2010 UnitedHealthcare Retiree Medical Guide

Medical Benefits Available to Union Pacific Retirees and their Dependents effective January 1, 2010

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

SUMMARY PLAN DESCRIPTION January 1, 2010

This booklet is a covered person's Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (ERISA). It describes the highlights of a covered person's rights and obligations under the employee welfare benefit plan established by Union Pacific Corporation, provided that the covered person is a participant of the Plan. It 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 Employees or Retirees. This Summary Plan Description does not create a contract of employment.

These benefits are covered by provisions of the Employee Retirement Income Security Act of 1974 (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. A description of ERISA provisions is found in the ERISA section of this document beginning on Page 87.

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INTRODUCTION

This 2010 UnitedHealthcare 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"), which is part of the Union Pacific Corporation Group Health Plan and reflects the Plan provisions effective January 1, 2010.

It is important to note that the benefits provided are covered by provisions of the Employee Retirement Income Security Act (ERISA) of 1974 as amended, a federal law which governs the operation of employee benefit plans. ERISA requires that you receive an easily understood description of your benefits (a "Summary Plan Description"). The information about your benefits described in this document, together with the information on the medical programs provided to certain retirees of Alton & Southern Railroad (whose benefit rights under the Plan are described in those documents) constitute the Summary Plan Description under ERISA.

This document, together with the information on the medical programs provided to certain retirees of Alton & Southern Railroad, also serves as the official plan document and will help you understand your benefits, as well as your rights under the plan and ERISA. For more information concerning your ERISA rights, see the ERISA section of this document.

While Union Pacific Corporation intends to continue the Plan indefinitely, it reserves the right to terminate or amend the Plan described in this Guide for any reason. If the Company through its Senior Vice President - Human Resources terminates or amends the Plan, benefits under the Plan for Retirees 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.

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 on Page 93 is an important reference tool designed to help you understand how the Plan works.

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**, effective January 1, 2004, your original hire date with: A) Union Pacific Corporation; or B) any Union Pacific affiliate that is a participating employer in the Union Pacific Corporation Flexible Benefits Program on December 31, 2003, is 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 31 days of your retirement to begin Retiree Medical 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 Coverage and waived your right to do so, you may later enroll yourself if all of the following conditions are met:

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, 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 31 days after the date of loss of coverage, or the employer's contributions were terminated, or exhaustion of COBRA coverage.

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 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, 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 31 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 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 31 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 31 days after the marriage, birth, adoption, or placement for adoption.

Effective Date of Coverage for Special Enrollment: Enrollment in retiree medical plan 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 31 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 31 days of the event.

To request special enrollment or obtain more information, contact the Union Pacific HR Service Center at 1-877-275-8747, Option 1.

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 medical coverage at your current location, you will be enrolled in a new medical coverage program if you relocate and your current medical coverage program is not available at your new location.

You must notify the Union Pacific HR Service Center of your new address within 31 days following your relocation. If your current medical coverage program is not available at your new location, your 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 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 zip code.
- 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 medical coverage will be effective on the first of the month following your Notification to the Union Pacific HR Service Center of your relocation to a new address. Any contributions for your new election will begin the month following the receipt of your completed election form.

Dependents:

For purposes of the UHC HDHP PPO and Retiree HRA, the following definitions apply. For all other Retiree Medical 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 a Child.
- A "Spouse" is the person to whom the Retiree is married in accordance with the law of the jurisdiction in which the Retiree is domiciled, except to the extent that such law contradicts the Defense of Marriage Act that generally provides that a same sex individual may not be treated as a Spouse. For purposes of eligibility under the Retiree Medical Program, a spouse is no longer considered a Dependent on the date a divorce decree is entered by the court.
- A "Child" is one of the following:
    1. An unmarried individual (son, stepson, daughter, or stepdaughter) who is directly related to the Retiree by blood, adoption (or placement for adoption), or marriage and who is under age 19, a disabled Child, or a Full-Time Student:
        a) If the Retiree:
            1) Expects to claim the individual as a Dependent on his/her federal income tax return for the Calendar Year; or
            2) Would be eligible to claim the individual as a Dependent on such return if:
                (i) The Retiree was not a Dependent of another individual (e. g. parent) under federal tax law, or

(ii) The individual earned less than the federal exemption amount for the Calendar Year; or

b) If the individual (although not described in a)):
   1) Receives over half of his/her support during the Calendar Year from the Retiree and his/her other parent;
   2) Is in the custody of the Retiree and/or his/her other parent for more than half of the Calendar Year; and
   3) Is not the subject of a multiple support agreement.

2. An unmarried individual under age 19 or a Full-Time Student if that individual's principal place of residence is the Retiree's home and if the Retiree expects to claim the individual as a Dependent on his/her federal income tax return for the Calendar Year;
3. An unmarried individual under age 19 or a Full-Time Student for whom the Retiree is required to enroll the individual pursuant to a Qualified Medical Child Support Order (QMCSO).

- A "Disabled Child" means an unmarried Child without regard to the Child's age 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 19 or ceasing Full-Time Student status if the Child was a covered Dependent on the day before the Child's 19th birthday or ceasing Full-Time Student status and only for the period during which the disability and coverage continue without interruption. The Employee must submit proof to the Plan Administrator, when requested, that the Child meets these conditions at the time the Child attains the age of 19 or ceases to be a Full-Time Student 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 "Full-Time Student" is an unmarried Child under age 25 who is attending an accredited educational institution full-time in accordance with the institution's policies. Retirees will be required to provide evidence of "full-time" status at the request of the medical coverage in which they are enrolled and periodically, as requested, by the Plan Administrator.

- A "Qualified Medical Child Support Order" or "QMCSO" is any judgment, order, or decree issued by a court of competent jurisdiction that provides Child support pursuant to a state domestic relations law or pursuant to an administrative proceeding authorized by state statute as described in section 1908 of the Social Security Act which provides for health benefit coverage of an alternate recipient. A QMCSO cannot require the Plan to provide any type or form of benefit or option not already provided under the Plan. The QMCSO must specify the name and address of the Retiree and each alternate recipient, describe the coverage to be provided, identify the period for which the coverage is to be provided, and specify the plan to which the QMCSO applies. 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 at 1-877-275-8747, Option 1, Monday through Friday, 9:00 AM to 4:00 PM Central Time, excluding holidays.

You are responsible for notifying the Union Pacific HR Service Center at 1-877-275-8747, Option 1, within 31 days after an event that either allows an individual to be considered a Dependent 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, evidence that they satisfy the Plan's definitions of Dependent and their social security numbers.

Your Cost for Coverage:

The coverage under this Plan is contributory. This means that Retirees must make contributions toward the cost of coverage.

WHEN BENEFITS END

Except as provided below regarding your Dependent who is no longer a Full-Time Student, medical benefits 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:

- You stop making any required contribution;
- You are rehired and become eligible for medical benefits as an active employee;
- Your Dependent no longer meets the definition of an eligible Dependent;
- The Plan is terminated or amended in a manner that causes your coverage to end;
- 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 2 of this document, and elects to do so;
- Your surviving Spouse covered by the Plan dies.

Retiree Medical Program coverage for a Full-Time Student age 19 or over will not terminate until the end of the month in which the earliest of the following events occurs:

- Six months following the date the individual is no longer a Full-Time Student;
- The date such individual attains age 25; or
- The date such individual no longer is an eligible Dependent, disregarding his/her loss of Full-Time Student status.

In order for Retiree Medical Program coverage to continue for the former Full-Time Student for six months following the date the individual is no longer a Full-Time Student (known as the 6-Month Rule), the Retiree must provide Notification to the Union Pacific HR Service Center within 31 days of the end of the 6-month period following the eligible Dependent losing Full-Time Student status.

Notwithstanding the provisions above, coverage provided to an individual who is a Full-Time Student and age 19 or older 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 Medically Necessary Leave of Absence ends;
- The date that is 1 year after the first day of the Medically Necessary Leave of Absence;
- The date on which the individual attains age 25; or
- The date such individual no longer is an eligible Dependent, disregarding the fact that the individual is not enrolled as a full-time student.

A Medically Necessary Leave of Absence of a Full-Time Student 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;
- Would cause the individual to fail to satisfy the definition of a Dependent Child because the individual would no longer be a Full-Time Student; and
- For which the Plan has received written certification by a treating physician of the individual which states that the individual is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. This certification must be provided to the Union Pacific HR Service Center within 31 days of the commencement of the leave of absence.

It is the Retiree's responsibility to provide notification within 31 days of any other event affecting the eligibility of a covered Dependent or an individual on a Medically Necessary Leave of Absence, such as marriage, attainment of age 25, the cessation of a Medically Necessary Leave of Absence, or any other reason that would cause the individual to fail to be a Dependent.

Continuation of Coverage:

Your covered Spouse and Children who are your covered Dependents immediately prior to your death will not cease to be eligible Dependents solely by reason of your death. Assuming the Plan is not terminated or amended in a manner that causes coverage to end, your surviving covered Spouse and other covered Dependents will be permitted to continue Retiree Medical Program benefits 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 medical Plan 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 medical Plan for up to 36 months under COBRA.

COBRA COVERAGE

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 1-877-275-8747, Option 1.

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 guide. 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 "Retiree HRA for Medicare Eligible Retirees and Dependents" section on Page 72 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 your participating employer, and that bankruptcy results in the loss of coverage of any Retiree covered under the Plan, 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 1-877-275-8747, Option 1. 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. 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.

The American Recovery and Reinvestment Act ("ARRA") provides for a new COBRA premium subsidy for qualified beneficiaries who become entitled to COBRA as a result of an involuntary termination of employment that occurred at some time from September 1, 2008, through March 31, 2010. More information regarding the COBRA subsidy provisions of the ARRA is available at www.dol.gov/ebsa/cobra.html**.**

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Healthcare Tax Credit Customer Contact Center toll free at 1-866- 628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

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.

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 Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, visit the EBSA Web site at www.dol.gov/ebsa, or contact EBSA at 1-866-444-3272. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

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 1-877-275-8747, Option 1. If you are currently receiving COBRA continuation coverage and have questions about such coverage, please contact the Plan's COBRA Administrator:

ADP COBRA Services
2575 Westside Parkway, Suite 500
Alpharetta GA 30004-3852

HIPAA Special Enrollment Rights:

The passage of the Health Insurance Portability and Accountability Act of 1996, or HIPAA, provides special enrollment rights to participate in group health plans (see Pages 2-3).

COBRA and HIPAA Administration:

Union Pacific Corporation has retained ADP COBRA Services to provide certain COBRA and HIPAA services. In this capacity, ADP COBRA Services handles Notifications, eligibility transmittals, record keeping, and billing services. Also, you may request a certificate of creditable coverage at any time while you are covered under the Union Pacific Corporation Group Health Plan and up to 24 months after such coverage ceases. To request a certificate of creditable coverage, please contact ADP COBRA Services at the following address:

ADP COBRA Services
2575 Westside Parkway, Suite 500
Alpharetta GA 30004-3852

If you have any questions about HIPAA or your current COBRA coverage, please contract ADP COBRA Services at 1-800-526-2720. If you have additional benefit questions, call the Union Pacific HR Service Center at 1-877-275-8747, Option 1. If you have changed marital status or you or your Dependents have changed addresses while receiving continuation of benefits under COBRA, you should notify ADP COBRA Services.

MEDICAL PLAN TYPES: AN OVERVIEW

The medical plan coverage 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 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, 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 network used by the Retiree Medical Program is the UHC "Choice Plus" network.

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 plan's claim administrator and the amount the Plan will pay for covered services will be based on the Plan'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 physician 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.

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 PLAN COVERAGES

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

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

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

The UHC HDHP PPO is described in this 2010 UnitedHealthcare Retiree Medical Guide. The BCBS HDHP PPO is described in the 2010 BlueCross/BlueShield Retiree Medical Guide.

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

- Retiree HRA coverage (administered by Extend Health and described in this 2010 UnitedHealthcare 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 Extend Health) that is first available in 2010. You may 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; and
    b. You had a balance remaining in your Transition HRA (if you retired before January 1, 2008, formerly known as an HRA).

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 1-877-275-8747, Option 1.

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."

Effective January 1, 2010, 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 Extend Health. In addition, if during the Calendar Year you or your Dependent reach age 65, or otherwise become Medicare eligible, coverage under the UHC HDHP PPO (or BCBS HDHP PPO, as applicable) for the 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 UHC HDHP PPO or the BCBS HDHP PPO (depending on your residential zip code) until he/she attains age 65 or otherwise becomes eligible for Medicare. 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 72.

