2017 BlueCross/ BlueShield Retiree Medical Guide

Medical Benefits Available to Union Pacific Retirees and their Dependents effective January 1, 2017

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

SUMMARY PLAN DESCRIPTION
January 1, 2017

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 of this document beginning on page155. This Summary Plan Description does not create a contract of employment.

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INTRODUCTION

This 2017 BlueCross/BlueShield Retiree Medical Guide (the "Guide") describes the healthcare benefits available to certain Union Pacific retirees and their Dependents through the Union Pacific Retiree Medical Program ("Plan" or "Retiree Medical Program"), and reflects the Retiree Medical Program provisions in effect January 1, 2017 for those residing in a BlueCard Network area. Technically, the Retiree Medical Program 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 ERISA and section 9831(a) of the Internal Revenue Code of 1986, as amended (the "Code") as a plan that, as of January 1, 2017, 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.

It is important to note that the benefits provided are covered by provisions of the Employee Retirement Income Security Act of 1974 as amended ("ERISA"), a federal law which governs the operation of employee benefit plans. ERISA requires that you receive 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 2017 UnitedHealthcare (UHC) HDHP PPO 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 2017 UnitedHealthcare (UHC) HDHP PPO 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.

While Union Pacific Corporation ("Company") intends to continue the Plan indefinitely, it 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 Plan, except where otherwise indicated. The "Glossary" section beginning on page 166 is an important reference tool designed to help you understand how the Plan works. Also, you will find definitions of other terms in the various sections of this Guide.

PLAN PARTICIPATION

Eligibility for Benefits at Retirement (Retirement Prior To January 1, 1992):
If you retired prior to January 1, 1992, and either were not eligible to continue participation in the Plan after retirement or were eligible but declined such participation, you may not elect to participate now (the exception being for those events as described in the "Special Enrollment Periods" section shown below).

Eligibility for Benefits at Retirement (Retirement On or After January 1, 1992):
IF:

- You participate in the Union Pacific Corporation Flexible Benefits Program immediately before you terminate employment,
- **AND** you do not elect COBRA continuation coverage with respect to your active employee medical coverage under the Union Pacific Corporation Group Health Plan (or your surviving Spouse did not elect COBRA coverage, if such active employee medical coverage terminated because of your death),
- **AND** upon termination of employment you are eligible (age 65 or at least age 55 with 10 years of vesting service) to begin receiving pension payments immediately (whether or not you actually begin to receive payments) from a qualified pension plan sponsored by Union Pacific Corporation or any of its subsidiaries participating in the Corporation's Flexible Benefits Program,
- **AND**, your original hire date with:
    a. Union Pacific Corporation; or
    b. any Union Pacific affiliate that was a participating employer in the Union Pacific Corporation Flexible Benefits Program on December 31, 2003,

  was before January 1, 2004,

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

Eligibility for Benefits at Retirement (Former Southern Pacific Retirees Retiring Before January 1, 1998):
If you retired prior to January 1, 1998 from Southern Pacific and were eligible and elected retiree medical coverage, you are eligible to participate in the Retiree Medical Program. If you retired prior to January 1, 1998, and either were not eligible to continue participation in the Plan after retirement or were eligible but declined such participation, you may not elect to participate now (the exception being for those events as described in the "Special Enrollment Periods" section shown below).

Retiree Coverage Election:
At the time you retire from Union Pacific, you must elect within 30 days of your retirement to begin Retiree Medical Program coverage or you will waive your right to this coverage and will not be allowed to enter the Plan at a later date, except as described in the section entitled "Special Enrollment Periods" shown below.

Special Enrollment Periods:
Regardless of whether you retired before or after January 1, 1992, if you were eligible to elect Retiree Medical Program coverage and waived your right to do so, you may later enroll yourself if the conditions described in either A. or B. are met:

A. Loss of Eligibility for Other Coverage.
    1. You were covered under a group health plan or health insurance coverage at the time coverage under this Plan was previously offered to you;
    2. Your coverage was terminated as a result of loss of eligibility for the coverage (including legal separation, divorce, annulment, death, termination of employment, eligibility for Medicare, or reduction in the number of hours of employment), or the employer's contributions were terminated, or your coverage under COBRA was exhausted, or you lost eligibility for coverage due to a relocation; and
    3. You request enrollment of yourself in this Plan not later than 30 days after the date of loss of coverage, or the employer's contributions were terminated, or exhaustion of COBRA coverage or lost eligibility due to your relocation.

B. No Longer Enrolled as a Dependent under Active Employee Coverage.
    1. You were enrolled in Union Pacific active nonagreement employee medical coverage under the Union Pacific Corporation Group Health Plan as a Dependent of your Spouse (as such terms are defined in the Union Pacific Corporation Group Health Plan) at the time coverage under this Plan was previously offered to you;
    2. Your Spouse had an annual open enrollment election right with respect to the Union Pacific Corporation Group Health Plan and elected not to enroll you in medical coverage under the

Corporation Group Health Plan as his/her Dependent for the Calendar Year for which the open enrollment election was made; And;

3. You request enrollment of yourself in this Plan not later than 30 days after the date you are no longer enrolled in Union Pacific active nonagreement employee medical coverage under the Union Pacific Corporation Group Health Plan as a Dependent of your Spouse.

In addition, your surviving Spouse may later enroll in the Plan if all of the following conditions are met:

1. You retired on or after January 1, 1999 and were eligible to elect Retiree Medical Program coverage, but either waived your right to do so or elected Retiree Only coverage;
2. Your surviving Spouse was covered under a group health plan or health insurance coverage at the time coverage under this Plan was previously offered to you;
3. Your surviving Spouse's coverage was terminated as a result of loss of eligibility for the coverage (including death, termination of employment, eligibility for Medicare, or reduction in the number of hours of employment), or the employer's contributions were terminated, or coverage under COBRA was exhausted; and
4. Your surviving Spouse requests enrollment in this Plan not later than 30 days after the date of loss of coverage, or the employer's contributions were terminated, or exhaustion of COBRA coverage.

When your surviving Spouse enrolls, he or she also may enroll your Child who meets the definition of a covered Dependent disregarding your death.

Addition of Dependents after Retirement: Except in the case when your surviving Spouse enrolls as described above and as provided below, only Dependents you enroll at the time you elect Retiree Medical Program coverage will receive coverage. However, you may later enroll an eligible Dependent (if you are enrolled) if all of the following conditions are met:

1. Your Dependent was covered under a group health plan or health insurance coverage at the time coverage under this Plan was previously offered to you; and
2. Your Dependent's coverage was terminated as a result of loss of eligibility for the coverage (including legal separation, divorce, death, termination of employment, reduction in the number of hours of employment), or the employer's contributions towards such coverage were terminated, or your Dependent's coverage under COBRA was exhausted; and

3. You requested enrollment of your Dependent in this Plan not later than 30 days after the date of loss of coverage, exhaustion of COBRA, or the employer's contributions were terminated.

In addition, if you are enrolled in the Plan (or were eligible to enroll in the Plan at retirement from Union Pacific but failed to enroll during your enrollment period) and a person becomes a Dependent of yours through marriage, birth, adoption or placement for adoption, then you may enroll yourself, your spouse and your new Dependent, provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective Date of Coverage for Special Enrollment: Enrollment in Retiree Medical Program coverage resulting from a birth, adoption, or placement for adoption of a Dependent Child will be effective as of the event date if notification is received within 30 days of the event. Enrollment in retiree medical plan coverage as a result of any other event described in this "Special Enrollment Periods" section will be effective on the first day of the month following the event date, if notification is received within 30 days of the event.

To request special enrollment or obtain more information, contact the Union Pacific HR Service Center at (877) 275-8747.

Claims paid for Dependents who are found to be ineligible for coverage will be the responsibility of the retiree. Family Deductibles and annual out-of- pocket or other Plan limitations will also be recalculated and may cause further expense to the retiree.

Coverage If You Relocate:
If you have retiree medical coverage at your current location ZIP code, you will be enrolled in a new medical coverage program if you relocate and your current retiree medical coverage program is not available at your new location ZIP code.

You must notify the Union Pacific HR Service Center of your new address within 30 days following your relocation. If your current retiree medical coverage program is not available at your new location, your retiree medical coverage will be as follows:

- If you are not Medicare-eligible, you will be enrolled in either the UHC HDHP PPO or the BCBS HDHP PPO, depending upon your residential address ZIP code at your new location, at the same level of coverage (i.e., single or family) received at your old location.
- If you are Medicare-eligible, your Retiree HRA coverage is not affected by your relocation. Your Dependents who are not Medicare-eligible, if any, will be enrolled in the UHC HDHP PPO or the BCBS HDHP PPO, depending upon your residential address ZIP code. (**Note:** If you have a Medicare Supplemental or Medicare Part D prescription

plan you should notify the carrier for those plan(s) directly of any address changes.)

- If you previously waived coverage at your old location, you will not receive coverage at your new location unless you experience another event described in the 'Special Enrollment Period' section that would allow you to enroll in coverage.

Your new retiree medical coverage will be effective as soon as administratively practicable following your notification to the Union Pacific HR Service Center of your relocation to a new address. Also, the contributions attributable to your new coverage will begin as soon as administratively practicable following your notification.

Dependents:

For purposes of the BCBS HDHP PPO and Retiree HRA, the following definitions apply. For all other Retiree Medical Program coverages, all terms are defined pursuant to the Plan documents that govern the specific coverage.

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

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

  A Spouse does not include an individual with whom the retiree has entered into a registered domestic partnership, civil union or other formal relationship recognized under state law that is not denominated as a marriage under the law of the state in which such relationship is established.

- A "Child" is one of the following:
  1. An individual (son, stepson, daughter, or stepdaughter) who is directly related to the retiree by blood, adoption (or placement for adoption), or marriage, or who is a foster child placed with the retiree by an authorized placement agency or by judgment, order, or decree of any court of competent jurisdiction, and who is under age 26.
  2. An unmarried individual not described in 1, above, who satisfies both a) and b), below:

a) Such individual is under age 26, 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).
4. A Disabled Child.

- A "Disabled Child" means an unmarried Child described in paragraph 1 or 2 of the definition of Child above (without regard to the Child's age but otherwise subject to all other applicable eligibility requirements) who is not self-supporting due to physical handicap, mental handicap, or mental retardation. A Child who is not self-supporting must be mainly dependent on the retiree for care and support. Coverage is available for a Disabled Child on or after attaining age 26 if the Child was a covered Dependent on the day before the Child's 26th birthday and only for the period during which the disability and coverage continue without interruption. The retiree must submit proof to the Plan Administrator, when requested, that the Child meets these conditions at the time the Child attains the age of 26 and throughout the period in which coverage is provided.
- A "disability" of a "Disabled Child," means the Child's inability to perform normal activities of a person of like age or sex.
- A "Qualified Medical Child Support Order" or "QMCSO" means any judgment, order, or decree issued by a court of competent jurisdiction that provides Child support pursuant to a state domestic relations law or pursuant to an administrative proceeding authorized by state statute as described in section 1908 of the Social Security Act which provides for health benefit coverage of an alternate recipient. A QMCSO cannot require 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 the Union Pacific HR Service Center (toll free at (877) 275-8747, Monday through Friday from 9:00 a.m. to 5:00 p.m. Central Time, excluding holidays).

You are responsible for notifying the Union Pacific HR Service Center at (877) 275-8747, within 30 days after an event that either allows an individual to be considered a Dependent (if you wish to enroll such Dependent in Retiree Medical Program coverage) or an event that disqualifies the individual from being considered a Dependent.

The Plan reserves the right to require documentation with respect to you and the individuals you elect to enroll in coverage, including but not limited to, social security numbers and evidence that such individuals satisfy the Plan's definitions of Dependent.

Your Cost for Coverage:
The coverage under this Plan is contributory. This means that retirees must make contributions toward the cost of coverage.

WHEN COVERAGE ENDS

Coverage provided to you and/or your covered Dependents under the Retiree Medical Program described in this document will end as of the last day of the month in which:

1. You stop making any required contribution;
2. You are rehired and become eligible for medical benefits as an active employee;
3. Your Dependent no longer meets the definition of an eligible Dependent;
4. The Plan is terminated or amended in a manner that causes your coverage to end;
5. You die without a surviving Spouse covered by the Plan (unless your surviving Spouse has a right to later enroll in the Plan, as described on page 4 of this document, and elects to do so); or
6. Your surviving Spouse covered by the Plan dies.

Notwithstanding #3 above, medical coverage provided to a Dependent on a Medically Necessary Leave of Absence* will not terminate until the end of the month in which the earliest of the following events occurs:

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

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

the leave of absence. A Medically Necessary Leave of Absence is a leave of absence that:

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

Continuation of Coverage:

Your covered Spouse and Children who are your covered Dependents immediately prior to your death will not cease to be eligible Dependents solely by reason of your death. Assuming the Plan is not terminated or amended in a manner that causes coverage to end, your surviving covered Spouse and other covered Dependents will be permitted to continue Retiree Medical Program coverage after your death so long as they continue to make the required contributions and meet the definition of a covered Dependent disregarding your death. A Child of a deceased retiree who meets the definition of a covered Dependent will continue to be eligible as a Dependent of a surviving covered Spouse. If, upon the death of the retiree, there is no surviving covered Spouse, the Child may have rights to continue benefits under the Retiree Medical Program for up to 36 months under COBRA.

If your Dependent(s) lose healthcare coverage due to loss of eligibility, your Dependent(s) may have rights to continue benefits under the Retiree Medical Program for up to 36 months under COBRA.

CONTINUATION OF COVERAGE UNDER COBRA

Introduction:

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage available under the Plan. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Union Pacific HR Service Center at (877) 275-8747.

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

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Generally under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. However, see the section: "Retiree HRA for Medicare Eligible Retirees and Dependents" on page 127 for special continuation of coverage rules applicable to the Retiree HRA.

If you are the Spouse of a retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

- Your Spouse dies; or
- You become divorced or legally separated from your Spouse.

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

- The covered parent dies;
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child."

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

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the retiree or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Other Qualifying Events:
For the other qualifying events (divorce or legal separation of the retiree and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days of the date on which coverage would end under the Plan because of the qualifying event. You must provide this notice by calling the Union Pacific HR Service Center at (877) 275-8747. When providing this notice, you must provide your name, employee ID or Social Security number, a description of the qualifying event, the date the qualifying event occurred, and the names of the individual(s) losing coverage as a result of the qualifying event. The retiree, Spouse or Dependent, or any person representing any of these individuals can provide this notification. Notification by the retiree, Spouse, or Dependent (or their representative) will satisfy this notification requirement with respect to all individuals who will lose coverage because of the qualifying event.

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the retiree, your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is a

proceeding in bankruptcy, COBRA continuation coverage for the retiree lasts for the retiree's lifetime and COBRA continuation coverage for the retiree's Spouse and Dependent Children may continue for 36 months after the retiree's death, if they survive the retiree. If the retiree is not living at the time of the proceeding in bankruptcy, but the retiree's surviving Spouse is covered by the Plan, COBRA continuation coverage lasts for the surviving Spouse's lifetime.

Premium for COBRA Continuation Coverage: You will be notified as to the amount of your required premium when you receive the notice of your right to continue coverage. The required premium is adjusted each Plan year to reflect actual and anticipated claims experience; thus, your required contribution may change during the continuation period. There is a grace period of 30 days from the premium due date for payment of the regularly scheduled premium. At the end of the continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under the Plan, if any.

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

1. The employer no longer provides group health coverage to any of its retirees;
2. The premium for your continuation coverage is not paid within 30 days of the due date;
3. You become covered after the date you elect COBRA coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have; or
4. You become entitled to Medicare benefits.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

In no event will COBRA continuation coverage last beyond 3 years from the date coverage was lost under the Plan as a result of the qualifying event that originally made a qualified beneficiary eligible to elect coverage.

Are There Other Coverage Options Besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions:
Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, visit the EBSA website at www.dol.gov/ebsa, or contact EBSA at (866) 444-3272. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

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

Plan Contact Information:
For general information about the Plan and COBRA continuation coverage, you may contact the Union Pacific HR Service Center, 1400 Douglas Street, STOP 0320, Omaha, NE 68179-0320, or at (877) 275-8747. If you are currently receiving COBRA continuation coverage and have questions about such coverage, please contact the Plan's COBRA Administrator:

PayFlex Systems USA, Inc.
Attn: Benefit Billing
PO Box 953374
St. Louis, MO 63195-3374
(800) 359-3921

COBRA Administration:
Union Pacific Corporation has retained PayFlex Systems USA to provide certain COBRA services. In this capacity, PayFlex Systems USA handles notifications, eligibility transmittals, record keeping, and billing services. If you have questions about these services, please contact PayFlex Systems USA at the following address:

PayFlex Systems USA, Inc.
Attn: Benefit Billing
PO Box 953374
St. Louis, MO 63195-3374
(800) 359-3921

If you have any questions about your current COBRA coverage, please contract PayFlex Systems USA at (800) 359-3921. If you have additional benefit questions, call the Union Pacific HR Service Center at (877) 275-8747. If you have changed

marital status or you or your Dependents have changed addresses while receiving continuation of benefits under COBRA, you should notify PayFlex Systems USA.

MEDICAL COVERAGE PROGRAM TYPES: AN OVERVIEW

The medical coverage program offered to retirees and Dependents is provided in two different ways, depending upon a person's location and entitlement to Medicare.

All coverage is self-insured by Union Pacific. This means that Union Pacific, not an insurance company, pays for covered services that are incurred and payable by the Plan. Union Pacific contracts with third parties to provide for administrative services, claims processing, network access, and related medical benefit support services for these self-insured medical arrangements.

A brief overview of each coverage type is presented below.

PPO Program:
A Preferred Provider Organization (PPO) is a network of Providers who have agreed to charge discounted rates for medical services in exchange for increased business opportunity. If you are covered by a PPO program, you are given incentives to use PPO Providers. These incentives are in the form of lower Deductibles (the portion of the medical expense paid by you before the Plan begins to pay for healthcare services), higher Plan Coinsurance (the portion of the medical expense paid by the Plan after the Deductible has been met), and lower Coinsurance Maximums. If you go outside the PPO Network for medical care, your expenses will be greater.

The PPO networks used by the Retiree Medical Program are the BlueCard network and the UHC "Choice Plus" network. The network available to you depends on your home address ZIP code. Note – The plan design features for Non-Network coverage for Retirees who enroll in the BCBS HDHP PPO and whose home residence ZIP code is in the state of Wyoming, have Deductibles, Coinsurance and Coinsurance Maximums that are the same for Network Providers and Non-Network Providers. This means there is not a plan design incentive to use Network Providers; however use of Network Providers still may be advantageous to benefit from discounted rates the Network Provider has agreed to accept for services.

PPO Providers also have agreed to accept contracted rates for covered services as payments in full. PPO Providers also file claims for you. The claims processor typically pays the Provider directly and sends you a notice of payment that identifies what amount has been paid and what amount is your responsibility. This notice is often called an Explanation of Benefits (EOB). If you use a Provider outside of the PPO Network, you will likely need to file the claim with your medical coverage program's claim administrator and the amount the Plan will pay

for covered services will be based on the medical coverage program's Reasonable and Customary Charges for such services. The non-PPO Provider may bill you for the balance between his/her fee and the Reasonable and Customary Charges. This is known as "balance billing."

You can select the Doctors of your choice within the PPO Network. You do not need to select a Primary Care Physician (PCP) in order to receive benefits. Nonetheless, it is still recommended that you select and contact a Doctor prior to requiring medical services. The PPO will provide you, upon request and without charge, a list of Hospitals, Doctors, and other Providers affiliated with the PPO.

Both the PPO offered by BlueCross/Blue Shield of Nebraska and the PPO offered by UnitedHealthcare are High Deductible Health Plans. A High Deductible Health Plan (HDHP) is a PPO designed to meet the requirements of a high deductible health plan under Internal Revenue Code section 223. As the name implies, an HDHP typically has a higher deductible than a PPO that is not designed to meet these requirements.

Retiree HRA Program:
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 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. The Retiree HRA gives you considerable flexibility to manage your out-of-pocket medical, dental, and vision expenses.

MEDICAL COVERAGE PROGRAM COVERAGES

Retirees and their Dependents who are not Medicare eligible may enroll in either:

- BCBS HDHP PPO (administered by BlueCross/BlueShield of Nebraska).
- UHC HDHP PPO (administered by UnitedHealthcare).

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

The BCBS HDHP PPO is described in this 2017 BlueCross/BlueShield Retiree Medical Guide. The UHC HDHP PPO is described in the 2017 UnitedHealthcare Retiree Medical Guide.

Retirees and their Dependents who are Medicare eligible may enroll in:

- Retiree HRA coverage (administered by Towers Watson One Exchange and described in this 2017 BlueCross/BlueShield Retiree Medical Guide).

Retiree Transition HRA:

Your participation in any of these programs is in addition to whatever coverage you may have under a Union Pacific Retiree Transition HRA. **The Retiree Transition HRA (administered by PayFlex) is different from the Retiree HRA administered by Towers Watson One Exchange**. No additional amounts are being credited to Retiree Transition HRAs. You have coverage under a Retiree Transition HRA if:

1) Immediately before your retirement you were enrolled in the Union Pacific Corporation Flexible Benefits Program in a UnitedHealthcare or BlueCross/BlueShield medical option that included a Transition HRA feature and;
2) At the time such coverage under the Flexible Benefits Program ceased,
    a) You did not elect to continue such coverage under COBRA;
    b) You had a balance remaining in your Transition HRA (if you retired before January 1, 2008, formerly known as an HRA) on December 31, 2016; and
    c) You have not waived Retiree Transition HRA benefits.

Retirees who qualify for a Retiree Transition HRA are mailed a separate document called the "Retiree Transition HRA Guide." Please consult this document for details about the Retiree Transition HRA Program. For information about the Retiree Transition HRA, you may also contact the Union Pacific HR Service Center at (877) 275-8747.

Impact of Medicare on Medical Plan Coverage and Benefits:

Medicare Part A and Part B is the primary coverage for retirees, and Spouses age 65 and above, or for under age 65 participants who have qualified for Medicare because of disability. If either the retiree or Spouse is Medicare- eligible, then Medicare is primary for Dependents age 65 and above or under age 65 if qualified for Medicare because of disability. You, your Spouse and other Dependents who are Medicare eligible are "Medicare Eligible Participants."

