2022 Retiree HRA Guide

(effective January 1, 2022)

Medical Benefits Available to Union Pacific Retirees and their Dependents who are Medicare Eligible

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

SUMMARY PLAN DESCRIPTION	January 1, 2022

This booklet describes a covered person's rights and obligations under an employee welfare benefit plan established by Union Pacific Corporation, provided that the covered person is a participant of the Plan. It includes information about who is covered, the kinds of benefits provided, limitations or restrictions you should know about, and how to claim benefits. All of the details of this Plan are not provided. 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 Retirees.

The benefits described herein are covered by provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA) – a federal law that 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 booklet is a covered person's Summary Plan Description for purposes of ERISA. A description of ERISA provisions is found in the ERISA section at the end of this booklet on page 37. This Summary Plan Description does not create a contract of employment.

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INTRODUCTION

This 2022 Retiree Health Reimbursement Account ("Retiree HRA") Guide (the "Guide") describes the healthcare benefits offered through the Union Pacific Retiree Medical Program ("Plan" or "Retiree Medical Program") to certain Union Pacific retirees and their Dependents who are Medicare eligible and reflects the Retiree HRA provisions in effect January 1, 2022.

Technically, the Retiree Medical Program (including the Retiree HRA) is part of the Union Pacific Corporation Group Health Plan ("UPC Group Health Plan"), but Retiree Medical Program benefits are offered only to Union Pacific retirees (and their Dependents) who satisfy the Retiree Medical Program's eligibility requirements.

Consequently, the Retiree Medical 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, 2022, has less than 2 participants who are current employees. Included are eligibility information, available benefits, limitations and restrictions you should be aware of, and information regarding how to claim your benefits.

This document describes Retiree Medical Program coverage for eligible retirees and their Dependents who are Medicare eligible and enrolled in the Union Pacific Retiree Medical Program (each a "Medicare Eligible Participant"). Retiree Medical coverage for eligible retirees and their Dependents who are not Medicare eligible is described in the 2022 United HealthCare Retiree Medical Guide ("UHC Retiree Medical Guide") or the 2022 BlueCross/BlueShield Retiree Medical Guide ("BCBS Retiree Medical Guide"), depending on the retiree's residential ZIP code.

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 Summary Plan Description for the Retiree Medical Program consists of this document, together with the UHC Retiree Medical Guide, the BCBS Retiree Medical Guide and the documents pertaining to the medical programs offered to certain retirees of Alton & Southern Railroad (whose benefit rights under the Plan are described in those documents).

This document, together with the UHC Retiree Medical Guide, the BCBS Retiree Medical Guide and the documents pertaining to the medical programs provided to certain retirees of Alton & Southern Railroad, also serve 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.

Union Pacific Corporation ("Company") reserves the right to terminate or amend the Plan 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 increase the 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 Retiree HRA, except where otherwise indicated. The "Glossary" section on page 46 defines certain capitalized terms used in the Guide. Other capitalized terms are defined in the various sections throughout the Guide.

RETIREE HRA PARTICIPATION AND CLOSURE

A Retiree HRA is an account that you may use to reimburse yourself for certain medical, dental, and vision expenses that are otherwise not reimbursed or reimbursable from any other source. This includes premiums paid for Medicare coverage for you and your Medicare eligible covered Dependents, including Medicare Part B premiums. If you do not use all of your Retiree HRA balance during the Calendar Year, any balance remaining is carried over and can be used to reimburse eligible expenses in a later Calendar Year, provided the Retiree HRA coverage remains in effect. The Retiree HRA gives you considerable flexibility to manage your out-of-pocket medical, dental, and vision expenses.

The Retiree HRA was closed to new entrants effective December 31, 2019. This means Retiree HRA coverage is available after December 31, 2019 only to those retirees with a Retiree HRA in existence on December 31, 2019 as a result of either the retiree or one or more of the retiree's covered Dependents being Medicare eligible on or before that date. Retiree HRA coverage will remain in effect after December 31, 2019 only for the period in which the retiree or surviving Spouse remains continuously enrolled in the Plan without interruption, but no later than December 31, 2023. (See "When Coverage Ends and Continuation of Coverage" on page 8).

Medicare Part A and Part B are considered the primary coverages for retirees, Spouses and Dependents age 65 and above, or for such persons under age 65 who have qualified for Medicare because of disability. Each such person is "Medicare eligible."

A Medicare Eligible Participant's (i.e., a Medicare eligible retiree or Dependent with Retiree HRA coverage) enrollment in a Medicare Part D plan on or after September 1, 2009 will not result in the termination of coverage under the Union Pacific Retiree Medical Program. Medicare Eligible Participants who enrolled in Medicare Part D coverage effective prior to September 1, 2009 were terminated from the Union Pacific Retiree Medical Program and coverage will not be reinstated.

Retiree Medical Program eligibility requirements and information about rights to enroll your **non-Medicare eligible** Dependents in Retiree Medical coverage can be found in

the "Special Enrollment Periods" section of the UHC Retiree Medical Guide or BCBS Retiree Medical Guide, as applicable to you.

MEDICAL COVERAGE PROGRAM COVERAGES

Retirees and their Dependents who are not Medicare eligible may enroll in one of the following programs:

- UHC HDHP PPO (as described in the UHC Retiree Medical Guide).
- BCBS HDHP PPO (as described in the BCBS Retiree Medical Guide).

All non-Medicare eligible retirees will have either the UHC HDHP PPO Program (within the UHC Choice Plus Network) or the BCBS HDHP PPO Program (within the BlueCard Network) available to them, depending upon their residential address ZIP code, but not both.

Retiree Medical Program coverage consisting of a Retiree HRA is available during 2022 only to those retirees who had a Retiree HRA in existence on December 31, 2019 as a result of either the retiree or one or more of the retiree's covered Dependents being Medicare eligible on or before that date. Retiree HRA coverage is administered by ViaBenefits and described in this 2022 Retiree HRA Guide.

The Plan reserves the right to require documentation with respect to you and the individuals enrolled in coverage, including but not limited to, social security numbers and evidence that such individuals satisfy the Plan's definition of Dependent. Claims paid for any person (retiree or Dependent) found to be ineligible for coverage will be the responsibility of the retiree.

Discretionary Authority of Plan Administrator and Other Fiduciaries:
In carrying out their respective responsibilities under the Retiree HRA and the Plan, the Plan Administrator, the third party claims administrator of the Retiree HRA and other plan fiduciaries shall have discretionary authority to determine facts, interpret and administer the terms of the Retiree HRA, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Retiree HRA and 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.

RETIREE HRA FOR MEDICARE ELIGIBLE RETIREES AND DEPENDENTS

Retiree HRA Components:
The Retiree HRA is self-insured by Union Pacific. This means that Union Pacific, not an insurance company, pays for expenses covered by the Retiree HRA. Union Pacific has contracted with ViaBenefits to administer Retiree HRAs.