The UHC Out-of-Area PPO available to Medicare Eligible Participants prior to 2010 and the Medicare Advantage HMOs available to certain Southern Pacific retirees prior to 2010 have been discontinued. If you are a Medicare Eligible Participant, the only medical coverage provided by the Union Pacific Retiree Medical Program is the Retiree HRA (and the Retiree Transition HRA, if available to you). If you wish to have medical coverage in addition to that provided under the Union Pacific Retiree Medical Program, you may want to consider enrolling in traditional Medicare coverage (i.e., Medicare Part A and Part B), Medicare Drug coverage (Part D), and an individual Medicare plan or other medical coverage available to you.

Important Medicare Part D Coverage Note:

The Union Pacific Retiree Medical Program previously had a rule that terminated coverage for any Medicare Eligible Participant who enrolled in Medicare Part D prescription drug coverage. This rule was eliminated effective September 1, 2009, and any Medicare Eligible Participant who enrolled in a Medicare Part D plan on or after September 1, 2009, did not have coverage under the Union Pacific Retiree Medical Program terminated as a result of such enrollment. 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 program and the Plan, the Plan Administrator and other plan fiduciaries and the third party claims administrator of the UHC HDHP PPO, the BCBS HDHP PPO, and the Retiree HRA shall have discretionary authority to make factual findings, to interpret the terms of the medical program, and to determine eligibility for and entitlement to plan benefits in accordance with the terms of the medical 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.

UNITEDHEALTHCARE HDHP PPO PROGRAM FOR RETIREES AND DEPENDENTS WHO ARE NOT MEDICARE ELIGIBLE

Components:

The UHC 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 UnitedHealthcare Insurance Company to administer the UnitedHealthcare Choice Plus PPO Network ("UHC PPO Network") and to administer claims and medical management services. In this capacity, UnitedHealthcare has been granted discretionary authority to interpret terms of the UHC HDHP PPO Program to determine entitlement to plan benefits in accordance with the terms of the Plan.
2. **Mental Health and Substance Abuse Treatment Benefits:** These benefits are self-insured by Union Pacific and are administered by United Behavioral Health (UBH). UBH has discretionary authority to interpret the terms of Mental Healthcare and Substance Abuse 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 UnitedHealth Pharmaceutical Solutions (UHPS)/Medco. In this capacity, UHPS/Medco 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 are self-insured by Union Pacific. 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 UHC HDHP PPO Program is offered through UHC's Choice Plus PPO Network. The pharmacy benefit is administered separately from the UHC PPO Network. The UHC PPO Network refers to the network of providers maintained by UHC for medical services and supplies. Also, UBH maintains its own network of mental health/substance abuse providers. You may view the online UnitedHealthcare Preferred Provider Directory available through the UHC Web site at www.myuhc.com or call 1-800-331-4370 to request a printed copy.

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

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

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

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

If you are in an area where the UHC PPO Network or a provider in the UBH Preferred Provider Program is available and a Non-Preferred Provider is used, a higher Deductible will apply. You will receive lower Plan Medical Coinsurance after the Deductible under the UHC HDHP PPO Program is met and be subject to the provider's billing for the difference between his/her bill and the amount determined by UnitedHealthcare or UBH

to be Reasonable and Customary. The lower Plan Medical Coinsurance will be calculated as a percent of the Reasonable and Customary amount. In addition, the Coinsurance Maximum will be higher if a Non-Preferred Provider is used.

NOTE:

- Non-Network expenses may be covered at the Network level. Even in the UHC PPO Network area, occasionally a provider in a particular specialty is not readily available. To accommodate these cases, whenever a network provider is not available within a 30-mile radius of 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 UnitedHealthcare, Plan Coinsurance will be based on Reasonable and Customary Charges. If an eligible Dependent does not reside with the Retiree, his/her residence is deemed to be the same as the Retiree's residence. However, to qualify for coverage of Non-Network expenses at the network level, the participant must contact UnitedHealthcare's Customer Service Department (1-800-331-4370) BEFORE services are rendered to verify that the Non-Network physician/specialist qualifies for coverage at the network level and to facilitate the appropriate payment of applicable claim(s).
- Services performed by radiologists, anesthesiologists, or pathologists. 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, or pathologists will be considered In-Network for the purpose of determining Plan benefits. If the radiologists, anesthesiologists, or pathologists are members of the UHC PPO Network, In-Network benefits will be based on contracted rates. If the radiologists, anesthesiologists, or pathologists are not members of the UHC PPO Network, In-Network benefits will be based on billed charges.

How to Determine if a Provider is in the UHC PPO Network: View the online UnitedHealthcare Preferred Provider Directory available through the UHC Web site at www.myuhc.com or call 1-800-331-4370 to request a printed copy.

Mental Healthcare and Substance Abuse Treatment: Your use of United Behavioral Health providers through Notification procedures (see section "When to Call United Behavioral Health" on Page 18) determines whether and to what extent benefits will be paid for inpatient and alternate care mental health/substance abuse services and supplies. You may call United Behavioral Health at 1-800-888-2998 for a confidential referral to an appropriate clinician or to insure proper Notification of your behavioral healthcare.

Pharmacy Benefits: Pharmacy benefits are governed by whether you use Network Pharmacies (see section "Pharmacy Benefits" on Page 54).

Vision Care Benefits: Vision care benefits are governed by whether you use participating vision care Providers (see section "Vision Care Benefits" on Page 68).

Plan Features:

This section describes the following features of the UHC 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 UHC HDHP PPO Program or the BCBS HDHP PPO Program available to them, depending on your residential 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 features that apply to the UHC HDHP PPO Program. Each feature is then described in the paragraphs that follow.

Program	Premium Contribution	Deductible	Retiree Coinsurance
UHC 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 plan coverage 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 Dependent enrolled in the UHC HDHP PPO, then your UHC 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 UHC HDHP PPO Program.

Deductible: The Deductible is the amount you pay each year before expenses are paid by the Plan. Under the UHC HDHP Program, there is a single Deductible for medical, including mental health and substance abuse 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 any number of members of your family incurs expenses equal to the family Deductible.

- For the UHC HDHP PPO Program, the amounts you pay for contracted rates with a Preferred Provider for Covered Medical Services are applied against the HDHP Deductible. If a Non-Preferred Provider is used to receive Covered Medical Services, only the amount you pay for Reasonable and Customary Charges for Covered Medical Services are 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 67 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.
- Amounts paid for over-the-counter drugs and vision care Copayments do not count toward your HDHP Deductible.
- The UHC 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 15.

Retire on a Date Other than January 1st: If you retire on a date other than January 1st of a Calendar Year and you enroll in the UHC HDHP PPO, the amount already paid toward active employee Deductibles in the year in which you retire will be counted toward Retiree Deductibles in the same Calendar Year.

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

After the HDHP Deductible is met, the Plan pays a specified percentage of the Covered Medical Services and Prescription Drug Products on the Prescription Drug List at a Network Pharmacy for the rest of the Calendar Year, and you pay the remaining percentage. The Medical Coinsurance and Pharmacy Coinsurance amounts are not identical.

- The Medical Coinsurance is a percentage of the contracted rate if a Preferred Provider is used. If a Non-Preferred Provider is used, a lower percentage of the Reasonable and Customary Charges for Covered Medical Services applies. Medical Coinsurance payments are capped by the annual HDHP Coinsurance Maximum.
- The Pharmacy Coinsurance percentage depends on the Plan's Prescription Drug List, with the member paying a smaller percentage for Tier-1 (typically Generic drugs), a greater percentage for Tier-2 (preferred brand-name drugs), and the highest percentage for Tier-3 (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. Per prescription Pharmacy Coinsurance payments are capped to lessen the burden of high cost drugs. 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 15.

Specific Pharmacy Coinsurance percentages, and per prescription minimum and maximum Pharmacy Coinsurance amounts are presented in the Schedule of Benefits, starting on Page 16.

Coinsurance Maximum: The Coinsurance Maximum is the amount you pay each year before the UHC HDHP PPO Program pays 100% of the Reasonable and Customary Charges or the contracted Preferred Provider rate for the rest of the Calendar Year for Covered Medical Services.

Under the UHC HDHP PPO Program, there is a single Coinsurance Maximum for medical and pharmacy expenses. Once the applicable Coinsurance Maximum is met the UHC 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 Reasonable and Customary Charges for Covered Medical Services and the Predominant Reimbursement Rate for Prescription Drug Products do not count against toward a Coinsurance Maximum.
- Expenses you pay to satisfy a Deductible do not count toward a Coinsurance Maximum.
- Any benefit reduction for not notifying UHC as described on Pages 18 does not count toward the Coinsurance Maximum.
- Any expense incurred for any health service that is not a Covered Medical 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 any number of members of your family incurs expenses equal to the family Coinsurance Maximum.

Specific Coinsurance Maximum features are presented in the Schedule of Benefits, starting on Page 15.

Retire on a Date Other than January 1st: If you retire on a date other than January 1st of a Calendar Year and you enroll in the UHC 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 Retiree 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.

When Covered Medical Services are received from Non-Network Providers as a result of an Emergency or as otherwise arranged through UnitedHealthcare or United Behavioral Health, eligible expenses are the fees that are negotiated with the Non-Network Provider. Charges for non-Emergency services received from Non-Network Providers are limited to the Reasonable and Customary amounts as determined by UnitedHealthcare or United Behavioral Health.

Eligible expenses for non-Emergency services received from Non-Network Providers are determined by UnitedHealthcare or United Behavioral Health at the billed rate up to the Reasonable and Customary limit. If the Provider is not a Participating Provider, the Plan will only consider the fees up to a Reasonable and Customary amount. The Non-Network Provider may bill you for the balance between his/her fee and the amount determined by UnitedHealthcare or United Behavioral Health to be Reasonable and Customary. This practice is known as "balance billing." Amounts charged above Reasonable and Customary limits are not "covered" expenses and do not count toward 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.

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

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

Maximum Lifetime Benefit: The Maximum Lifetime Benefit for Covered Medical Services, including Mental Health/Substance Abuse Services, for Retirees and their Dependents is $1,000,000 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 Medical Services.

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

Plan Benefits Offered:

The following table provides an overview of the UHC 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.

SCHEDULE OF BENEFITS UHC HDHP PPO		
Plan Feature	**Network**	**Non-Network**
Medical Care		
Annual HDHP Deductible ▪ Individual ▪ Family: 2+ Persons	 $2,750 $5,500	 $ 5,500 $11,000
Note: The Annual HDHP Deductible applies to both Medical and Pharmacy benefits and must be met before the Plan pays benefits.		
Plan/Retiree Medical Coinsurance after HDHP Deductible (Medical benefits other than managed Mental Health/ Substance Abuse) ▪ Plan pays ▪ You pay	 80% 20%	 60% 40%
HDHP Coinsurance Maximum (Annual Limit after HDHP Deductible including Mental Health/Substance Abuse and Pharmacy benefits) ▪ Individual ▪ Family: 2+ Persons	 $2,750 $5,500	 $ 5,500 $11,000
Preventive Care (As outlined under "Additional Programs to Help You Manage Your Health," see Page 40)	Paid at 100%	No benefits are paid for a Non-Network Provider

SCHEDULE OF BENEFITS UHC HDHP PPO		
Plan Feature	**Network**	**Non-Network**
Managed Mental Health/Substance Abuse Treatment		
Plan/Retiree Medical Coinsurance after HDHP Deductible ▪ Plan pays ▪ You pay	UBH Provider 80% 20%	Non-UBH Provider 60% 40%
Inpatient Mental Health	All inpatient mental healthcare must be preauthorized by United Behavioral Health	
Inpatient Substance Abuse	All inpatient substance abuse treatment must be Preauthorized by United Behavioral Health	
Medical Care and Mental Health/Substance Abuse Treatment		
Maximum Lifetime Benefit (Combined)	$1,000,000 Per Person	
Pharmacy Program		
Retail (Up to 31-day supply) **Retiree Retail Pharmacy Coinsurance after HDHP Deductible** 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** 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%	
*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.		
Note: The Annual HDHP Deductible applies to both Medical and Pharmacy benefits and must be met before the Plan pays benefits.		

Care Coordination Program:

The Care Coordination Program is designed to encourage an efficient system of care for you and your enrolled Dependents by identifying and addressing possible unmet covered healthcare needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management programs. Care Coordination activities are not a substitute for the medical judgment of your physician. The ultimate decision as to what medical care you or your Dependents actually receive must be made by the covered person and his or her physician. Care Coordination is triggered when UnitedHealthcare receives Notification of an upcoming treatment or service. The Notification process serves as a gateway to Care Coordination activities and is an opportunity for you to let UnitedHealthcare know that you are planning to receive specific healthcare services. To assist you and your physicians with access to healthcare services, UnitedHealthcare may contact you when certain treatments are involved.