Retiree Medical Program coverage for Medicare Eligible Participants enrolled in the Union Pacific Retiree Medical Program consists of a Retiree Health Reimbursement Account ("Retiree HRA") administered by Towers Watson One Exchange. In addition, if during the Calendar Year you or your Dependent reach age 65, or otherwise become Medicare eligible, coverage under the BCBS HDHP PPO (or UHC HDHP PPO as applicable) for the Medicare Eligible Participant(s) will cease and coverage for the Medicare Eligible Participant will be provided by the Retiree HRA. This change in coverage will be effective the first of the month in which the Medicare Eligible Participant is eligible for Medicare coverage. A non-

Medicare eligible participant will be covered under the BCBS HDHP PPO or the UHC 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. In addition, unreimbursed dental and vision care expenses incurred by a non-Medicare eligible participant may be reimbursed from the Retiree HRA. For details regarding the Retiree HRA, see the "Retiree HRA for Medicare Eligible Retirees and Dependents" section of this document, beginning on page 127.

Important Medicare Part D Coverage Note:
A Medicare Eligible Participant's 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.

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

BLUECROSS/BLUESHIELD HDHP PPO PROGRAM FOR RETIREES AND DEPENDENTS WHO ARE NOT MEDICARE ELIGIBLE

Components:
The BCBS HDHP PPO Program consists of four components, and each component has its own network of Preferred Providers:

1. **PPO Network Benefits**: These benefits are self-insured by Union Pacific. Union Pacific has contracted with BlueCross/BlueShield of Nebraska to administer the BCBS PPO Network and to administer claims and medical management services. Generally, benefits are offered through the BlueCard Network. In this capacity, BlueCross/BlueShield has been granted discretionary authority to interpret terms of the BCBS HDHP PPO Program to determine entitlement to plan benefits in accordance with the terms of the Plan.
2. **Mental Healthcare and Substance Use Disorder Treatment**

Benefits: These benefits are self-insured by Union Pacific and are administered by BlueCross/BlueShield. BCBS has discretionary authority to interpret the terms of Mental Healthcare and Substance Use Disorder Treatment benefits and to determine entitlement to plan benefits in accordance with the terms of the Plan.

3. **Pharmacy Benefits**: These benefits are self-insured by Union Pacific and are administered by UHC/OptumRx. In this capacity, UHC/OptumRx has discretionary authority to interpret the terms of the pharmacy benefits and to determine entitlement to plan benefits in accordance with the terms of the Plan.
4. **Vision Care Benefits:** These benefits enable you to pay discounted rates for exams, frames, and lenses at participating Providers. Union Pacific has contracted with EyeMed Vision Care to administer the vision care benefits. EyeMed has discretionary authority to interpret the terms of the vision care benefits and to determine entitlement to plan benefits in accordance with the terms of the Plan.

Preferred Provider:
The BCBS HDHP PPO offers health benefits through a Preferred Provider Organization (PPO) network. BlueCross/BlueShield of Nebraska is the contract administrator for these benefits. BlueCross/BlueShield of Nebraska, as well as BlueCross/BlueShield plans in other states, has contracted with a PPO network of Hospitals, Doctors and other Healthcare Providers, each in their own geographical area. All BlueCross/BlueShield plans participate in a national program called the BlueCard Program. Each plan has a network of providers who specifically have agreed to participate as a member of the BlueCard Program provider network. The providers in the BlueCard Program network will be referred to collectively in this document as "Preferred Providers." You may view the online BlueCross/BlueShield Preferred BlueCard Provider Directory available through the BCBS website at www.mybenefitshome.com or call (888) 445-6383 to request a printed copy.

The BlueCard Program also enables the plan servicing the geographic area where you receive your care to apply their contracted rate. In this way, you are able to take advantage of the local BlueCross/BlueShield Plan's Participating Provider and Preferred (BlueCard) Provider agreements.

How does the BlueCross/BlueShield Network add value? By using Preferred (BlueCard) Providers, you benefit from these important advantages:

- Preferred Providers accept your Deductible and/or Coinsurance amount(s) plus this Plan's benefit payment as payment in full for a

covered service (unless a benefit maximum has been met); therefore, you have a lower out-of-pocket expense in most cases.

- Lower Coinsurance requirements in most cases. (Coinsurance is the percentage of each allowable charge which you must pay after any applicable Deductible amount has been met.)
- Lower Medical Coinsurance Maximums in most cases. (After your Medical Coinsurance Maximum has been met, most benefits are payable at 100% of the allowable charge.)
- When this Plan pays benefits for services provided to you, it pays directly to the Preferred Provider. Because of this, you may only have to pay a Preferred Provider your Deductible and/or Coinsurance amount(s) at the time covered services are provided.
- Preferred Providers also file your claims for you.

Who is Your BCBS BlueCard Network? BlueCross/BlueShield has contracted with a great number of Providers to provide healthcare services for you and your eligible Dependents. You can search for network providers by accessing www.mybenefitshome.com on the internet or by calling (888) 445- 6383). BlueCross/BlueShield is solely responsible for the selection, credentialing, and monitoring of Providers in the BCBS BlueCard Network. All Providers selected by BlueCross/BlueShield are independent contractors. Union Pacific and its participating subsidiaries do not guarantee the quality of care provided by the BCBS BlueCard Network. You are responsible for choosing a Doctor or Hospital for your care and determining the appropriate course of medical treatment.

About Your BCBS BlueCard Network: BlueCross/BlueShield has carefully selected the participating Doctors and Hospitals. The qualifications of each Healthcare Provider have been reviewed so that you and your Dependents will be provided with quality care at a discounted fee.

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

The final choice of Healthcare Providers is yours. However, if you receive services from a Healthcare Provider included in the BCBS BlueCard Network, the Plan's Coinsurance may be increased, which may decrease the amount you must pay. The benefits are outlined in the Schedule of Benefits on page 28.

The BCBS HDHP PPO allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in the BCBS BlueCard Network and who is available to accept you or your covered Dependent(s). For Children, you may designate a pediatrician as the primary care Provider. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, contact BlueCross/BlueShield at (888) 445-6383 or www.mybenefitshome.com.

You do not need prior authorization from a BCBS HDHP PPO in which you are enrolled or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the BCBS BlueCard Network who specializes obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.
For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BlueCross/BlueShield at (888) 445-6383 or www.mybenefitshome.com.

SPECIAL PROVISIONS THAT APPLY TO PREFERRED PROVIDER NETWORKS

Non-Network expenses may be covered at the Network level. Even in the BCBS PPO Network area, occasionally a provider in a particular specialty is not readily available. To accommodate these cases, whenever a network provider is not available within a 30-mile radius of a retiree's residence, the retiree may use a non-Network provider and still obtain the network level of benefits (i.e., lower Deductibles and higher Plan Coinsurance, if applicable). Since the non-Network provider does not have a contract with BCBS, Plan benefits payable will be based on the Maximum Benefit Amount. If an eligible Dependent does not reside with the retiree, his/her residence is deemed to be the same as the retiree's residence. **To qualify for coverage of non-Network expenses at the In-Network benefit level, the participant must contact the BCBS Customer Service Department (888)445-6383 BEFORE services are rendered** to verify that the non-Network Doctor qualifies for coverage at the network level and to facilitate the appropriate payment of applicable claim(s).

Services performed by radiologists, anesthesiologists, pathologists, or laboratories: If a member receives Inpatient care or Outpatient Surgery care from a network Hospital or network Ambulatory Surgical Center, the services performed by radiologists, anesthesiologists, pathologists or laboratories will be considered In-Network for the purpose of determining Plan benefits. If the radiologists, anesthesiologists, pathologists or

Under certain circumstances, you will be required to notify BCBS in order to avoid having your benefits reduced. See "Reduced Benefits for Failure to follow Required Review Procedures" beginning on page 30 for additional information.

Blue*Card* Program (National):
BlueCross/BlueShield of Nebraska plans across the country participate in the BlueCard Program. This program enables the plan servicing the geographic area where healthcare services are provided to receive and apply their contracted rate for covered services.

When you obtain healthcare services through the BlueCard Program, the amount you pay for covered services is usually calculated on the lower of:

- The billed charges for your covered services, or
- The contracted amount that the local BlueCross/BlueShield (Host Blue) passes onto BlueCross/BlueShield of Nebraska.

Often, this contracted amount will consist of a simple discount which reflects the actual price paid by the Host Blue. The contracted amount may also be billed charges reduced to reflect an average expected savings with your Healthcare Provider or with a specified group of providers.

The contracted amount may also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered the final price.

BlueCross/BlueShield of Nebraska will calculate your liability for any covered healthcare services in accordance with the applicable state statute in effect at the time you received your care**.** BlueCross/BlueShield of Nebraska will process your claim, issue the applicable benefit payment, and create your Explanation of Benefit documents.

An Important Reminder: If more than one Doctor is involved in your care, it is important for you to check the preferred status of each provider. This is especially important when you are receiving services from multiple providers while hospitalized. If you wish to stay within the Preferred Provider Network, make sure your attending Doctor knows this. Ask that you be informed, before the service is performed, if he or she is referring you to a provider outside the Preferred Provider Network.

Notice: If you receive services from a Preferred Provider, your liability will generally be less than if you receive services from a non-Preferred Provider. You may contact the Customer Service Department for BlueCross/BlueShield of

Nebraska to obtain information on Preferred Providers. The telephone number for the Customer Service Department for BlueCross/BlueShield of Nebraska is listed on page 178 of this booklet.

Plan Features:
This section describes the following features of the BCBS HDHP PPO Program: premium contribution, deductibles, coinsurance amount, PPO Provider charges, reasonable and customary limit for charges by non-PPO Providers, and the maximum lifetime benefit limit.

Note: Retirees and Dependents who are not Medicare eligible will have either the BCBS HDHP PPO Program or the UHC HDHP PPO Program available to them, depending on your residential address ZIP code, but not both.

Cost Sharing: "Cost sharing" is a term that refers to the ways in which the Plan and the retiree each pays for a portion of the cost of medical care coverage. Cost of medical coverage is shared through a combination of premium contributions and subsidies, as well as through pay-as-you-go Deductibles and/or Coinsurance.

The following table indicates which features apply to the BCBS HDHP PPO Program. Each feature is then described in the paragraphs that follow.

Program	Premium Contribution	Deductible	Retiree Coinsurance
BCBS HDHP PPO Program	Yes	Yes, higher for Non-Network Providers	Yes, higher for Non-Network Providers

Premium Contribution: You pay a portion of the cost of your medical coverage program in the form of a premium contribution, an after-tax deduction from your monthly pension check or you pay directly to Union Pacific. The amount of the premium contribution depends on your coverage level (Retiree Only or Family). If you are enrolled in the Retiree HRA and have one or more non-Medicare eligible Dependents enrolled in the BCBS HDHP PPO, then your BCBS HDHP PPO premium contribution will be the amount charged for Retiree Only coverage. The services of an actuary and/or underwriter are used to determine premiums for the BCBS HDHP PPO Program.

Deductible: The Deductible is the amount you pay each year before expenses are paid by the Plan. Under the BCBS HDHP PPO Program, there is a single Deductible for medical, including mental healthcare and substance use disorder treatment and pharmacy expenses ("HDHP Deductible").

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

- For the BCBS HDHP PPO Program, the amounts you pay for contracted rates with a Preferred Provider for Covered Services are applied against the HDHP Deductible. If a Non-Preferred Provider is used to receive Covered Services, only the amount you pay up to the Maximum Benefit Amount for Covered Services is applied against the HDHP Deductible.
- The amount paid at a Network Pharmacy for Prescription Drug Products on the Prescription Drug List (See the Pharmacy Section on page 122 for the definition of these terms) is applied against the HDHP Deductible. If you obtain a Prescription Drug Product from a non-Network Pharmacy, only the amount you pay up to the Predominant Reimbursement Rate for a Prescription Drug Product on the Prescription Drug List is applied against the HDHP Deductible. Medications not listed on the Prescription Drug List are excluded from coverage.
- Amounts paid for over-the-counter drugs and vision care Copayments do not count toward your HDHP Deductible.
- The BCBS HDHP PPO Program has a higher HDHP Deductible to meet if Non-Preferred Providers are used. Any eligible expenses incurred will apply to either or both the In-Network and Outside Network HDHP Deductible amounts.

Specific Deductible features are presented in the Schedule of Benefits, starting on page 28.

Retire on a Date Other than January 1st: If you were enrolled in a Medical Care Program Option (other than an HMO) under the Union Pacific Corporation Group Health Plan immediately before you retired, and you retire on a date other than January 1st of a Calendar Year and enroll in the BCBS HDHP PPO, the amount already paid toward active employee Deductibles in the year in which you retire will be counted toward the Retiree Medical Program Deductible in the same Calendar Year.

Coinsurance Amount: Coinsurance is the percentage of the covered expenses for which benefits are payable under the BCBS HDHP PPO Program after application of the HDHP Deductible and before you reach the applicable Coinsurance Maximum.

After the HDHP Deductible is met, the Plan pays a specified percentage of the Covered Services and Prescription Drug Products on the Prescription Drug List and you pay the remaining percentage, up to the Coinsurance Maximum.

- The Medical Coinsurance is a percentage of the fee-for-service contracted rate if a Preferred Provider is used. If a Non-Preferred Provider is used, a lower percentage of Maximum Benefit Amount for Covered Services applies. Your medical Coinsurance payments are capped by the Annual HDHP Coinsurance Maximum.
- The Pharmacy Coinsurance percentage depends on the Plan's Prescription Drug List. The member pays a smaller percentage for Tier-1 (typically Generic drugs), a greater percentage for Tier-2 (typically Preferred brand-name drugs), and the highest percentage for Tier-3 (typically Non-Preferred brand name drugs). There is a per prescription Pharmacy Coinsurance payment equal to the lesser of actual costs or a minimum Pharmacy Coinsurance amount. In addition, the Pharmacy Coinsurance is a percentage of the Prescription Drug Cost if the prescription is dispensed by a Network Pharmacy. If a non- Network Pharmacy is used, the Pharmacy Coinsurance is a percentage of the Prescription Drug Product's Predominant Reimbursement Rate. Per prescription Pharmacy Coinsurance payments are capped to lessen the burden of high cost drugs. Your Pharmacy Coinsurance payments are capped by the Annual HDHP Coinsurance Maximum.

Specific Medical Coinsurance features are presented in the Schedule of Benefits, starting on page 28.

Specific Pharmacy Coinsurance percentages, and per prescription minimum and maximum Pharmacy Coinsurance amounts are presented in the Schedule of Benefits, starting on page 28.

Coinsurance Maximum: The Coinsurance Maximum is the amount you pay each year before the BCBS HDHP PPO Program pays 100% of the fee-for- service contracted Preferred Provider rate or the Maximum Benefit Amount for the rest of the Calendar Year for Covered Services ("Coinsurance Maximum" or "HDHP Coinsurance Maximum").

Under the BCBS HDHP PPO, there is a single Coinsurance Maximum for medical and pharmacy expenses. Once the applicable Coinsurance Maximum is met the BCBS HDHP PPO Program pays 100% of the Prescription Drug Cost or

Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List.

- Expenses above Maximum Benefit Amount for Covered Services and the Predominant Reimbursement Rate for Prescription Drug Products do not count toward a Coinsurance Maximum.
- Expenses you pay to satisfy a Deductible do not count toward a Coinsurance Maximum.
- Any benefit reduction for not notifying BCBS as described on page 28 does not count toward the Coinsurance Maximum.
- Any expense incurred for any health service that is not a Covered Service does not count toward the Coinsurance Maximum.

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

Specific Coinsurance Maximum features are presented in the Schedule of Benefits, starting on page 28.

Retire on a Date Other than January 1st: If you were enrolled in a Medical Care Program Option (other than an HMO) under the Union Pacific Corporation Group Health Plan immediately before you retired, and you retire on a date other than January 1st of a Calendar Year and enroll in the BCBS HDHP PPO, the Coinsurance amount already paid by you under your active medical coverage in the year in which you retire will be counted toward the Retiree Medical Program Coinsurance Maximum in the same Calendar Year.

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

Out-of-network Emergency Care will be considered as having been provided by a Network Provider. If the Covered Person receives initial, short-term (48 hours or less) Outpatient care by a Non-Network Physician or other Non-Network Provider for an Emergency Medical Condition and/or accidental Injury, benefits for those Covered Services will be subject to the In-Network Deductible, Coinsurance, and/or Copayment. Benefits for Inpatient Services will continue to

be paid at the In-network level, as long as the Services are for an Emergency Medical Condition. In addition, any Covered Services provided by a Non- Network urgent care Physician and/or other Non-Network professional Provider will be paid at the In-network level when the corresponding facility charges are paid subject to the In-network benefit amount.

Eligible expenses for non-Emergency services received from non-Network Providers are determined by BlueCross/BlueShield of Nebraska at the billed rate up to the Maximum Benefit Amount. If the Provider is not a Participating Provider, the Plan will only consider the fees up to a Maximum Benefit Amount. The non-Network Provider may bill you for the balance between his/her fee and the amount determined by BlueCross/BlueShield of Nebraska to be the Maximum Benefit Amount. This practice is known as "balance billing." Amounts charged above Maximum Benefit Amount are not "covered" expenses and do not count toward the Deductible or Coinsurance Maximum.

To save money and time, you should use a Network Provider whenever possible to:

- Receive contracted rates, often at a substantial discount,
- Avoid "Balance Billing," and
- Eliminate claim forms.

Maximum Benefit Amount: The Maximum Benefit Amount is a maximum amount determined by BlueCross/BlueShield of Nebraska to be reasonable. The Maximum Benefit Amount will be the amount agreed upon between BlueCross/BlueShield of Nebraska and Participating Providers for the Covered Service. If no amount has been established for a Covered Service, BlueCross/BlueShield of Nebraska may consider the charges submitted by providers for like procedures, a relative value scale that compares the complexity of services provided, or any other factors deemed necessary.

Maximum Lifetime Benefit: The Maximum Lifetime Benefit for Covered Services, including Mental Healthcare/Substance Use Disorder Services, for retirees and their Dependents is $2,000,000 per person beginning with expenses paid by the Plan once you have retired (i.e., expenses paid while covered as an active employee are not included). Amounts for outpatient pharmacy benefits paid by the Plan are not counted towards the Maximum Lifetime Benefit for Covered Services.

Note: Additional limitations that apply to specific benefits are described throughout this document.

Plan Benefits Offered – Schedule of Benefits:
Benefits are payable under the BCBS HDHP PPO for Covered Services and supplies performed or prescribed by a Doctor, which are deemed Medically Necessary as determined by BlueCross/BlueShield of Nebraska for medical services, medical supplies, and/or prescription drugs or for Mental Healthcare/Substance Use Disorder Treatment. Such services and supplies must be provided while coverage is in effect.

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

2017 SCHEDULE OF BENEFITS BCBS HDHP PPO		
Plan Feature	**Network**	**Non-Network**
Medical Care, Mental Healthcare and Substance Use Disorder Treatment		
Annual HDHP Deductible • Individual • Family: 2+ Persons	 $2,600 $5,200	 $ 5,200 $10,400
Note: The Annual HDHP Deductible applies to both Medical and Pharmacy benefits and must be met before the Plan pays benefits. The Annual HDHP Coinsurance Maximum also applies to both Medical and Pharmacy benefits.		
Plan/Retiree Medical Coinsurance after HDHP Deductible • Plan pays • You pay	 80% 20%	 60% 40%
HDHP Coinsurance Maximum (Annual Limit after HDHP Deductible) • Individual • Family: 2+ Persons	 $2,900 $5,800	 $ 5,800 $11,600
Preventive Care (As outlined under "Health Management Programs" see page 81 and "Preventive Pharmacy Benefits" see page 110)	Paid at 100%	No benefits are paid for a Non-Network Provider
Medical Care and Mental Healthcare/Substance Use Disorder Treatment		
Maximum Lifetime Benefit (Combined)		$2,000,000 Per Person

2017 SCHEDULE OF BENEFITS BCBS HDHP PPO		
Plan Feature	**Network**	**Non-Network**
Pharmacy Program		
Retail (Up to 31-day supply)* **Retiree Retail Pharmacy Coinsurance after HDHP Deductible** You pay: Tier 1 – Generic Tier 2 – Preferred Tier 3 – Non-Preferred	Pharmacy Coinsurance Percentage** ($10 minimum,*** $100 maximum Retiree Pharmacy Coinsurance payment per prescription) 20% 30% 40%	
Mail Order (Up to 90-day supply) **Retiree Mail Order Pharmacy Coinsurance after HDHP Deductible** You pay: Tier 1 – Generic Tier 2 – Preferred Tier 3 – Non-Preferred	Pharmacy Coinsurance Percentage** ($25 minimum,*** $150 maximum Retiree Pharmacy Coinsurance payment per prescription) 15% 25% 40%	
* Certain Generic drugs may be purchased at a Retail Pharmacy for a 90-day supply. Contact UHC/OptumRx for more information. ** Retiree Pharmacy Coinsurance counts towards the annual HDHP Coinsurance Maximum. *** If the actual cost of the drug is less than the stated minimum, the member will pay the actual drug cost. Outside Network limits are not applicable for Retirees with a home residence ZIP code in Wyoming (see note on page 14).		
Note: The Annual HDHP Deductible applies to both Medical and Pharmacy benefits and must be met before the Plan pays benefits.		

Medical Care Management Program

What is Medical Care Management ("MCM")? Union Pacific desires to provide you and your family with a healthcare benefit plan that financially protects you from significant healthcare expenses. While part of increasing healthcare costs result from new technology and important medical advances, another significant cause is the way healthcare services are used.

Some studies indicate that a high percentage of the cost for healthcare services may be unnecessary. For example, Hospital stays may be longer than necessary. Some Hospitalizations may be entirely avoidable such as when Surgery could be performed at an Outpatient facility with equal quality and safety. Also, Surgery is sometimes performed when other treatment could be more effective. All of these instances increase costs for you and Union Pacific.

BlueCross/BlueShield is available to assist you in determining whether or not proposed services are appropriate for reimbursement under the Plan. The MCM Program is not intended to diagnose or treat medical conditions, guarantee benefits or validate eligibility. The personnel who conduct the MCM Program focus their review on the appropriateness for reimbursement of Hospital stays and proposed surgical procedures.

The BCBS HDHP PPO does not claim to cover all medical expenses that you or your Doctor may decide to incur. You and your Doctor decide what services and supplies are given, but this Plan only pays for Covered Benefits or Services that are Medically Necessary as determined by BlueCross/BlueShield.

Required Hospital Admission Review: You are required to call the Medical Care Management Program at (800) 247-1103 five days before any admission to a Hospital. You must also call within two business days of any Emergency admission, or, if not medically possible, as soon as reasonably possible; otherwise a non-notification penalty will apply. When you call, it will be necessary to provide the Program with your name, the patient's name, Patient's ID Number, the name of the Doctor and Hospital, the reason for the Hospitalization and any other information needed to complete the review.