If you are or your Dependent is a Medicare Eligible Participant and became a Medicare Eligible Participant prior to January 1, 2020, Union Pacific credits your Retiree HRA with an amount that may be used to pay certain medical expenses that are not otherwise reimbursed or reimbursable from any other source. Retirees are not permitted to contribute to a Retiree HRA. The amount credited to your Retiree HRA will depend upon the number of Medicare Eligible Participants you have enrolled in coverage under the Union Pacific Retiree Medical Program.

- Your HRA will be credited for the 2022 Calendar Year with $500 if you, your Spouse or other Dependent is the only Medicare Eligible Participant enrolled in the Retiree Medical Program ("Single Retiree HRA Coverage"). Your HRA will be credited for the 2022 Calendar Year with $750 if both you and your Spouse are Medicare Eligible Participants, or if you (or your Spouse) and at least one other of your Dependents are Medicare Eligible Participants ("Family Retiree HRA Coverage").

- If you have a Dependent who is not Medicare eligible, medical coverage for such Dependent is provided under the UHC HDHP PPO or the BCBS HDHP PPO (depending on your residential address ZIP code) until he/she attains age 65 or otherwise becomes eligible for Medicare, assuming he/she otherwise remains eligible for Retiree Medical Program coverage. If during the 2022 Calendar Year you or your Dependent reach age 65, or otherwise become Medicare eligible, coverage under the UHC HDHP PPO (or BCBS HDHP PPO, as applicable) for the person becoming Medicare eligible will cease and Retiree Medical Program coverage instead will be provided by the Retiree HRA. This change in coverage will be effective the first of the month in which the person is eligible for Medicare coverage. If this change from PPO coverage to Retiree HRA coverage causes your level of Retiree HRA coverage to change from Single Retiree HRA Coverage to Family Retiree HRA Coverage, your Retiree HRA will be credited with an additional amount equal to the prorated difference between the $750 credit for Family Retiree HRA Coverage and the $500 credit for Single Retiree HRA Coverage. For example, if your Retiree HRA Coverage changes from Single to Family on July 1, 2022, an additional $125 will be credited to your Retiree HRA. This additional amount is 6/12ths of the difference between the $750 Family coverage credit and the $500 Single coverage credit.

- If an event occurs in a Calendar Year that results in your Retiree HRA coverage level changing from Family Retiree HRA Coverage to Single Retiree HRA Coverage (e.g., death of your Spouse), the amount credited to your Retiree HRA for such Calendar Year will not be reduced as result of such change. The amount credited for Single Retiree HRA Coverage in a subsequent Calendar Year will equal the Single Retiree HRA Coverage credit amount determined by Union Pacific for such subsequent Calendar Year.

Here's How it Works:
Your Retiree HRA can be used to pay for any eligible out-of-pocket medical expense listed in the Expense Item Table on page 13, which is incurred by the Medicare Eligible Participant after such individual begins Retiree HRA coverage. For families in which at least one eligible participant is not a Medicare Eligible Participant, claims reimbursed from the Retiree HRA for expenses incurred by the non-Medicare participant are limited to dental or vision out-of-pocket expenses.

If you do not use all of your Retiree HRA balance during the Calendar Year, any balance remaining is carried over and can be used to pay eligible medical expenses in a later Calendar Year, provided the Retiree HRA coverage remains in effect. However, eligible medical expenses incurred in one Calendar Year cannot be reimbursed using amounts credited to your Retiree HRA in a subsequent Calendar Year.

Claims and Carryover Provisions: Only eligible expenses incurred while you (or your eligible Dependent) are covered by the Retiree HRA may be reimbursed from the Retiree HRA. 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" on page 29). A balance in your Retiree HRA that is not used to pay for eligible expenses incurred in the Calendar Year is carried over and can be used to pay for eligible expenses incurred in the following Calendar Year(s), provided the Retiree HRA coverage remains in effect. Any balance remaining at your death after claims run-out is forfeited, unless you have a Spouse or other Dependent(s) covered under the Plan at the time of your death. The claims run-out period is 180 days after your date of death, during which time your representative can submit claims incurred by you prior to your death for reimbursement from the Retiree HRA.

Coverage If You Relocate:

You should notify Union Pacific Workforce Shared Services if you relocate. However, your Retiree HRA coverage is not affected by your relocation.

WHEN COVERAGE ENDS AND CONTINUATION OF COVERAGE

In addition to closing the Retiree HRA, the Company has decided to terminate Retiree HRA coverage effective December 31, 2023. Any balance remaining in your Retiree HRA on that date will be forfeited, subject to any post-year end Retiree HRA claim processing run-out period available to you at that time.

Retiree HRA coverage provided to you and/or your covered Dependents may end earlier than December 31, 2023. Retiree HRA coverage will end as of the last day of the month of the first to occur of the following events, if the event occurs before December 31, 2023:

1. You are rehired and become eligible for medical benefits as an active employee;
2. Your covered Dependent no longer meets the definition of "Dependent";

3. You die without a surviving Spouse covered by the Plan (However, if your surviving Spouse is not Medicare eligible at the time of your death, he or she has a right to later enroll in Retiree Medical Program coverage offered to non-Medicare eligible Surviving Spouses if the conditions required for special enrollment are met. See the "Special Enrollment Periods" section of the UHC Retiree Medical Guide or BCBS Retiree Medical Guide, as applicable to you, for more information.);
4. Your surviving Spouse covered by the Plan dies; or
5. The Plan is terminated or amended in a manner that causes your coverage to end prior to December 31, 2023.

Assuming the Retiree HRA is not terminated or amended in a manner which causes coverage to end earlier, Retiree HRA coverage will continue beyond the date described in events 2 – 4 above in the circumstances described below. **However, in no circumstance will Retiree HRA coverage extend beyond December 31, 2023**.

- Your surviving covered Spouse will be permitted to continue Retiree HRA coverage after your death until the earlier of: a) your surviving Spouse's death; or b) December 31, 2023. 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, any remaining covered Dependents will be permitted to continue Retiree HRA benefits until the earlier of: a) 36 months after the end of the month of your surviving Spouse's death; or b) December 31, 2023. If, upon the death of the retiree, there is no surviving covered Spouse, any remaining covered Dependents will continue to be eligible for Retiree HRA coverage until the earlier of: a) 36 months after the end of the month of your death; or b) December 31, 2023.

- In the event you become divorced or legally separated from your covered Spouse, your former Spouse may continue Retiree HRA benefits under a separate Retiree HRA that will be established to pay eligible claims of your former Spouse. Coverage under the former Spouse's Retiree HRA will begin the first of the month following the month in which your divorce decree is entered by the court or legal separation occurred. The amount available for coverage in the former Spouse's Retiree HRA at such time will equal the amount available in your Retiree HRA at the end of the month in which the divorce decree is entered by the court or legal separation occurred. Coverage under the former Spouse's Retiree HRA will continue until the earlier of: a) 36 months after the end of the month in which your divorce decree is entered by the court or legal separation occurred; or b) December 31, 2023.