The ultimate decisions on medical care must be made by the covered person and his/her physician. Care Coordination only determines if the listed service or supply is a Covered Medical Service according to the Plan benefits and provisions. No benefits are payable unless Care Coordination determines that the services and supplies are covered under the Plan.

The following covered services and supplies under the UHC HDHP PPO are subject to Care Coordination. UnitedHealthcare must be notified prior to any of the following services or supplies being given:

- Admissions, including Hospital rehabilitation and skilled nursing facilities.
    - For inpatient confinement, UnitedHealthcare must be notified of the scheduled admission date at least five working days before the start of the confinement. An admission date may not have been set when the confinement was planned. UnitedHealthcare must be notified again as soon as the admission date is set.
    - Notification must be performed whether In-Network or Out-of-Network.
- Breast reconstruction (other than mastectomy).
- Dental services due to an accident, except for emergency services, in which case Notification should occur within two business days.
- Cancer Resource Services (the initiation of cancer treatment).
- Durable Medical Equipment (for items with a purchase/cumulative rental cost over $1,000).
- Emergency health services that result in an inpatient stay (if an Emergency Admission occurs, the Employee should call within two business days).
- Home healthcare services, including (but not limited to) home health aid, home infusion therapy, occupational therapy, physical therapy, private duty Nurses, respiratory therapy, and skilled nursing.
- Hospice care, including home care and inpatient hospice services.
- Maternity services (if stay exceeds the 48/96-hour guidelines).
    - Inpatient confinement for delivery of child: UnitedHealthcare must be notified only if the inpatient care for the mother or Child is expected to continue beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section. For inpatient care (for either the mother or Child) which continues beyond the 48/96 hour limits, UnitedHealthcare must be notified before the end of these time periods.
    - Non-emergency inpatient confinement without delivery of child: Confinement during pregnancy but before the admission for delivery, which is not Emergency care, requires Notification as a scheduled confinement. UnitedHealthcare must be notified prior to the scheduled admission.
- Obesity surgery, including bariatric surgery. UnitedHealthcare must be notified before the surgery is scheduled to allow UnitedHealthcare to determine if the surgery meets the requirements of a Covered Medical Service (see list of covered services).
- Rhinoplasty.
- Sclerotherapy and ligation, vein stripping: Removal of varicose veins and other vein abnormalities.
- United Resource Network (URN) includes the following specialized Network services:
    - Congenital heart disease.
    - Kidney Resource Services.
    - Neonatal Resource Services.
    - Transplant Resource Services (Organ/Tissue Transplants):
        - UnitedHealthcare must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:
            - The evaluation.
            - The donor search.
            - The organ procurement/tissue harvest.
            - The transplant.

          Notification initiates transplant benefit determination.

Note: Approval by Care Coordination does not guarantee that benefits are payable under this Plan. Benefits are based on:

- The covered services and supplies actually performed or given.
- The covered person's eligibility under the UHC HDHP PPO on the date the covered services and supplies are performed or given.
- Deductibles, Coinsurance, maximum limits, and all other terms of the UHC HDHP PPO Program.

Notification: It is the covered person’s responsibility to notify UnitedHealthcare before receiving any of the services or supplies listed above as being subject to Care Coordination. In many cases, if you use a participating Provider, the participating Provider will notify UnitedHealthcare on your behalf. However, you should always check with your participating Provider since it is your responsibility to make sure UnitedHealthcare is properly notified. Unless otherwise indicated, UnitedHealthcare must be notified at least five working days before the service is given unless the service is provided under emergency circumstances.

Notification must be provided to UnitedHealthcare by calling the toll-free number (1-800-331-4370) shown on the Employee’s Medical I.D. Card. UnitedHealthcare will work with the covered person and his/her physician to

coordinate healthcare services. The covered person, the physician, and the facility will be sent a letter confirming the results of the call.

A Covered Person can appeal a Non-Coverage Determination by calling UnitedHealthcare: If the covered person or the physician does not agree with UnitedHealthcare's non-coverage determination, it can be appealed. (See "Medical Claim Questions and Appeals" section on Page 50 of this document.)

Emergency Care: When Emergency care is required and results in a confinement, the covered person (or that person's representative or physician) must call UnitedHealthcare within two working days of the date the confinement begins.

When the Emergency care has ended, however, UnitedHealthcare must be called before any additional services that require Notification are received.

Definition of Covered Medical Services: Covered Medical Services are those health services, supplies, or equipment provided for the purpose of preventing, diagnosing, or treating a sickness, injury, or symptoms. Covered Medical Services are provided:

- When the Plan is in effect;
- Prior to the date that any of the individual termination conditions set forth in this Guide occur; and
- Only when the person who receives services is a covered person and meets all eligibility requirements specified in the Plan.

A Covered Medical Service must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and is based on trials that meet the following designs:
    - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.), and
    - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is the most cost-effective method and yields a similar outcome to other available alternatives.
- It is a health service or supply that is generally described in this section and which is not excluded under Expenses Not Covered.

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

Reduced Benefits for Failure to follow Required Review Procedures: When the required review procedures are followed, your benefits will be unaffected. However, Covered Benefits or Services are reduced by $300.00 if the Covered Person does not call UHC as required. 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.

Mental Healthcare or Substance Abuse Treatment:

When to Call United Behavioral Health: You must call United Behavioral Health at 1-800-888-2998 **before** receiving covered Mental Healthcare or Substance Abuse Treatment in order to avoid a reduction in benefits. Benefits for inpatient Mental Healthcare or Substance Abuse Treatment are reduced by $300.00 if United Behavioral Health is not called before receiving treatment. The purpose of the call is to help ensure the appropriate resources are made available considering the level and kind of services required. United Behavioral Health can refer you to a Behavioral Health Provider with the professional skills and experience that match your needs. Receiving this help is especially important in the field of behavioral health and substance abuse because individuals are often less familiar with the types of behavioral health Providers and specialties available.

In addition, you must call UBH regarding all inpatient Mental Healthcare or Substance Abuse Treatment (including all alternative levels of care) before receiving these services in order to receive Plan benefits without penalty. This applies to both In-Network and Outside Network inpatient care. Alternative levels of care

include 24-hour residential treatment, partial hospitalization, day and evening structured programs, halfway houses, and recovery homes. Benefits for inpatient Mental Healthcare or Substance Abuse Treatment are reduced by $300 if UBH is not called before receiving treatment. This reduction in benefits will not apply to the Deductible or Coinsurance Maximum.

How to Call United Behavioral Health: United Behavioral Health can be contacted by calling 1-800-888-2998. You can appeal United Behavioral Health's decision not to make a referral or a decision regarding whether a treatment is Medically Necessary (see "Medical Claim Questions and Appeals" on Page 50 of this document).

Emergency Care/Treatment: Emergency Mental Healthcare or Substance Abuse Treatment does not require a call to United Behavioral Health **before** receiving treatment in order to determine whether services or supplies are Medically Necessary. In an Emergency, calling United Behavioral Health will result in an immediate referral to an appropriate Network facility or Provider for evaluation and treatment. If you are unable to call United Behavioral Health at the time of the Emergency, United Behavioral Health must be notified within 48 hours from the time Emergency care is received.

Benefits under this Plan for Mental Healthcare or Substance Abuse Treatment are payable at the Network level as shown in the Schedule of Benefits. However, benefits are reduced by $300 if you do not call as required above in a timely manner for Emergency Mental Healthcare or Substance Abuse Treatment or for a referral for additional services after Emergency Mental Healthcare or Substance Abuse Treatment has ended. This reduction in benefits will not apply to the Deductible or Coinsurance Maximum.

Medical and Mental Health Services:

This section describes many of the typical examples of covered services and supplies and limits that may apply to the benefits provided by the UHC HDHP PPO Program which is administered by UnitedHealthcare and United Behavioral Health. To obtain information about a specific medical service or supply, call UnitedHealthcare's Customer Service at 1-800-331-4370 or United Behavioral Health at 1-800-888-2998.

The UHC HDHP PPO does not claim to cover all medical expenses that you may incur. To be covered by the Plan, UnitedHealthcare or United Behavioral Health must determine that the services and supplies are Necessary or Medically Necessary, respectively, and given for the diagnosis or treatment of an accidental injury or illness. These requirements apply to the UHC HDHP PPO Program (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 given, but this Plan only pays for Covered Services and supplies which are deemed Necessary or Medically Necessary as determined by UHC or by UBH.

Necessary Medical Services or Supplies: If a Doctor recommends that you receive medical services or supplies, UnitedHealthcare will make the decision as to whether:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:
    - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not permitted to choose which treatment is received.)
    - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is the most cost-effective method and yields a similar outcome to other available alternatives.
- It is a health service or supply that is generally described in this section and which is not excluded under Expenses Not Covered.

Medically Necessary Mental Health/Substance Abuse Services: If a Doctor recommends that you receive mental health/substance abuse services, United Behavioral Health will make the decision as to whether such service is:

- Consistent with the symptoms and signs of diagnosis and treatment of the covered person's behavioral disorder, psychological injury, or chemical dependency; and
- Consistent in type and amount with regard to the standards of good clinical practice; and

- Not solely for the convenience or preference of the covered person or his/her healthcare Provider; and
- The least restrictive and least intrusive appropriate supplies or level of service which can be safely provided to the covered person; and
- Such service is qualified for benefits under the Plan.

United Behavioral Health may consult with professional clinical consultants, peer review committees, or other appropriate sources for recommendations regarding whether particular services, supplies, or accommodations provided to, or to be provided to, a covered person are Medically Necessary.

With respect to both medical and mental health services and supplies, decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies as described.

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, Healthy Pregnancy, Disease Management for Coronary Artery Disease, Congestive Heart Failure, Diabetes and Asthma, Cancer Resource Services, Transplant Management, Optum Connect24, and Medical Case Management and are described in more detail starting on Page 40.

Benefits paid for the Covered Medical 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 15.

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Acupuncture	Acupuncture services provided by a licensed Provider who is qualified in the use of acupuncture, or acupuncturist licensed by the state, or certified by the National Commission of Acupuncturists. 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 physician's office and treatment (injection administered by a Nurse)	
Ambulance Services	**Emergency Only:** Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. **Non-Emergency:** Local transportation by professional ambulance, other than air ambulance, to and from a medical facility. Longer distance transportation by ambulance or air ambulance to the nearest medical facility qualified to give the required treatment where medically necessary. Air ambulance transport is covered in the following circumstances: Patient requires transport to a Hospital or from one Hospital to another because the first Hospital does not have the required services and/or facilities to treat the patient, and ground ambulance transportation is not medically appropriate because of the distance involved, or because the patient has	

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	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 physician 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 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, and d) Treatment of physical complications in all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Such coverage is subject to annual Deductibles, Coinsurance, and other provisions that are applicable to other benefits of the UHC HDHP PPO Program.	Breast Reconstruction, other than in conjunction with a mastectomy, that does not meet the criteria established through the Notification process is not covered.
Breast Reduction	Breast reduction surgery is a Covered Medical 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 pain attributable to macromastia.	Breast reduction surgery is NOT a Covered Medical Service when performed to improve appearance or for the purpose of improving athletic performance.

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	In addition, the surgery must be determined not to be cosmetic by Care Coordination. Breast reduction surgery is covered when a reconstruction has been performed on the other breast (See **Special Notice Regarding Mastectomies**, above).	
Cancer Clinical Trials	Covered only through the Cancer Resource Network (see Page 44).	Not covered unless allowed through the Cancer Resource Network (see Page 44).
Cardiac and Pulmonary Rehabilitation Services	Services must be performed by a licensed therapy Provider under the direction of a physician. Benefits are available only for the rehabilitation services that are expected to result in significant physical improvement in the patient's condition within 2 months of the start of treatment. The primary intent is to improve the functional capacity of the heart and/or lungs and provide the necessary skills for self-monitoring of unsupervised exercise.	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 physician for a Necessary course of treatment given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine. Limited to 30 visits per Calendar Year.	Massage therapy is NOT covered.
Cochlear Implant	Covered if diagnosis of severe to profound bilateral sensorineural hearing loss and severely difficult speech discrimination, or post-lingual sensorineural deafness in an adult.	
Cosmetic Services	The following cosmetic procedures are covered, provided Notification is received and has been approved the procedure is for: • Correction of a congenital anomaly. • Repair, following accidental injury. • Reconstructive Surgery (See Surgery, Page 33).	Cosmetic services that do not receive approval through the Notification process or are not one of these three listed procedures will not be covered.