Reduced Benefits for Failure to follow Required Review Procedures: Benefits under this Plan are payable as shown in the Schedule of Benefits. However, benefits for Covered Services are reduced by $300 if the covered person does not call BlueCross/BlueShield of Nebraska as required in a timely manner. This reduction is also referred to as a "penalty". This reduction or penalty in benefits will not apply to your Deductible, Coinsurance or Coinsurance Maximum.

Emergency Care/Treatment: Emergency Mental Healthcare or Substance Use Disorder Treatment does not require a call to BlueCross/BlueShield before receiving treatment in order to determine whether services or supplies are Medically Necessary. In an Emergency, calling BlueCross/BlueShield will result in an immediate referral to an appropriate network facility or provider for evaluation and treatment. If you are unable to call BlueCross/BlueShield at the time of the Emergency, BlueCross/BlueShield must be notified within two business days from the time Emergency Care is received, or, if not medically possible, as soon as reasonably possible; otherwise a non-notification penalty will apply.

Discharge Planning: Discharge planning is a process that begins prior to your scheduled hospital admission. Working with you, your family, your attending Doctor(s), and hospital staff, BCBSNE will help plan for and coordinate your discharge to assure that you receive safe and uninterrupted care when needed at the time of discharge.

Case Management Services: Case Management is a voluntary program in which a case manager, with input from you and your health care providers, assists when you are facing and/or recovering from a hospital admission, dealing with multiple medical problems or facing catastrophic needs. BCBSNE case managers can provide educational support, assist in coordinating needed health care services, put you in touch with community resources, assist in addressing obstacles to your recovery such as benefit and caregiver issues and answer your questions.

Large Case Management: Large case management (a voluntary program) is designed to help manage the care of patients who have special or extended care Illnesses or injuries. The primary objective of large case management is to identify and coordinate cost-effective medical care alternatives meeting accepted standards of medical practice. Large case management also monitors the care of the patient, offers emotional support to the family and coordinates communications among Healthcare Providers, patients and others.

Benefits may be modified by BlueCross/BlueShield to permit a method of treatment not expressly provided for but not prohibited by law, rules or public policy. This may occur if BlueCross/BlueShield determines that such modification is more cost-effective than continuing a benefit to which you or your eligible Dependents may otherwise be entitled. BlueCross/BlueShield also reserves the right to limit payment for services to those amounts that would have been charged had the service been provided in the most cost-effective setting in which the service could safely have been provided.

Examples of Illnesses or Injuries that may be appropriate for large case management include, but are not limited to:

- Terminal Illnesses.
    - Cancer.
    - AIDS.
- Chronic Illnesses.
    - Multiple sclerosis.
    - Renal failure.
    - Obstructive pulmonary disease.
    - Cardiac conditions.
- Accident victims requiring long-term rehabilitative therapy.
- Newborns with high-risk complications or multiple birth defects.
- Diagnosis involving long-term IV therapy.

- Illnesses not responding to medical care.
- Mental and nervous disorders - adult and child.
- Burns, strokes, and cases requiring complex care.
- Applied Behavioral Analysis (for treatment of Autism)

Newborns' and Mothers' Health Protection Act of 1996: In accordance with the Newborns' and Mothers' Health Protection Act (NMHPA), enacted on September 26, 1996, group health plans and health insurance issuers 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 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 her newborn earlier than 48 hours after vaginal delivery or 96 hours after a cesarean section. In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the Plan or insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act of 1998: The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998.

If you or your Dependent receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, coverage will be provided for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Doctor and the patient. Such coverage is subject to Annual Deductibles, Coinsurance provisions and other provisions that are applicable to other benefits of the Plan.

Medical and Mental Healthcare Services:
This section describes many of the typical examples of Covered Services and supplies and limits that may apply to the benefits provided under the BCBS HDHP PPO, which is administered by BlueCross/BlueShield of Nebraska. To obtain information about a specific medical service or supply, BlueCross/BlueShield Customer Service at 1-888-445-6383.

This Plan does not claim to cover all medical expenses that you may incur. To be covered by the Plan, BlueCross/BlueShield must determine that the services and supplies are Medically Necessary, and given for the diagnosis or treatment

of an accidental injury or illness. These requirements apply whether or not you receive services or supplies from participating or non-participating Providers.

Important: You and your Doctor decide which services and supplies are provided, but this Plan only pays for Covered Services which are deemed Medically Necessary as determined by BlueCross/BlueShield.

Benefits are available under the Plan for Medically Necessary and scientifically validated services. Services provided by all Healthcare Providers are subject to utilization review by BlueCross/BlueShield of Nebraska. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Doctor. BlueCross/BlueShield of Nebraska will determine whether services provided are Medically Necessary under the terms of the Plan, and will determine eligibility for and entitlement to Plan benefits. Please refer to the definitions in the back of this book for a description of these terms.

Medically Necessary: Healthcare Services ordered by a Treating Doctor exercising prudent clinical judgment, provided to covered person for the purposes of prevention, evaluation, diagnosis or treatment of that covered Person's Illness, Injury or Pregnancy, that are:

1. Consistent with the prevailing professionally recognized standards of medical practice and known to be effective in improving healthcare outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the covered person's Illness, Injury or Pregnancy. The most appropriate setting and the most appropriate level of service is that setting and that level of service, considering the potential benefits and harms to the patient. When this test is applied to the care of an Inpatient, the covered person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and
3. Not more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patients Illness, Injury or Pregnancy, without adversely affecting the covered person's medical condition; and
4. Not provided primarily for the convenience of the following:
    a. The covered person
    b. The Doctor
    c. The covered person's family
    d. Any other person or Healthcare Provider; and

5. Not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

BlueCross/BlueShield of Nebraska will determine whether a service is Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Treating Doctor.

Healthcare Providers: The Plan provides benefits only for Covered Benefits or Services rendered by a Doctor, Practitioner, Nurse, Hospital or Specialized Treatment Facility as those terms are specifically defined in the Definitions section.

Custodial Care: The Plan does not provide benefits for services and supplies that are furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a Healthcare Provider.

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

Residential Treatment Facility: A facility which provides a program of effective Mental Healthcare Services or Substance Use Disorder treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Doctor and approved by the Mental Healthcare/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured environment:
    - room and board;
    - evaluation and diagnosis;
    - counseling; and
    - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital for purposes of the Plan.

Partial Hospitalization/Day Treatment: A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care, specifically designed for the diagnosis and active treatment of a Mental/Nervous Disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or Hospitalization.

Partial Hospitalization programs must provide diagnostic services; services of social workers; psychiatric Nurses and staff trained to work with psychiatric patients; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

The facility providing the build Partial Hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a Doctor.

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

- Surgical services;
- Emergency Health Services; or
- Rehabilitative, laboratory, diagnostic or therapeutic services.

Mental Healthcare/Substance Use Disorder: If a Doctor recommends that you receive mental healthcare/substance use disorder services, BlueCross/BlueShield will make the decision as to whether:

- Such medical service or confinement is Medically Necessary in terms of generally accepted medical standards; or
- Such service or confinement is a Covered Benefit or Service under the Plan.

In addition to the items discussed in the following section, specific programs are offered to help you manage your health. These programs include Preventive Care, Baby BluePrint® Healthy Pregnancy Program, Disease Management for Coronary Artery Disease, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Asthma, Diabetes, Transplant Management Program, Blues On Call℠ Nurseline and the Alternate Medical Treatment Program. These programs are described in more detail starting on page 85.

Amounts payable for the Covered Benefits or Services shown below depend on the network status of the provider. What you pay and what the Plan pays is described in more detail starting on page 28.

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

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	necessary because of the distance involved, or because the patient has an unstable condition requiring medical supervision and rapid transport.	
Anesthesia	Anesthesia and related services given in connection with a covered surgical procedure.	
Audiologists	Charges by a licensed or certified audiologist for Doctor prescribed hearing evaluations to determine the location of a disease within the auditory system; for validation or organicity tests to confirm an organic hearing problem.	Charges for services relating to prescription hearing aids or basic hearing evaluations.
Breast Pumps	Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the rental or purchase cost of one breast pump in conjunction with childbirth.	Benefits are only available if obtained by a Network DME provider with an accompanying prescription from your Doctor.
Breast Reconstruction	Breast reconstruction required as a result of a mastectomy. **Special Notice Regarding Mastectomies:** If you or your Dependent receives a mastectomy, the covered benefits for the patient also include coverage for: a) All stages of reconstruction of the breast on which the mastectomy has been performed, b) Surgery and reconstruction of the other breast to produce a symmetrical appearance, c) Prostheses including	Breast Reconstruction, other than in conjunction with a mastectomy, that does not meet the criteria established through the notification process.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	mastectomy bras and lymphedema stockings for the arm, and d) Treatment of physical complications in all stages of mastectomy, including lymphedemas, e) replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy, f) other services required by the Women's Health and Cancer Rights Act of 1998, including breast treatment of complications, in a manner determined in consultation with the attending Doctor and patient. Such coverage is subject to annual Deductibles, Coinsurance, and other provisions that are applicable to other benefits of the BCBS HDHP PPO Program.	
Breast Reduction	Breast reduction Surgery is a Covered Service with documentation of the following functional impairments: 1. Shoulder grooving or excoriation resulting from the brassiere shoulder straps, due to the weight of the breasts; AND 2. Documentation from medical records of medical services related to complaints of the shoulder, neck or back	Breast reduction Surgery is NOT a Covered Service when performed to improve appearance or for the purpose of improving athletic performance.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	pain attributable to macromastia. In addition, the Surgery must be determined not to be cosmetic by BlueCross/BlueShield Medical Management. Breast reduction surgery is covered when a reconstruction has been performed on the other breast (See **Special Notice Regarding Mastectomies**, above).	
Cardiac and Pulmonary Rehabilitation Services	Services must be performed by a licensed therapy Provider under the direction of a Doctor. Benefits are available only for the rehabilitation services that are expected to result in significant physical improvement in the patient's condition within four months of the start of treatment. The primary intent is to improve the functional capacity of the heart and provide the necessary skills for self-monitoring of unsupervised exercise.	Membership to health clubs or equipment to use at home is not covered. The Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
Chiropractic Care/Spinal Manipulation	Services of a spinal treatment specialist in the specialist's office for chiropractic and osteopathic manipulative therapy, including diagnosis and related treatment. Limited to 30 visits per Calendar Year.	Massage therapy is NOT covered. The Plan excludes treatment that ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.
Clinical Trials	Approved Clinical Trials for qualified individuals, as described in the PPACA	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	Approved Clinical Trials: A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following: • A federally funded or approved trial. • A clinical trial conducted under an FDA investigational new drug application. • A drug trial that is exempt from the requirement of an FDA investigational new drug application.	
Cochlear Implant	Covered if diagnosis of severe to profound bilateral sensorineural hearing loss and severely difficult speech discrimination, or post-lingual sensorineural deafness in an adult.	
Cosmetic Services	The following cosmetic procedures are covered, provided notification is received and the procedure has been determined to be reconstructive rather than cosmetic: • Correction of a congenital anomaly. • Repair, following accidental injury. • Reconstructive Surgery (See Surgery, page 64).	Cosmetic services that do not meet the criteria listed will not be covered.
Dental Services	The following services and supplies are covered only if needed because of accidental Injury to natural teeth: • Oral Surgery.	Dental services that are not a result of an Accident. Dental damage that occurs as a result of normal activities of daily living or extraordinary

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	• Full or partial dentures. • Fixed bridgework. • Prompt repair to natural teeth. • Crowns. • Required anesthesia to perform covered dental services. Accident/Injury must have occurred while coverage is in effect. Dental treatment is covered only if needed because of accidental injury to natural sound teeth. Services must be: • Provided by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). • As a result of damage severe enough that the initial contact with the Doctor or Dentist occurred within 72 hours of the Accident. Benefits are available only for treatment of sound, natural teeth. The Dentist must certify that the Injury to the tooth was a virgin or unrestored tooth; has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally during chewing and speech.	use of teeth. Dental Services that are submitted for payment consideration under the BCBS HDHP PPO are subject to the notification procedures for determination of meeting the criteria as a Covered Service.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	Services for final treatment to repair the damage must be started within 3 months of the Accident and completed within 12 months of the Accident.	
Diabetic Supplies	Diabetic supplies including syringes, test strips and lancets are covered under the Pharmacy Program (see page 98). Insulin pump and Glucose Monitors are covered under Durable Medical Equipment.	
Dialysis	Covered services subject to coordination with Medicare for End Stage Renal Disease.	
Disposable Medical Supplies	Must be prescribed by Doctor, including ostomy supplies.	Non-prescribed supplies.
Durable Medical Equipment	Durable Medical Equipment that meets each of the following criteria: a. Ordered or provided by a Doctor for Outpatient use; b. Used for medical purposes; c. Not consumable or disposable; and d. Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet the patient's functional needs, DME benefits are available only for the most cost effective piece of equipment. Examples include: • Equipment to assist mobility such as wheelchairs, Hospital type beds, oxygen	A brace that straightens or changes the shape of the body part is an orthopedic device and is not covered under the DME benefit, except for cranial banding. Dental braces are also excluded from coverage. Air conditioners, humidifiers, dehumidifiers, air purifiers and filters are not covered. Tanning beds are not covered. Hearing aids, fittings and replacement hearing aids are not covered. You must purchase or rent the DME from the vendor BlueCross/BlueShield Medical Management identifies.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	concentrator units and the purchase or rental of equipment to administer oxygen (including tubing and connectors). • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure is covered. • Burn garments. • Insulin pumps. • Cranial banding. • Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that treat curvature of the spine are covered under the DME benefit. The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.	
Emergency Health Services (i.e., Emergency Room)	A true Emergency is paid at the In-Network level regardless of the network status of the facility that provides the Emergency health services. A true Emergency is defined as a serious medical condition or symptom resulting from Injury, sickness or mental Illness which arises suddenly, and in the judgment of a reasonable person requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health. If	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	the Emergency Health Services visit results in an Inpatient stay, notification is required. The participant must call within two business days of admission; or, if not medically possible, as soon as reasonably possible; otherwise, a non-notification penalty of $300 will apply.	
Enteral Nutrition	Defined as the delivery of nutrients in liquid form directly into the stomach, duodenum or jejunum, and used when the patient's condition precludes oral intake. Enteral nutrition is covered when it is the sole source of nutrition or when a certain nutritional formula treats inborn error of metabolism.	
Family Planning	See Reproductive Services (page 59).	
Gender Dysphoria Services that are submitted for payment consideration under the BCBS HDHP PPO are subject to the notification procedures for determination of meeting the criteria as a Covered Service.	Non-surgical treatment: See Mental Healthcare Benefits (page 51). Laboratory testing to monitor the safety of continuous hormone therapy. Hormone replacement therapy covered under the Pharmacy Program. Surgical treatment: See Surgery (page 64).	Sperm preservation in advance of hormone treatment or gender surgery. Cryopreservation of fertilized embryos. Treatment received outside the United States.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Hearing Care	Hearing screenings as part of a routine preventive office visit are covered under the Preventive Services Benefit.	Hearing aids, fittings and replacement hearing aids are not covered.
Home Healthcare (Notification required)	Services received from a home health agency that are both ordered by a Doctor and provided by or supervised by a registered Nurse in your home. Benefits are available only when the home health agency services are provided on a part-time, intermittent schedule and when skilled home healthcare is required. Skilled home healthcare is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: 1. Delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; 2. Ordered by the Doctor; 3. Delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; 4. Ordered by the Doctor;	Custodial Care or care for the purpose of assisting with the activities of daily living, including, but not limited to dressing, feeding, bathing or transferring from a bed to a chair, are not covered. A service will not be determined to be "skilled" simply because there is not an available caregiver.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	5. Is not delivered for the purpose of assisting with the activities of daily living; 6. Requires clinical training in order to be delivered safely and effectively; and 7. Is not Custodial Care. BlueCross/BlueShield Medical Management will decide if skilled home healthcare is required by reviewing both the skilled nature of the service and the need for Doctor-directed medical management. Limited to any combination of 40 Network and Non-Network visits per Calendar Year. One visit equals four hours of skilled care services.	
Hospice Care (Notification required)	Hospice care that is recommended by a Doctor. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and for short-term grief counseling for	Volunteer services or services normally provided at no charge. Private duty nursing. Legal or financial advice. Counseling by clergy or any volunteer group not specifically rendered by and charged for by the hospice. Services provided by a person who

