by any other party against the recovery) even if the covered person has not been compensated for all of his/her injuries and even if the recovery is described as being for other than medical expenses (for example, pain and suffering or emotional distress). This right is not dependent upon the third party admitting responsibility, and is not dependent upon the execution of an agreement by the covered person (or that person's legal representative) to the right of recovery. The Plan shall automatically have a lien against the proceeds of any such recovery to the extent of the claims it has paid.

"Subrogation" refers to the Plan's right to seek payment and/or reimbursement from a person or organization responsible, or potentially responsible, for the Plan's payment of health care expenses you incurred in connection with a sickness or injury. The Plan also has the right to seek payment and/or reimbursement from you if you receive a payment, settlement, judgment or award from a person, organization or insurance company in connection with a sickness or injury caused or alleged to be caused by the person or organization. The Plan has this right regardless of whether:

- liability is admitted by any potentially responsible person or organization;
- the payment, settlement, judgment or award you received identifies medical benefits provided by the Plan; or
- the payment, settlement, judgment or award is otherwise designated as "pain and suffering" or "non-economic damages" only.

The Plan shall have a first priority lien on the proceeds of any payment, settlement or award you receive in connection with a sickness or injury caused by a person or organization. The lien shall be in the amount of benefits paid on your behalf regardless of whether you are made-whole for your loss or because you have incurred attorney fees or costs. The Plan will provide eligible benefits when needed, but you may be asked to show, execute and/or deliver documents, or take other necessary actions to support the Plan in any subrogation efforts. Neither you nor any of your Dependents shall do anything to prejudice the right given to the Plan by this Subrogation section without the Plan's consent. Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your Dependents, or when enforcing this provision is prohibited by an applicable state or federal law.

By filing a claim under the Plan, you are accepting the terms of this subrogation provision. You must immediately give written notice to PayFlex 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.

If a covered person does not seek recovery from a third party, the Plan may proceed in the name of the covered person against the third party.

## MEDICAID

Benefits paid on behalf of a covered retiree or Dependent will be made in accordance with any assignment of rights made by or on behalf of such retiree or Dependent that is required under a State's Medicaid law. The Plan will not take into account a retiree'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 a retiree 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 retiree or Dependent to such payment for benefits.

#### REFUND FOR OVERPAYMENT OF BENEFITS

PayFlex has the right to a refund of any benefits it pays to you if you or your Dependents did not pay for those expenses or if you or your Dependents were reimbursed for any of those expenses by a source other than PayFlex. 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 Plan. 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, PayFlex may, in addition to other rights it may have, reduce the amount of any future benefits payable under the Plan and under any group benefits plan it issued to your employer by the amount of the refund.

#### EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974

##### **Introduction:**

The Plan is covered by provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA), a federal law which governs the operation of employee benefit plans. It is important to understand some of the provisions of this law since they could affect you. This document helps you use your benefits and understand your rights under the Plan and ERISA.

##### **Summary Plan Description:**

ERISA requires that you receive easily understood descriptions of your benefits, called summary plan descriptions. The information about your benefits described in this document constitutes the Summary Plan Description under ERISA.

##### **Plan Sponsorship:**

The Plan's coverage is sponsored by:  
Union Pacific Corporation  
1400 Douglas Street  
Omaha, NE 68179

The plan is extended to eligible retirees of participating Union Pacific subsidiaries. A complete list of these subsidiaries, including their addresses, and employer identification numbers, is available in the Union Pacific Human Resources Department in Omaha, Nebraska, and may be obtained upon written request.

##### **Plan Administrator:**

The official Plan Administrator of the Plan is the Executive Vice President & Chief Human Resources Officer, Union Pacific Railroad Company. The Plan Administrator administers the Plan and makes decisions about how plan provisions apply in specific cases. To contact the Plan Administrator, forward your correspondence to:

Executive Vice President & Chief Human  
Resources Officer,  
Union Pacific Railroad Company  
1400 Douglas Street, Stop 0320  
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 HR Services with any questions at (877) 275-8747.

##### **Your ERISA Rights:**

As a participant in the Plan, you have certain rights and protection under ERISA. For example:

- You may examine free of charge all official documents related to the Plan. These include a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. You can examine copies of these documents in the Human Resources Department in Omaha or at your Company Headquarters if copies are kept there.

- Copies of the documents governing the operation of the Plan, including the latest annual report, and an updated summary plan description, can be acquired by writing to the Plan Administrator. You may have to pay a reasonable photocopying charge.
- You will automatically receive a yearly summary of the Plan's financial report.
- The Plan 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).
- 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
  - Physical complications in all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Doctor and the patient. Such coverage is subject to other provisions that are applicable to the Plan benefits.
  - You may continue healthcare coverage for you and your Dependents if there is a loss of group health coverage as a result of a qualifying event. See the "Continuation of Coverage".

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or anyone else, may discharge or discriminate against you in a way that would prevent you from obtaining benefits under the Plan or exercising rights under ERISA.

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, you can take steps to enforce your rights. For example, if you do not receive Plan materials within 30 days of a request, you may file suit in federal court. The court may require the Plan Administrator to provide the materials and pay you as much as \$110 per day until you receive them, 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.