- Except in the case where your covered Dependent continues Retiree HRA coverage as a result of being on a Medically Necessary Leave of Absence*, in the event your covered Dependent no longer meets the definition of a Dependent, your Dependent may continue Retiree HRA benefits under a separate Retiree HRA that will be established to pay eligible medical claims of your Dependent. A separate Dependent Retiree HRA will be established for each Dependent that no longer meets the definition of a Dependent. Coverage under the Dependent's Retiree 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 HRA at such time will equal the amount available in your Retiree 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 HRA will continue until the earlier of: a) 36 months after the end of the month in which your Dependent no longer meets the definition of a Dependent; or b) December 31, 2023.

- If your Dependent is no longer your Dependent because he/she is no longer attending an accredited post-secondary educational institution on a full-time basis in accordance with the institution's policies and is no longer eligible to continue coverage as a result of being on a Medically Necessary Leave of Absence*, a separate Dependent Retiree HRA will begin the first of the month following the month in which such Dependent is no longer eligible to continue coverage as a result of being on a Medically Necessary Leave of Absence. The amount available for coverage in the Dependent's Retiree HRA at such time will equal the amount available in your Retiree HRA at the end of the month in which your Dependent is no longer eligible to continue coverage as a result of being on a Medically Necessary Leave of Absence. Coverage under such Retiree HRA will continue until the earlier of: a) 36 months after the end of the month in which your Dependent's Retiree HRA coverage terminated as a result of being on a Medically Necessary Leave of Absence; or b) December 31, 2023.

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 HRA. This notice must be provided by calling Union Pacific Workforce Shared 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.

*A Medically Necessary Leave of Absence is a leave of absence 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 and which:

- commences while the individual is suffering from a serious illness or injury;
- is Medically Necessary;

- results in the individual losing student status at such educational institution; and
- 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 Union Pacific Workforce Shared 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, 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.

If You Have Questions:
Questions concerning the Plan or your continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, 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 Plan and continuation coverage, you may contact Union Pacific Workforce Shared Services, 1400 Douglas Street, STOP 0320, Omaha, NE 68179-0320, or at (877) 275-8747.

ELIGIBLE EXPENSES

Expenses that are eligible for reimbursement from the Retiree HRA include the following:

- Non-group plan Medical and Medicare premiums.
- Non-group plan Dental premiums.
- Non-group plan Vision and hearing premiums.
- Medical deductibles, copayments or coinsurance.
- Dental deductibles, copayments or coinsurance.
- Prescription drug deductibles, copayments or coinsurance.
- Certain over-the-counter expenses.

Individual health insurance coverage that is paid for by the Retiree HRA, if any, is not subject to the rules and consumer protections of ERISA. You should contact your state insurance department for more information regarding your rights and responsibilities if you purchase individual health insurance coverage.

The table below includes specific details regarding eligible and ineligible expenses:

Expense Item	Eligible?	Claim Details
Abortion	Yes	
Acne products - Products specifically marketed for and used to treat acne	Yes	
Acne products - Products used for general hygiene such as facial wash, cleansers, toners, and medicated makeup	No	
Acupuncture - Treatment for a medical condition	Yes	
Additional card expense	No	
Advance payments - Nonrefundable advance payments to a private institution for Lifetime care, treatment, and training of a physically or mentally impaired dependent after the death or disability of a legal guardian	Yes	You must provide a statement of medical necessity from a Doctor documenting the disability or mental impairment
Alcohol or drug addiction - Payments to a treatment center for alcohol or drug addiction, including meals and lodging	Yes	
Allergy prevention products - Products purchased or used to alleviate allergies, such as a pillow, mattress, or vacuum	Yes	You must provide a statement of medical necessity from a Doctor documenting the diagnosed allergy and that the expense is for a product that will help alleviate the allergy symptoms
Allergy testing and shots	Yes	
Ambulance service	Yes	
Arch support - Supportive foot products prescribed by a Doctor to treat a medical condition	Yes	
Artificial limbs	Yes	
Automobile insurance premiums	No	

Expense Item	Eligible?	Claim Details
Automobile modifications - Modifications include special hand controls and other equipment installed in an automobile for a person with a disability	Yes	You must provide a statement of medical necessity from a Doctor documenting the disability
Birth control pills - Prescribed birth control pills	Yes	
Birth control products - Prescribed devices such as diaphragms, IUDs, and Norplant, in addition to over-the-counter items such as home pregnancy tests, condoms, gels, and foams	Yes	
Blood donation - Costs associated with blood donation, including self-administered blood donations, storage fees, and processing fees	Yes	
Blood pressure monitors - Costs include electronic monitors and replacement blood pressure cuffs	Yes	
Body scans	Yes	
Bottled water	No	
Braille books and magazines - Costs are limited to those that exceed regular printed editions	Yes	You must provide a receipt or advertisement with the price of the regular printed version of the book or magazine and a receipt of the Braille material
Breast augmentation - Examples include implants and injections	No	Surgery or procedures that aren't Medically Necessary aren't eligible
Breast pumps - Pump prescribed by a Doctor for a medical reason	Yes	Breast pumps used for nursing and routine post-partum care aren't eligible
Chelation therapy - Therapy used to treat a medical condition, such as lead poisoning	Yes	
Childbirth classes - Classes necessary to reduce pain during labor and delivery. An example is Lamaze	Yes	Expenses related to parenting techniques, infant CPR, and breast feeding are not covered
Chiropractor - Treatment for a medical condition	Yes	
Christian science Practitioner - Medical expenses paid to a Practitioner for medical care	Yes	

Expense Item	Eligible?	Claim Details
COBRA premiums - Premiums paid on an after tax basis for continuation of group medical, dental, or vision coverage	No	
Contact lenses and solutions - Products include saline solution and enzyme cleaner	Yes	
Cosmetic services and products - Surgery that isn't Medically Necessary. Examples include liposuction, hair transplants, electrolysis, laser treatments, and face-lifts	No	
Cosmetic services and products - Those necessary to improve a deformity related to a congenital abnormality or an Injury resulting from an accident, trauma, or disfiguring disease (post-mastectomy Reconstructive Surgery, for example)	Yes	You must provide a statement of medical necessity from a Doctor documenting the deformity, disfigurement or Injury
Counseling - Marriage or family counseling	No	Other types of counseling, such as mental health and psychiatric services, are eligible
Crutches	Yes	
Dental coinsurance - Amounts not covered by your or your spouse's dental plans	Yes	
Dental copayments	Yes	
Dental debit card - Dental Debit Card Expense	No	
Dental deductibles - Deductibles under your or your spouse's dental plans	Yes	
Dental expenses - Examples include fees for X-rays, fillings, braces, extractions, crowns, and orthodontia	Yes	