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. The following Hospice Care Benefits are covered: • Room and board charges in a Hospice Facility, except for charges that exceed the Hospital's most common semi-private room rate for any day you are Hospital confined; or charges that exceed the Hospice Facility's most common semi-private room rate for any day you are confined in a freestanding Hospice Facility. A Hospice Facility must offer a hospice program that is approved by BlueCross/BlueShield and must either be a Hospital, a freestanding Hospice Facility that provides Inpatient care, or an organization that provides healthcare services in your home. The facility can provide these services using its own staff or by contracting with other organizations. • Skilled nursing or home health aide services provided by a Nurse or a licensed practical Nurse; • Counseling to enhance your peace of mind if your Doctor determines	lives in your home or who is a member of your immediate family.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	that your mental state is caused by your terminal Illness. Such counseling is also covered for members of your family after your death. • Up to 7 days of respite care given by a homemaker service; • Physical, respiratory, or speech therapy; • Services of a licensed nutritionist or dietician if needed as part of your hospice care; • Local ambulance or special transport service between your home and the Hospice Facility; • Other services which your Doctor and BlueCross/BlueShield determine to be Medically Necessary and which are provided through the hospice program, such as medical supplies, medicines, drugs, Doctor's services, and the rental or purchase of Durable Medical Equipment, whichever is less expensive.	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Hospital – Inpatient Stay (Notification required)	Notification is required for elective admissions (five days before the admission), non-elective admissions (within one business day of admission), and Emergency Admissions (within two business days of admission, or if not medically possible, as soon as reasonably possible after admission). Benefits available for services and supplies (including room and board) received during the Inpatient stay in a semi-private room (two or more beds). Private rooms are covered up to the highest semi-private room rate for that facility, except that the extra costs of a private room can be covered: 1. When the Hospital is an all private room Hospital; 2. When the Hospital's semi-private rooms are filled and only a private room is available; or 3. When a private room must be used to keep the patient isolated because of the patient's diagnosis.	Charges over and above the highest semi-private room rate are not covered, except as noted in the adjacent covered benefits paragraph.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Infertility	See Reproductive Services (page 59).	
Infertility – Assisted Reproductive Technology	See Reproductive Services (page 59).	
Inpatient Prescription Drugs	See Prescribed Drugs and Medicines (page 57).	
Laboratory Services	Laboratory tests for diagnosis or treatment are covered expenses.	
Maternity Care	See Reproductive Services (page 59).	
Medical Supplies	Surgical supplies (such as bandages and dressings). Supplies given during Surgery or a diagnostic procedure are included in the overall cost for that Surgery or diagnostic procedure. Blood or blood derivatives only if not donated or replaced. Ostomy supplies.	
Mental Healthcare Benefits (Notification required for inpatient)	Mental Healthcare Services include those received on an Inpatient or intermediate care basis in a hospital or Alternate Facility, and those received on an Outpatient basis in a provider's office or at an Alternate Facility. Benefits for Mental Healthcare Services include:	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Mental Healthcare Benefits (Notification required for inpatient)	• mental healthcare evaluations and assessment; • diagnosis; • treatment planning; • referral services; • medication management; • inpatient services; • partial hospitalization/day treatment; • Intensive Outpatient Treatment; • services at a Residential Treatment Facility; • individual, family and group therapeutic services; • crisis intervention; and • psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses. BCBS will determine if an Inpatient stay is Medically Necessary. If an inpatient stay is required, it is covered on a semi-private room basis; except: 1. When the hospital is an all private room hospital When the hospital's semi-private rooms are filled and only a private room is available; 2. When the Hospital's semi-private rooms are filled and only a private room is available.	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	3. When a private room must be used to keep the patient isolated because of the patient's diagnosis. You are encouraged to contact BCBS for referrals to providers and coordination of care. **Special Mental Healthcare Programs and Services:** Special programs and services that are contracted under BCBS may become available to you as part of your Mental Healthcare Services benefit. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through BCBS, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the covered person and is not mandatory. Mental Healthcare and Substance Use Disorder Treatment services and supplies are subject to Deductibles and Coinsurance as presented in the Schedule of Benefits on page 28.	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Neurobiological Disorders – Mental Healthcare Services for Autism Spectrum Disorders (Notification required for inpatient or for Applied Behavioral Analysis)	The Plan pays benefits for psychiatric services for Autism Spectrum Disorders that are both of the following: • Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and • Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning. These benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Service for which benefits are available under the applicable medical Covered Services categories as described in this section. Benefits include: • diagnostic evaluations and assessment; • treatment planning; • referral services; • medical management; • Inpatient/24-hour supervisory care; • Partial Hospitalization /Day Treatment; • Intensive Outpatient Treatment; • services at a Residential	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	Treatment Facility; • individual, family, therapeutic group and provider-based case management services; • applied behavioral analysis • psychotherapy, consultation and training session for parents and paraprofessional and resource support to family; • crisis intervention; and • transitional care. You are encouraged to contact BCBS for referrals to providers and coordination of care. Neurobiological Disorders – Mental Healthcare Services for Autism Spectrum Disorder services and supplies are subject to Deductibles and Coinsurance as presented in the Schedule of Benefits (starting on page 28).	
Nutritional Counseling	Covered Services provided by a registered dietician in an individual session for covered persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus. • Coronary artery disease.	Nutritional counseling for: • Weight loss/obesity. • Conditions which have not been shown to be nutritionally related, including but not limited to chronic fatigue syndrome and hyperactivity.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	• Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias.	Benefits are limited to three individual sessions during a covered person's participation in the Plan.
Obesity Surgery	See Surgery (page 64).	
Organ/Tissue Transplants	Services and supplies for Medically Necessary organ or tissue transplants are covered subject to the following limitations. Organ/Tissue Transplant benefits for HDHP PPO members are subject to HDHP Deductible and Medical Coinsurance. **Donor Charges for Organ/Tissue Transplants:** Donor charges are considered covered expenses ONLY if the recipient is a covered person under the Plan. If the recipient is not a covered person, no benefits are payable for donor charges. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Service unless the search is made in connection with a transplant procedure arranged by a designated transplant facility. See the Transplant Management Program for additional covered benefits for certain qualified transplant procedures (page 83).	
Orthognathic Surgery	See Surgery (page 64).	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Outpatient Therapy	Short-term Outpatient rehabilitation services (including habilitation services), limited to 30 visits per year for the combination of: • Physical therapy. • Occupational therapy. • Speech therapy. Rehabilitation services must be provided by a licensed therapy Provider under the direction of a Doctor. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. The therapy must be ordered and monitored by a Doctor as part of a Medically Necessary course of treatment for a bodily injury or disease. The therapy must be ordered and monitored by a Doctor as part of a Medically Necessary course of treatment for a bodily injury or disease. The therapy must be provided in accordance with a written treatment plan approved by a Doctor. Benefits for speech therapy are available only when the speech impediment or speech dysfunction results from Injury, stroke, a congenital anomaly or if such therapy is considered "habilitative services." Habilitative services are healthcare services that help a covered person keep, learn or improve skills and functioning for daily living.	The Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Vocational rehabilitation is not covered.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	Medical care and treatment by a Doctor including hospital, office and home visits, and Emergency room services. Covered Services received in a Doctor's office including: • Treatment of a sickness or Injury. • Preventive medical care. • Voluntary family planning. • Well-baby and well-child care. • Routine well woman examinations, including pap smears, pelvic examinations, and mammograms. • Routine physical examinations, including hearing screenings. • Immunizations.	
Physical Therapy	See Outpatient Therapy (page 56).	
Prescribed Drugs and Medicines	Prescribed drugs and medicines for Inpatient services are covered under the medical plan provisions.	
Preventive Care	See Preventive Care on page 81 under "Health Management Programs."	
Pulmonary Rehabilitation	See Cardiac and Pulmonary Rehabilitation Therapy on	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Prosthetic Devices	Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to: • Artificial limbs. • Artificial eyes. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The device must be ordered or provided either by a Doctor, or under a Doctor's direction.	Duplicate prosthetics, appliance cost for the replacement of stolen prosthetic devices and prosthetics that are less than five years old are not covered.
Pulmonary Rehabilitation Therapy	See Cardiac and Pulmonary Rehabilitation Therapy on page 39.	
RAPL (Radiology, Anesthesiology, Pathology and Lab)	Services performed by radiologists, anesthesiologists, pathologists and laboratory.	
Reconstructive Surgery	See Surgery (page 64).	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Reproductive Services (All Inpatient hospitalizations are subject to the notification requirements.)	**Family Planning:** Norplant and IUDs are covered under the medical plan provisions. When Reproductive Services are billed as a preventive care service, these services will be paid as described under Preventive Care. **Infertility** - Assisted Reproductive Technology treatments, including (but not limited to) artificial insemination, GIFT, ZIFT, or in-vitro fertilization, are Covered Benefits or Services. This includes confinement in a Hospital or specialized facility in connection with infertility treatments. Covered infertility treatment services include the following: • In vitro fertilization. • Artificial insemination. • The use of donor ovum and donor sperm and related costs, including collection and preparation. • Embryo transfer. • Gamete intrafallopian transfer. • Zygote intrafallopian transfer.	Oral contraceptives and Depo-Provera are not covered under this medical program, but are covered under the Pharmacy Program. Injectable drug therapy that is self administered is not covered under this medical program but is covered under the Pharmacy Program. (See Pharmacy on page 97) The Plan will not pay for the cost of donor sperm or egg or any related donor fees.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	• Tubal ovum transfer. • Surgery. • Injectable drug therapy administered within the Doctor's office. **Maternity Care:** Benefits for pregnancy will be paid at the same level as benefits for any other condition, Sickness or Injury, unless the services are considered to be preventive services, which are payable at 100% of In-Network covered expenses. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. There is a special prenatal program to help during pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify BlueCross/BlueShield Medical Management during the first trimester, but no later than one month prior to the anticipated childbirth. See ***Baby BluePrints***® (page 82). The Plan will pay benefits for an Inpatient Stay for the birth of a child of at least 48 hours for the mother and newborn child following a normal vaginal delivery and 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending Provider	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	may discharge the mother and/or the newborn child earlier than these minimum time frames. You must notify Medical Management as soon as reasonably possible, if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. **Sterilization:** Covered services include vasectomy and tubal ligation.	Reversals are not covered.
Second/Third Opinions	See Surgery (page 64).	
Skilled Nursing Facility/Inpatient Rehabilitation Facility (Notification required)	Skilled Nursing Facility/Inpatient Rehabilitation Facility benefits are payable for room and board charges for up to 45 days of confinement in a Skilled Nursing Facility/Inpatient Rehabilitation Facility if the charges are incurred while you are confined in the Facility and while coverage is in effect. Such confinement must be due to an injury or Illness covered by the Plan. The stay must: a. Be for convalescent care; b. Start immediately after the end of a Hospital stay for which benefits are payable under the Plan; and c. Be for the same or related condition as the Hospital stay.	
Speech Therapy	See Outpatient Therapy (page 56).	
Sterilization	See Reproductive Services (pg 59)	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Substance Use Disorder Treatment (Notification required for inpatient)	Substance Use Disorder Services include those received on an Inpatient or intermediate care basis in a Hospital or an Alternate Facility and those received on an Outpatient basis in a provider's office or at an Alternate Facility. Benefits for Substance Use Disorder Services include: • Substance Use Disorder or chemical dependency evaluations and assessment; • diagnosis; • treatment planning; • detoxification (sub-acute/non-medical); • Inpatient services; • Partial Hospitalization/Day Treatment; • Intensive Outpatient Treatment; • services at a Residential Treatment Facility; • referral services; • medication management; • individual, family and group therapeutic services; and • crisis intervention. The appropriate setting for the treatment will be determined by Medical Necessity. If an Inpatient Stay is required, it is a covered on a Semi-private	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	Room basis; except: 1. When the Hospital is an all private room Hospital; 2. When the Hospital's semi-private rooms are filled and only a private room is available; 3. When a private room must be used to keep the patient isolated because of the patient's diagnosis. You are encouraged to contact BCBS for referrals to providers and coordination of care. **Special Substance Use Disorder Programs and Services** Special programs and services that are contracted under BCBS may become available to you as part of your Substance Use Disorder Services benefit. The Mental Healthcare Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	of your Substance Use Disorder which may not otherwise be covered under this Plan. You must be referred to such programs through BCBS, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the covered person and is not mandatory. Substance Use Disorder Treatment services and supplies are subject to Deductibles and Coinsurance as presented in the Schedule of Benefits (starting on page 28).	
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (All Inpatient hospitalization is subject to the notification requirements)	Professional fees for surgical procedures and other medical care related to the surgical procedure received from a Doctor in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, Outpatient Surgery facility, Birthing Center, or via a Doctor house call. Benefits include the facility charge and the charge for required services, supplies and equipment. **Reconstructive Surgery:** Reconstructive Surgery to improve the function of a	Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. The following are not covered by the Second/Third Surgical Opinion Program: • An opinion on a surgical procedure that would not be covered under the BCBS HDHP PPO. • Any charges in connection with a surgical procedure, if they are

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	body part when the malfunction is the direct result of one of the following: • Birth defect. • Sickness. • Surgery to treat a sickness or accidental injury. • Accidental injury. • Reconstructive breast Surgery following a mastectomy. • Reconstructive Surgery to remove scar tissue on the neck, face or head if the scar tissue is due to sickness or accidental injury. **Special Notice Regarding Mastectomies:** If you or your Dependent receives a mastectomy, the covered benefits for the patient will also include coverage for: a. All stages of reconstruction of the breast on which the mastectomy has been performed; b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; c. Prostheses including mastectomy bras and lymphedema stockings for the arm; and d. Treatment of physical complications in all stages of mastectomy, including lymphedemas, e. Replacement of an existing breast implant if	payable under other provisions of the BCBS HDHP PPO. • Diagnostic surgery performed by the Doctor who gives the opinion. • More than two opinions per surgical procedure after the initial recommendation for surgery. Obesity surgery is subject to notification requirements before the surgery is scheduled. If it is determined that obesity surgery services do not meet the definition of a Covered Service, the services will not be covered. Non-surgical treatment of obesity, including morbid obesity, is not covered. **Note:** Abdominoplasty and panniculectomy are not covered, even when recommended as a result of approved obesity surgery services. Orthognathic surgery is not covered for the following symptoms: • Myofacial, neck, head and shoulder pain. • Irritation of head/neck muscles. • Popping/clicking of

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	the initial breast implant followed mastectomy, and f. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast treatment of complications, in a manner determined in consultation with the attending Doctor and the patient. **Such coverage is subject to Annual Deductibles, Coinsurance and other provisions applicable to the other benefits of the BCBS HDHP PPO Program.** **Assistant Surgeon Services:** Covered expenses for assistant surgeon services are limited to one-fifth of the amount of covered expenses for the surgeon's charge for the Surgery. An assistant surgeon must be a Doctor. **Second Surgical Opinion Program:** This voluntary program applies when a Doctor recommends that you or a covered Dependent undergo any elective or non-Emergency surgical procedure. You may voluntarily obtain a Second Surgical Opinion for any non-Emergency surgical procedure. The purpose of the Second Surgical Opinion is advisory only. It is the patient's decision whether or	temporomandibular joint(s). • Potential for development or exacerbation of temporomandibular joint dysfunction. • Teeth grinding. • Treatment of malocclusion.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	not to undergo the Surgery. Benefits for the Second Surgical Opinion are subject to the cost sharing features of the Plan, such as Deductible and Coinsurance. Benefits will be payable for a third opinion on the same basis as benefits for the second opinion. The Doctor who gives the second opinion must: a. Be qualified to render an opinion on the specific surgical procedure in question, and b. Examine you in person. **Obesity Surgery:** Surgical treatment for severe/morbid obesity, as defined by NIH (National Institutes on Health) must meet the following: • **Severe Obesity:** BMI of 35-40 with co-morbidities, or • **Morbid Obesity:** BMI of 40 or greater. In addition, the patient's medical history must demonstrate that dietary attempts at weight control have been ineffective, and that there is no specifically correctable cause for obesity (e.g. an endocrine disorder). Benefits are payable only for services from a Network Provider. BCBS must be notified before the obesity surgery is scheduled. **Orthognathic Surgery** is covered in the following situations:	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	• A jaw deformity resulting from facial trauma or cancer; or • A skeletal anomaly of either the maxilla or mandible that demonstrates a functional medical impairment such as one of the following: ▪ Inability to incise solid foods; or ▪ Choking on incompletely masticated solid foods; or ▪ Damage to soft tissue during mastication; or ▪ Speech impediment determined to be due to the jaw deformity; or ▪ Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity. ▪ Orthognathic Surgery, jaw alignment and treatment for the Temporo Mandibular Joint as a treatment of obstructive sleep apnea. **Gender Dysphoria Surgery:** The Plan covers genital surgery and surgery to change secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty) and related services when the following eligibility qualifications for surgery are met:	Cosmetic Procedures, including the following: • Abdominoplasty. • Blepharoplasty. • Breast enlargement, including augmentation mammoplasty and breast implants.

	• The treatment plan must conform to identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance; and • For irreversible surgical interventions, the Covered Person must be age 18 years or older; and • Prior to surgery, the covered person must complete 12 months of successful continuous full time real life experience in the desired gender. Important: - Certain covered persons will be required to complete continuous hormone therapy prior to surgery. In consultation with the covered person's Physician, this will be determined on a case-by-case basis through the prior authorization process. - Augmentation mammoplasty is allowed if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role. BCBSNE has specific guidelines regarding Benefits for treatment of gender dysphoria (Gender Identity Disorder). Contact BCBSNE at 800-642-8980 for information	• Body contouring, such as lipoplasty. • Brow lift. • Calf implants. • Cheek, chin, and nose implants. • Injection of fillers or neurotoxins. • Face lift, forehead lift, or neck tightening. • Facial bone remodeling for facial feminizations. • Hair removal. • Hair transplantation. • Lip augmentation. • Lip reduction. • Liposuction. • Mastopexy. • Pectoral implants for chest masculinization. • Rhinoplasty. • Skin resurfacing. • Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). • Voice modification surgery. • Voice lessons and voice therapy.

	about these guidelines. • The treatment plan must conform to identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance; and • For irreversible surgical interventions, the Covered Person must be age 18 years or older; and • Prior to surgery, the covered person must complete 12 months of successful continuous full time real life experience in the desired gender. Important: - Certain covered persons will be required to complete continuous hormone therapy prior to surgery. In consultation with the covered person's Physician, this will be determined on a case-by-case basis through the prior authorization process. - Augmentation mammoplasty is allowed if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role. UHC has specific guidelines regarding Benefits for treatment of gender dysphoria (Gender Identity Disorder). Contact UHC at 800-642-8980 for information about these guidelines.	• Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.

Transplants	See Organ/Tissue Transplants (page 55).	

Additional Exclusions:
The BCBS HDHP PPO does not cover any expenses incurred for services, treatments, items or supplies described in this section, even if either or both of the following are true:

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

The services, treatments, items, or supplies listed in this section are not Covered Services, except as may be specifically provided for in the section on "Medical and Mental Healthcare Services" beginning on page 32 of this document. Note also the exclusions stated in the "Covered Services" section beginning on page 36 under the column headed "What's Not Covered."

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
Alternative Treatments	• Acupressure. • Aromatherapy. • Hypnotism. • Massage therapy. • Rolfing. • Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
Comfort or Convenience	• Television. • Telephone. • Beauty/barber service. • Guest service. • Supplies, equipment, and similar incidental services and supplies for personal comfort (i.e., air conditioners, air purifiers and filters, batteries and battery charges, dehumidifiers, humidifiers). • Devices and computers to assist in communication and speech. • Home remodeling to accommodate a health need, such as (but not limited to) ramps and swimming pools.
Cosmetic Services	• All cosmetic services except those described under "Covered Services" on page 40.
Dental	• Dental care, except as described under "Medical Services" on page 40 of this document. • Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums (i.e., extraction, restoration and replacement of teeth, medical or surgical treatments of dental

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
	conditions, services to improve dental clinical outcomes). • Dental implants. • Dental braces. • Dental x-rays, supplies and appliances, and all associated expenses, including Hospitalizations and anesthesia. The only exceptions to this are for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic injury, cancer, or cleft palate; in which case, the treatment and anesthesia required to perform the treatment will be covered. • Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
Drugs under the Medical Plan	• Prescription drug products for Outpatient use that are filled by a Prescription Order or Refill. • Self-injectable medications. • Non-injectable medications provided in a Doctor's office, except as required in an Emergency. • Over-the-counter drugs and treatments. • Coordination of Benefits as a secondary payment for Prescription Drugs purchased through a non-Union Pacific Health Plan.
Experimental, Investigational, or Unproven Services	• Experimental, investigational, or unproven services are excluded. The fact that an experimental, investigational, or unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental, investigational, or unproven in the treatment of that particular condition.
Foot Care	• Except when needed for severe systemic disease, routine foot care (including the cutting or removal of corns and calluses) and nail trimming, cutting, or debriding. • Hygienic and preventive maintenance foot care (i.e., cleaning and soaking the feet, applying skin creams in order to maintain skin tone, other services that are performed when there is not a

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
	localized Illness, injury or symptom involving the foot). • Treatment of flat feet. • Treatment of sublaxation of the foot. • Shoe orthotics. • Shoes (standard or custom), lifts and wedges. • Shoe inserts. • Arch supports.
Mental Healthcare/Substance Use Disorder	• Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. • Treatment for mental Illness that will not substantially improve beyond the current level of functioning or that are not subject to favorable modification or management according to prevailing national standards of clinical practice as reasonably determined by BlueCross/BlueShield. • Services utilizing methadone treatment as maintenance, I.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. • Treatment provided in connection with or to comply with involuntary commitments, police detentions, and other similar arrangements unless authorized by BlueCross/BlueShield. • Services or supplies for the diagnosis or treatment of mental Illness, alcoholism, or substance use disorder disorders that, in the reasonable judgment of BlueCross/BlueShield, are any of the following: ▪ Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. ▪ Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome,

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
	and therefore considered experimental. ▪ Do not typically result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. ▪ Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. ▪ Not consistent with BlueCross/BlueShield's guidelines or best practices as modified from time to time. • Mental Healthcare Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* • Mental Healthcare Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. • Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by BCBS. • Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. • Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act.* • Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical*

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
	Manual of the American Psychiatric Association. • Mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.* • Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services, except for autism screening for children at 18 and 24 months as preventive care under PPACA. • Pastoral counselors. • Treatment provided in connection with caffeine use. • Routine use of psychological testing without specific authorization. Note: BlueCross/BlueShield may consult with professional clinical Consultants, peer review committees, or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.
Nutrition	• Megavitamin and nutrition based therapy. • Except as described under "Covered Services" on page 44 enteral feedings and other nutritional and electrolyte supplements (including infant formula and donor breast milk; infant formula available over the counter is always excluded), dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat/cholesterol), oral vitamins, and oral minerals except when the sole source of nutrition. • **Note:** Limited nutritional counseling services are covered for specified diseases as described under "Covered Services" on page 54

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
Physical Appearance	• Cosmetic procedures, including, but not to: ▪ Pharmacological regimens, nutritional procedures, or treatments. ▪ Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures). ▪ Skin abrasion procedures performed as a treatment for acne. • Physical conditioning program (such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation). • Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. • Wigs regardless of the reason for the hair loss, except for loss of hair resulting from treatment of a malignancy, hair loss due to alopecia or similar conditions or permanent loss of hair from an accidental injury.
Providers	• Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Doctor or other Provider. Services which are self-directed to a freestanding or Hospital-based diagnostic facility. Services ordered by a Doctor or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Doctor or other Provider: ▪ Has not been actively involved in your medical care prior to ordering the service, or ▪ Is not actively involved in your medical care after the service is received. ▪ This exclusion does not apply to mammography testing. • Services performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent, or child. This includes any service the Provider may perform on himself or herself. • Services performed by a Provider with your same

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
	legal residence. • Services of a provider or facility beyond the scope of their medical license.
Services provided under Another Plan	• Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes (but is not limited to) coverage required by Workers' Compensation, no-fault auto insurance, or similar legislation. If coverage under Workers' Compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness, or mental Illness that would have been covered under Worker's Compensation or similar legislation had that coverage been elected. (Note: Medical services that are Covered Services provided to treat an on-duty injury, where the company is not at fault and no FELA claim will be filed will be allowed to be paid by the Plan.) • Health services for treatment of military service related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you. • Health services while on active military duty.
Transplants	• Health services for organ and tissue transplants, except those described under the "Transplant Management Program" on page 83 of this document. • Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan). • Health services for transplants involving mechanical or animal organs. • Any solid organ transplant that is performed as a treatment for cancer. • Any multiple organ transplant not listed as a Covered Service.
Travel	• Health services provided in a foreign country

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
	unless required as Emergency health services. • Travel or transportation expenses even though prescribed by a Doctor. Some travel expenses related to covered transplantation services may be reimbursed, as described on page 84.
Vision and Hearing	• Purchase cost of eyeglasses, contact lenses, or hearing aids. (See "Vision Care Benefits" on page 124). • Fitting charge for hearing aids, eyeglasses, or contact lenses. • Surgery that is intended to allow you to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, radial keratotomy, laser, and other refractive eye Surgery.
All Other Exclusions	• Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing. • Any charges higher than the actual charge. The actual charge is defined as the Provider's lowest routine charge for the service, supply, or equipment. • Any charges for services, supplies, or equipment advertised by the Provider as free. • Any charges by a Provider sanctioned under a federal program for reason of fraud, abuse, or medical competency. • Any charges prohibited by federal anti-kickback or self-referral statutes. • Any charges by a resident in a teaching hospital where a faculty Doctor did not supervise services. • Any additional charges submitted after payment has been made and your account balance is zero. • Any Outpatient facility charge in excess of payable amounts under Medicare. • Appliances for snoring. • Breast reduction Surgery, except as described under "Covered Services" on page 38. • Charges in excess of eligible expenses or in excess of any specified limitation. • Custodial Care.

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
	• Domiciliary care. • Growth hormone therapy. • Health services and supplies that do not meet the definition of a Covered Service. • Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends. • Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. • Health services provided by a Non-Network Provider for which the Annual Deductible is waived. • Inpatient Private Duty Nursing. • Non-prescribed disposable medical supplies. • Non-surgical treatment of obesity, including Morbid Obesity. • Orthognathic Surgery and jaw alignment, except what is described on page 55 of this document. • Orthoptic therapy services for the treatment of convergence insufficiency or any other purpose. • Orthotic appliances that straighten or re-shape a body part, except as described under Durable Medical Equipment. Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. • Outpatient rehabilitation services, spinal treatment, or supplies including (but not limited to) Spinal Manipulations by a chiropractor or other Doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. • Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Plan when: ▪ Related to judicial or administrative

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
	proceedings or orders. ▪ Conducted for purposes of medical research. ▪ Required to obtain or maintain a license of any type. • Psychosurgery. • Respite care. • Rest cures. • Services or supplies received before you become covered under this plan. • Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, a congenital anomaly, or if such therapy is considered "habilitative services." Habilitative services are healthcare services that help a covered person keep, learn or improve skills and functioning for daily living. • Speech therapy to treat stuttering, stammering, or other articulation disorders.

HEALTH MANAGEMENT PROGRAMS

Preventive Care Benefits: The BCBS HDHP PPO supports you and your family in keeping healthy by offering preventive healthcare benefits. Benefits are payable for Covered Services for preventive healthcare benefits you receive while you are covered under this Plan if certain conditions are met.

If you use a Preferred Provider, preventive healthcare benefits are payable at 100% of the Maximum Benefit Amount. No preventive healthcare benefit is available from a non-network Doctor, unless there are no participating providers available. In that case, it is your responsibility to call BlueCross/BlueShield to find an alternative Doctor and if you have made prior arrangements with BlueCross/BlueShield to use an alternative Doctor, preventive healthcare benefits are payable at 100% of the Maximum Benefit Amount.

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

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

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.

2. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

3. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

4. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Benefits for the Preventive Services outlined above will be paid at 100% in accordance with the Schedule of Benefits Summary included at the end of this document.

A complete list of preventive services may be found at the BlueCross/BlueShield website here.

"Baby BluePrints" Healthy Pregnancy Program:
If You Are Pregnant, Now Is the Time to Enroll in Baby BluePrints

If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about your health and your developing baby's health. To help you understand and manage every stage of pregnancy and childbirth, BCBSNE offers the Baby BluePrints® Healthy Pregnancy Program. By enrolling in this free program you will have access to online information on all aspects of pregnancy and childbirth.