You may file suit in a state or federal court if your claim for benefits is totally or partially denied or ignored. In addition, if you disagree with the 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 the "Questions and Appeals" section.

If there are Plan assets and should fiduciaries misuse the Plan's money, or you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person sued to pay costs and fees. If you lose (for example, if the court finds your claim frivolous), the court may order you to pay costs and fees.

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

**Claiming Your Benefits:**

You must file a claim if you are eligible for a benefit from the Plan. There is a time limit for sending claim forms so be sure of the Plan's deadlines. You could lose benefits if you delay filing. You should refer to the "Claims" section regarding the filing of claims.

**How You Can Appeal:**

If your claim is denied, you have the right to appeal that decision. You also can submit in writing reasons why you think your claim should not be denied. Please refer to the "Questions and Appeals" 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 beneficiary chooses to take legal action against the Plan over terms of the Plan, legal process should be served on:

Executive Vice President & Chief Human  
Resources Officer,  
Union Pacific Railroad Company  
1400 Douglas Street, Stop 0320  
Omaha, NE 68179  
(402) 544-5000

**Future of the Plan:**

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

**Discretionary Authority of Plan Administrator and Other Plan Fiduciaries:**

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to ascertain facts, to interpret the terms of the Plan, and to determine entitlements to benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Plan Administrator may designate other persons to carry out such of his responsibilities under the Plan for the operation and administration of the Plan as he deems advisable and delegate to the persons designated such of his powers as he 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 Plan by the persons so designated by the Plan Administrator shall have the same force and effect for all purposes as if such action or determination had been made or taken by the Plan Administrator.

**Important Plan Information:**

The following chart lists the employer identification, policy and plan number for the Plan. It also lists plan years, the 12-month period for which Union Pacific maintains financial records for the Plan.

Technically, the Plan is known as a welfare benefit plan.

The Employer Identification Number (EIN) assigned by the IRS to Union Pacific Corporation as the Plan Sponsor is 13-2626465.

PLAN NAME	PLAN NO. & TYPE	INSURANCE CARRIER, ADMINISTRATOR OR TRUSTEE	CONTRACT OR POLICY NO.	PLAN YEAR	CONTRIBUTION SOURCES
Union Pacific Corporation Group Health Plan	502 Group Health Plan			1/1 - 12/31	Employers
Retiree Transition Health Reimbursement Account Program					
Retiree Transition HRA Medical Benefits		PayFlex Systems USA, Inc. 10802 Farnam Drive Omaha, NE 68154	102922		

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996**

The Health Insurance Portability & Accountability Act (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 Union Pacific Corporation Group Health Plan (for purposes of this HIPAA section, the "Group Health Plan"), including the Union Pacific Retiree Transition Health Reimbursement Account Program, which is part of the Group Health Plan and described in this Retiree Transition HRA 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 section.

**Entities Responsible for HIPAA Compliance:**

For Retiree T-HRA Program benefits provided to retirees, the Group Health Plan is responsible for complying with HIPAA's privacy rules with respect to the Protected Health Information the Group Health Plan creates, maintains, or receives.

**Availability of Notice of Privacy Practices:**

The Group Health Plan has adopted a Notice of Privacy Practices ("Notice") which is available upon request to Group Health Plan participants. To request a copy of this Notice, contact Union Pacific HR Services:

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

The remainder of this Health Insurance Portability and Accountability Act of 1996 section applies only to the Retiree T-HRA Program benefits under the Group Health 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 and Summary Health Information, and 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:

- Executive Vice President & Chief Human Resources Officer, Union Pacific Railroad Company
- Assistant Vice President HR Operations, Union Pacific Railroad Company
- Union Pacific Human Resources Services
- Union Pacific Human Resources Benefits Group
- Union Pacific Human Resources Compensation Group
- Union Pacific Human Resources Information Systems Group
- Union Pacific Payroll Group
- Union Pacific Audit Group

These employees shall only have access to and use Protected Health Information to the extent necessary to perform the Plan administrative functions that Union Pacific performs for the Plan. In the event that any of these employees do not comply with the provisions of this paragraph, the employee shall be subject to disciplinary action by Union Pacific for non-compliance pursuant to Union Pacific's employee discipline and termination procedures.

**Reports of Non-Compliance:** If you suspect an improper use or disclosure of Protected Health Information, you may report the occurrence to the Plan's Privacy Office:

Union Pacific HR Services  
Attn: HIPAA Privacy  
1400 Douglas Street, Stop 0320  
Omaha, NE 68179  
(877) 275-8747

**Definitions:**

For purposes of this Health Insurance Portability and Accountability Act of 1996 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 PHONE NUMBERS**

Union Pacific HR Services - 9:00 a.m. to 5:00 p.m. (CT)

Toll-Free.....(877) 275-8747

Fax Number.....(402) 233-2736

Mailing Address.....1400 Douglas Street, Stop 0320, Omaha, NE 68179

PayFlex

- Member website .....[www.payflex.com](http://www.payflex.com)
- Retiree Transition HRA claim forms and claim questions ..... (844) 729-3539
- Fax number for submitting claims..... (855) 703-5305



It is your right and responsibility to learn as much as you can about the wide variety of Union Pacific benefits and how you can make the most of all that is available to you. Please retain a copy for use throughout the year.