Expense Item	Eligible?	Claim Details
Dental implants - Fees for insertion of artificial tooth, bone grafting, and follow-up care	Yes	You must provide either a statement of medical necessity from a provider indicating that dental implants are the only course of treatment for the condition or an explanation of benefits indicating the amount paid by an insurance plan
Dental reasonable/customary - Amounts not paid by a dental plan that exceed reasonable and customary limits	Yes	
Dentures	Yes	
Diaper service - Cost for an agency that delivers and picks up cloth diapers	No	
Diapers (adult) - Diapers necessary as a result of a medical condition	Yes	
Diapers (child)	No	
Dietician services - Fees paid to a dietician when referred by a Doctor for treatment of a medical condition	Yes	
Disability construction costs - Examples include constructing entrance or exit ramps, adding handrails, or modifying stairways at a personal residence for disability of an employee or dependent	Yes	You must provide a statement of medical necessity from a Doctor documenting the disability
Disability equipment - Equipment installed in the home or car for use by a disabled employee or dependent	Yes	You must provide a statement of medical necessity from a Doctor documenting the disability
DNA testing - DNA testing for paternal responsibility	No	
Ear wax removal materials - Kits and ear drops must be prescribed by a Doctor for a medical condition	Yes	You must provide a statement of medical necessity from a Doctor describing the medical condition
Earplugs - Plugs must be prescribed by a Doctor for a medical condition	Yes	You must provide a statement of medical necessity from a Doctor describing the medical condition
Erectile dysfunction - Medication prescribed by a Doctor to treat a medical condition	Yes	Nonprescription medications require a statement of medical necessity from a Doctor describing the medical condition

Expense Item	Eligible?	Claim Details
Exercise equipment - Equipment recommended by a Doctor for the treatment of a medical condition	Yes	You must provide a statement of medical necessity from a Doctor describing the medical condition, such as a cardiac condition
Exercise equipment - Equipment used for general health purposes or prevention of an undiagnosed disease	No	
Eye examinations	Yes	
Eye Surgery - Surgery to correct defective vision	Yes	
Eyeglass tinting and coating	Yes	
Eyeglasses - Costs include prescription glasses and nonprescription reading glasses	Yes	
Flu shots	Yes	
Fluoride treatment - Costs include prescription or nonprescription fluoride and installation and monthly rental charges of a home water unit when recommended by a Dentist	Yes	
Food (prescribed) - Foods prescribed by a Doctor to treat a medical condition. Examples are baby formula and gluten- free and lactose-free foods. Costs are limited to those that exceed common versions of the product	Yes	You must provide a statement of medical necessity from a Doctor describing the medical condition. You must also provide a receipt or advertisement with the price of the commonly available version of the food and a receipt of the prescribed food
Funeral and burial expenses	No	
Future payments - Down payments or payments for services that have not been rendered or products not received	No	Lump-sum payments for future orthodontia services are an eligible exception; once the service is rendered, an itemized bill indicating the service date is required for the expenses to be eligible
Guide dog	Yes	
Health club or YMCA dues - Examples include membership and personal trainer fees	No	
Hearing aids	Yes	
Guide dog	Yes	

Expense Item	Eligible?	Claim Details
Health club or YMCA dues - Examples include membership and personal trainer fees	No	
Hearing aids	Yes	
Hearing coinsurance - Amounts not covered by your or your spouse's hearing plans	Yes	
Hearing copayments	Yes	
Hearing debit card - Hearing Debit Card Expense	No	
Hearing deductible - Deductibles under your or your spouse's hearing plans	Yes	
Hearing expenses - Costs include examinations and hearing aid batteries	Yes	
Hearing reasonable/customary -		
Hearing-impaired phone tools - Telephone equipment that allows a hearing-impaired person to communicate over a regular telephone	Yes	
Hearing-impaired TV equipment - Equipment that displays the audio part of television programs as subtitles for a hearing-impaired person	Yes	
Herbal remedies - Remedies that are prescribed by a Doctor for a medical condition	Yes	You must provide a statement of medical necessity documenting that the herbal remedy is necessary to treat a medical condition, Injury, or Illness and is not for general health purposes
Hospital care - Inpatient care, including the cost of a private room	Yes	Fees for personal convenience items, such as a television, telephone, and concierge services, aren't eligible
Household help - Expenses for help with physical housework, even if recommended by a Doctor, due to an inability of employee, dependent, or retiree	No	

Expense Item	Eligible?	Claim Details
Humidifiers - Cost of portable units prescribed by a Doctor for treatment of a medical condition	Yes	
Hypnosis - Hypnosis prescribed for medical reasons	Yes	
Illegal medical treatment - Including Surgery	No	
Immunizations	Yes	
Ineligible expense - Not covered	No	
Infertility - Treatments for infertility, including artificial insemination, in-vivo or in-vitro fertilization, embryo placement, egg and sperm storage, and ovulation monitors	Yes	
Laboratory and X-ray fees	Yes	
Laetrile - Anti-cancer drug	No	
Language training - Training for a child with dyslexia or other learning disabilities. Fees for regular schooling aren't eligible	Yes	
LASIK Surgery	Yes	
Lead-based paint removal - Costs for residences with children who have or had lead poisoning	Yes	
Legal fees - Fees paid to authorize treatment for mental Illness, excluding guardianship or estate management fees	Yes	
Lens replacement insurance - Insurance to replace eyeglass or contact lenses	No	
Life insurance premiums - Premiums paid for the following policies: life insurance, repayment for loss of earnings, and accidental loss of life, limbs, or sight	No	
Lodging - Cost of lodging not provided in a Hospital or similar institution while away from home if primarily for and essential to medical care (limited to $50 per person per night)	Yes	The $50 is applicable to only the patient and caregiver ($100 limit per night); you must provide a statement of medical necessity from a Doctor documenting the medical condition

Expense Item	Eligible?	Claim Details
Long-term care premiums - Premiums paid on a policy for future long-term care needs	Yes	Fees for Doctors, therapists, and other medical Practitioners are eligible, but fees for the long- term care facility aren't eligible
Long-Term Care Facility	No	Expenses for room and board at a long-term care facility
Long-Term Care Facility Fees – Fees for room and board at a long-term care facility	No	
Massage therapy - Therapy prescribed by a Doctor to treat an Injury or trauma	Yes	You must provide a statement of medical necessity documenting that massage therapy is necessary to treat a medical condition, Injury, or Illness and is not for general health purposes
Mastectomy-related bras - Bras prescribed by a Doctor	Yes	
Maternity care - Service and supplies from Doctors, midwives, clinics, Hospitals, and laboratories	Yes	3D and 4D ultrasounds are not eligible
Maternity clothes	No	
Mattresses - Mattresses prescribed by a Doctor to treat a medical condition	Yes	You must provide a statement of medical necessity documenting that the mattress is necessary to treat a medical condition, Injury, or Illness and is not for general health purposes
Medic alert identifications - Bracelet or necklace prescribed by a Doctor in connection with treating a medical condition	Yes	
Medical coinsurance - Amounts not covered by your or your spouse's medical plans	Yes	
Medical conference - Admission and transportation costs	Yes	
Medical contract fees - Annual contract costs for exclusive provider care	No	Itemized expenses for services provided are eligible
Medical copayments	Yes	
Medical debit card - Debit Card Medical Expense	No	