Baby BluePrints will also provide you with personal support from a Nurse Health Coach available to you throughout your pregnancy. All covered persons are eligible to use this program.

Participation in the Baby BluePrint® Healthy Pregnancy Program is completely voluntary and any participant information is strictly confidential.

Disease Management Program: The Disease Management Program focuses on coronary artery disease (CAD), congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, and diabetes. The Disease Management Program is designed to provide health information and support

services to help members manage their chronic health condition. Program participants gain understanding of their condition, and how to identify symptoms and keep them under control. It is offered to non-Medicare eligible retirees and Spouses as a free benefit with no out-of-pocket expenses.

Optum Health Care Solutions administers the program to help you learn about eating healthier, exercising, taking your medications correctly, and managing your stress levels.

By learning how to manage a chronic condition between regularly scheduled visits to the doctor, many participants in the Disease Management program feel better, live healthier and make fewer trips to the Hospital and Emergency room. The program provides access to a toll-free support line at (800)331-4370 for answers to questions about your condition, symptoms, medications or other health concerns, any time day or night. Health education information also is available on the Optum website www.myuhc.com and through complimentary education materials periodically sent to your home.

There is no charge for the services provided through the Disease Management Program. Participation in the Disease Management program is completely voluntary and any retiree information is strictly confidential and only shared with designated Doctors or Healthcare Providers in determining the best treatment plan.

Transplant Management Program: You may choose to utilize one of the BlueCross/BlueShield designated Blue Distinction Centers for Transplants. Blue Distinction Centers for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. They offer comprehensive transplant services through a coordinated, streamlined transplant management program.

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

The Plan covers Transplants included as a Qualified Procedure (listed below) when Medically Necessary.

Qualified Procedures:

- Heart transplants;
- Lung transplants;
- Heart/Lung transplants;
- Liver transplants;

- Kidney transplants;
- Pancreas transplants;
- Kidney/Pancreas transplants;
- Liver/Kidney transplants;
- Intestinal transplants;
- Liver/Intestinal transplants;
- Bone Marrow/Stem Cell transplants;
- Other transplant procedures when BlueCross/BlueShield determines that it is Medically Necessary to perform the procedure at a designated transplant facility.

Medical Care and Treatment: Covered Services provided in connection with the transplant will be covered according to the Schedule of Benefits for the BCBS Medical Option you selected. These services include:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- Hospital and Doctor fees.
- Transplant procedures.
- Follow-up care for a period up to one year after the transplant.
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search.
- Donor costs that are directly related to organ removal are Covered Services for which benefits are payable through the organ recipient's coverage under the Plan.

Transportation and Lodging: BlueCross/BlueShield will assist the patient and family with travel and lodging arrangements subject to the following requirements:

- Benefits will be available for transportation and lodging for the covered person and a traveling companion if the transportation and lodging are directly related to, or resulting from, a covered transplant procedure. This benefit is only available if the treating facility is 50 or more miles away (one way) from the covered person's home and the treating facility is a Preferred Provider. This transportation coverage may include transportation by an ambulance if that transportation meets the requirements of BlueCross/BlueShield.
- These Transportation benefits of the patient are subject to Deductible or Coinsurance Amounts.
- The covered person is responsible to send a letter to BlueCross/BlueShield of Nebraska to inform them that these expenses have been incurred. Applicable receipts must be provided along with written documentation confirming the name of the patient (and

companion if applicable), the date/dates of travel, the facility where transplant services were received, treatment dates, and any other necessary information. Once provided with this information, BlueCross/BlueShield of Nebraska will review the documentation to determine if charges are eligible for reimbursement. If benefits are available, payment will be issued directly to the retiree.

BLUES ON CALL℠ 24/7 NURSELINE & HEALTH DECISION SUPPORT

Just call (888) BLUE-428 ((888) 258-3428) to be connected to a specially-trained wellness professional. You can talk to a Health Coach whenever you like, any time of the day, any day of the week.

Health Coaches are specially-trained registered Nurses, dietitians and respiratory therapists who can help you make more informed health care and self-care (when appropriate) decisions. They can assist with a health symptom assessment, provide health-related information, and discuss your treatment options.

Please be assured that your discussions with your Health Coach are kept strictly confidential.

Help with common Illnesses, injuries and questions - Health Coaches can address any health topic that concerns you:

- Everyday conditions, such as a rash, an earache or a sprain;
- A recent diagnosis you've received;
- A scheduled medical test;
- Planned Surgery or other medical procedure;
- Questions to ask your Doctor at your next appointment;
- How to care for a Child or elder.

ALTERNATE MEDICAL TREATMENT PROGRAM

Under the Alternate Medical Treatment Program, BlueCross/BlueShield Medical Care Management reviews your medical treatment for a condition caused by a Severe Personal Injury or Sickness to determine whether or not you qualify for Alternate Medical Treatment Benefits. The use of Alternate Medical Treatment is entirely voluntary.

The scope of benefits in an individual case may be expanded solely on a concurrent/prospective basis as determined by BlueCross/BlueShield, to include payment for specific services which would not ordinarily be included as Covered Services. It must appear that use of such services will:

1. Equal or reduce costs;
2. Improve the quality of medical care; and/or
3. Be medically more appropriate than an alternate Covered Service.

BlueCross/BlueShield Medical Care Management will advise the Covered Person and the provider in writing when, and to what extent, payment for such Services will be made. Such expansion of the scope of benefits will not constitute an amendment to this Plan, nor provide a continuing right to receive such Services. Benefits for Alternate Medical Treatment under this clause is solely at the discretion of BlueCross/BlueShield Medical Care Management.

HOW TO FILE MEDICAL CLAIMS

This section provides information about how and when to file a claim under the BCBS HDHP PPO. If you are Medicare eligible and have a Retiree HRA, information regarding how to file a claim under the Retiree HRA can be found on page 131 of this document. If you have a Retiree Transition HRA, information regarding how to file a Transition HRA claim can be found in the 2017 Retiree Transition HRA Guide. For all BCBS HDHP PPO claims and appeals, Union Pacific has delegated to BCBSNE the exclusive and discretionary authority to find facts and to interpret and administer the provisions of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. The decisions of BCBSNE are conclusive and binding. Please note that the decisions of BCBSNE are based whether or not the services are Medically Necessary, whether or not benefits are available under the Plan for the proposed treatment or procedure, and whether or not the services are provided in the appropriate setting.

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

Your Explanation of Benefits Statement:

When you submit a claim, you will receive an Explanation of Benefits (EOB) statement that lists:

- the provider's actual charge;
- the allowable amount as determined by BCBSNE;
- the Copayment, Deductible and Coinsurance amounts, if any, that you are required to pay;
- total benefits payable; and

- the total amount you owe.

In those instances where you are not required to submit a claim because, for example, the network provider will submit the bill as a claim for payment under its contract with BCBSNE, you will receive an EOB only when you are required to pay amounts other than your required copayment. If you do not have access to a computer or prefer to continue receiving printed EOBs, please notify Member Service by calling the number on the back of your ID card.

If you receive services from a Network provider, you will not have to file a claim. The network provider is responsible for filing claims. BCBSNE pays the network provider directly. However, you are responsible for paying Coinsurance and/or Deductible amounts to a network provider when a bill is received from the provider. If a network provider bills the covered person for any Covered Services in excess of the HDHP Deductible or Medical Coinsurance Amount, contact BCBS.

If you receive services from an out-of-Network provider, you may be required to file the claim yourself. Claim forms can be obtained by contacting Member Service using the telephone number on your ID card, retrieved from www.mybenefitshome.com or filed electronically through the www.mybenefitshome.com website: 'Your Spending' and then 'Submit a Manual Claim'.

You have the right to designate an authorized representative to file or pursue a request for pre-service reimbursement or a Post-Service Claim on your behalf. BCBSNE reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by BCBSNE will, in the case of an urgent care claim, permit a Physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative. You or your representative shall notify BCBSNE in writing of the designation.

Post-Service Claims:
Post-Service claims, also known as retroactive reviews, are those claims that are filed for payment of benefits after medical care has been received without first receiving a precertification.

Filing a Post-Service claim is simple. Just take the following steps:
Know your benefits. Review this information to see if the services you received are eligible under the Plan.
Get an Itemized Bill. Itemized bills must include:

- The name and address of the service provider;
- The patient's full name;
- The date of service or supply;
- A description of the service or supply;

- The amount charged;
- The diagnosis or nature of Illness;
- For Durable Medical Equipment, the Doctor's certification;

For private duty nursing, the Nurse's license number, charge per day and shift worked, and signature of provider prescribing the service;

Please note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from the provider) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

Copy Itemized Bills. You must submit originals, so you may want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

Complete a Claim Form. Make sure all information is completed properly, and then sign and date the form. The Union Pacific group number is 13942. After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the back of your ID card.

Remember: Multiple services for the same family member can be filed with one claim form. However, a separate claim form must be completed for each member. Your claims must be submitted no later than 12 months from the date of service.

You must submit a claim for benefits within one year after the date of service. If a non-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you do not provide this information to BCBSNE within one year of the date of service, benefits for that health service will be denied or reduced at the discretion of BCBSNE. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient stay, the date of service is the date your Inpatient stay ends.

Benefit Determinations Involving Post-Service Claims:
BCBSNE will notify you in writing of its determination on your Post-Service Claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by BCBSNE for an additional 15 days, provided that BCBSNE determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day Post-Service Claim determination period. If an extension of time is necessary because you failed to submit information necessary for BCBSNE to make a decision on your Post-Service Claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at

least 45 days in which to submit the information before a decision is made on your Post-Service Claim. If your claim is denied, see the "If Your Claim is Denied" section, below.

Non-Urgent Pre-Service Claims:
Pre-Service claims, also known as precertifications or as prospective reviews, are those claims that require notification prior to receiving medical care. Call Member Service using the toll-free telephone number on the back of your ID card to submit a Pre-Service claim. Pre-Service claims begin upon BCBSNE receipt of your treatment information.

After receiving the request for care, BCBSNE:

- verifies your eligibility for coverage and availability of benefits;
- reviews diagnosis and plan of treatment;
- assesses whether care is Medically Necessary and appropriate;
- authorizes care and assigns an appropriate length of stay for Inpatient Admissions

Inpatient Admission requests are reviewed by a BCBSNE Nurse to ensure it is appropriate for the treatment of your condition, Illness, disease or Injury, in accordance with standards of good medical practice, and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an Inpatient due to the nature of the services rendered for your condition and you cannot receive safe or adequate care as an Outpatient.

Benefit Determinations Involving Non-Urgent Pre-Service Claims:
You will receive written notice of any decision on a request for Pre-Service Claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date BCBSNE receives your claim. However, this 15-day period of time may be extended one time by BCBSNE for an additional 15 days, provided that BCBSNE determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 15-day Pre-Service Claim determination period. If an extension of time is necessary because you failed to submit information necessary for BCBSNE to make a decision on your pre-service claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your Pre-Service Claim.

Notices of Determination Involving Non-Urgent Pre-Service Claims:
Any time your pre-service claim is approved, you will be notified in writing that your claim has been approved. If your claim is denied, see the "If Your Claim is Denied" section, below.

Concurrent Care Claims:
Concurrent care claims are those claims to extend an on-going course of treatment that was previously approved for a specific period of time or number of treatments. Concurrent reviews are used to assess the medical necessity and appropriateness of the length of stay and Level of Care.

Benefit Determinations Involving Concurrent Care Claims:
If an on-going course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an Urgent Care claim as defined below, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 2 4 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care claim and decided according to the urgent claims procedures described below. If an on-going course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a non-Urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service claims procedures described above, whichever applies.

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

Notices of Determination Involving Concurrent Care Claims:
Any time your concurrent care service claim is approved, you will be notified in writing that your claim has been approved. If your claim is denied, see the "If Your Claim is Denied" section, below.

Urgent Care Claims*:*
Urgent Care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function, or (in the opinion of a Doctor with knowledge of your medical condition) could cause severe pain. Network Providers can electronically submit Urgent Care claims on a member's behalf. Out-of-network Urgent Care claims are submitted by members in the same manner as non-Urgent Care claims.

Benefit Determinations Involving Urgent Care Claims:
If your request involves an Urgent Care claim, BCBSNE will make a decision on your request as soon as possible, taking into account the medical exigencies involved. You will receive notice of the decision that has been made on your Urgent Care claim not later than 72 hours following receipt of your claim.

If BCBSNE determines in connection with an Urgent Care claim that you have not provided sufficient information to determine whether or to what extent benefits are provided under your coverage, you will be notified within 24 hours following BCBSNE's receipt of your claim of the specific information needed to complete your claim. You will then be given 48 hours to provide the specific information to BCBSNE. BCBSNE will thereafter notify you of its determination on your claim as soon as possible but not later than 48 hours after the earlier of (i) its receipt of the additional specific information, or (ii) the date BCBSNE informed you that it must receive the additional specific information.

If you receive the service before receiving the benefit determination, the claim will be considered a Post-Service Claim.

Notices of Determination Involving Urgent Care Claims:
Any time your Urgent Care claim is approved, you will be notified in writing that your claim has been approved. If your Urgent Care request is denied, see the "If Your Claim is Denied" section, below.

If Your Claim is Denied:
If your claim is denied, you will receive written notice of the adverse determination. 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. If your claim was denied because the services were not Medically Necessary or experimental/investigative, the denial notice will include an explanation of this determination. The notice will describe any additional material or information needed to perfect your claim and an explanation of why the material or information is important, and provide the claim appeal procedures.

For a description of your right to file an appeal concerning an adverse determination of your claim see the Medical Appeals Procedure section, below.

MEDICAL APPEALS PROCEDURE:
Your benefit program maintains an appeal process involving two levels of review with the exception of Urgent Care claims (which involve a single level of review). At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on your behalf. You or your representative shall notify BCBSNE in writing of the designation.

For purposes of the appeal process, "you" includes designees, legal representatives and, in the case of a minor, parent(s) entitled or authorized to act on your behalf.

BCBSNE reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by BCBSNE shall, in the case of an Urgent Care claim, permit your Doctor or other provider of health care with knowledge of your medical condition to act as your representative.

At any time during the appeal process, you may contact Member Service at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

Initial Review:
If you receive notification that a claim has been denied by BCBSNE, in whole or in part, you may appeal the decision. Your appeal must be submitted to the appeals address listed on the explanation of benefits (EOB) form or by contacting Customer Service at the number on the back of your ID card not later than 180 days from the date you received notice from BCBSNE of the adverse benefit determination.

Upon request to BCBSNE, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

A representative from Appeal Review will review the initial appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on your appeal, Appeal Review will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by BCBSNE. Appeal Review will also afford no deference to any previous adverse benefit determination regarding the claim that is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, Appeal Review will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous

adverse benefit determination regarding the claim that is the subject of your appeal.

Your appeal will be promptly investigated and BCBSNE will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-Urgent Care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal;
- When the appeal involves an Urgent Care claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal; or
- When the appeal involves a Post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

In the event BCBSNE renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, a reference to the part of the Plan on which the denial is based, and the procedure for appealing the decision of a claim that is not an urgent care claim. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the services were not Medically Necessary or experimental/investigative, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal and a statement regarding your right to pursue legal action in accordance with §502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The decision of BCBSNE on your appeal of your Urgent Care claim is final and binding. The decision of BCBSNE on your appeal of your non-Urgent Care pre-service claim is also final and binding, unless you decide to proceed with a second level review of such claim. Your decision to proceed with a second level review of a pre-service claim (other than an Urgent Care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of your claim before pursuing a claim for benefits in court under § 502(a) of ERISA. Your decision of whether to proceed with a second level appeal will have no effect on your rights to any other benefits under the Plan. Should you elect to pursue the second level review before filing a claim for benefits in court, the Plan:

- Will not later assert in a court action under § 502(a) of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;

- Agrees that any statute of limitations applicable to the claim for benefits under § 502(a) of ERISA will not commence (i.e. run) during the second level review; and
- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding a second level review of your claim, you should contact Member Service using the telephone number on your ID card.

Your decision to proceed with a second level review of your Post-service claim is mandatory. In other words, you are required to pursue the second level review of your denied Post-service claim before pursuing a claim for benefits in court under § 502 of ERISA.

Second Level Review:
If you are dissatisfied with the decision following the initial review of your appeal (other than the review of an Urgent Care claim), you may request to have the decision reviewed by BCBSNE. You must submit a second level appeal of your denied Post-service claim in order to preserve your right to bring a civil action under § 502(a) of ERISA concerning the Plan's denial of your claim. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) to the appeals address listed on the explanation of benefits (EOB) form or by contacting Customer Service at the number on the back of your ID card within 45 days from the date of an adverse benefit determination.

Upon request to BCBSNE, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

A representative from Appeal Review will review your second level appeal. The representative will be an individual who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the matter under review.

In rendering a decision on the second level appeal, Appeal Review will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by BCBSNE. Appeal Review will also afford no deference to any previous adverse benefit determination regarding the matter under review.

In rendering a decision on a second level appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested

benefit is medically necessary and appropriate or experimental/investigative, Appeal Review will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

Your second level appeal will be promptly investigated and BCBSNE will provide you with written notification of its decision within the following time frames:

- When the appeal involves a non-Urgent Care pre-service claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 business days following receipt of the appeal; or
- When the appeal involves a Post-service claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

In the event BCBSNE renders an adverse benefit determination on your second level appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, a reference to the part of the Plan on which the denial is based and a statement regarding your right to pursue legal action in accordance with §502(a) of ERISA. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the services were not Medically Necessary or experimental/investigative, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal. The decision of BCBSNE on your second level appeal is final and binding.

COORDINATION OF BENEFITS:

Coordination of benefits applies when a covered retiree or a covered Dependent has health coverage under the BCBS HDHP PPO and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. The other of the plans involved will pay benefits next: that plan is Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your plan.
- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.
- When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the plan which covered the parent longer will be the primary plan. If the dependent child's parents are separated or divorced, the following applies:
    - The parent with custody of the child pays first.
    - The coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
    - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:
    - the benefits of a plan covering the person as an employee (other than a laid-off or retired employee or as the dependent of such person) shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person and if the other plan does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

Impact of Government Plans Other than Medicare on Benefits: Benefits will not be payable to the extent that they are available to you under any government plan, program, or coverage, other than Medicare. This is true whether or not you have enrolled for all government plans for which you are eligible.

This will not apply if the law mandates that benefits under this Plan be paid first, or if the government plan was not in effect on the date that your benefits became effective under this Plan.

Right to Exchange Information: To enforce the Coordination of Benefits provision, BlueCross/BlueShield has the right to give or receive information on

your benefits and expenses without your consent. Any claim you submit must have the information that is needed to apply the Coordination of Benefits provision (i.e., proof of other coverage).

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

BCBS HDHP PPO PROGRAM: PHARMACY BENEFITS

The BCBS HDHP PPO includes a Network Retail Pharmacy, Network Mail Order Pharmacy Service, Specialty Pharmacy Service, and a non-Network Retail Pharmacy feature. The Network Retail Pharmacy, Network Mail Order Pharmacy Service, Specialty Pharmacy Service, and non-Network Retail Pharmacy feature applies to covered outpatient prescription drugs. Whomever you elect to cover under the BCBS HDHP PPO Program is considered a "Covered Person" for purposes of the Pharmacy Program section of this document. You can find the meaning of other capitalized terms found in this Section in the Pharmacy Program Definitions that begins on page 120 of this document and in the Glossary Section of this document, beginning on page 166.

The Pharmacy benefits under the BCBS HDHP PPO Program are provided by UHC/OptumRx.

Identification (ID) Card - Network Pharmacy:
You must either present your UHC/OptumRx Rx Only ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UHC/OptumRx during regular business hours. The Union Pacific group number for UHC/OptumRx is 183842. If you are registered at www.myuhc.com, you can access your ID card through your mobile device at either www.myuhc.com or through UHC's Health4Me app.

If you do not present your UHC/OptumRx Rx Only ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the amount charged by the pharmacy for the Prescription Drug Product at the pharmacy. You may seek reimbursement as described in the "How to File Pharmacy Claims" section. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility at the time the Prescription Drug Product was dispensed. The amount of the reimbursement will be based on the Prescription Drug Cost, less any Deductible or Pharmacy Coinsurance payment that applies.

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

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

Additional Information About Your Prescriptions:
Retirees can find helpful resources for prescription drugs, such as cost and the usage of a drug, drug interactions and side effects, clinical programs, pharmacy locations, cost saving options, and Specialty Pharmacies by visiting the UHC website. You may also determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing. To access this site, log onto your account at www.myuhc.com; then click on "Pharmacies & Prescriptions." You will find a menu of pharmacy items, as well as search capabilities. You may also call members services at (800) 331-4370.

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

Prescribed drugs and medicines for inpatient services are covered as medical expenses under the BCBS HDHP PPO provisions. The BCBS HDHP PPO provisions also apply to outpatient prescription drugs that are administered in a Doctor's office or other licensed outpatient setting, unless the drugs are excluded from the BCBS HDHP PPO under "Additional Exclusions" on page 71.These drugs and medicines eligible for payment under the medical program provisions then are not payable under the pharmacy provisions. Likewise, the drugs and medicines eligible under the pharmacy provisions then are not payable under the Medical provisions.

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

- Prescribed to treat a Covered Services (see page 36); or to treat conception;
- The prescription is not experimental, investigational, or unproven; and
- Determined by UHC/OptumRx to be Medically Necessary.

Supply Limits:

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

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing online at www.myuhc.com or by calling member services at (800) 331-4370 and choosing the pharmacy prompt.

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

Benefits may not be available for the Prescription Drug Product if, after UHC/OptumRx reviews the documentation provided, UHC/OptumRx determines that the Prescription Drug Product is not prescribed to treat a Covered Medical Service, or that it is experimental, investigational, or unproven, and is determined by UHC/OptumRx to be Medically Necessary. You may appeal this determination as described in the "Pharmacy Claim Questions and Appeals" section on page 118.

If you are using a Network Retail Pharmacy, your pharmacist will be notified that your Doctor must get approval for the prescription to be covered, by calling (800) 331-4370. If you are using the UHC/OptumRx Mail Order Pharmacy Service, the pharmacist will call your Doctor to start the approval process. For prescriptions, your Doctor will be asked to provide information to determine if the prescription meets the coverage conditions of your pharmacy benefit. The information your Doctor provides will be reviewed, and coverage will be approved or denied. Letters will be sent to you and your Doctor to explain any denial decision and provide instructions on how to appeal if coverage was denied.