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Dental Services	The following services and supplies are covered only if needed because of accidental injury to natural teeth: • Oral surgery. • Full or partial dentures. • Fixed bridgework. • Prompt repair to natural teeth. • Crowns. • Required anesthesia to perform covered dental services. Accident/injury must have occurred while coverage is in effect. Dental treatment is covered only if needed because of accidental injury to natural teeth. Services must be: • Provided by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry DMD). • As a result of damage severe enough that the initial contact with the Doctor or dentist occurred within 72 hours of the accident. Benefits are available only for treatment of sound, natural teeth. The dentist must certify that the injury to the tooth was a virgin or unrestored tooth; has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally during chewing and speech. Services for final treatment to repair the damage must be started within 3 months of the accident and completed within 12 months of the accident.	Dental services that are not a result of an accident. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of teeth. Dental Services that are submitted for payment consideration under the UHC HDHP PPO are subject to the Notification procedures for determination of meeting the criteria as a Covered Medical Service.
Diabetic Supplies	Diabetic supplies including syringes, test strips and lancets are covered under the Pharmacy Program (see Page 54). 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 physician, including ostomy supplies.	Non-prescribed supplies.

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Durable Medical Equipment (Notification is required on any DME expense over $1,000.)	Durable Medical Equipment that meets each of the following criteria: a) Ordered or provided by a Physician 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 concentrator units and the purchase or rental of equipment to administer oxygen (including tubing and connectors), and braces (including adjustments to shoes to accommodate braces that stabilize any injured body part). • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure is covered. • Devices that replace a limb or body part, including artificial limbs, artificial eyes, breast prosthesis (as required by the Woman's Health and Cancer Rights Act of 1998).	A brace that straightens or changes the shape of the body part is an orthopedic device and is not covered under the DME benefit. Air conditioners, humidifiers, dehumidifiers, air purifiers and filters are not covered. Tanning beds, duplicate prosthetics, appliance cost for the replacement of stolen prosthetic devices and prosthetics that are less than five years old are not covered. Hearing aids, fittings and replacement hearing aids are not covered**.** The purchase of all DME is subject to the Notification requirements to determine if the equipment meets these criteria before benefit payment will be considered.
Emergency Health Services (i.e., Emergency Room)	A true Emergency is paid at the Network level regardless 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 the Emergency health services visit results in an inpatient stay, Notification is required. The participant must call with 48 hours of admission; otherwise a non-Notification penalty will apply.	

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
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 31).	
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 Physician and provided by or supervised by a registered Nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home healthcare is required. Skilled home healthcare is skilled nursing, skilled teaching, and skilled rehabilitation services when the care: 1) Is 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) Is ordered by the Physician; 3) Is not delivered for the purpose of assisting with the activities of daily living; 4) Requires clinical training in order to be delivered safely and effectively; and 5) Is not Custodial Care. Care Coordination will decide if skilled home healthcare is required by reviewing both the skilled nature of the service and the need for Physician-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.	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.

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Hospice Care (Notification Required)	Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and for short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. The following Hospice Care Benefits are covered: • Room and board charges in a hospice facility, except for charges that exceed the Hospital's most common semi-private room rate for any day you are Hospital confined; or charges that exceed the hospice facility's most common semi-private room rate for any day you are confined in a freestanding hospice facility. A hospice facility must offer a hospice program that is approved by Care Coordination and must either be a Hospital, a freestanding hospice facility that provides inpatient care, or an organization that provides healthcare services in your home. The facility can provide these services using its own staff or by contracting with other organizations. • Skilled nursing or home health aide services provided by a Nurse or a licensed practical Nurse; • Counseling to enhance your peace of mind if your Doctor determines that your mental state is caused by your terminal illness. Such counseling is also covered for members of your family after your death. Bereavement counseling associated with hospice care is limited to six visits; • Up to 7 days of respite care;	Volunteer services or services normally provided at no charge. Private duty nursing for custodial care. Legal or financial advice. Counseling by clergy or any volunteer group not specifically rendered by and charged for by the hospice. Services provided by a person who lives in your home or who is a member of your immediate family.

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	• 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 UnitedHealthcare determine to be Necessary and which are provided through the hospice program, such as medical supplies, medicines, drugs, Doctor's services, and the rental or purchase of durable medical equipment, whichever is less expensive.	
Hospital – Inpatient Stay (Notification Required)	Notification is required for elective admissions (five days before the admission), non-elective admissions (within one day of admission), and Emergency Admissions (within 48 hours or 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.
Infertility	See Reproductive Services (Page 31).	
Infertility – Assisted Reproductive Technology	See Reproductive Services (Page 31).	
Inpatient Prescription Drugs	See Prescribed Drugs and Medicines (Page 30).	
Laboratory Services	Laboratory tests for diagnosis or treatment are covered expenses.	
Maternity Care	See Reproductive Services (Page 31).	

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
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 and Substance Abuse Treatment Benefits (Notification Required)	Benefits for covered services and supplies including, but not limited to: • Assessment. • Diagnosis. • Treatment planning. • Medication management. • Individual, family and group psychotherapy. • Psychological education. • Psychological testing. Additional covered services and supplies specific to Mental Healthcare and Substance Abuse Treatment are listed below: • Licensed Counselor Services. • Treatment Center Services (including room and board). • Other Services and Supplies. Mental Healthcare and Substance Abuse Treatment services and supplies are subject to Deductibles and Coinsurance as presented in the Schedule of Benefits for the HDHP PPO on Page 15. Notification requirements described in the Mental Healthcare or Substance Abuse Treatment section also apply (Page 18). Covered expenses for Mental Healthcare or Substance Abuse Treatment count toward the HDHP Coinsurance Maximum. After HDHP Coinsurance Maximum is reached, benefits for Mental Healthcare or Substance Abuse Treatment are payable at 100%.	

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Nutritional Counseling	Covered Medical Services provided by a registered dietician in an individual session for covered persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. Benefits are limited to three individual sessions during a Covered Person's participation in the Plan.	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.
Obesity Surgery	See Surgery (Page 34).	
Organ/Tissue Transplants	Services and supplies for 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 45).	
Orthognathic Surgery	See Surgery (Page 35).	

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
Outpatient Therapy	Short-term outpatient rehabilitation 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 Physician. 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 Necessary course of treatment for a bodily injury or disease. The therapy must be given 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 or a congenital anomaly**.**	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
Physician Services	Medical care and treatment by a Physician including Hospital, office and home visits, and Emergency room services. Covered Medical Services received in a Physician'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.	
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 40 under "Additional Programs to Help You Manage Your Health."	
Pulmonary Rehabilitation Therapy	See Cardiac and Pulmonary Rehabilitation Services on Page 22.	

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
RAPL (Radiology, Anesthesiology, Pathology and Lab)	Services performed by radiologists, anesthesiologists, pathologists and laboratory.	
Reconstructive Surgery	See Surgery (Page 33).	
Reproductive Services (All inpatient hospitalizations are subject to the Notification Requirements.)	**Family Planning:** Norplant, diaphragms and IUD are covered under the medical plan provisions.	Oral contraceptives and Depo-Provera are not covered under this medical program, but are covered under the Pharmacy Program.
	Infertility: Assisted Reproductive Technology: Assisted reproductive technology treatments, including (but not limited to) artificial insemination, GIFT, ZIFT, or In-Vitro Fertilization, are covered expenses subject to limitations as noted herein. This includes confinement in a Hospital or specialized facility in connection with infertility treatments. For services received on or after January 1, 2004, this benefit has a Lifetime Maximum of $20,000 for Network and Non-Network services combined. The Lifetime Maximum applies to all medical plans sponsored by the Employer or Union Pacific Corporation and administered by UnitedHealthcare. Covered infertility treatment services include the following: • In vitro fertilization. • Artificial insemination. • Embryo transfer. • Gamete intrafallopian transfer. • Zygote intrafallopian transfer. • Tubal ovum transfer. • Surgery. • Injectable drug therapy administered within the physician's office.	
	Maternity Care: Benefits for pregnancy will be paid at the same level as benefits for any other condition, sickness or injury. 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 Care Coordination during the first trimester, but no later than one month prior to the anticipated	

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	Childbirth. See "Healthy Pregnancy Program" under Additional Programs to Help You Manage Your Health on Page 43. 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 may discharge the mother and/or the newborn Child earlier than these minimum time frames. For inpatient care (for either the mother or Child) which continues beyond the 48/96 hour limits, Care Coordination must be notified before the end of these time periods.	
	Sterilization: Covered services include vasectomy and tubal ligation.	Reversals are not covered.
Second/Third Opinions	See Surgery (Page 34).	
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 that lasted at least 5 days and 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 30).	
Sterilization	See Reproductive Services (Page 31).	
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 Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, outpatient surgery facility, birthing center, or via a Physician house call. Benefits	

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	include the facility charge and the charge for required services, supplies and equipment.	
	Reconstructive Surgery: Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following: • Birth defect. • Sickness. • Surgery to treat a sickness or accidental injury. • Accidental injury. • Reconstructive breast surgery following a Necessary mastectomy. • Reconstructive surgery to remove scar tissue on the neck, face or head if the scar tissue is due to sickness or accidental injury. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.	Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure.
	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; and d) 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 other provisions applicable to the other benefits of the UHC HDHP PPO Program.	

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	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. Surgical assistant services are not covered.	
	Second Surgical Opinion Program: This voluntary program applies when a Doctor recommends that you or a covered Dependent undergo any elective or non-Emergency surgical procedure. You may voluntarily obtain a second surgical opinion for any non-emergency surgical procedure. The purpose of the second surgical opinion is advisory only. It is the patient's decision whether or not to undergo the surgery. Benefits for the Second Surgical Opinion are subject to the cost sharing features of the 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.	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 UHC HDHP PPO Program. • Any charges in connection with a surgical procedure, if they are payable under other provisions of the UHC HDHP PPO Program. • 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: 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. • **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. UHC must be notified before the obesity surgery is scheduled.	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 Medical 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.

UHC HDHP PPO COVERED SERVICES		
Type of Service	**What's Covered**	**What's Not Covered**
	Orthognathic surgery is covered in the following situations: • A jaw deformity resulting from facial trauma or cancer; or • A skeletal anomaly of either the maxilla or mandible that demonstrates a functional medical impairment such as one of the following: ▪ Inability to incise solid foods; or ▪ Choking on incompletely masticated solid foods; 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 temporomandibular joint as a treatment of obstructive sleep apnea.	Orthognathic surgery is not covered for the following symptoms: • Myofacial, neck, head and shoulder pain. • Irritation of head/neck muscles. • Popping/clicking of temporomandibular joint(s). • Potential for development or exacerbation of temporomandibular joint dysfunction. • Teeth grinding. • Treatment of malocclusion.
Transplants	See Organ/Tissue Transplants (Page 29).	

Additional Exclusions:
The UHC HDHP PPO Program 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:

- It is recommended or prescribed by a physician.
- It is the only available treatment for your condition.

The services, treatments, items, or supplies listed in this section are not Covered Medical Services, except as may be specifically provided for in the section on "Medical and Mental Health Services" beginning on Page 19 of this document. Note also the exclusions stated in the "Covered Services" section (Page 20) 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 22.
Dental	• Dental care, except as described under "Covered Services" on Page 23 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 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 given in a physician'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.

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
Foot Care	• Except when needed for severe systemic disease, routine foot care (including the cutting or removal of corns and calluses) and nail trimming, cutting, or debriding. • Hygienic and preventive maintenance foot care (i.e., cleaning and soaking the feet, applying skin creams in order to maintain skin tone, other services that are performed when there is not a localized illness, injury or symptom involving the foot). • Treatment of flat feet. • Treatment of sublaxation of the foot. • Shoe orthotics.
Mental Health/Substance Abuse	• Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. • Services for mental health and substance abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. • Treatment for mental illness that will not substantially improve beyond the current level of functioning or that is not subject to favorable modification or management according to prevailing national standards of clinical practice as reasonably determined by United Behavioral Health. • 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 United Behavioral Health. • Residential treatment services • Services or supplies for the diagnosis or treatment of mental illness, alcoholism, or substance abuse disorders that, in the reasonable judgment of United Behavioral Health, are any of the following: ▪ Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. ▪ Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. ▪ Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. ▪ Not consistent with United Behavioral Health's guidelines or best practices as modified from time to time. United Behavioral Health 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. • Pastoral counselors. • Treatment provided in connection with autism, except speech therapy for a Child under age three whose speech is impaired due to infantile autism. • Treatment provided in connection with tobacco dependency. • Routine use of psychological testing without specific authorization.
Nutrition	• Megavitamin and nutrition based therapy. • Except as described under "Covered Services" on Page 25, enteral feedings and other nutritional and electrolyte supplements (including infant formula and donor breast milk), dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat/cholesterol), oral vitamins, and oral minerals except when the sole source of nutrition. **Note:** Limited nutritional counseling services are covered as described under "Covered Services" on Page 29.