Expense Item	Eligible?	Claim Details
Medical deductibles - Deductibles under your or your spouse's medical plans	Yes	
Medical equipment - Costs to buy or rent durable equipment prescribed by a medical Practitioner to alleviate or treat a medical condition. Examples include medical beds, nebulizers, and sleep therapy devices	Yes	
Medical information - Amounts paid to a medical information plan for storage and retrieval of medical information	Yes	
Medical reasonable/customary - Amounts not paid by a medical plan that exceed reasonable and customary limits	Yes	
Medical services - Services provided by Doctors, surgeons, specialists, or other medical Practitioners	Yes	
Medical supplies - Over-the- counter items such as bandages, thermometers, and heating pads	Yes	
Medicare Part B Premiums	Yes	
Medicare Part D Premiums	Yes	
Menstrual products	Yes	
Mental health - Includes psychoanalysis or amounts paid to a psychiatrist, psychologist, Hospital, clinic, or mental health facility for medical care	Yes	
Mentally handicapped home - Costs of keeping a mentally retarded person in a special home, as recommended by a psychiatrist, to help the person adjust from life in a mental Hospital to community living	Yes	You must provide a statement of medical necessity documenting that the special home or facility is necessary to assist the person in adjusting from life in a mental Hospital to community living
Nursing or retirement home fee - Medical care portion of a fee for an eligible dependent	Yes	Fees for Doctors, therapists, and other medical Practitioners are eligible, but fees for the nursing or retirement home facility aren't eligible

Expense Item	Eligible?	Claim Details
Nursing services - Wages and other amounts paid for nursing services to a patient at home or in a facility, such as a nursing home or rehabilitation center	Yes	Home healthcare and private duty nursing are eligible

Nursing services for newborns - Services by a Nurse or attendant to care for a normal and healthy newborn at a Hospital or at home	No	
Nutritional supplements - Supplements taken for general health purposes. Examples include protein supplements, energy bars, and sports drinks	No	You must provide a statement of medical necessity documenting that the nutritional supplement is necessary to treat a medical condition, Injury, or Illness and is not for general health purposes
Occupational therapy - Therapy received as medical treatment	Yes	
Organ donor - Surgical, Hospital, laboratory, and transportation expenses for an organ donor, if you paid the donor's expenses	Yes	
Orthodontic fees - Orthodontic fees paid in a lump sum and in monthly installments	Yes	
Orthopedic shoes and orthotics - Shoes and orthotics prescribed by a Doctor for a medical condition	Yes	
Over-the-counter medications - Medications taken for general health purposes	No	
Over-the-counter medications - Medications taken to relieve pain, colds, and medical conditions	Yes	
Oxygen or oxygen equipment - Costs for rental or purchased equipment to relieve breathing problems caused by a medical condition	Yes	
Pain relievers	Yes	

Expense Item	Eligible?	Claim Details
Personal-use items - Includes toiletries and cosmetics, unless used to prevent or ease a physical or mental defect or Illness; In this case, only the excess of cost over the normally used item is reimbursable	No	
Personal-use items - Personal- use item used to prevent or ease a physical or mental defect or Illness. Costs are limited to those that exceed common versions of the product	Yes	
Physical examinations - Routine physical examinations and related charges	Yes	
Physical therapy - Therapy prescribed by a Doctor as treatment for a medical condition	Yes	
Post Tax Dental Premiums - Premiums paid on an after-tax basis for any type of dental insurance coverage, including premiums for private insurance not provided by an employer	Yes	
Post Tax Medical Premiums - Premiums paid on an after-tax basis for any type of medical insurance coverage, including premiums for private insurance not provided by an employer	Yes	
Post Tax Vision Premiums - Premiums paid on an after-tax basis for any type of vision insurance coverage, including premiums for private insurance not provided by an employer	Yes	
Premiums for medical insurance - Premiums paid on an after-tax basis for any type of medical insurance coverage, including premiums for private insurance not provided by an employer	Yes	You must provide indication that the medical premium is after-tax when a payroll or retirement statement is used to document the medical premium expense - handwritten or verbal confirmation won't be accepted

Expense Item	Eligible?	Claim Details
Pretax Dental Premiums - Premiums paid on a before-tax basis for any type of dental insurance coverage.	No	
Pretax Vision Premiums – Premiums paid on a before-tax basis for any type of vision insurance coverage.	No	
Prenatal vitamins - Vitamins prescribed by a Doctor for use during pregnancy	Yes	
Prescription debit card - Prescription Debit Card Expense	No	
Prescription drugs - Exceptions may apply to drugs prescribed for cosmetic or general health purposes	Yes	Claims for reimbursement of drug or medicine expenses must include a copy of your prescription
Prosthetics	Yes	
Psychiatric care - Medical costs for psychiatric care	Yes	
Psychiatric expenses - Includes psychoanalysis or amounts paid to a psychologist for medical care	Yes	
Sales taxes - Sales and service taxes on eligible medical care or products	Yes	
School (alternative) - Costs of sending a problem child to an alternative school for benefits the child may receive from the course of study and disciplinary methods	No	
School payments for disabled - Expenses paid to an alternative school for a child with a severe learning disability if the main reason is using the school's resources for relieving the disability	Yes	You must provide a statement of medical necessity documenting the school is necessary to relieve the child's learning disability
Shipping - Charges to ship an eligible medical product	Yes	
Social activities - Activities such as dancing or swimming lessons, even if recommended by a Doctor for general health improvement	No	

Expense Item	Eligible?	Claim Details
Speech therapy - Speech therapy costs when prescribed as treatment for medical conditions such as autism, dyslexia, developmental delays, and rehabilitation.	Yes	
Sterilization - Costs of sterilization (vasectomy or tubal ligation) and reversal of sterilization operations	Yes	
Stop-smoking program	Yes	
Sunglasses - Sunglasses prescribed by an eye Doctor for light sensitivity	Yes	You must provide a statement of medical necessity documenting that the sunglasses are necessary to treat a medical condition, Injury, or Illness and are not for general health purposes
Support hose - Hose prescribed by a Doctor for a medical condition	Yes	The hose must be primarily manufactured and marketed for relief of a medical condition - however, hosiery primarily marketed for fashion isn't eligible
Taxes - Social Security and Medicare taxes paid for a Nurse, attendant, or other person who provides medical care	Yes	
Teeth whitening or bonding - Costs include bleaching and special whitening toothpaste. These expenses are always considered cosmetic and aren't eligible	No	
Toothbrush - Any type of toothbrush even if recommended by a Dentist or orthodontist	No	
Transportation expenses - Costs to receive medical care - including airfare, parking, tolls, taxis, rental cars, buses, gas for your car, or mileage	Yes	You must provide a statement of medical necessity from a Doctor documenting the medical condition for any expense $100 or more if no diagnosis has been submitted previously