If you use a non-Network Pharmacy, coverage authorization still applies and will be reviewed at the time that you submit a claim for reimbursement or you or your Doctor check beforehand by calling (800) 331-4370 to ensure that the medications prescribed are in conformance with their coverage authorization. Only approved claims will be reimbursed. Retirees will also receive a statement outlining the authorization procedures.

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

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

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

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

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

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

To learn more about medication patient safety programs and coverage authorizations through your pharmacy benefit, call UHC/OptumRx at (800)331-4370 and choosing the pharmacy prompt.

Notification Requirements:

Network Pharmacy Notification*:* When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing Provider, the pharmacist, or you are responsible for notifying UHC/OptumRx.

Non-Network Pharmacy Notification: When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Doctor must notify UHC/OptumRx as required.

If UHC/OptumRx is not notified before the Prescription Drug Product is dispensed, you can ask UHC/OptumRx to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from UHC/OptumRx as described in the "How to File Pharmacy Claims" section, page 116.

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

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

Progression Rx/Step Therapy:
Prescription Drug Products belonging in certain therapeutic classes are subject to step therapy requirements. This means that, in order to receive benefits for such Prescription Drug Products you will be required to try a lower cost Prescription Drug Product in the same therapeutic class first. You may determine whether a particular Prescription Drug Product is subject to step therapy requirements by visiting www.myuhc.com or by calling UHC/OptumRx at (800) 331-4370 and choosing the pharmacy prompt.

Specialty Pharmacy Services:
Certain pharmacy prescriptions are made using special compounds, which are not ordinarily kept in stock and may require advance notice to fill.

UHC/OptumRx has established a group of Specialty Pharmacies with clinical expertise in dispensing specialty drugs that must be filled through a UHC/OptumRx Specialty Pharmacy. Prescriptions obtained through a Specialty Pharmacy are dispensed in 31-day quantities and delivered directly to your home.

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

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

You will have access to a Specialty Pharmacy pharmacist who has been trained in dispensing of your drug and is available 24 hours a day, seven days a week, to answer your questions.
Your prescription will be delivered directly to your home.
Refills will be coordinated between the Specialty Pharmacy and your Doctor, delivered directly to your home every 31 days.

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

Benefits for the Specialty Pharmacy drugs are payable, following the Schedule of Benefits on page 111 entitled "Prescription Drugs from Retail or Specialty Pharmacy."

Note: A Prescription Order or Refill for a Prescription Drug Product identified as a "Specialty Drug" and required to be filled by a UHC Specialty Pharmacy cannot be written for a 90-day supply and cannot be obtained through the Discretionary Mail Order Pharmacy Program. Specialty Pharmacy prescriptions are dispensed in 31-day quantities.

To contact the Specialty Pharmacy referral line for any questions call (800) 331-4370. You will be provided contact information for the specific Specialty Pharmacy that specializes in the drug you use. OptumRx will work with you to establish your contact with the Specialty Pharmacy.

Mandatory Mail Order Program:

The Mandatory Mail Order Program (MMO) is a program that requires you to use the Mail Order Pharmacy to obtain certain maintenance medications.

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

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

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

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

OptumRx
P.O. Box 2975
Mission, KS 66201

If you have a new Prescription Order or Refill for a Prescription Drug Product listed as a MMO maintenance medication that must be filled by the Mail Order Pharmacy, or if you have an existing Prescription Order or Refill for such a Prescription Drug Product at the time you become enrolled in the BCBS HDHP PPO, you may fill your prescription up to a maximum of two times at a Retail Pharmacy and still receive benefits under the Pharmacy Program. If you fill your Prescription Order or Refill for a MMO maintenance medication at a Retail Pharmacy, you will receive a letter from UHC/OptumRx, indicating that your prescription for the maintenance medication must be filled through the Mail Order Pharmacy after the second fill, and that you must ask your Doctor to write a new prescription for the maintenance medication as a 90-day supply. After the second fill at a Retail Pharmacy, continued use of a Retail Pharmacy for a MMO maintenance medication will no longer be covered under the Pharmacy Program.

Opting Out of Mandatory Mail Order

The MMO program is designed to provide maintenance medications to you at the

lowest cost for both you and the Plan. However, because of continually changing market conditions, there are some instances when purchasing through MO may not be your lowest cost option. If you are able to obtain the medication at a Retail Pharmacy at a lower cost than the Mail Order Pharmacy cost, you can opt out of the Mandatory Mail Order Program by calling OptumRx at (800) 331-4370. You may then continue to use that Retail Pharmacy to purchase your maintenance medication and the medication will be covered under the Pharmacy Program.

To contact the Mail Order Pharmacy for any questions call (800) 331-4370.

Discretionary Mail Order Program:
A Mail Order Pharmacy Service option is available for your convenience. You must pay 100% of the Prescription Drug Cost for the Prescription Drug Product until you meet the HDHP Deductible. Refer to "Pharmacy Benefit Payment Information, Deductible" on page 105. After you have met your HDHP Deductible, you must pay for the Prescription Drug Product according to the three-tier Coinsurance structure shown in the Benefit Information table for Mail Order Prescription Drug Products. Payment is made for up to a 90-day supply for each prescription filled by the Mail Order Pharmacy Service. The original prescription must be written for a 90-day supply, plus refills.

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

- You or your Doctor must complete a Mail Order Form. This form can be found on the pharmacy link through www.myuhc.com. The form can be faxed by your Doctor or you can mail it to:

  OptumRx
  P.O. Box 2975 Mission,
  KS 66201

- The prescription should be written for a 90-day supply, plus refills.
- You can contact the Mail Order Pharmacy to find out the cost of the prescription by calling OptumRx at (800) 331-4370.
- Your payment options for the Mail Order Pharmacy Service are:
  - Payment by credit card or debit card;
  - Payment by check with your order;
  - Payment by ACH transfer or "Tele-check" handled over the telephone (Note: there are no additional fees for this service); or
  - You can submit an order and be billed for the cost of a 90-day prescription up to $100.
- If your doctor has prescribed a 90-day medication with refills, after the initial prescription submitted, you can request a refill over the phone or at www.myuhc.com.

- When your prescription expires, you will need to request a new

prescription from your Doctor. Your prescription may be for up to 12 months. Then a 90-day supply will be delivered directly to your home.

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

For additional information about your pharmacy benefits, call UHC/OptumRx at (800) 331-4370 and choose the pharmacy prompt or visit the prescription drug section at www.myuhc.com.

Pharmacy Benefit Payment Information:

Deductible: You are responsible for paying the cost of covered pharmacy and Covered Services until the HDHP Deductible is met before pharmacy benefits are payable under the Plan. (For more information on the HDHP Deductible, see page 26 of this Guide.) The HDHP Deductible, including family limits, is listed in the following table.

- The amounts you pay for contracted rates with a Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Deductible. If a non-Network Pharmacy is used, only the amounts you pay up to the Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Deductible.
- The amounts you pay for contracted rates with a Preferred Provider for Covered Services are also applied against the HDHP Deductible. If a Non-Preferred provider is used to receive Covered Services, only the Maximum Benefit Amount for Covered Services is applied against the HDHP Deductible.

HDHP DEDUCTIBLE	
Network	$2,600 per covered person per Calendar Year, not to exceed $5,200 for all covered persons in a family.
Non-Network	$5,200 per covered person per Calendar Year, not to exceed $10,400 for all covered persons in a family.

After the HDHP Deductible is met, you are responsible for paying the applicable Pharmacy Coinsurance payment, described below.

Pharmacy Coinsurance Payment: The Pharmacy Coinsurance Payment that you will be required to pay depends on (1) the type of pharmacy that fills the

prescription (i.e., Retail Pharmacy, Specialty Pharmacy, Mail Order Pharmacy, or Non-Network Pharmacy), and (2) the Tier that the prescription falls in. After the HDHP Deductible is met, you are responsible for paying the applicable Pharmacy Coinsurance payment, up to the HDHP Coinsurance Maximum (described in the following Payment Information Schedule), when Prescription Drug Products that are on the UHC/OptumRx Prescription Drug List are obtained from a Retail, Mail Order or Specialty Pharmacy. The amount you pay for the HDHP Deductible or any non-covered drug product will not be included in calculating the HDHP Coinsurance Maximum. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and the UHC/OptumRx contracted rates (the UHC/OptumRx Prescription Drug Cost) will not be available to you.

- After the HDHP Deductible is met, the amounts you pay for contracted rates with a Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Coinsurance Maximum. If a non-Network Pharmacy is used, only the amounts you pay up to the Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Coinsurance Maximum.
- After the HDHP Deductible is met, the amounts you pay for contracted rates with a preferred provider for Covered Services are also applied against the HDHP Coinsurance Maximum. If a Non-Preferred provider is used to receive Covered Services, only the Maximum Benefit Amount for Covered Services is applied against the HDHP Coinsurance Maximum.

PAYMENT INFORMATION SCHEDULE		
Payment Term	**Description**	**Amounts**
Pharmacy Coinsurance Payment	Pharmacy Coinsurance payments for a Prescription Drug Product on the Prescription Drug List at a Network Pharmacy are a percentage of the Prescription Drug Cost. Pharmacy Coinsurance payments for a Prescription Drug Product on the Prescription Drug List at a non-Network Pharmacy are a percentage of the Predominant Reimbursement Rate.	For Prescription Drug Products at a Retail or Mail Order Network Pharmacy, you are responsible for paying the lower of: • The applicable Pharmacy Coinsurance payment; or • The Prescription Drug Cost for that Prescription Drug Product. See the Pharmacy Coinsurance

PAYMENT INFORMATION SCHEDULE		
Payment Term	**Description**	**Amounts**
	Your Pharmacy Coinsurance payment is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product. **Note:** The tier status of a Prescription Drug Product can change periodically, generally quarterly, based on the Prescription Drug List Management Committee's periodic tier decisions. When that occurs, your Pharmacy Coinsurance payment may change. If there is a tier change which increases your Pharmacy Coinsurance payment for a medication you have previously filled with UHC/OptumRx you will be notified by UHC/OptumRx either by letter or by sending information to the pharmacy when the prescription is being processed. In addition, you can go to www.myuhc.com, or call UHC/OptumRx at (800) 331-4370 for the most up-to-date tier status.	percentage stated in the Benefit Information table on page 111 for amounts.

PAYMENT INFORMATION SCHEDULE		
Payment Term	**Description**	**Amounts**
	After meeting the HDHP Deductible, the HDHP Coinsurance Maximum is the maximum amount you are required to pay for Covered Services and/or Prescription Drug Products on the UHC/OptumRx Prescription Drug List in a single Calendar Year. Once you reach the HDHP Coinsurance Maximum, you will not be required to pay Pharmacy Coinsurance payments for covered Prescription Drug Products on the UHC/OptumRx Prescription Drug List for the remainder of the Calendar Year. Note: For prescriptions purchased at a Non- Network Pharmacy, any charges above the Predominant Reimbursement Rate are not considered by the Plan as benefit payments and do not count toward your HDHP Coinsurance Maximum.	**Network:** Combined medical and prescription Coinsurance Maximum of $2,900 per covered person per Calendar Year, not to exceed $5,800 for all covered persons in a family. **Non-Network:** Combined medical and prescription Coinsurance Maximum of $5,800 per covered person per Calendar Year, not to exceed $11,600 for all covered persons in a family. The HDHP Coinsurance Maximum does not include the Annual HDHP Deductible.

Three-Tier Pharmacy Coinsurance: Your Pharmacy Coinsurance Payment under the BCBS HDHP PPO Program once the HDHP Deductible has been met depends on the tier to which the Prescription Drug Product is assigned. Prescription Drug Products are assigned to one of three tiers by UHC/OptumRx. Each tier is assigned a Pharmacy Coinsurance percentage, with a minimum and maximum (listed on page 111). Tier 3 Prescription Drug Products have the highest Pharmacy Coinsurance Payment percentage and Tier 1 Prescription Drug Products have the lowest percentage. The tier assignments change periodically. Tiers indicate how much you will pay for a medication after you

have satisfied the HDHP Deductible. You can obtain information regarding which drugs fall into the different tiers by going to www.myuhc.com or by calling member services at (800) 331-4370 and choosing the pharmacy prompt.

Sometimes your Doctor may prescribe a medication to be "dispensed as written" when a lower tier or lower cost brand or Generic alternative drug is available.

As part of your Plan, the pharmacist may discuss with your Doctor whether an alternative drug might be appropriate for you. You and your Doctor should make the final decision on your medication, and you can always choose to keep the original prescription at the higher Pharmacy Coinsurance payment. The difference between the Pharmacy Coinsurance Payment for the originally prescribed Prescription Drug Product and the Pharmacy Coinsurance Payment for the alternative Prescription Drug Product is included in your Coinsurance Maximum.

Preventive Pharmacy Benefits: Certain Prescription Drug Products that are categorized as preventive care benefits under the Patient Protection and Affordable Care Act (PPACA) are available to members at no charge and are not subject to deductible or coinsurance provisions of the Plan if such Prescription Drug Products are received from a Network Pharmacy. Whether a Prescription Drug Product is available to members at no charge may determined by going to the "Pharmacies & Prescriptions" section of www.myuhc.com, or by calling UHC/OptumRx at (800) 331-4370 for the most up-to-date status.

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

UHC/OptumRx may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly. These changes may occur without prior notice to you.

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

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

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please go to www.myuhc.com or call UHC/OptumRx at (800) 331-4370 for the most up-to-date tier status.

Benefit Information:
The following tables describe Pharmacy Coinsurance payments and benefits for retirees and Dependents.

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
Network and Non-Network Pharmacy Benefits and Supply Limits	**Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)**
Network Retail or Specialty Pharmacy Benefits are provided for outpatient Prescription Drug Products on the Prescription Drug List dispensed by a Retail Network Pharmacy as written by the Provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Certain generics may also be dispensed by a Network Retail Pharmacy up to a 90-day supply.	Your Pharmacy Coinsurance payment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please go to www.myuhc.com, or call UHC/OptumRx at (800) 331-4370 to determine tier status. • **20%** of the **Prescription Drug Cost** for a Tier-1 Prescription Drug Product. • **30%** of the **Prescription Drug Cost** for a Tier-2 Prescription Drug Product. • **40%** of the **Prescription Drug Cost** for a Tier-3 Prescription Drug Product.

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
Network and Non-Network Pharmacy Benefits and Supply Limits	**Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)**
	Each Network Retail or Specialty Pharmacy Prescription Order or Refill for the Tiers above is subject to a per prescription minimum Pharmacy Coinsurance payment of $10 (or the actual drug cost if less) and a per prescription Pharmacy Coinsurance Maximum payment of $100. COVERED AT NO COST (Deductible and Coinsurance do not apply): • Prescription Drug Products that are preventive care under the PPACA NOT COVERED: • Mandatory Mail Order (MMO) drugs filled at a Retail Pharmacy after the 2-fill transition period; or • Specialty Pharmacy drugs, including self-injectable infertility drugs, filled at a Retail Pharmacy.
Non-Network Retail Pharmacy Benefits are provided for outpatient Prescription Drug Products on the Prescription Drug List dispensed by a non-Network Retail Pharmacy as written by the Provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. If the Prescription Drug Product on the Prescription Drug List is dispensed by	Your Pharmacy Coinsurance payment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please go to www.myuhc.com, or call UHC/OptumRx at (800) 331-4370 to determine tier status. • **20%** of the **Predominant Reimbursement Rate** for a Tier-1 Prescription Drug Product. • **30%** of the **Predominant**

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
Network and Non-Network Pharmacy Benefits and Supply Limits	**Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)**
a non-Network Retail Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with UHC/OptumRx. The Plan will not reimburse you for your Deductible, Pharmacy Coinsurance payment or the difference between the billed cost and the Predominant Reimbursement Rate for that Prescription Drug Product. In addition, the Plan will not reimburse you for any drug not on the Prescription Drug List. **In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.**	**Reimbursement Rate** for a Tier-2 Prescription Drug Product. • **40%** of the **Predominant Reimbursement Rate** for a Tier-3 Prescription Drug Product. Each non-Network Retail Prescription Order or Refill for the Tiers above is subject to a per prescription minimum Pharmacy Coinsurance payment of $10 (or the actual drug cost if less) and a per prescription Pharmacy Coinsurance Maximum payment of $100. NOT COVERED: • Mandatory Mail Order (MMO) drugs filled at a Retail Pharmacy after the 2-fill transition period; or • Specialty Pharmacy drugs, including self-injectable infertility drugs, filled at a Retail Pharmacy.
Network Mail Order Pharmacy Benefits are provided for outpatient Prescription Drug Products on the Prescription Drug List dispensed by a Network Mail Order Pharmacy as written by the Provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.	Your Pharmacy Coinsurance payment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please go to www.myuhc.com, or call UHC/OptumRx at (800) 331-4370 to determine tier status. • **15%** of the **Prescription Drug Cost** for a Tier-1 Prescription Drug Product. • **25%** of the **Prescription Drug**

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
Network and Non-Network Pharmacy Benefits and Supply Limits	**Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)**
	Cost for a Tier-2 Prescription Drug Product. • **40%** of the **Prescription Drug Cost** for a Tier-3 Prescription Drug Product. Each Mail Order Prescription Order or Refill for the Tiers above is subject to a per prescription minimum Pharmacy Coinsurance payment of $25 (or the actual drug cost if less) and a per prescription Pharmacy Coinsurance Maximum payment of $150. COVERED AT NO COST (Deductible and Coinsurance do not apply): • Prescription Drug Products that are preventive care under the PPACA

What's Not Covered - Exclusions:

The following exclusions apply to the Pharmacy Program (Note - Some items excluded here may be covered under the retiree medical provisions):

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) exceeding the supply limit.
- Prescription Drug Products that are prescribed, dispensed, or intended for use while you are an inpatient (e.g., patient at a Hospital, Skilled Nursing Facility, etc.).
- Medications used for experimental indications and/or dosage regimens determined by UHC/OptumRx to be experimental, investigational or unproven.
- Prescription Drug Products which UHC/OptumRx has determined are not Medically Necessary.
- Prescription Drug Products for which the prescription is more than one year old.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal

government (e.g., Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

- Prescription Drug Products that are subject to the Mandatory Mail Order Program when dispensed at a Retail Pharmacy following the two prescription transition period (unless you meet the conditions to opt-out of the MMO program with respect to a specific Prescription Drug Product and have elected to do so).
- Prescription Drug Products that are subject to the Specialty Pharmacy Program when dispensed at a Retail Pharmacy (i.e., not dispensed through a Specialty Pharmacy).
- Prescription Drug Products that are subject to the Progression Rx Step Therapy Program and for which you have not satisfied the program requirements to use a different Prescription Drug or Pharmaceutical Product first.
- Prescription Drug Products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws (e.g., Federal Employers' Liability Act or "FELA"), whether or not a claim for such benefits is made or payment or benefits are received. (Note, Prescription Drug Products prescribed to treat an on-duty injury, where the company is not at fault and no FELA claim will be filed, will be allowed to be paid by the Plan, subject to the terms, conditions and other exclusions of the Plan.)
- Any product dispensed for the purpose of appetite suppression and other weight loss products.
- A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by UHC, must typically be administered or supervised by a qualified Provider or licensed/certified health professional in an outpatient setting. These medications may be covered under the Medical Coverage Program. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment, prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered (see "Prescription Drug Product" definition on page 122. Certain Durable Medical Equipment may be covered under the BCBS HDHP PPO Program.
- Coordination of benefits on Prescription Drug Products, including prescriptions on the UHC/OptumRx Prescription Drug List.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride and single entity vitamins, unless such general vitamins qualify to be covered as Preventive Care under PPACA.
- Unit dose packaging of Prescription Drug Products.

- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be on the Prescription Drug List.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Glucose monitors.
- Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
- Drugs available over the counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products comprised of components that are available in over-the-counter form or equivalent, unless such drugs available over the counter qualify to be covered as Preventive Care under PPACA.
- New Prescription Drug Products and/or new dosage forms that have not yet been reviewed by the Prescription Drug List Management Committee until the date they are reviewed and assigned to a tier.
- Prescription Drug Products that are provided under any other plan to which your employer sponsors or contributes.
- Prescription Drug Products to the extent that benefits for such products are provided under this Plan or under any other plan to which your employer sponsors or contributes.
- Injectable Prescription Drug Products that must be administered by a licensed healthcare professional; which, if covered, would be paid under the retiree medical program provisions. (This exclusion does not apply to certain insulin or self-administered injectables that are covered by the Plan and can be injected subcutaneously. The list of drugs which are considered "self-administered injectables" is determined by UHC/OptumRx. To verify if an injectable drug is considered a self-administered injectable, go to www.myuhc.com or call UHC/OptumRx at (800) 331-4370.
- Prescribed devices or supplies of any type including colostomy supplies or contraceptive devices and supplies.
- Progesterone suppositories.
- A Prescription Drug Product requested to be filled by the Network Mail Order Pharmacy for which an original Prescription Order or Refill is not submitted to the Network Mail Order Pharmacy. A Prescription Order or Refill provided to another pharmacy cannot be transferred to the Network Mail Order Pharmacy.

How to File Pharmacy Claims:

For all claims and appeals for Pharmacy Program benefits provided under the BCBS HDHP PPO, Union Pacific has delegated to UHC/OptumRx the

exclusive and discretionary authority to find facts and to interpret facts and administer the provisions of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. The decisions of UHC/OptumRx are conclusive and binding.

No claim forms are needed if you obtain prescription drugs from a Network Retail Pharmacy, Specialty Pharmacy or via the Mail Order Pharmacy Service.

If you obtain prescription drugs from a non-Network Pharmacy, you will need to pay the entire cost of each Prescription Order or Refill at the time it is filled. Unless your claim is for Urgent Care (defined below), you must then submit a claim to UHC/OptumRx, within 12 Calendar Months of the date you fill the Prescription Order or Refill. UHC/OptumRx will review your claim. The reimbursement claim form includes instructions on how to complete and where to send the form. To obtain a claim form, call (800) 331-4370 or visit the "Pharmacies & Prescriptions" section of www.myuhc.com. You will usually be reimbursed for a Covered Prescription Drug Product within 30 days after receipt of your claim form. The completed claim form, along with the prescription receipt, must be sent to:

OptumRx
P.O. Box 29046
Hot Springs, AR 71903

If you have a claim for Urgent Care, UHC/OptumRx will review your claim as an Urgent Care claim. You, your Doctor or your pharmacist must submit your urgent care claim by calling UHC/OptumRx at (800) 331-4370. An Urgent Care claim is a claim for care where the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- would, in the opinion of a Doctor with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment being requested.