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
On-Duty Injury	• Health services or supplies received as a result of an on-duty injury regardless of fault.
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 legal residence.
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. • 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 45 of this document. • Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (donor costs for removal are not a Covered Service 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 Medical Service.

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
Travel	• Health services provided in a foreign country unless required as Emergency health services. • Travel or transportation expenses even though prescribed by a physician. Some travel expenses related to covered transplantation services or cancer treatment related services may be reimbursed as described on Pages 44-45.
Vision and Hearing	• Purchase cost of eyeglasses, contact lenses, or hearing aids. (See "Vision Care Benefits" on Page 68 for a description of the vision care services available to persons participating in the UHC HDHP PPO Program). • Fitting charge for hearing aids, eyeglasses, or contact lenses. • Surgery that is intended to allow you to see better without glasses or other vision correction, including 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 physician 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 21. • Charges in excess of eligible expenses or in excess of any specified limitation. • Custodial care. • Domiciliary care. • Growth hormone therapy. • Health services and supplies that do not meet the definition of a Covered Medical Services. • 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 and/or Coinsurance are waived. • Inpatient private duty nursing. • Non-prescribed disposable medical supplies. • Non-surgical treatment of obesity, including morbid obesity. • Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except what is described on Page 35 of this document. • Orthoptic therapy services for the treatment of convergence insufficiency or any other purpose.

ADDITIONAL EXCLUSIONS	
Type of Service	**What's Not Covered**
	• 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 proceedings or orders. ▪ Conducted for purposes of medical research. ▪ Required to obtain or maintain a license of any type. • Private duty nursing. • Psychosurgery. • Respite care. • Rest cures. • Services or supplies received before you become covered under this plan • Sex transformation operations. • Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, or a congenital anomaly. • Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies. • Tobacco dependency services, treatments, or supplies received as a result of a tobacco dependency.

Additional Programs to Help You Manage Your Health:

Preventive Care Benefits: UHC supports you and your family in keeping healthy by offering preventive healthcare benefits. Benefits are payable for Covered Benefits or 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 services described below are payable at 100% of covered expenses. No preventive healthcare benefit is available from a Non-Network Provider. When there are no participating providers available, it is your responsibility to call UHC to find an alternative Physician. If you have made prior arrangements with UHC to use an alternative Physician, preventive healthcare benefits are payable at 100% of the Reasonable and Customary Amount.

If a condition requiring medical services or treatment is identified as a result of preventive services received, the Physician providing the preventive services should use a preventive care code for the primary code on the billing statement and a diagnostic code for the discovered condition as a secondary code in order to receive 100% preventive care coverage under this Plan. An individual with symptoms who wishes to be examined by a Physician should make a regular appointment and be covered under the Plan provisions for medical care (Deductible and Coinsurance would apply). Individuals with symptoms or at high risk for disease may need additional services or more frequent interventions. Additional services as part of a course of treatment are not considered preventive and are subject to the same cost sharing provisions as other Covered Medical Services.

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 UnitedHealthcare and (b) the services are coded as routine/preventive, rather than with a diagnostic code.

Program Description	Covered Preventive Care Benefits	U.S. Preventive Services Task Force Guidelines
The Preventive Care Program is designed to encourage Employees and family members to receive appropriate preventive care. The standards used in developing this program are based upon the U.S. Preventive Services Task Force Guidelines (www.ahrq.gov/clinic/USpstfix.htm).	**The medical services and supplies listed below are payable at 100% of covered expenses, as described below.**	**These recommendations are based upon the U.S. Preventive Services Task Force Guidelines and are provided for information purposes only. For a list of the medical services and supplies considered preventive healthcare services and supplies under the Plan, see the column, "Covered Preventive Care Benefits."**
The UHC HDHP PPO supports you and your family in keeping healthy by offering preventive healthcare benefits. Benefits are payable for covered services and supplies for preventive healthcare benefits you receive while you are covered under this Plan if certain conditions are met. **Preventive Care Guidelines:** UnitedHealthcare has adopted preventive care guidelines based on the recommendations of the U.S. Preventive Services Task Force. Individuals with symptoms or at high risk for disease may need additional services or more frequent interventions. Additional services as part of a course of treatment are not considered preventive and are subject to the same cost sharing provisions as other Covered Medical Services. If a condition requiring medical services or treatment is identified as a result of preventive services received, the Doctor providing the preventive services should use a preventive care code for the primary code on the billing statement and a diagnostic code for the discovered condition as a secondary code in order to receive 100% preventive care coverage under this Plan. An individual with symptoms who wishes to be examined by a Doctor should make a regular appointment and would be covered under the Plan provisions for medical care (Deductible and Coinsurance would apply).	**Infants:** • Well Baby visits. • Recommended immunizations. • PKU Test. • Influenza (flu) vaccine. • Routine laboratory screening and routine medical tests, including basic vision and hearing screening, performed in conjunction with Well Baby visits. **Children:** • Annual Wellness Exam, school or sports physical. One such exam per Calendar Year, paid as Preventive Service. Such exam may include: ▪ Booster immunizations, as required. ▪ HPV Vaccine. * ▪ Influenza (flu) vaccine. ▪ Routine laboratory screening and routine medical tests, including basic vision and hearing screening, performed in conjunction with the Annual Wellness visit. **Prevention for Women:** • Annual physical or Well Woman Exam. One such exam per Calendar Year, paid as Preventive Service. Such exam may include: ▪ Pelvic and breast examination. ▪ Mammogram, including charges for radiologist. ▪ Pap smear test. ▪ Blood pressure screening. ▪ Cholesterol and blood glucose tests.	**Infants (Age 0 to 2) Recommendations:** Newborn to age 2 should receive immunizations and PKU Test. Influenza vaccine is recommended at 12 months; annually thereafter for all children. **Children (Age 2 thru Teen Years) Recommendations:** Booster immunizations as needed, Influenza (flu) vaccine. For Females, HPV vaccine (a series of three injections), commencing as early as age 9. **Women (Ages 20 to 65) Recommendations:** Annual Well Woman Exam, including breast and pelvic exam, Pap. Mammogram every 1 to 2 years, commencing at age 40; earlier with higher risk due to family history. Colonoscopy every 10 years, commencing at age 50; earlier with higher risk due to family history.

Program Description	Covered Preventive Care Benefits	U.S. Preventive Services Task Force Guidelines
The Preventive Care Program is designed to encourage Employees and family members to receive appropriate preventive care. The standards used in developing this program are based upon the U.S. Preventive Services Task Force Guidelines (www.ahrq.gov/clinic/USpstfix.htm).	**The medical services and supplies listed below are payable at 100% of covered expenses, as described below.**	**These recommendations are based upon the U.S. Preventive Services Task Force Guidelines and are provided for information purposes only. For a list of the medical services and supplies considered preventive healthcare services and supplies under the Plan, see the column, "Covered Preventive Care Benefits."**
Note: Recommended annual services are paid under the Plan Benefits once per calendar year regardless of the number of months since the last covered service.	▪ STD and Chlamydia. ▪ Colonoscopy, paid as Preventive Service, following your physician's recommendation, but no more frequent than once every 36 months. ▪ Influenza (flu) vaccine. ▪ Routine laboratory screening and routine medical tests performed in conjunction with the Annual Wellness visit. **Prevention for Men:** • Annual physical. One such exam per Calendar Year, paid as Preventive Service. Such exam may include: ▪ Prostate exam and PSA test. ▪ Blood pressure screening. ▪ Cholesterol and blood glucose tests. ▪ STD screening. ▪ Colonoscopy, paid as Preventive Service, following your physician's recommendation, but no more frequent than once every 36 months. ▪ Influenza (flu) vaccine. ▪ Routine laboratory screening and routine medical tests performed in conjunction with the Annual Wellness visit. **Mature Adults:** • Annual physical. One such exam per Calendar Year, paid as Preventive Service. Such exam may include: ▪ Blood pressure screening. ▪ Cholesterol and blood glucose tests.	**Men (Ages 20 to 65) Recommendations:** Annual prostate exam and PSA blood test, commencing at age 50; earlier with higher risk due to family history. **All Adults (Ages 65+) Recommendations:** Females at increased risk for Osteoporosis should obtain screening, commencing at age 60, no more frequently than every 2 years.

Program Description	Covered Preventive Care Benefits	U.S. Preventive Services Task Force Guidelines
The Preventive Care Program is designed to encourage Employees and family members to receive appropriate preventive care. The standards used in developing this program are based upon the U.S. Preventive Services Task Force Guidelines (www.ahrq.gov/clinic/USpstfix.htm).	**The medical services and supplies listed below are payable at 100% of covered expenses, as described below.**	**These recommendations are based upon the U.S. Preventive Services Task Force Guidelines and are provided for information purposes only. For a list of the medical services and supplies considered preventive healthcare services and supplies under the Plan, see the column, "Covered Preventive Care Benefits."**
	▪ STD screening ▪ Mammogram and pap smear test (female). ▪ Prostate exam and PSA Test (male). ▪ Zoster (Shingles) vaccine.* ▪ Routine screening for Osteoporosis (bone density testing). ▪ Screening for AAA by ultrasonography, one time test per lifetime. ▪ Colonoscopy, paid as Preventive Service, following your physician's recommendation, but no more frequent than once every 36 months. ▪ Influenza (flu) vaccine. ▪ Routine laboratory screening and routine medical tests performed in conjunction with the Annual Wellness visit.	Males who have ever smoked should have AAA ultrasonography, one time test, between ages 65 to 75. Zoster vaccine for adults age 60 and older.
***NOTE:** Certain vaccines, such as HPV and Zoster (Shingles) vaccines require special storage requirements and may not be kept on hand by physicians or local pharmacies. UHPS has arranged for "Next-Day" delivery for these vaccines to your physician's office or your pharmacy. To make these arrangements, call Prescription Solutions at 1-866- 218-7398.		

Exclusions to Preventive Services	Medical services not described in the column "Covered Preventive Care Benefits" above, are not payable at 100% of covered expenses as a preventive healthcare benefit. Such services include, but are not limited to, ECG or EKG / stress test, LDCT, and chest x-rays. Medical services and supplies that are not preventive services may be a Covered Medical Service under the UHC HDHP PPO and if so, are subject to the same cost sharing provisions as other Covered Medical Services. All other UHC HDHP PPO exclusions also will apply.

Healthy Pregnancy Program: The Healthy Pregnancy Program offers personal support through all stages of pregnancy and delivery. The program focuses on providing information needed to make healthy choices during your pregnancy, birth, delivery, and afterward. It is offered to Retirees and Dependents as a free benefit with no out-of-pocket expenses.

To get the best possible benefit from the program, it is recommended that enrollment occurs in the first 12 weeks, but no later than week 34, of pregnancy. To enroll, simply call UnitedHealthcare's Customer Service number at 1-800-331-4370 between the hours of 7:00 AM and 9:00 PM CT, Monday through Friday (excluding holidays), and follow the prompts to speak to a Health Pregnancy Nurse.

Participation in the Healthy Pregnancy Program is completely voluntary and any employee information is strictly confidential.

Disease Management Program: The Disease Management Program focuses on coronary artery disease (CAD), congestive heart failure (CHF), and diabetes. The disease management program is designed to provide health information and support services to help individuals 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.

Nurtur, a national disease management company, administers the program to help you learn about eating healthier, exercising, taking your medications correctly, and managing your stress levels. In addition, Nurtur will help if you are a smoker who is ready to quit.

By learning how to manage a chronic condition between regularly scheduled visits to the Doctor, many participants in Nurtur's 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 (1-888-252-7708) 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 Nurtur Web site at www.mynurturhealth.com and through complimentary education materials periodically sent to your home.

Participation in the Nurtur program is completely voluntary and any Retiree information is strictly confidential and only shared with designated physicians or healthcare Providers in determining the best treatment plan.

Cancer Resource Services: Care Coordination will arrange for access to certain In-Network Providers participating in the Cancer Resource Services (CRS) Program for the provision of oncology services. Oncology services include covered services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to oncology. An individual can also call the Nurse Consultants at CRS at 1-866-936-6002, from 7:00 AM - 9:00 PM CT, Monday through Friday (excluding holidays), or visit the CRS Web site at www.urncrs.com. The Cancer Resource Services (CRS) Program is not available to Medicare primary Retirees or Dependents. **Note:** Cancer Resource Services benefits are subject to the HDHP Deductible.

Cancer Clinical Trials and Related Treatment and Services: Such treatment and services must be recommended and provided by a Physician in a cancer center. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given.