Expense Item	Eligible?	Claim Details
Tutoring - Tutoring fees, recommended by a Doctor, for a child who has severe learning disabilities caused by a mental or physical impairment, including nervous system disorders	Yes	You must provide a statement of medical necessity from a Doctor documenting the medical condition
Umbilical cord storage - Costs to collect, freeze and store umbilical cord blood only when a medical condition is present. Storage when no medical condition is present isn't eligible	Yes	You must provide a statement of medical necessity from a Doctor documenting the medical condition
Uniforms	No	
Unknown debit card MCC Code - Medical Debit Card Expense	No	
UVR treatments - Ultraviolet radiation treatments recommended by a Doctor for a medical condition, such as chronic psoriasis	Yes	
Vacation or travel - Time off or travel for general health purposes	No	
Vaccinations - Amounts paid for vaccinations or immunizations against disease	Yes	
Varicose vein Surgery - Expenses associated with the removal of varicose veins prescribed by a Doctor for treatment of a medical	Yes	You must provide a statement of medical necessity from a Doctor documenting the medical condition
Veneers - Only when covered by an insurance plan or recommended by a Dentist as the only course of treatment	Yes	You must provide either a statement of medical necessity from a provider indicating that veneers are the only course of treatment for the condition or an explanation of benefits indicating the amount paid by an insurance plan
Vision coinsurance - Amounts not covered by your or your spouse's vision plans	Yes	
Vision copayments	Yes	
Vision debit card - Vision Debit Card Expense	No	

Expense Item	Eligible?	Claim Details
Vision deductibles - Deductibles under your or your spouse's vision plans	Yes	
Vision expenses - Costs not covered by a vision plan	Yes	
Vision reasonable/customary - Amounts not paid by a vision plan that exceed reasonable and customary limits	Yes	
Vitamins - If prescribed by a Doctor to cure a medical condition; not eligible if simply taken for general health purposes	Yes	You must provide a statement of medical necessity from a Doctor documenting the medical condition
Vitamins - Taken for general health purposes	No	
Warranties - Warranties purchased for health-related equipment	No	
Weight loss - Program for general health	No	
Weight loss - Program to cure a medical condition and must be prescribed by a Doctor	Yes	Examples include medical costs and program fees for support groups and non-medically supervised programs; eligible programs include Weight Watchers, NutriSystem, and Medifast (food is often a part of these programs; however, the fees associated with food are not eligible). You must provide a statement of medical necessity from a Doctor documenting the medical condition.
Wheelchair	Yes	
Wigs - Wigs purchased with Doctor's recommendation for the mental health of a patient who has lost all of his or her hair from	Yes	
Work transportation expenses - Transportation costs to and from work, even though a physical condition may require special means of transportation	No	

Expense Item	Eligible?	Claim Details
Work-related medical expenses - Costs for an accident or Illness not covered by workers' compensation or another medical plan	Yes	

Restriction on Eligible Expenses for non-Medicare eligible Retirees or Dependents: For families in which at least one eligible member is not a Medicare Eligible Participant, claims allowable for reimbursement from the Retiree HRA for the non-Medicare member are limited to dental or vision out-of-pocket expenses. This restriction is designed to allow non-Medicare members enrolled in the UHC HDHP PPO or BCBS HDHP PPO to maintain eligibility to contribute to a Health Savings Account (HSA).

Only eligible expenses incurred while you (or your eligible Dependent) are covered by the Retiree HRA may be reimbursed from the Retiree HRA. Claims for reimbursement from the Retiree HRA may be filed as eligible expenses are incurred. An eligible expense is incurred when the services are provided and not when you are formally billed, charged or pay for the services. Reimbursement of eligible expenses will be paid only after the services are rendered. You may request reimbursement of eligible expenses **up to the remaining balance in your Retiree HRA** at any time after the eligible expense is incurred. After a claim is filed, ViaBenefits will make a benefit determination as set forth in the "Benefit Determinations" section below.

RETIREE HRA CLAIMS AND APPEALS

You have the flexibility to submit HRA claims two ways – online or manually (paper claim form) in order to obtain benefits from your Retiree HRA. Please see "How to File a Claim" below.

In addition, for your convenience, certain insurance carriers have arranged with ViaBenefits to provide you with the option of the insurance carrier submitting claims on your behalf through a process called "Auto Reimbursement." ViaBenefits can identify for you which insurance carriers provide this option. If you are covered by such an insurance carrier and elect to participate in auto reimbursement, after you have paid your insurance premium to the carrier, the carrier will notify ViaBenefits and thereby generate an HRA claim on your behalf in the amount of the premiums you have paid. Upon claim approval, ViaBenefits will automatically send you the reimbursement amount without you having filed a claim form.

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.

How to File a Claim: 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 Retiree HRA for the expense.

To receive a reimbursement from your Retiree HRA, you must file a claim, along with appropriate proof of expenses, unless your claim is filed using the "Auto Reimburse" process described above. Retiree HRA claims forms are available online at https://my.viabenefits.com/unionpacific or by calling ViaBenefits at (800) 935-7780.

Paper Claim Form Submissions:

1. Complete the information on the front of the claim form.
2. Prepare your supporting documentation:
   a. If you are submitting a claim for your monthly premiums, attach a copy of the premium invoice from your plan or a copy of your bank statement/cashed check that can verify the payment. When submitting a claim, use the cover period start date as the date of service, not the date of payment. For example, if you are requesting reimbursement of January premiums, use January 1st as the service date.

   For other healthcare expenses, attach copies of the corresponding itemized receipts or Explanation of Benefits (EOB) from your health plan. The receipt must include the following information:
      1) Date of service.
      2) Name of provider or supplier.
      3) Name of patient.
      4) Identification of product or description or service
      5) Amount paid.

   b. If you are submitting a claim for a drug or medicine, include a copy of your prescription for such drug or medicine.
3. Sign and date your form.

4. Submit your claim(s) by mail or fax:
   a. Mail your claim form and supporting documents to:
      ViaBenefits
      P.O. Box 2396
      Omaha, NE 68103-2396
   b. Fax your claim form and supporting documents to (855) 321-2605. Your claim should be page 1 of your fax, followed by the copy of your receipts or other supporting documents. You do no need to include a cover sheet.