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

In the case of a claim for coverage involving Urgent Care, you will be notified of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours of receipt of the claim. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified as soon as possible, but not later than 24 hours after receipt of your claim. In this case you will be notified of the

information necessary to complete the claim you will have 48 hours to provide the information. You will then be notified of the decision as soon as possible, but not later than 48 hours after the earlier of: UHC/OptumRx's receipt of the information or the end of the 48 hour period given to provide the information.

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

If your claim is denied, UHC/OptumRx will send you a denial notice, which 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. If your claim was denied because the prescription drug has not been approved for that use, the denial notice will include an explanation of this determination. The notice will describe any additional material or information needed to perfect your claim and an explanation of why such material or information is necessary. It also will provide the claim appeal procedures.

Pharmacy Claim Questions and Appeals:
In the event you receive an adverse determination following a request for coverage of a claim, you have the right to appeal the adverse benefit determination to UHC/OptumRx in writing within 180 days of receipt of notice of the initial coverage decision. If a non-Urgent Care claim is denied, there are two levels of appeal to UHC/OptumRx. If an Urgent Care claim is denied, there is only one level of appeal.

Appeal of Non-Urgent Pharmacy Claims: To initiate a request for an appeal of a non-urgent claim denial, you or your Doctor must provide in writing, your name, member ID, Doctor's name and phone number, the prescription drug for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. This information must be mailed to the OptumRX, PO Box 30432, Salt Lake City, UT, 84130- 0432.

UHC/OptumRx will review your first level appeal and a decision regarding your appeal will be sent to you within a reasonable period of time, but not later than 30 days of receipt of your written request. If your appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the prescription drug has not been approved for that use, the denial notice will include an explanation of this determination. The notice will describe your right

to receive, upon request and at no charge, the information used to review your request for coverage and will describe the second level appeal procedures.

If you are not satisfied with the coverage decision made on the first level appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. You must submit a second level appeal in order to preserve your rights to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") concerning the Plan's denial of your claim. To initiate a second level appeal, you or your Doctor must provide in writing, your name, member ID, Doctor's name and phone number, the prescription drug for which benefit coverage has been denied, a statement of each and every reason why you believe your claim should be approved, and any additional information that may be relevant to your second level appeal. This information must be mailed to OptumRX, PO Box 30432, Salt Lake City, UT, 84130-0432. Your second level appeal will be reviewed by UHC/OptumRx. UHC/OptumRx will notify you and your Doctor in writing within a reasonable period of time, but not later than 30 days of receipt of your written request for appeal. The decision of UHC/OptumRx made on your second level appeal is final and binding.

If your second level appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the prescription drug has not been approved for that use, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and at no charge, the information used to review your second level appeal. You have the right to bring a civil action under Section 502(a) of ERISA if your second level appeal is denied.

Appeal of Urgent Pharmacy Claims: You have the right to request an urgent appeal of an adverse determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your Doctor may call UHC/OptumRx at (800) 331-4370 or write to OptumRX, P.O. Box 30432, Salt Lake City, UT, 84130-0432. Your appeal of an Urgent Care claim must identify each and every reason why you believe your claim should be approved. Appeals of Urgent Care claims are reviewed by UHC/OptumRx. In the case of an urgent appeal for coverage involving Urgent Care, you will be notified of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours of receipt of the claim. The decision of UHC/OptumRx of an Urgent Care appeal is final and binding.

If your Urgent Care appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the prescription drug has not been approved for that use, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and at no charge, the information used to review your appeal. You have the right to bring a civil action under Section 502(a) of ERISA if your Urgent Care appeal is denied.

Pharmacy Appeals Process: UHC/OptumRx will review all first level, second level, and Urgent Care appeals. Any review on appeal will not give deference to previous claim denials. You will have the right to submit documents and other information relating to your claim. Your second level appeal must specify each and every reason why you believe your claim should be approved. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim, nor a subordinate of the person who denied your claim. The review on appeal will take into account all comments, documents, records and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. If the initial denial is based in whole or in part on a medical judgment, UHC/OptumRx will consult with a healthcare professional with appropriate training and experience in the relevant medical field. This healthcare professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination. If UHC/OptumRx obtained advice from medical or vocational experts with respect to your claim, these experts will be identified, regardless of whether UHC/OptumRx relied on their advice when deciding your claim. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Pharmacy Benefit Defined Terms:

Annual HDHP Deductible: See definition in the Medical Section, page 24.

Annual HDHP Coinsurance Maximum: See definition in the Medical Section, page 24.

Brand-Name: A Prescription Drug Product (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer or (2) that UHC/OptumRx identifies as a brand-name product, based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors. You should know that all

products identified as a "brand name" by the manufacturer, pharmacy or your Doctor may not be classified as brand name by the Plan.

Generic: A Prescription Drug Product (1) that is chemically equivalent to a Brand-name drug or (2) that UHC/OptumRx identifies as a Generic product based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Doctor may not be classified as a Generic by the Plan.

Medically Necessary: Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

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

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

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

  The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical

policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.UnitedHealthcareOnline.com.

Network Pharmacy: A pharmacy that has:

- Entered into an agreement with UHC/OptumRx or the UHC/OptumRx designee to provide Prescription Drug Products to covered persons,
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products, and
- Been designated by UHC/OptumRx as a Network Pharmacy.

A Network Pharmacy can be a Retail Pharmacy, Specialty Pharmacy or Mail Order Pharmacy.

New Prescription Drug Product: A Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the Food and Drug Administration (FDA), and ending on the earlier of the following dates:

- The date it is assigned to a tier by the Prescription Drug List Management Committee.
- December 31st of the following Calendar Year.

Predominant Reimbursement Rate: The amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and sales tax. UHC/OptumRx calculates the Predominant Reimbursement Rate using the UHC/OptumRx Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Cost*:* The rate UHC/OptumRx has agreed to pay its Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List: A list that identifies those Prescription Drug Products for which Benefits are available under the Plan. This list is subject to periodic review and modification by UHC/OptumRx (generally quarterly). You may determine to which tier a particular Prescription Drug Product has been assigned at www.myuhc.com or by calling UHC/OptumRx at (800) 331-4370.

Prescription Drug List Management Committee*:* The committee that UHC/OptumRx designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product*:* A medication, product or device that has been approved by the FDA and, under federal or state law, can be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
    - Standard insulin syringes with needles;
    - Blood-testing strips - glucose;
    - Urine-testing strips - glucose;
    - Ketone-testing strips and tablets;
    - Lancets and lancet devices.
- Neocate Infant Formula (if it is the sole source of nutrition).

Prescription Order or Refill: The directive to dispense a Prescription Drug Product issued by a duly licensed Healthcare Provider whose scope of practice permits issuing such a directive.

BCBS HDHP PPO PROGRAM: VISION CARE BENEFITS

As a participant in the BCBS HDHP PPO, you and your eligible Dependents are eligible to receive discounted vision care services through the Access Plan D Program administered by EyeMed Vision Care.

What's Covered:
The Access Plan D Program enables you to pay discounted rates for exams, frames, and lenses at participating EyeMed Vision Care Providers. The cost to you is shown as follows:

Vision Care Services	Member Cost
Exam with Dilation as Necessary	$5 off routine exam $10 off contact lens exam
Complete Pair of Glasses Purchase	Frame, lenses, and lens options must be purchased in the same transaction to receive full discount.
Standard Plastic Lenses: Single Vision Bifocal Trifocal	 $50 $70 $105
Frames	Any frame available at Provider location: 35% off retail price
Lens Options: UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Polycarbonate Standard Progressive(Add-on to Bifocal) Standard Anti-Reflective Coating Other Add-Ons and Services	 $15 $15 $15 $40 $65 $45 20% discount
Contact Lens Materials: (Discount applied to materials only) Disposable Conventional	 0% off retail price 15% off retail price
Frequency: Examination Frame Lenses Contact Lenses	 Unlimited Unlimited Unlimited Unlimited

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained Providers, this discount may not always be available from a Provider in your immediate location.

For a location near you and the discount authorization please call (877) 5LASER6 ((877) 552-7376).

Member will receive a 20% discount on those items purchased at participating Providers that are not specifically covered by this discount design. The 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Vision Care Provider's professional services or contact lenses. Retail prices may vary by location.

This discount design is offered with the EyeMed Vision Care Access panel of Providers.

Limitations/Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
- Services provided as a result of any Worker's Compensation law
- Discount is not available on those frames where the manufacturer prohibits a discount

How to access the Access Plan D Program:

- Call EyeMed Vision Care Member Service at (866) 723-0513. Representatives are available Monday through Saturday from 8:00 a.m. to 11:00p.m., and Sunday from 11:00 a.m. to 8:00 p.m. Eastern Time.
- After receiving your authorization for discounted eyewear, make an appointment with one of the participating Providers and advise them that you are authorized to purchase discounted eyewear through EyeMed Vision Care's Access Plan D Program.

Participating EyeMed Vision Care Providers:

EyeMed Vision Care has developed a network of retail locations, licensed optometrists, and ophthalmologists. Participating Providers have agreed to discounted fees. You may locate a participating Provider by following the instructions shown below:

1. Go to the EyeMed Vision Care website at http://www.eyemed.com
2. Follow the green bar to the right and click on "Member Login."
3. Under "Provider Locator," click on "Find a Provider."
4. Choose "Access" on the "Choose Network" drop down list. Then enter your ZIP code and click on "Get Results."

EyeMed Vision Care is solely responsible for the selection, credentialing, and monitoring of Providers in its Network. All Providers selected by EyeMed Vision Care are independent contractors. Union Pacific and its participating subsidiaries do not guarantee the quality of care provided by these Providers.

How to File Vision Claims:
No claim forms are needed for vision care benefits. However, you may contact EyeMed Vision Care if you have questions regarding your vision care benefits.

Appeal of Denied Vision Claims:
A denied claim may be requested to be reviewed. To make this request, the member must send EyeMed a written letter of appeal no more than 180 calendar days after the date of the denied claim. The written letter of appeal should include the following:

1. The claim number, a copy of the EyeMed denial information, or a copy of the EyeMed Explanation of Benefits;
2. The item of vision coverage that the member feels was misinterpreted or inaccurately applied; and
3. Additional information from the eye care Provider that will assist EyeMed in completing its review of the appeal, such as documents, medical and/or financial records, questions or comments.

The written letter of appeal should be mailed to the following address:

FAA EyeMed Vision Care
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, OH 45040

Time Frames for Appealed Claims:

Activity	Time Frame
Claimant – Appeal of Adverse Determination	180 calendar days after the denial
Plan – Decision on Appeal	60 calendar days

EyeMed will review the appeal for benefits and notify the member in writing of its decision, as well as the reasons for the decision, with reference to specific plan provisions.

Member Grievance Procedure: If a member is dissatisfied with the services provided by an EyeMed Provider, the member should either write to EyeMed at the address indicated above or call the EyeMed Member Services toll free telephone number at (866) 939-3633. The EyeMed Member Services representative will log the telephone call and attempt to reach a resolution to the issues raised by the member. If a resolution is not able to be reached during the telephone call, the EyeMed Member Services representative will document all of the issues or questions raised. EyeMed will use its best efforts to contact the member within 4 business days with an acknowledgement to the issues or questions raised, and will resolve the issue within 30 calendar days. If the member is not satisfied with the resolution, they may appeal the grievance by using the appeal procedures set forth above.

For more information on member rights and how to obtain further review under the Employee Retirement Income Security Act of 1974 as amended ("ERISA"), please refer to the ERISA section beginning on page 155 of this document.

For all claims and appeals for vision care benefits under the BCBS HDHP PPO Program, Union Pacific has delegated to EyeMed Vision Care the exclusive and discretionary authority to find facts and to interpret and administer the provisions of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. The decisions of EyeMed Vision Care are conclusive and binding.

RETIREE HRA FOR MEDICARE ELIGIBLE RETIREES AND DEPENDENTS

Retiree HRA Components:
Retiree Medical Program coverage for retirees and their Dependents who are Medicare eligible and enrolled in the Union Pacific Retiree Medical Program ("Medicare Eligible Participant") consists of a Retiree HRA administered by Towers Watson One Exchange. A Retiree HRA is an account used to pay certain medical expenses incurred after you begin Retiree HRA coverage that are otherwise not reimbursed or reimbursable from any other source. The Retiree HRA gives you considerable ability to manage your out-of-pocket medical expenses.

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 Towers Watson One Exchange to administer Retiree HRAs.

If you or your Dependent is Medicare eligible, Union Pacific credits your Retiree HRA with an amount that may be used to pay certain medical expense that are not otherwise reimbursed or reimbursable from any other source. The amount credited to your Retiree HRA will depend upon the number of Medicare eligible individuals enrolled in coverage under the Union Pacific Retiree Medical Program. Your HRA will be credited for the 2017 Calendar Year with $1,200 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 2017 Calendar Year with $1,860 if both you and your Spouse are Medicare eligible, or if you (or your Spouse) and at least one other of your Dependents are Medicare eligible ("Family Retiree HRA Coverage"). If you, your Spouse or other Dependent first become Medicare eligible during the Calendar Year, the annual amount credited to your Retiree HRA based on your Retiree HRA coverage (Single or Family Retiree HRA Coverage) for such Calendar Year will be prorated on a monthly basis. For example, if you, your Spouse or other Dependent first become Medicare eligible on June 22, 2017, 7/12ths of $1,200 (the Single Retiree HRA Coverage amount) will be credited in your Retiree HRA for the Calendar Year because Retiree HRA coverage is effective the first of the month in which the Medicare Eligible Participant is eligible for Medicare.

If during the 2017 Calendar Year your level of Retiree HRA coverage changes from Single Retiree HRA Coverage to Family Retiree HRA Coverage as a result of you or your Dependent becoming Medicare eligible, your Retiree HRA will be credited with an additional amount. This amount is the prorated difference between the $1,860 credit for Family Retiree HRA Coverage and the $1,200 credit for Single Retiree HRA Coverage. For example, if your Retiree HRA Coverage changes from Single to Family on July 1, 2017, an additional $330 will be credited to your Retiree HRA. This additional amount is 6/12ths of the difference between the $1,860 Family coverage credit and the $1,200 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.

Here's How it Works:

Your Retiree HRA can be used to pay for any eligible out-of-pocket medical expense listed in the table beginning on page 133, 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. 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 131). 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). 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.

Retiree HRA Continuation of Coverage:
Assuming the Retiree HRA is not terminated or amended in a manner which causes coverage to end, your surviving covered Spouse will be permitted to continue Retiree HRA benefits after your death until your surviving Spouse's death.

A Child of a deceased retiree who meets the definition of a covered Dependent will continue to be eligible as a Dependent of a surviving covered Spouse. If your surviving Spouse dies, any remaining covered Dependents will be permitted to continue Retiree HRA benefits until 36 months after the end of the month of your surviving Spouse's death. If, upon the death of the retiree, there is no surviving covered Spouse, any remaining covered Dependents will continue to be eligible for benefits under the Retiree HRA until 36 months after the end of the month of your death.

In the event you become divorced or legally separated from your covered Spouse, your Spouse may continue Retiree HRA benefits under a separate Retiree HRA that will be established to pay eligible claims of your Spouse. Coverage under the 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 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 Spouse's Retiree HRA will continue until 36 months after the end of the month in which your divorce decree is entered by the court or legal separation occurred.

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 36 months after the end of the month in which your Dependent no longer meets the definition of a Dependent.

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 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.

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 the Union Pacific HR Service Center 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.

Retiree HRA Claims:
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 Towers Watson One Exchange to provide you with the option of the insurance carrier submitting claims on your behalf through a process called "Auto

Reimbursement." Towers Watson One Exchange 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 Towers Watson One

Exchange and thereby generate an HRA claim on your behalf in the amount of the premiums you have paid. Upon claim approval, Towers Watson One Exchange 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. Retiree HRA claims forms are available online at https://medicare.oneexchange.com/unionpacific or by calling Towers Watson One Exchange 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.
    b. 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.
    c. 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:

        OneExchange
        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://medicare.oneexchange.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 OneExchange 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 Towers Watson One Exchange website at https://medicare.oneexchange.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 OneExchange, and we will send you a copy of the form. Once the form is filled out, send it to OneExchange using the contact information on the form. You may cancel this form at any time by calling OneExchange.

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

- Medical premiums.
- Medicare premiums.
- Dental premiums.
- 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.

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	Yes	

Expense Item	Eligible?	Claim Details
medical condition		
Additional card expense - 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	
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	Yes	

Expense Item	Eligible?	Claim Details
pregnancy tests, condoms, gels, and foams		
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	
COBRA premiums - Premiums paid on an after tax basis for continuation of group medical,	No	

Expense Item	Eligible?	Claim Details
dental, or vision coverage		
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	Yes	You must provide a statement of medical necessity from a doctor

Expense Item	Eligible?	Claim Details
medical condition		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
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	No	Lump-sum payments for future orthodontia services are an eligible exception; once the service is rendered, an itemized

Expense Item	Eligible?	Claim Details
received		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	
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 - Amounts not paid by a hearing plan that exceed reasonable and customary limits	Yes	
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

Expense Item	Eligible?	Claim Details
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	
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	No	

Expense Item	Eligible?	Claim Details
contact lenses		
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
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

Expense Item	Eligible?	Claim Details
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	
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	

Expense Item	Eligible?	Claim Details
Medicare Part D Premiums	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
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	Yes	

Expense Item	Eligible?	Claim Details
monthly installments		
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	Over-the-counter medications are eligible for reimbursement only if a Doctor has prescribed the medication.
Oxygen or oxygen equipment - Costs for rental or purchased equipment to relieve breathing problems caused by a medical condition	Yes	
Pain relievers	Yes	
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	Yes	

Expense Item	Eligible?	Claim Details
premiums for private insurance not provided by an employer		
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
Pretax Dental Premiums - Premiums paid on a before-tax basis for any type of dental insurance coverage.	No	
Pretax Medical Premiums - Premiums paid on a before-tax basis for any type of medical 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	Yes	Claims for reimbursement of drug or medicine expenses must

Expense Item	Eligible?	Claim Details
for cosmetic or general health purposes		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	
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	

Expense Item	Eligible?	Claim Details
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
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

Expense Item	Eligible?	Claim Details
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 condition	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	
Vision deductibles - Deductibles under your or your spouse's vision plans	Yes	

Expense Item	Eligible?	Claim Details
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 disease	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 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, Towers Watson One Exchange will make a benefit determination as set forth in the "Benefit Determinations" section below.

If your claim is approved, Towers Watson One Exchange 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.

Towers Watson One Exchange 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 Towers Watson One Exchange at (800) 935-7780 or through the Towers Watson One Exchange website at https://medicare.oneexchange.com/unionpacific.

Explanation of Payment (EOP) Statements: Each time OneExchange 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 Towers Watson One Exchange at (800) 935-7780.

Benefit Determinations: If your claim is denied, you will receive a written notice from Towers Watson One Exchange 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. Towers Watson One Exchange 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, Towers Watson One Exchange 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, Towers Watson One Exchange 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.

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 Towers Watson One Exchange at (800) 935-7780 before requesting a formal appeal. If the Towers Watson One Exchange 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 131, you may appeal it as described below without first informally contacting Towers Watson One Exchange Customer Service. If you

first informally contact Towers Watson One Exchange 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.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND OTHER FIDUCIARIES

In carrying out their respective responsibilities under BCBS HDHP PPO Program, the Retiree HRA Program, and the Plan, the Plan Administrator and other plan fiduciaries including BlueCross/BlueShield, United Healthcare (UHC)/OptumRx, EyeMed Vision Care and Towers Watson One Exchange shall have discretionary authority to find facts, interpret and administer the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of BCBS HDHP PPO Program, the Retiree HRA Program, 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, an arbitration, payment from the third party's insurance company, or uninsured/underinsured motorist coverage), the Plan has a right to funds obtained as a result of that recovery to the extent of the claims 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 Plan, 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 BlueCross/BlueShield (for BCBS HDHP PPO Program medical benefits and mental healthcare/substance use disorder benefits), UHC/OptumRx (for BCBS HDHP PPO Program prescription benefits), EyeMed Vision Care (for BCBS HDHP PPO Program vision care benefits), or Towers Watson One Exchange (for Retiree HRA benefits). 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

BlueCross/BlueShield, EyeMed Vision Care, UHC/OptumRx, or Towers Watson One Exchange have the right to a refund of any Medical, Mental Healthcare/Substance Use Disorder, Vision Care, Prescription Benefits or Retiree HRA benefits, respectively they 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 BlueCross/BlueShield, EyeMed Vision Care, UnitedHealthcare (UHC/OptumRx), or Towers Watson One Exchange. The refund is the difference between the amount of benefits actually paid and the amount that should have been paid under the terms of the Plan. In addition, the Plan has a right to a refund of any benefit amount paid in excess of the benefit amount you are entitled to receive under the terms of the Plan.

If you do not promptly refund the required amount, BlueCross/BlueShield, EyeMed Vision Care, UHC/OptumRx, or Towers Watson One Exchange may, in addition to other rights they may have, reduce the amount of any future benefits payable under the BCBS HDHP PPO or Retiree HRA and under any group benefits plan they 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 (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 2017 UnitedHealthcare HDHP PPO 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 0330
Omaha, NE 68179

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

Plan Administrator:
The official Plan Administrator of the Plan is the Vice President- Human Resources, 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:

Vice President-Human Resources Union Pacific
Railroad Company
1400 Douglas Street, Stop 0320
Omaha, NE 68179
Telephone: (402) 544-5000

The Human Resources Department provides administrative services, answers questions, and generally acts as the Plan Administrator's representative in handling day-to-day matters involving Plan participants. Feel free to contact the Union Pacific HR Service Center 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 Human Resources Department in Omaha or at your company headquarters if copies are kept there, all documents governing the plan, including insurance contracts 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, 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 plan as a result of a qualifying event. You, your Spouse or your dependents may have to pay for such coverage. Review the terms of the applicable plan and any other documents governing the plan on the rules regarding your COBRA continuation coverage rights.

Maternity and Newborn Infant Coverage:
- For those retiree medical program options that provide maternity or newborn infant coverage, those plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Certain Mastectomy Coverage:
- For those retiree medical program options that cover mastectomies, if you or your dependent receives a mastectomy, the covered benefits for the patient will also include coverage for:
    - 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 annual Deductibles, Coinsurance and Copay provisions, and other provisions that are applicable to the other benefits of the retiree medical program option.