Transportation and Lodging: Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the recipient receiving cancer-related treatment associated with the Cancer Resource Services Program, and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site where services are given for the purposes of an evaluation, the procedure or other treatment, or Necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Expenses related to transportation of the patient are subject to the HDHP Deductible and Coinsurance amounts.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated United Resource Networks Facility.
- If the patient is a covered Dependent minor Child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

There is a combined overall Lifetime Maximum of $10,000 per Covered Person for all transportation, lodging, and meal expenses incurred by the patient and companion(s) and reimbursed under the UHC HDHP PPO Programs in connection with all cancer-related services.

To take full advantage of the CRS benefits, you must contact Cancer Resource Services at 1-866-936-6002 prior to receiving care at a participating Cancer Resource Services Center.

Transplant Management Program: Access to a network of transplant centers is provided through UnitedHealthcare's Transplant Management Program.

If a Qualified Procedure (listed below) is Necessary, the covered expenses for services provided in connection with the transplant procedure are subject to the HDHP Deductible and Medical Coinsurance. In addition, certain travel and accommodation expenses are covered as described below.

Qualified Procedures:

- Heart transplants.
- Lung transplants
- Heart/Lung transplants.
- Liver transplants.
- Kidney transplants.
- Pancreas transplants.
- Kidney/Pancreas transplants.
- Bone Marrow/Stem Cell transplants.
- Other transplant procedures when UnitedHealthcare determines that it is Necessary to perform the procedure at a designated transplant facility.

Medical Care and Treatment: The covered expenses for services provided in connection with the transplant are subject to the HDHP Deductible and Medical Coinsurance. These services include:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- Hospital and physician 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 health services for which benefits are payable through the organ recipient's coverage under the Plan.

Transportation and Lodging: UnitedHealthcare's Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging, and meals for the transplant recipient and a companion are available under the UHC HDHP PPO Program as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or Necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people.
- Expenses related to transportation of the patient are subject to the HDHP Deductible and Coinsurance amounts.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the designated transplant facility.
- If the patient is a covered Dependent minor Child, the transportation expenses of two companions will be covered, and lodging and meal expenses will be reimbursed up to the $100 per diem rate.
- There is a combined overall Lifetime Maximum of $10,000 per Covered Person for all transportation, lodging, and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under the UHC HDHP PPO Program in connection with all transplant procedures.

Transplants Not Performed at a Designated Transplant Facility: If a transplant procedure is Necessary but not performed at a designated transplant facility, eligible expenses will be covered as would any other expense covered under the Plan, subject to Deductibles and Coinsurance. The transportation and lodging provision will not apply.

Optum Connect 24: Retirees and their Dependents are eligible to participate in the Optum Connect 24 Program. Optum Connect 24 is a health information service you can call toll free 24 hours a day to receive information, education, and support for any health-related concern at no cost to you at 1-888-243-6948, Option 1. You and your Dependents will be able to talk to one of the registered Nurses to receive education and support that can help you and your family choose what kind of care to seek.

Connect 24 also offers a Health Information Library that supplies you with recorded messages on a wide variety of health and well-being issues at 1-888-243-6948, Option 2.

Another feature of Optum is HealthForums, which offers a wealth of health and well-being information.

Retirees enrolled in the UHC HDHP PPO Program may access the HealthForums information at www.myuhc.com.

Alternate Medical Treatment Benefits: Under the Alternate Medical Treatment Benefits Program (a voluntary program), a Care Coordination Consultant 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 the Alternate Medical Treatment is entirely voluntary.

Services or Supplies That May Be Covered Alternate Medical Treatment Expenses: The following services or supplies may, at the sole discretion of UnitedHealthcare, be covered Alternate Medical Treatment expenses:

- Medical services or supplies such as:
  - Home healthcare services, including, but not limited to, total parenteral nutrition (TPN), antibiotic administration, cardiac rehabilitation, respiratory therapy, drugs and durable medical equipment;
  - Extended Care Facility/Skilled Nursing Facility services; or
  - Rehabilitation services.
- Non-medical services or supplies, which may improve your medical condition, aid you in rehabilitation, or facilitate independent living.

How the Program Works:

Notice and Evaluation: A Consultant may be notified of your medical condition either by calling 1-800-331-4370 (directly) or by receipt of your medical claim form (indirectly). Once notified, the Consultant will discuss with the attending Doctor whether or not you are a candidate for the Alternative Medical Treatment Benefits Program.

Development, Review, and Approval: If you are a candidate, the Consultant will outline a Proposed Plan of Alternate Medical Treatment that meets the guidelines of the Alternative Medical Treatment Benefits Program. If the Consultant determines that the proposed plan would be more effective than your current and/or projected medical treatment and would also be in your best interest, the proposed plan will be approved as the Specific Plan of Alternate Medical Treatment.

Suggestion: The Specific Plan of Alternate Medical Treatment will be suggested to you and the attending Doctor and, at that point, you can both decide whether or not it should be implemented. If the decision is to implement the Specific Plan of Alternative Medical Treatment, you will be eligible to receive Alternate Medical Treatment Benefits. These may be in addition to the medical benefits provided under the other provisions of this Plan. If you and the attending Doctor decide not to implement the Specific Plan of Alternate Medical Treatment, the expenses will be considered for payment in accordance with other provisions of this Plan, and you will not be eligible to receive Alternate Medical Treatment Benefits.

Re-evaluation: The Specific Plan of Alternate Medical Treatment will be monitored by the Consultant, along with your progress. If deemed appropriate by UnitedHealthcare, modification to such plan will be suggested. If you and the attending Doctor decide the suggested changes should be implemented, the Specific Plan of Alternate Medical Treatment will be changed. UnitedHealthcare has the right to end your participation in the Alternative Medical Treatment Benefits Program upon notice to you and the attending Doctor.

Payment of Alternate Medical Treatment Benefits: Benefits will be paid for expenses incurred in connection with a Specific Plan of Alternate Medical Treatment only if UnitedHealthcare determines that:

- The expenses will be incurred for a medical condition; and
- Instead of the expenses for Alternate Medical Treatment Benefits, you would incur other expenses for the same medical condition, which are covered under the other provisions of the UHC HDHP PPO; and
- The total estimate of anticipated expenses for Alternate Medical Treatment Benefits would be less than the total anticipated expenses provided under the other provisions of this Plan.

Benefits are paid by applying Deductible and Coinsurance as outlined under the normal plan provisions.

The Maximum Lifetime Benefit shown in the Schedule of Benefits tables will still apply even if an Alternate Medical Treatment Plan is used.

Contacting UnitedHealthcare for Assistance:

UnitedHealthcare's Customer Service Department can be reached at 1-800-331-4370. If possible, please have your Medical ID Card available before calling

UnitedHealthcare representatives are available from 7:00 AM to 9:00 PM Central Time, Monday through Friday (excluding holidays).

MyUHC.com - UnitedHealthcare's Customer Web Site:

The UnitedHealthcare customer Web site at www.myuhc.com is your online gateway to a broad range of tools and services.

To register:

- Go to www.myuhc.com.
- Click the "Register Now" button.
- Enter your Social Security Number and Date of Birth. If you prefer you may follow the link to register with ID card information instead of your Social Security Number.
- Choose a User Name and Password.

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

- Confirm eligibility, specific benefits, Deductible.
- Review claims status and claims history.
- View exact replicas of your Explanation of Benefits at any time.
- Find a Network physician or Hospital.
- Print a temporary Medical ID Card or order a replacement Medical ID Card.
- Receive a personalized e-mail newsletter with health topics of interest.

How to File Medical Claims:

This section provides information about how and when to file a claim. For all claims and appeals, Union Pacific has delegated to UnitedHealthcare or United Behavioral Health the exclusive and discretionary right to interpret and administer the provisions of the Plan. The decisions of UnitedHealthcare or United Behavioral Health are conclusive and binding. Please note that the decisions of UnitedHealthcare or United Behavioral Health are based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Post-Service Claims: Post-service claims are those claims that are filed for payment of benefits after medical care has been received.

Pre-Service Claims: Pre-service claims are those claims that require Notification prior to receiving medical care.

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 physician with knowledge of your medical condition) could cause severe pain.

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.

Filing a Claim for Benefits - Post-Service Claims: If Covered Medical Services are received from a Network Provider, there is no need to file a claim. The Network Provider is responsible for filing claims. Generally, Network Providers submit claims within 90 days of the date of service. UnitedHealthcare or United Behavioral Health pays the Network Provider directly. You are responsible for paying Deductibles and/or Coinsurance when a bill is received from the Provider. If a Network Provider bills you for any Covered Medical Services other than Deductibles and/or Coinsurance, contact UnitedHealthcare or United Behavioral Health. Although it is not customary, Network Providers may request the Deductible payment at the time services are rendered.

When Covered Medical Services are received from a Non-Network Provider, result from an Emergency, or result from a referral to a Non-Network Provider, the covered person is responsible for filing a claim. You must file the claim in a format that contains all of the information required as described below in the "Required Information" section. Claim forms can be obtained by calling the Union Pacific HR Service Center at 1-877-275-8747, Option 1. The Union Pacific group number is 183842. The completed claim form, along with your medical documentation, must be submitted to:

UnitedHealthcare
P.O. Box 740800
Atlanta GA 30374-0800

A claim for benefits must be submitted 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 file a claim with UnitedHealthcare or United Behavioral Health within one year of the date of service, benefits for that health service will be denied or reduced at the discretion of UnitedHealthcare or United Behavioral Health. 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.

If the covered person provides written authorization to allow direct payment to a Provider, all or a portion of any eligible expenses due to a Provider may be paid directly to the Provider instead of being paid to the covered person. UnitedHealthcare or United Behavioral Health will not reimburse third parties who have purchased or have been assigned benefits by physicians or other Providers.

Filing a Claim for Benefits - Pre-Service Claims and Urgent Claims: If you have a pre-service claim or an urgent care claim, you or your physician can file your claim verbally by contacting UnitedHealthcare at 1-800-331-4370 or United Behavioral Health at 1-800-888-2998. When you call UnitedHealthcare for Notification of a Pre-service or an urgent care claim, select the prompt for Care Coordination.

Filing a Claim for Benefits - Concurrent Claims: If an on-going course of treatment was previously approved for a specific period of time or for a number of treatments and your request to extend the treatment is an urgent care claim, you or your physician can file your claim verbally by contacting UnitedHealthcare at 1-800-331-4370 or United Behavioral Health at 1-800-888-2998. If an on-going course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a non-urgent circumstance, you must file a claim form and submit it to the above address indicated for mailing post-service claims.

Required Information: When there is a claim for benefits from UnitedHealthcare or United Behavioral Health, you must provide all of the following information:

Post-Service Claims:

1. The covered person's name and address;
2. The member and group number stated on your Medical ID Card; and
3. An itemized bill from the Provider that includes the following:
    a) Patient diagnosis;
    b) Date(s) of service;
    c) Procedure code(s) and descriptions of service(s) rendered;
    d) Charge for each service rendered;
    e) Provider of service name, address and Tax Identification Number;
    f) The date the Injury or Sickness began; and

g) A statement indicating either that the Covered Person is or is not enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Pre-Service Claims and Urgent Care Claims:

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

Payment of Benefits: Through UnitedHealthcare or United Behavioral Health, a benefit determination will be made as set forth below. Benefits will be paid to you unless either of the following is true:

- The Provider notifies UnitedHealthcare or United Behavioral Health that your signature is on file, assigning benefits directly to that Provider, or
- You make a written request for the Non-Network Provider to be paid directly at the time the claim is submitted.

Benefit Determinations:

Post-Service Claims: Post-service claims are those claims that are filed for payment of benefits after medical care has been received. If your Post-service claim is denied, you will receive a written notice from UnitedHealthcare or United Behavioral Health within 30 days of receipt of the claim as long as all needed information was provided with the claim. UnitedHealthcare or United Behavioral Health 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, UnitedHealthcare or United Behavioral Health will notify you of the denial within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims: Pre-service claims are those claims that require Notification or approval prior to receiving medical care. If your claim was a Pre-service claim and was submitted properly with all needed information, you will receive written notice of the claim decision from UnitedHealthcare or United Behavioral Health within 15 days of receipt of the claim. If you filed a Pre-service claim improperly, UnitedHealthcare or United Behavioral Health will notify you of the improper filing and how to correct it within 5 days after the Pre-service claim was received. If additional information is needed to process the Pre-service claim, UnitedHealthcare or United Behavioral Health will notify you of the information needed within 15 days after the claim was received and may request a one-time extension for not longer than 15 days, pending your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, UnitedHealthcare or United Behavioral Health will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Urgent Claims: Urgent care claims are those claims that require 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 physician with knowledge of your medical condition) could cause severe pain. In these situations:

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

If you filed an Urgent care claim improperly, UnitedHealthcare or United Behavioral Health will notify you of the improper filing and how to correct it within 24 hours after the Urgent Claim was received. If additional information is needed to process the claim, UnitedHealthcare or United Behavioral Health will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

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

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

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

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

If Your Claim is Denied: If your claim is denied, UnitedHealthcare or United Behavioral Health 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. If your claim was denied because the services were not Necessary, Medically Necessary, or experimental, 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.