Online Claim Form Submission:

1. Log onto https://my.viabenefits.com/unionpacific.
2. Under **My Account**, click **Login**. **Note:** If you are a first time user, you will need to create a new account by clicking on **Register**.)
3. Go to the **Funds & Reimbursements** section and select the **File Reimbursement Requests** link.
4. Select the **Financial Center** tab, then the **File a Spending Account Request** under the **My Account Actions** section.
5. To enter your reimbursement, select the expense type, enter the date you incurred the expense, and the amount of the expense. If you have more than one reimbursement, click the **Add Another Expense** button and enter the information. Once you have finished entering all of your reimbursements, click **Next**.
6. Confirm the details of your reimbursement(s), and then click **Next**. To edit your reimbursement(s), click **Previous**.
7. Please select a method to submit your receipts for this reimbursement. We recommend uploading your receipts/documentation, as this will expedite the processing of your reimbursements. You may also fax or mail your receipts/documentation.
8. To submit your receipts online, check the **Signature** box, then click the **Upload** button, and then follow the directions provided. Note that receipts submitted online must be in PDF format and less than 5 megabytes.
9. To submit your receipts by fax, click the Fax button, and then follow the directions provided to create your coversheet. Print and sign your coversheet, and then fax it and your documentation to the number provided on the coversheet. Be sure to include all of your receipts and supporting documentation. A reimbursement is not considered complete and cannot be approved until all of its supporting documentation is received.
10. To submit a reimbursement through the mail or fax, use the ViaBenefits reimbursement request form. Please follow the instructions carefully and use the address or fax number listed on the reimbursement request form. Remember to include your receipts or other documents you need to support your reimbursement request.

Note: Once your claim and receipts have been received and approved, you will generally receive payment within 14 days. If you are set up on direct deposit, payment will generally be issued within 2 to 3 days of the claim approval. Visit the ViaBenefits website at https://my.viabenefits.com/unionpacific for the most current status of your claim.

Assistance with your reimbursement funding: An Authorization to Release Protected Information (ARPI) form allows you to designate someone of your

choice to see your allocation and fund balance, submit reimbursement requests and check on the status. This permits the person you designated to speak on your behalf without your presence on the telephone.

To print a copy of the ARPI from your online account, go to the **Funds & Reimbursements** section and select the **File Reimbursements Requests** link. Next select the **Resource Center** tab where you will find the list of available forms including the ARPI form to download and print. You can also call ViaBenefits, and we will send you a copy of the form. Once the form is filled out, send it to ViaBenefits using the contact information on the form. You may cancel this form at any time by calling ViaBenefits.

If your claim is approved, ViaBenefits will process a payment from your Retiree 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 HRA.

ViaBenefits will send this payment to you either via mailed check to your address of record or by direct deposit to the bank account of your choice. If you wish to setup direct deposit you may receive instructions how to do so by calling ViaBenefits at (800) 935-7780 or through the ViaBenefits website at https://my.viabenefits.com/unionpacific.

Explanation of Payment (EOP) Statements: Each time ViaBenefits processes a request for reimbursement, you will be sent an Explanation of Payment (EOP). This statement includes a summary of your paid reimbursements, available balance, and the amounts you have been reimbursed. A check will be included with the EOP for those without direct deposit. The EOP will list the reason for denial when a reimbursement request is denied.

If you have a question concerning your claim, you can contact ViaBenefits at (800) 935-7780.

Benefit Determinations: If your claim is denied, you will receive a written notice from ViaBenefits 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. ViaBenefits 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, ViaBenefits 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, ViaBenefits 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, provide the claim appeal procedures and time limits applicable to such procedures, and provide a description of your right to request all documentation relevant to your claim.

You must first exhaust your appeal right (described below) before you have a right to bring a civil action under ERISA regarding your denied claim.
Retiree HRA Questions and Appeals:
This section provides information to help you with the following:

- You have a question or concern about your Retiree HRA 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 ViaBenefits at (800) 935-7780 before requesting a formal appeal. If the ViaBenefits 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" on page 29 you may appeal it as described below without first informally contacting ViaBenefits Customer Service. If you first informally contact ViaBenefits Customer Service and later wish to request a formal appeal in writing, you may do so by filing an appeal with the Plan Administrator as described below.

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

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

This written appeal must include your name, a description of the claim determination that you are appealing, a statement of each and every 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 appeal request must be submitted to the Plan Administrator within 180 days after you receive the claim denial.

Any review on your appeal will not give deference to the previous claim denial. The Plan Administrator (or delegate) will review your 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 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 and appeal for Retiree HRA benefits. The Plan Administrator (or delegate) will notify you in writing of its decision regarding your appeal within a reasonable period of time, but not later than 60 days from receipt of your request for review of the claim denial. The decision of the Plan Administrator (or delegate) on your appeal is final and binding. If your appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. 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 the Employee Retirement Income Security Act, as amended ("ERISA") if your appeal is denied.

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

The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"), which has since been extended. The Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in the section "Retiree HRA Claims and Appeals" – for you to submit or request any or all of the following:

- an initial claim for benefits; or
- an appeal of your denied claim.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your right to claim benefits will be extended as necessary to comply with applicable Federal requirements implemented in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in the section "Retiree HRA Claims and Appeals" - you may have additional time to do so. Please contact ViaBenefits at (800) 935-7780 for more information.

Discretionary Authority of Plan Administrator and Other Fiduciaries:
In carrying out their respective responsibilities under the Retiree HRA and the Plan, the Plan Administrator, the third party claims administrator of the Retiree HRA and other plan fiduciaries shall have discretionary authority to determine facts, interpret and administer the terms of the Retiree HRA, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Retiree HRA and 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 as a result of an intentional act or negligence, the third party's insurer or any other source (for example, funds recovered in a lawsuit, a settlement, or an arbitration 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 the Plan 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 Retiree HRA, you are accepting the terms of this subrogation provision. If you pursue a recovery from a responsible third party, you must immediately give written notice to ViaBenefits. 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 the eligibility of a retiree or Dependent 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

ViaBenefits has the right to a refund of any Retiree HRA benefits it paid 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 ViaBenefits. 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 Retiree HRA. 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 Retiree HRA and the Plan.

If you do not promptly refund the required amount, ViaBenefits may, in addition to other rights it may have, reduce the amount of any future benefits payable under the Retiree HRA and under any group benefits plan it issued to your employer by the amount of the refund.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

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, together with the 2022 UHC Retiree Medical Guide, the 2022 BCBS Retiree Medical Guide and documents pertaining to the medical programs provided to certain retirees of Alton & Southern Railroad constitute the Summary Plan Description under ERISA.

Plan Sponsorship:
The Plan's coverage is sponsored by:

Union Pacific Corporation
1400 Douglas Street, Stop 0320
Omaha, NE 68179

The Plan is extended to eligible retirees of Union Pacific Corporation and participating Union Pacific subsidiaries. A complete list of these subsidiaries, including their addresses, and employer identification numbers, is available in the Union Pacific Workforce 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 0350
Omaha, NE 68179
(402) 544-5000

The Workforce Resources Department provides administrative services, answers questions, and generally acts as the Plan Administrator's representative in handling day-to-day matters involving Plan participants. Feel free to contact Union Pacific Workforce Shared Services with any questions.