Prudent Actions by Plan Fiduciaries:
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

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

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

Under ERISA, there are steps you can take to enforce your rights. For example, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days of a request, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you as much as $110 per day until you receive the materials, unless they were not sent due to reasons beyond the Plan Administrator's control. To ensure your request was not lost in the mail, you should call the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. However, before filing a lawsuit you must first exhaust all appeals required by the plan. Please refer to each benefit section regarding claims and appeals. If there are Plan assets and should Plan fiduciaries misuse a plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions:
If you have any questions about your plan, you should contact the Human Resources Department. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your

telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claiming Your Benefits:
You generally 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. You should refer to the claims and appeals sections regarding the filing of claims.

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 claims and appeals sections regarding how you can appeal.

Besides having the right to appeal, you or your authorized representative can examine any Plan documents (except legally privileged information) related to your claim.

Serving Legal Process:
If you or your beneficiary chooses to take legal action against the Plan over terms of the Plan, legal process should be served on:

Vice President-Human Resources Union Pacific
Railroad Company
1400 Douglas Street, Stop 0320
Omaha, NE 68179
Telephone: (402) 544-5000

Future of the Plan:
While Union Pacific intends to continue the Plan indefinitely, it reserves the right to terminate or amend the Plan for any reason. If the Company terminates or amends the Plan, benefits under the Plan would cease or change. The Company may also 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.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries:
In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to ascertain facts, to interpret the terms of the Plan, and to determine entitlements

to benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Plan Administrator may designate other persons to carry out such of 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 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. The EIN assigned to the Plan Administrator is 81-3337785.

PLAN NAME	PLAN NO. & TYPE	INSURANCE CARRIER, ADMINISTRATOR OR TRUSTEE	CONTRACT OR POLICY NO.	PLAN YEAR	CONTRIBUTION SOURCES
Union Pacific Corporation Group Health Plan Retiree Medical Program (A) Medical Benefits (1)BCBS HDHP PPO Program – (a) Medical & Mental Healthcare/ Substance Use Disorder	502 Group Health Plan	(a) BlueCross /BlueShield Fifth Avenue Place 120 Fifth Avenue Pittsburgh, PA 15222-3099	129716 – Medical and Mental Healthcare	1/1 - 12/31	Retirees and Employers

PLAN NAME	PLAN NO. & TYPE	INSURANCE CARRIER, ADMINISTRATOR OR TRUSTEE	CONTRACT OR POLICY NO.	PLAN YEAR	CONTRIBUTION SOURCES
(b) Pharmacy		(b) OptumRx 11000 Optum Circle Eden Prairie, MN 55344	183842 – Pharmacy		
(c) Vision Care		(c) EyeMed Vision Care LLC 4000 Luxottica Place Mason, OH 45040	9235524 – Vision Care		
(2)UHC HDHP PPO Program –					
(a)Medical		(a)United HealthGroup 9900 Bren Road East, Minnetonka, MN 55343	183842 – Medical, Pharmacy, & Mental Health		
(b) Pharmacy		(b)OptumRx 11000 Optum Circle Eden Prairie, MN 55344			
(c)Mental Healthcare/ Substance Use Disorder		(c) Optum Behavioral Health 1100 Optum Circle, Eden Prairie, MN 55344			
(d)Vision Care		(d) EyeMed Vision Care LLC 4000 Luxottica Place Mason, OH 45040	9235524 – Vision Care		
(3)Retiree HRA		(3) Towers Watson One Exchange 10975 South Sterling View Drive, Suite A-1 South Jordan, UT 84095			

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 Medical Program, 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 all Retiree Medical Program benefits provided to retirees, the Group Health Plan is responsible for complying with HIPAA's privacy rules with respect to the Protected Health Information the Group Health Plan creates, maintains, or receives.

Availability of Notice of Privacy Practices:
The Group Health Plan, 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 Plan participants in the Group Health Plan. To request a copy of this Notice, contact the Union Pacific HR Service Center:

Union Pacific HR Service Center
1400 Douglas Street, Stop 0320
Omaha, NE 68179-0320
(877) 275-8747
(402) 544-4000

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

1. The Plan receives proper written authorization from the participant or the participant's representative. The authorization must specifically authorize the use or disclosure. A proper authorization form is required for uses by or disclosure to Union Pacific if the use or disclosure does not meet the condition described in Paragraphs 2, 3, or 4 below;
2. The Plan discloses information to Union Pacific that is, for purposes of HIPAA's privacy rule, enrollment or disenrollment information;
3. The Plan provides Union Pacific with Protected Health Information in the form of Summary Health Information for the purposes of obtaining premium bids, or determining whether to modify, amend or terminate the Plan provided, however, that such Protected Health Information used for 'underwriting purposes' (as defined in the HIPAA regulations) shall not include Protected Health Information that is 'genetic information' (as defined in the HIPAA regulations); or
4. The Plan receives a signed certification from Union Pacific that the plan documents restrict the use and disclosure of the Protected Health Information as required by the HIPAA regulations on privacy and confidentiality, and Union Pacific agrees to comply with the restrictions, and the information has been requested to carry out administrative functions (i.e., payment or health care operations functions) which Union Pacific performs for the Plan, and the uses and disclosures of Protected Health Information by Union Pacific will be restricted to plan administration functions performed by Union Pacific on behalf of the Plan in accordance with the plan document.

Conditions of Disclosure:
Union Pacific agrees that with respect to Protected Health Information disclosed to Union Pacific by the Plan, other than enrollment/disenrollment information, 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 Plan or as required by law.
b. Ensure that any agents to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to Union Pacific with respect to Protected Health Information.
c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan, program or arrangement of Union Pacific.
d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
e. Make available to a Plan participant who requests access, the Plan participant's Protected Health Information in accordance with the HIPAA regulations.

f. Make available to a Plan participant who requests an amendment, the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with the HIPAA regulations.
g. Make available to a Plan participant, who requests an accounting of disclosures of the participant's Protected Health Information, the information required to provide an accounting of disclosures in accordance with the HIPAA regulations.
h. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA regulations.
i. If feasible, return or destroy all Protected Health Information received from the Plan that Union Pacific still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
j. Ensure that the adequate separation between the Plan and Union Pacific required in the HIPAA regulations is satisfied.

Adequate Separation between Plan and Plan Sponsor:
Union Pacific shall only allow access to Protected Health Information to employees whose duties include performing administrative functions on behalf of the Plan and are in the following categories:

- Vice President-Human Resources, Union Pacific Railroad Company
- Assistant Vice President HR Operations, Union Pacific Railroad Company
- Union Pacific Human Resources Service Center
- Union Pacific Human Resources Benefits Group
- Union Pacific Human Resources Compensation Group
- Union Pacific Human Resources Information Systems Group
- Union Pacific Payroll Group
- Union Pacific Audit Group

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

Reports of Non-Compliance:
If you suspect an improper use or disclosure of Protected Health Information,

you may report the occurrence to the Plan's Privacy Office:

Union Pacific HR Service Center
Attn: HIPAA Privacy
1400 Douglas Street, Stop 0320
Omaha NE 68179
(877) 275-8747
(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 Plan. Protected Health Information does not include individually identifiable health information in employment records held by Union Pacific. "Individually identifiable health information" is information, including demographic information, that is collected from an individual and created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare services to an individual; or the past, present, or future payment for the provision of healthcare services to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information includes information of persons who are living and persons who have been deceased for 50 years or less. The following components of an individual's information are considered Protected Health Information:

a. Names;
b. Street address, city, county, precinct, ZIP code;
c. Dates directly related to a participant, including birth date, health facility admission and discharge date, and date of death;
d. Telephone numbers, fax numbers, and electronic mail addresses;
e. Social security numbers;
f. Medical record numbers;
g. Health plan beneficiary numbers;
h. Account numbers;
i. Certificate/license numbers;
j. Vehicle identifiers and serial numbers, including license plate numbers;
k. Device identifiers and serial numbers;
l. Web universal resource locators (URLs);
m. Internet Protocol (IP) address numbers;
n. Biometric identifiers, including finger and voice prints;
o. Full face photographic images and any comparable images; and
p. Any other unique identifying number, characteristic, or code.

"Summary Health Information" means information that may be individually identifiable health information, and:

a. Summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
b. From which the applicable information described in the HIPAA regulations has been deleted, except that the geographic information need only be aggregated to the level of a five-digit ZIP code.

GLOSSARY

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under previously explained provisions of this Plan.

Accident - An unforeseen and unavoidable event resulting in an Injury, which is not due to any fault of the covered person.

Ambulatory Surgical Facility - A public or private facility licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of Doctors; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Annual - A twelve-month (12) period that usually (unless otherwise stated) begins on January 1 and ends twelve (12) consecutive months later on December 31.

Balance Billing (or Bills) - A billing from a medical provider that is usually for an amount that the BlueCross/BlueShield Health Plan did not pay. Most often, the member is financially responsible for balance bills, but in some instances, the provider could be Balance Billing in error. For instance, network, or contracted, providers are prohibited from Balance Billing, when the balance results from charges that exceed contractually agreed-upon rates.

Benefit Year - The 12-month period beginning January 1 and ending December 31. All Annual Deductibles, Coinsurance Maximums and benefit maximums accumulate during the Benefit Year.

Birthing Center - A public or private facility, other than private offices or clinics of Doctors, which meets the freestanding Birthing Center requirements of the State Department of Health in the state where the covered person receives the services.

The Birthing Center must provide:

- A facility which has been established, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a Child born at the center;
- Supervision of at least one specialist in obstetrics and gynecology; a Doctor or certified Nurse midwife at all births and immediate postpartum period;
- Extended staff privileges to Doctors who practice obstetrics and gynecology in an area Hospital;
- At least 2 beds or 2 birthing rooms;
- Full-time nursing services directed by an RN or certified Nurse midwife;
- Arrangements for diagnostic X-ray and lab services; and
- The capacity to administer local anesthetic or to perform minor Surgery.

In addition, the facility must only accept patients with low-risk pregnancies, have a written agreement with a Hospital for Emergency transfers, and maintain medical records on each patient and Child.

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

Covered Services - Benefits, services, and supplies that are covered under the Plan which are determined to be Medically Necessary and satisfy other terms and conditions of the Plan.

Custodial Care - The level of care that consists primarily of assisting with the activities of daily living such as bathing, continence, dressing, transferring and eating. The purpose of such care is to maintain and support the existing level of care and preserve health from further decline. Custodial Care is care given to a patient who:
1. is mentally or physically disabled; and
2. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home, and
3. is not under active and specific medical, surgical or psychiatric treatment, ordered by a Doctor which will reduce the disability to the extent necessary to allow the patient to function outside such environment or without such assistance within a reasonable time, not to exceed one year in any event.

A Custodial Care determination may still be made if the care is ordered by a Doctor or services are administered by a registered or licensed practical Nurse.

Customer Service - A department of BlueCross/BlueShield of Nebraska dedicated to answering your questions concerning your membership, benefits, etc. A Plan Customer Service representative is available to assist you during

regular business hours by calling (888) 445-6383, Monday through Friday, 7:00 a.m. to 7:00 p.m. Central Time, or by writing to BlueCross/BlueShield of Nebraska, P.O. Box 890062, Camp Hill, PA 17089-0062.

Doctor or Physician- A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (D.O.) and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

Durable Medical Equipment - Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of Illness or Injury; and is appropriate for use in the home. To be covered, DME must be Medically Necessary and prescribed for use in your home. DME includes items such as oxygen equipment, wheelchairs, Hospital beds, and other items that are determined Medically Necessary.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn Child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Care - The treatment of bodily injuries resulting from an Accident, or following the sudden onset of a medical condition, or following, in the case of a chronic condition, a sudden and unexpected medical event that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing your health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- causing serious impairment to bodily functions; and/or
- causing serious dysfunction of any bodily organ or part

and for which care is sought as soon as possible after the medical condition becomes evident to you.

Employer - Union Pacific Corporation, its subsidiaries, and affiliates electing to participate in the Union Pacific Retiree Medical Program.

Experimental/Investigative -The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined to be medically effective for the condition being treated. An intervention is considered to be Experimental/Investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or, available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or, the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or, the intervention does not improve health outcomes; or, the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be Experimental/Investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Medical researchers constantly experiment with new medical equipment, drugs and other technologies. In turn, health care plans must evaluate these technologies.

Decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with a nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "Experimental/Investigative" and is not generally covered. However, it may be re-evaluated in the future.

Situations may occur when you elect to pursue Experimental/Investigative treatment. If you have a concern that a service you will receive may be experimental/investigational, you or the Hospital and/or professional provider may contact BCBSNE's Member Service to determine coverage.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association***:**

■ *Diagnostic criteria for adults and adolescents*:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

■ *Diagnostic criteria for children:*

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-

tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
- A strong dislike of ones' sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

■ The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

HDHP - Refers to a High Deductible Health Plan which meets the rules outlined by the Internal Revenue Code in terms of minimum deductible and maximum out-of-pocket. When the plan meets the requirements set forth by the IRS, enrolled individuals may qualify to participate in a tax-favored Health Savings Account (HSA).

Home Healthcare Agency - A public or private agency or organization, licensed and operated according to the law, that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group and at least one Doctor and one registered graduate Nurse to supervise the services provided.

Hospice Facility(ies) - A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive and other related care for a covered person diagnosed as terminally ill with a medical prognosis that life expectancy is 6 months or less.

The facility must have an interdisciplinary medical team consisting of at least one Doctor, one registered Nurse, one social worker, one volunteer and a volunteer program.

A Hospice Facility is not a facility, or part thereof which is primarily a place for rest, Custodial Care, the aged, drug addicts, alcoholics or a hotel or similar institution.

Hospital - A public or private facility, licensed and operated according to the law, which provides care and treatment by Doctors and Nurses at the patient's expense of an Illness or Injury through medical, surgical and diagnostic facilities on its premises.

A Hospital does not include a facility or any part thereof, which is, other than by coincidence, a place for rest, the aged or convalescent care.

Illness - Any bodily sickness, disease, or Mental/Nervous Disorder. For purposes of this Plan, pregnancy will be considered as any other Illness.

Injury - A condition that results independently of an Illness and all other causes and is a result of an externally violent force or Accident.

Inpatient - Treatment in an approved facility during the period when charges are made for room and board.

Lifetime - The periods of time you or your eligible Dependents participate in this Plan.

Maximum Benefit Amount - A maximum amount determined by BlueCross/BlueShield of Nebraska or a BlueCard Program On-site Plan to be reasonable. The Maximum Benefit Amount will be the amount agreed upon between BlueCross/BlueShield of Nebraska and BluePreferred and Participating Providers of the covered service, or the maximum amount agreed upon by the On-site and it contracting providers. If no amount has been established for a covered service, BlueCross/BlueShield of Nebraska may consider the charges submitted by providers for like procedures, a relative value scale which compares the complexity of services provided, or any other factors deemed necessary.

Medicaid - Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

Medically Necessary (Medical Necessity) - Healthcare Services ordered by a Treating Doctor exercising prudent clinical judgment, provided to covered person for the purposes of prevention, evaluation, diagnosis or treatment of that covered Person's Illness, Injury or Pregnancy, that are:

1. Consistent with the prevailing professionally recognized standards of medical practice and known to be effective in improving healthcare outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the covered person's Illness, Injury or Pregnancy. The most appropriate setting and the most appropriate level of Service is that setting and that level of Service, considering the potential benefits and harms to the patient. When this test is applied to the care of an Inpatient, the covered person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and
3. Not more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patients Illness, Injury or Pregnancy, without adversely affecting the

covered Person's medical condition; and

4. Not provided primarily for the convenience of the following:
    a. The covered person;
    b. The Doctor;
    c. The covered person's family;
    d. Any other person or health are provide; and
    e. Not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

BlueCross/BlueShield of Nebraska will determine whether services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Treating Doctor.

Medicare - Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Mental/Nervous Disorder - For purposes of this Plan, a Mental/Nervous Disorder is any diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition, revised), except as specified in Medical Expenses Not Covered, for which treatment is commonly sought from a psychiatrist or mental healthcare provider. The DSM is a clinical diagnostic tool developed by the American Psychiatric Association and used by mental healthcare professionals. Diagnoses described in the DSM will be considered mental/nervous in nature, regardless of etiology.

Mental/Nervous Treatment Facility - A public or private facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of Mental/Nervous Disorders and professional nursing services provided by licensed practical Nurses who are directed by a full-time RN. The facility must also have a Doctor on staff or on call.

The facility must prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs.

Morbid Obesity - A diagnosed condition in which the body weight exceeds the normal weight by either 100 pounds or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed.

The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes or heart disease.

Nurse - A person acting within the scope of his/her license and holding the degree of Registered Graduate Nurse (RN), Licensed Vocational Nurse (L.V.N.)

or Licensed Practical Nurse (L.P.N.).

Oral Surgery - Necessary procedures for Surgery in the oral cavity, including pre- and post-operative care, which are not related to dental Surgery or diagnoses.

Outpatient - Treatment either outside of a Hospital setting or at a Hospital when room and board charges are not incurred. A Hospital or other healthcare facility stay not exceeding 23 hours in length is considered to be Outpatient.

Partial Hospitalization/Day Treatment - A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care, specifically designed for the diagnosis and active treatment of a Mental/Nervous Disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or Hospitalization.
Partial Hospitalization programs must provide diagnostic services; services of social workers; psychiatric Nurses and staff trained to work with psychiatric patients; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

The facility providing the Partial Hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a Doctor.

Plan Administrator - The Plan Administrator is the Vice President-Human Resources, Union Pacific Railroad Company. The Plan Administrator administers the Plan and makes decisions about how Plan provisions apply in specific cases not otherwise assigned to BlueCross/BlueShield.

Plan Sponsor - Union Pacific Corporation.

Plan Year - The 12-month fiscal period for BlueCross/BlueShield Health Plan members beginning January 1ST and ending December 31ST.

Practitioner - Doctor or person acting within the scope of applicable state licensure/certification requirements and holding the degree of Medical Doctor (MD), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (DC), Doctor of Optometry (OD), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Ed.D., Psy.D.), Master of Social Work (M.S.W.), Occupational Therapist, Nurse Practitioner, or Registered Respiratory Therapist.

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

- With respect to medical services or supplies, Blue Cross/Blue Shield's BlueCard Network.
- With respect to pharmacy services, a pharmacy that participates in the UnitedHealth Pharmaceutical Solutions pharmacy network.
- With respect to vision care, a vision care provider who participates in EyeMed Vision Care's network of vision care providers.

Preferred Provider Organization (PPO) - A large group of Healthcare Providers constructed and contracted BlueCross/BlueShield to provide certain services for which benefits are considered at special levels.

Psychiatric Day Treatment Facility(ies) - A public or private facility, licensed and operated according to the law, which provides:

- Treatment for all its patients for not more than 8 hours in any 24-hour period;
- A structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and
- Supervision by a Doctor certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Hospitals.

Reconstructive Surgery - A procedure performed to restore the anatomy and/or functions of the body which are lost or impaired due to an Injury or Illness.

Rehabilitation Facility(ies) - A legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, Custodial Care, ambulatory or part-time care services, or an institution which primarily provides treatment of Mental/Nervous Disorders, substance use disorder or tuberculosis, except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of mental/nervous conditions or substance use disorder in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Healthcare Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Residential Treatment Facility(ies): A facility which provides a program of effective Mental Healthcare Services or Substance Use Disorder treatment and

which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Doctor and approved by the Mental Healthcare/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured environment:
    - room and board;
    - evaluation and diagnosis;
    - counseling; and
    - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital for purposes of the Plan.

Second Surgical Opinion - Examination by a Doctor who is certified by the American Board of Medical Specialists in a field related to the proposed Surgery to evaluate the medical advisability of undergoing a surgical procedure.

Skilled Nursing Facility - A public or private facility, licensed and operated according to the law, which provides: permanent and full-time facilities for 10 or more resident patients; a registered Nurse or Doctor on full-time duty in charge of patient care; at least one registered Nurse or licensed practical Nurse on duty at all times; a daily medical record for each patient; transfer arrangements with a Hospital; and a utilization review plan. The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their Illness or Injury, and is not, other than by coincidence, a rest home for Custodial Care or for the aged.

Specialized Treatment Facility(ies) - A Specialized Treatment Facility, as the term relates to this Plan, includes Birthing Centers, Ambulatory Surgical Facilities, Hospice Facilities, Skilled Nursing Facilities, Mental/Nervous Treatment Facilities, Psychiatric Day Treatment Facilities, Substance Use Disorder Treatment Facilities, Chemical Dependency/Substance Use Disorder Day Treatment Facilities, Rehabilitation Facilities, and Residential Treatment Facilities, as those terms are specifically listed in Covered Medical Expenses.

Spinal Manipulation - The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Substance Use Disorder Treatment Facility(ies) - A public or private facility licensed and operated according to the law, which provides:

- A program for diagnosis, evaluation and effective treatment of substance use disorder;
- Detoxification services; and
- Professional nursing services provided by licensed practical Nurses who are directed by a full-time RN.
- The facility must have a Doctor on staff or on call.

The facility must also prepare and maintain a written plan of treatment for each patient based on medical, psychological and social needs.

Surgery - Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through any natural body opening or incision.

Year - See Benefit Year

BENEFIT PHONE NUMBERS

Union Pacific HR Service Center — 9:00 a.m. to 5:00 p.m. (CT)
Toll-Free ..... (877) 275-8747
Fax Number .....(402) 233-2736
Mailing Address..... 1400 Douglas Street, Stop 0320, Omaha, NE 68179

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

BlueCross/BlueShield (BCBS) HDHP PPO Program

- Website..... *www.mybenefitshome.com*
- Member only website ..... *www.mybenefitshome.com*
- Coverage questions, hospital pre-certification, claim forms and claim questions .....(888)-445-6383

UHC/OptumRx Prescription Benefits (for retirees enrolled in the BCBS HDHP PPO Program)

- Member Only website ..... *www.myuhc.com*
- General questions about the retail or Mail Order program, to order mail order refills, or to locate a participating pharmacy.....(800) 331-4370

Disease Management Program (for retirees less than age 65, or otherwise not Medicare eligible, enrolled in the BCBS HDHP PPO Program)

- United Healthcare/Optum Website…..... *www.myuhc.com*
- To enroll.....(800) 331-4370

Optum Connect 24

- For retirees enrolled in a BCBC HDHP PPO Program ..... *www.myuhc.com*
- Questions about general healthcare needs .....(800) 331-4370

EyeMed Vision Care (for retirees enrolled in the BCBS HDHP PPO Program)

- Website/Provider Directory……..……*www.eyemed.com*
- Member Services.....(866) 723-0513

Towers Watson One Exchange (for Medicare Eligible Participants)

- Website.....*https://medicare.oneexchange.com/unionpacific*
- Retiree HRA claims, eligible expenses 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.