Medical Claim Questions and Appeals:

This section provides information to help you with the following:

- You have a question or concern about Covered Medical Services or your benefits.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

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

What to Do First: If the question or concern is about a benefit determination, you may informally contact UnitedHealthcare Customer Service at 1-800-331-4370 before requesting a formal appeal. If the UnitedHealthcare 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 Medical Claims" on Page 47, you may appeal it as described below without first informally contacting UnitedHealthcare Customer Service. If you first informally contact UnitedHealthcare Customer Service and later wish to request a formal appeal in writing, you should contact UnitedHealthcare Customer Service and request an appeal. If you request a formal appeal, a UnitedHealthcare Customer Service representative will provide you with the information necessary to submit an appeal.

How to Appeal a Claim Decision: If you disagree with a claim determination after following the above steps, you can contact UnitedHealthcare or United Behavioral Health in writing to formally request an appeal. An appeal of an urgent claim denial can be made via telephone (see "Appeals Determinations - Urgent Claims" on Page 52). All other appeal requests must be sent to:

UnitedHealthcare
P.O. Box 740800
Atlanta GA 30374-0800

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

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

Your first appeal request must be submitted to UnitedHealthcare or United Behavioral Health within 180 days after you receive the claim denial.

Appeal Process: Any review on appeal (first level, second level, or urgent claim appeal) will not give deference to the previous claim denials. A qualified individual who was not involved in the decision being appealed or a subordinate of the individual who decided the initial claim will be appointed to decide the appeal. The review will take into account all documents and other information you submit relating to your appeal, regardless of whether such documents or information were submitted or considered in previous claim decisions. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination, nor a subordinate of a healthcare professional involved in the prior determination.

UnitedHealthcare or United Behavioral Health may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits, including the identification of the medical experts consulted regarding your appeal.

Appeals Determinations - Pre-Service and Post-Service Claims: For pre-service and post-service claim appeals, you will be provided written or electronic Notification of a decision on your appeal as follows:

- For appeals of pre-service claims (as defined in "How to File Medical Claims" on Page 47 of this document), the first level appeal will be conducted and you will be notified by UnitedHealthcare or United Behavioral Health of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal, if requested, will be conducted and you will be notified by UnitedHealthcare or United Behavioral Health of the decision within 15 days from receipt of a request for review of the first level appeal decision. The decision of UnitedHealthcare or United Behavioral Health on your second level appeal is final and binding.

- For appeals of post-service claims (as defined in "How to File Medical Claims" on Page 47 of this document), the first level appeal will be conducted and you will be notified by UnitedHealthcare or United Behavioral Health of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal, if requested, will be conducted and you will be notified by UnitedHealthcare or United Behavioral Health of the decision within 30 days from receipt of a request for review of the first level appeal decision. The decision of UnitedHealthcare or United Behavioral Health on your second level appeal is final and binding.

If your first level appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. 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 Necessary, Medically Necessary or experimental, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal, and will describe the second level appeal procedures.

If you are not satisfied with the first level appeal decision of UnitedHealthcare or United Behavioral Health, you have the right to request a second level appeal from UnitedHealthcare or United Behavioral Health. Your second

level appeal request must be submitted to UnitedHealthcare or United Behavioral Health within 60 days from receipt of the first level appeal decision and must specify each and every reason why you believe your claim should be approved. The denial notice from your first level appeal will indicate what information you need to include when making a second level appeal. You may include with your appeal information that was not submitted as part of your original claim or first level appeal. 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 services were not Necessary, Medically Necessary or experimental, 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 UHC or UBH on your second level appeal is final and binding. You have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") if your second level appeal is denied.

Appeals Determinations - Urgent Claims: For appeals of urgent claims (as defined in "How to File Medical Claims" on Page 47 of this document), the urgent claim appeal does not need to be submitted in writing. You or your physician should call UnitedHealthcare at 1-800-331-4370 or United Behavioral Health at 1-800-888-2998 as soon as possible. Your urgent claim appeal must specify each and every reason why you believe your claim should be approved. UnitedHealthcare or United Behavioral Health will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition. The decision of UHC or UBH made on your Urgent Claim appeal is final and binding.

If your urgent claim 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 services were not Necessary, Medically Necessary or experimental, 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. In addition, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act ("ERISA") if your Urgent Claim appeal is denied.

Appeals Determinations - Concurrent Care Claims: For appeals of concurrent care claims (as defined in "How to File Medical Claims" on Page 47 of this document), the appeal of a denial of a concurrent care claim will be decided according to the urgent claim, or pre-service and post-service claim appeal procedures described above, whichever applies.

Coordination of Benefits:

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

Example of Coordination of Benefits:

Assume: a) Deductibles have been met
b) UHC HDHP PPO Program is Secondary

Allowable Expense	$100
Other Plan Benefit at 75%	$75

Coinsurance:

UHC HDHP PPO Program Benefit paid at 80% ($80 less amount paid by Other Plan)	$5
Total Paid Benefit from Both Plans	$80
Retiree's Out of Pocket Expense	$20

How Coordination Works: When the UHC HDHP PPO Program is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When the UHC HDHP PPO Program is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than the amount the UHC HDHP PPO Program would have paid if it were the Primary Plan.

Any reductions in benefits will be applied equally to each benefit that would have been paid under the UHC HDHP PPO Program.

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

- For you, your plan will pay its benefits first.
- For your Spouse, if he/she is covered as an employee under another plan, that plan would pay benefits first.
- If your Dependent Children are covered under plans of both you and your Spouse, the UHC HDHP PPO Program would pay its benefits first if your birthday falls earlier in the Calendar Year than your Spouse's birthday. If your Spouse's birthday is earlier in the Calendar Year, your Spouse's plan would pay benefits first. This is called the "Birthday Rule." The year of birth is ignored. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
- If the other plan has a different rule to determine which plans pays benefits first, UnitedHealthcare and United Behavioral Health will use that plan's rule in determining which plan pays benefits first.
- For a Dependent Child with separated or divorced parents, benefits will be determined in the following order:
    - The plan of the parent with custody;
    - The plan of the Spouse of the parent with custody;
    - Finally, the plan of the parent without custody.

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

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, UnitedHealthcare and United Behavioral Health have the right to give or receive information on your benefits and expenses without your consent. Any claim you submit must have the information that is needed to apply the Coordination of Benefits provision (i.e., proof of other coverage).

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

UHC HDHP PPO PROGRAM: PHARMACY BENEFITS

The UHC HDHP PPO Program administered by UnitedHealthcare includes a Network Retail Pharmacy, Network Mail Order Pharmacy Service, and a non-Network Retail Pharmacy feature. The Network Retail Pharmacy, Network Mail Order Pharmacy Service, and non-Network Retail Pharmacy feature apply to covered outpatient prescription drugs.

The Pharmacy benefits under the UHC HDHP PPO Program are provided by UnitedHealth Pharmaceutical Solutions (UHPS)/Medco Health Solutions (Medco).

Identification (ID) Card - Network Pharmacy:

You must either show your UnitedHealthcare 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 UHPS/Medco during regular business hours.

If you do not present your UnitedHealthcare 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 when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Pharmacy Coinsurance payment and any Deductible that applies.

Limitation on Selection of Pharmacies:

If UHPS/Medco 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, UHPS/Medco 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, UHPS/Medco 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 physician or discuss the medication with you and suggest that you speak with your physician. This program is used if you use a Network Pharmacy.

Additional Information:

Retirees can find helpful resources for prescription drugs, such as cost and drug use, drug interactions and side effects, clinical programs, pharmacy locations, and specialty pharmacies by visiting the UHPS/Medco Prescription Web site. 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 be directed to a menu of pharmacy items, as well as search capabilities. You may also call UHPS/Medco at 1-800-331-4370.

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 a medical expense under the UHC HDHP PPO Program provisions. The UHC HDHP PPO Program provisions also apply to outpatient prescription drugs that are not payable under the Network Pharmacy or Non-Network Pharmacy Service unless the drugs are excluded from the UHC HDHP PPO Program under "Additional Exclusions" on Page 35.

Benefits for Outpatient Prescription Drug Products*:* Benefits for outpatient Prescription Drug Products on the Prescription Drug List are payable when UHPS/Medco determines the outpatient Prescription Drug Product is, in accordance with UHPS/Medco guidelines, prescribed to treat a Covered Medical Service (see Page 19) or to prevent conception, provided that the Prescription Drug Product is not experimental, investigational, or unproven.

Supply Limits: Benefits for Prescription Drug Products are subject to the supply limits that are stated in the Benefit Information table on Page 61. For a single prescription for up to 31 days, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that UHPS/Medco 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 UHPS/Medco at 1-800-331-4370 and choosing the pharmacy prompt.

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

If you are using a Network Retail Pharmacy, your pharmacist will be notified that your physician must call a toll-free telephone number to get approval for the prescription to be covered. If you are using the UHPS/Medco Mail Order Pharmacy Service, the pharmacist will call your physician to start the approval process. For retail and mail order prescriptions, your physician will be asked to provide information to determine if the prescription meets the coverage conditions of your pharmacy benefit. The information your physician provides will be reviewed, and coverage will be approved or denied. Letters will be sent to you and your physician to explain the 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 physician can check beforehand by calling 1-800-331-4370 to ensure that the medications prescribed are in conformance with their coverage authorization. Claims submitted will only be reimbursed, if approved. 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.

If your prescription exceeds the limit and you are using a Network Retail Pharmacy or the UHPS/Medco Mail Order Pharmacy Service, your physician or pharmacist will be notified of the quantity covered under a single prescription for up to 31 days. You will have the option to:

- Accept the established quantity limit
- Pay additional out-of-pocket costs or Pharmacy Coinsurance payments for amounts that exceed the quantity limit
- Discuss alternatives with your physician 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 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.

QLLs and QDs 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.

Examples of medications that are subject to Quantity Level Limits include:

- Actos (all dosages): 31 tablets per 31-day supply
- Imtrix 25 mg tablet: 9 tablets per prescription or 18 tablets per 31-day supply
- Albuterol Inhaler 17 gm: 1 inhaler per 31-day supply

Examples of medications that are subject to Quantity per Duration include:

- Enbrel: 8 vials (2 cartons) per 31-day supply
- Celebrex 100 mg: 62 capsules per 31-day supply
- Genotropin 5.8 mg: 27 cartridges per 31-day supply

The Quantity Level Limits and Quantity per Duration limits are subject to change at the discretion of UHPS/Medco. 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 UHPS/Medco 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 UHPS/Medco at 1-800-331-4370.

Notification Requirements:

Benefits are payable for an outpatient Prescription Drug Product on the UHPS/Medco Prescription Drug List when UHPS/Medco determines that the Prescription Drug Product is, in accordance with UHPS/Medco approved guidelines:

- Prescribed to treat a Covered Medical Service (see Page 19) or to prevent conception.
- Not experimental, investigational, or unproven.

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

Non-Network Pharmacy Notification: When Prescription Drug Products are dispensed at a Non-Network Pharmacy, you or your physician must notify UHPS/Medco as required.

If UHPS/Medco is not notified before the Prescription Drug Product is dispensed, you can ask UHPS/Medco 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 UHPS/Medco as described in the "How to File Pharmacy Claims" section, Page 65.

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 UHPS/Medco contracted pharmacy reimbursement rates (the UHPS/Medco Prescription Drug Cost) will not be available to you at a Non-Network Pharmacy.

Benefits may not be available for the Prescription Drug Product if, after UHPS/Medco reviews the documentation provided, UHPS/Medco determines that the Prescription Drug Product is not is prescribed to treat a Covered Medical Services or it is Experimental, Investigational or Unproven. You may appeal this determination as described in the "Pharmacy Claim Questions and Appeals" section on Page 65.

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

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. UHPS has established a group of Specialty Pharmacies with clinical expertise in dispensing specialty drugs that must be filled through a UHPS Specialty Pharmacy. Prescriptions obtained through a Specialty Pharmacy are dispensed in 31-day quantities and delivered directly to your home. A list of the medical conditions serviced and the 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 Prescription Order or Refill for a Prescription Drug Product that must be obtained through a Specialty Pharmacy, you will receive assistance from the UHPS Specialty Pharmacy referral line to help you transfer your prescription. Your Prescription Order or Refill will be transferred to the UHPS Specialty Pharmacy as follows:

- You will receive a letter of Notification from UHPS. You will then contact the UHPS Specialty Pharmacy referral line included with the letter.
- The applicable UHPS Specialty Pharmacy will place an outreach call to your current pharmacy and physician.
- The UHPS Specialty Pharmacy will facilitate the transfer of your prescription to the UHPS Specialty Pharmacy. You will need to furnish payment information; however, you do not need to obtain a new prescription.
- You will have access to a 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 UHPS Specialty Pharmacy and your physician, delivered directly to your home every 31 days.