Your ERISA Rights:
As a participant in the Plan, 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:

- Examine, without charge, in the Workforce Resources Department in Omaha or at your company headquarters if copies are kept there, all documents governing the plan, including insurance contracts, if any, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of the documents governing the operation of the Plan, including insurance contracts, if any, 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.
- 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 the Retiree HRA as a result of a qualifying event. Review the section, "WHEN COVERAGE ENDS AND CONTINUATION OF COVERAGE" for rules regarding your continuation coverage rights.

Maternity and Newborn Infant Coverage:
The Plan 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:
If you or your covered Dependent receives a mastectomy, the covered benefits for the patient will also include coverage of eligible out-of-pocket medical expenses for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; 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 all terms and conditions applicable to Retiree HRA benefits.

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 the 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 any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan 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 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 section, "RETIREE HRA CLAIMS AND APPEALS," for more information.

If there are Plan assets and should Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the 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 the Plan, you should contact the Workforce Resources Department. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration toll free at 866/444/3272 or by visiting EBSA's website at www.dol.gov/ebsa.

Claiming Your Benefits:
You must file a claim if you are eligible for a benefit from the Plan. Often, there are time limits for sending claim forms so be sure of the Plan's deadlines. You

could lose benefits if you delay filing. Please refer to the section, "RETIREE HRA CLAIMS AND APPEALS," for more information.

How You Can Appeal:
If your claim is denied, you have the right to appeal that decision. You may also submit in writing reasons why you think your claim should not be denied. Please refer to the section, "RETIREE HRA CLAIMS AND APPEALS," for more information.

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 0350
Omaha, NE 68179
(402) 544-5000

Future of the Plan:
Union Pacific reserves the right to terminate or amend the Plan 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 would cease or change. The Company may also require or increase 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.

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 determine facts, interpret the terms of the Plan, and 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 her responsibilities under the Plan for the operation and administration of the Plan 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 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 number, policy/contract numbers and plan number for the Plan. It also lists the Plan year, the twelve-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.	INSURANCE CARRIER, ADMINISTRATOR OR TRUSTEE	CONTRACT OR POLICY NO.	PLAN YEAR	CONTRIBUTION SOURCES
Union Pacific Corporation Group Health Plan - Retiree Medical Program Retiree HRA	502 Group Health Plan	ViaBenefits 10975 South Sterling View Drive, Suite A-1 South Jordan, UT 84095		1/1 - 12/31	Employers

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability & Accountability Act (HIPAA) and regulations there under 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 Retiree HRA, which is part of the Group Health Plan and described in this 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 HRA benefits provided to retirees and their Dependents, 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, with respect to benefits under the Group Health Plan that are self-insured by Union Pacific, has adopted a Notice of Privacy Practices ("Notice") which is available upon request to participants in the Group Health Plan. To request a copy of this Notice, contact:

Union Pacific Workforce
Shared Services
1400 Douglas Street, Stop 0320
Omaha, NE 68179-0320
(877) 275-8747 or (402) 544-4000

Permitted and Required Uses and Disclosure of Protected Health Information:
The Group Health Plan may disclose Protected Health Information to Union Pacific only if one of the following applies:

1. The Group Health 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 Group Health Plan discloses information to Union Pacific that is, for purposes of HIPAA's privacy rule, enrollment or disenrollment information;
3. The Group Health 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 Group Health 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 Group Health Plan receives a signed certification from Union Pacific that the Group Health 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 Group Health 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 Group Health Plan in accordance with the Group Health Plan document.

Conditions of Disclosure:
Union Pacific agrees that with respect to Protected Health Information disclosed to Union Pacific by the Group Health Plan, other than enrollment/disenrollment information, Summary Health Information, or disclosure 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 Group Health Plan or as required by law.
b. Ensure that any agents to whom it provides Protected Health Information received from the Group Health 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 Group Health 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 Group Health Plan participant who requests access, the Group Health Plan participant's Protected Health Information in accordance with the HIPAA regulations.
f. Make available to a Group Health 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 Group Health 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 Group Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Group Health Plan with the HIPAA regulations.
i. If feasible, return or destroy all Protected Health Information received from the Group Health 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 Group Health Plan and Union Pacific required in the HIPAA regulations is satisfied.

Adequate Separation between Group Health 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 Group Health Plan and are in the following categories:

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

These employees shall only have access to and use Protected Health Information to the extent necessary to perform the Group Health Plan administrative functions that Union Pacific performs for the Group Health 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 Group Health Plan's Privacy Office:

Union Pacific Workforce
Shared Services
Attn: HIPAA Privacy
1400 Douglas Street
Omaha, NE 68179
(877) 275-8747 or (402) 544-4000

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 Group Health 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 Group Health 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

GLOSSARY

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

Child means 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, and
    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); or
4. A Disabled Child.

Dependent means the retiree's Spouse or the retiree's Child.

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 at the time the Child attains the age of 26 and throughout the period in which coverage is provided.

Disability of a "Disabled Child," means the Child's inability to perform normal activities of a person of like age or sex.

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

Hospital is an institution operated as required by law that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic, and surgical facilities, by or under the supervision of a staff of Doctors.
- Has 24-hour nursing services.

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

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

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

Medicare refers to Parts A, B, C, and D of the insurance program established by Title XVIII, United States Social Security Act, as amended.

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

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 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. If you are required to enroll an alternate recipient pursuant to a QMCSO, your election under the Retiree Medical Program may be changed to provide coverage for such alternate recipient. Additional information, including a copy of guidelines for preparing and administering QMCSOs, may be obtained by calling Union Pacific Workforce Shared Services at (877) 275- 8747, Monday through Friday, 9:00 AM to 5:00 PM Central Time, excluding holidays.

Spouse means the individual 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 individual is entered into, regardless of whether such marriage is recognized in the jurisdiction in which the retiree is domiciled. An individual who is the retiree's Spouse is no longer considered a retiree's Spouse on the date a decree of divorce, legal

separation or annulment between the retiree and his or her Spouse is entered by a court, regardless of whether such individual remains the retiree's 'spouse' after that date under the terms of such decree or any applicable state law.

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.

BENEFIT PHONE NUMBERS

Union Pacific Workforce Shared Services — 9:00 a.m. to 5:00 p.m. (CT)
Toll-Free.....(877) 275-8747
Fax Number.....(402) 233-2736
Email Address…….....HRSC@up.com
Mailing Address.....1400 Douglas Street, Stop 0320, Omaha, NE 68179

- All General Nonagreement or Retirement Benefit Questions
- Medical/Dental/Vision
- Pension
- Service Awards/Retirement Awards

ViaBenefits

- Website.....https://my.viabenefits.com/unionpacific
- Retiree HRA claims and other questions.....(800) 935-7780
- Voluntary decision support services to choose individual Medicare plan coverage.....(800) 935-7780

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.