If you have a new prescription for a Prescription Drug Product that must be filled by a UHPS Specialty Pharmacy, you may fill your new prescription and up to three fills at a Retail Pharmacy before the Plan will require you to fill such prescription by the UHPS Specialty Pharmacy. A Prescription Order or Refill that is required to be filled by a UHPS Specialty Pharmacy which is filled at a Retail Pharmacy after meeting this limit will not be covered under the Pharmacy Program. Note, however, all Prescription Orders or Refills for a Prescription Drug Product classified as a self-injectable infertility drug must be filled at a UHPS Specialty Pharmacy with the very first prescription and ongoing. No benefits are payable under the Pharmacy Program if a Prescription Order or Refill for a self-injectable infertility drug is filled by a pharmacy other than a UHPS Specialty Pharmacy.

Benefits for the Specialty Pharmacy drugs are payable, following the Schedule of Benefits on Page 61 entitled "Prescription Drugs from Retail or Specialty Pharmacy."

The toll-free number to contact the UHPS Specialty Pharmacy referral line for any questions is 1-866-429-8177. You will be provided contact information for the specific Specialty Pharmacy that specializes in the drug you use. UHPS will work with you to establish your contact with the Specialty Pharmacy and transfer your Prescription Order or Refill to the Specialty Pharmacy.

Mandatory Mail Order Program:

The Mandatory Mail Order Program is a program that requires you to use the Mail Order Pharmacy to obtain certain maintenance medications. Maintenance medications are Prescription Drug Products, which are designed to be prescribed as an ongoing therapy. Maintenance medications can be purchased more conveniently, at a lesser cost to you and the Plan, through the Mail Order Pharmacy. A list of the Prescription Drug Products that must be dispensed through the Mandatory Mail Order program can be found on the pharmacy link through www.myuhc.com.

A Prescription Order or Refill for a Prescription Drug Product that is listed by UHPS/Medco as a Mandatory Mail Order (MMO) maintenance medication that must be must be written for a 90-day supply. Your physician 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 3 refills. A 3-month supply will be dispensed and delivered directly to your home every 90 days. You will receive reminders when it is time to refill your prescription, which you may do by telephone or online.

For prescriptions being filled for the first time through the Mail Order Pharmacy, you must complete a Mail Order Form. You may request a copy of this form by calling the Union Pacific HR Service Center at 1-877-275-8747, Option 1.

The form must be mailed to:

Medco
P.O. Box 747000
Cincinnati OH 45274-7000

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 Plan, you may fill your prescription and up to three fills at a Retail Pharmacy and still receive benefits under the Pharmacy Program. A Prescription Order or Refill for a MMO maintenance medication that is required to be filled by the Mail Order Pharmacy that is filled at a Retail Pharmacy after meeting this limit will not be covered 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 UHPS/Medco, indicating that your prescription for the maintenance medication must be filled through the Mail Order Pharmacy, and that you must ask your physician to write your next Prescription Order or Refill for the maintenance medication for a 90-day supply.

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

The toll-free number to contact the Mail Order Pharmacy for any questions is 1-800-331-4370.

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 "Payment Information, Deductible" on Page 58. After you have met your applicable 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 must complete a Mail Order Form. This form can be found on the www.myuhc.com Web site under "Pharmacies & Prescriptions," "Order & Refill Prescriptions," and "Forms & Cards." The form can be mailed to:
  Medco
  P.O. Box 747000
  Cincinnati OH 45274-7000
- 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.
- 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 $200.
- If your doctor has prescribed a refill, you can request a refill over the phone or via the intranet at www.myuhc.com.
- When your prescription expires, you will need to request a new prescription from your physician. Your prescription may be for up to 12 months. Then a 90-day supply will be delivered directly to your home every 90 days.

Note: A Prescription Order or Refill for a Prescription Drug Product identified as a "Specialty Drug" and required to be filled by a UHPS 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 UHPS/Medco at 1-800-331-4370 and choose the pharmacy prompt or visit the prescription drug section at www.myuhc.com.

Payment Information:

Deductible: You are responsible for paying the HDHP Deductible before pharmacy benefits are payable under the Plan. (For more information on this Deductible, see Page 15 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 Medical Services are also applied against the HDHP Deductible. If a Non-Preferred provider is used to receive Covered Medical Services, only the Reasonable and Customary Charges for Covered Medical Services are applied against the HDHP Deductible.

HDHP DEDUCTIBLE	
Network	$2,750 per Covered Person per Calendar Year, not to exceed $5,500 for all Covered Persons in a family.
Non-Network	$5,500 per Covered Person per Calendar Year, not to exceed $11,000 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: 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 UHPS/Medco Prescription Drug List are obtained from a Retail or Mail Order 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 UHPS/Medco contracted rates (the UHPS/Medco Prescription Drug Cost) will not be available to you.

- 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.
- The amounts you pay for contracted rates with a preferred provider for Covered Medical Services are also applied against the HDHP Coinsurance Maximum. If a Non-Preferred provider is used to receive Covered Medical Services, only the Reasonable and Customary Charges for Covered Medical Services are applied against the HDHP Coinsurance Maximum.

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. Your Pharmacy Coinsurance payment is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product.	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 percentage stated in the Benefit Information table on Page 61 for amounts.

PAYMENT INFORMATION SCHEDULE		
Payment Term	**Description**	**Amounts**
	Note: The tier status of a Prescription Drug Product can change periodically, generally quarterly, but no more than six times per Calendar Year based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, your Pharmacy Coinsurance payment may change. Please go to www.myuhc.com or call UHPS/Medco at 1-800-331-4370 for the most up-to-date tier status.	
HDHP Coinsurance Maximum	The maximum amount you are required to pay for Covered Medical Services and/or Prescription Drug Products on the UHPS 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 UHPS/Medco 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 for benefit payment by the Plan and do not count toward your HDHP Coinsurance Maximum.	**Network:** $2,750 per Covered Person per Calendar Year, not to exceed $5,500 for all covered persons in a family. **Non-Network:** $5,500 per Covered Person per Calendar Year, not to exceed $11,000 for all covered persons in a family. The HDHP Coinsurance Maximum does not include the Annual HDHP Deductible.

Three-Tier Pharmacy Coinsurance: The percentage Pharmacy Coinsurance payment depends on which tier the medication is placed within the Prescription Drug List (PDL) at the time the Prescription Order or Refill is dispensed.

Here is how the Three-tier Pharmacy Coinsurance structure works when you use a Network Pharmacy, subject to the minimums and maximums listed on Page 16:

- **Highest Pharmacy Coinsurance Payment:** You will pay the highest Pharmacy Coinsurance payment for any drugs that are listed as Tier-3 on the Prescription Drug List. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
- **Middle Pharmacy Coinsurance Payment:** You will pay a mid-level Pharmacy Coinsurance payment for lower cost Brand-Name drugs (and some newly available Generic drugs) that are listed as Tier-2 on the Prescription Drug List.
- **Lowest Pharmacy Coinsurance Payment**: You will pay the lowest Pharmacy Coinsurance payment for drugs that are listed as Tier-1 on the Prescription Drug List (most Generic drugs). Generic drugs are subject to the same rigid U.S. Food and Drug Administration standards for quality, strength, and purity as their Brand-Name counterparts. Generic drugs usually cost less than Brand-Name drugs. Please ask your Doctor to prescribe Generic medications for you whenever appropriate.

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 Coinsurance payment.

Coverage Policies and Guidelines: The UHPS/Medco Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on the Plan's behalf. The PDL 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, as well as whether 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.

UHPS/Medco 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 PDL 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 a determination that is made by the covered person and the prescribing Physician.

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 UHPS/Medco at 1-800-331-4370 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.	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 UHPS/Medco at 1-800-331-4370 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. 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 maximum Pharmacy Coinsurance payment of $100. Specialty Pharmacy drugs filled at a Network Pharmacy after the 3-fill transition period or any self-injectable infertility drug filled at a Network Retail Pharmacy will not be covered.

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)**
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 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 UHPS/Medco. 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.	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 UHPS/Medco at 1-800-331-4370 to determine tier status. • **20%** of the **Predominant Reimbursement Rate** for a Tier-1 Prescription Drug Product. • **30%** of the **Predominant Reimbursement Rate** for a Tier-2 Prescription Drug Product. • **40%** of the **Predominant Reimbursement Rate** for a Tier-3 Prescription Drug Product. Each 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 maximum Pharmacy Coinsurance payment of $100. Specialty Pharmacy drugs filled at a Retail Pharmacy, whether Network or Non-Network, after the 3-fill transition period or any self-injectable infertility drug filled at a Non-Network Retail Pharmacy will not be covered.

PRESCRIPTION DRUGS FROM MAIL ORDER PHARMACY	
Mail Order Network Pharmacy Benefits and Supply Limits	**Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)**
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 UHPS/Medco at 1-800-331-4370 to determine tier status. • 15% of the Prescription Drug Cost for a Tier-1 Prescription Drug Product. • 25% of the Prescription Drug 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 maximum Pharmacy Coinsurance payment of $150.

Payment Example: Assume you have satisfied your HDHP Deductible. If you purchase a Tier-1 drug at a Non-Network Pharmacy and the Non-Network Pharmacy's billed rate is $100 and the Predominate Reimbursement Rate is $85, you will pay $100 to the Non-Network Pharmacy. You may then file a claim and be reimbursed for all but $32 (a Pharmacy Coinsurance amount of $17 – 20% of the Predominant Reimbursement Rate of $85 – plus the $15 difference between the Non-Network Pharmacy's Rate and the Predominant Reimbursement Rate.)

Mail Order Service Pharmacy Savings Examples: The following are examples of how using the Mail Order Pharmacy Service may provide cost savings to you. The examples assume you have met your HDHP Deductible, but have not reached your HDHP Coinsurance Maximum.

	Retail Network		**Mail Order**	**Retail Network vs. Mail Order Savings**
Category/Drug	**31-day Supply at a Retail Network Pharmacy**	**93-day Supply (3 x 31-day supply) at a Retail Network Pharmacy**	**90-day Supply using UHPS/Medco Mail Order Service**	**90-day supply: Mail Order versus Retail**
Tier-1	Price* $25.00 20% Pharmacy Coinsurance minimum $10 maximum $100 Your Coinsurance cost: $10.00 Cost/day: $0.3225	Price* $75.00 20% Pharmacy Coinsurance minimum $30 maximum $300 Your Coinsurance cost: $30.00 Cost/day: $0.3225	Price* $68.00 15% Pharmacy Coinsurance minimum $25 maximum $150 Your Coinsurance cost: $25.00 Cost/day: $0.2777	$4.03 Save 16%
Tier-2	Price* $100.00 30% Pharmacy Coinsurance minimum $10 maximum $100 Your Coinsurance cost: $30.00 Cost/day: $0.9677	Price* $300.00 30% Pharmacy Coinsurance minimum $30 maximum $300 Your Coinsurance cost: $90.00 Cost/day: $0.9677	Price* $270.00 25% Pharmacy Coinsurance minimum $25 maximum $150 Your Coinsurance cost: $67.50 Cost/day: $0.7500	$19.60 Save 29%
Tier-3	Price* $150.00 40% Pharmacy Coinsurance minimum $10 maximum $100 Your Coinsurance cost: $60.00 Cost/day: $1.9354	Price* $450.00 40% Pharmacy Coinsurance minimum $30 maximum $300 Your Coinsurance cost: $180.00 Cost/day: $1.9354	Price* $405.00 40% Pharmacy Coinsurance minimum $25 maximum $150 Your Coinsurance cost: $150.00 Cost/day: $1.6666	$24.19 Save 16%
*Prices are for illustrative purposes only.				

Infertility Prescription Drug Benefit: Infertility prescription drug benefits are limited to a $10,000 Lifetime Maximum benefit. The $10,000 Lifetime Maximum under the Pharmacy Program is separate from and does not apply to the infertility benefit under the Medical Program or count toward the Medical Infertility Lifetime Maximum. Infertility drugs come in multiple forms (e.g., table or capsule form, self-injectable, and other forms, etc.). Infertility drugs that are self-injectable must be purchased through the Specialty Pharmacy Program, starting with the first month of utilization, in order to be considered for coverage under the Pharmacy program. The Deductible and Coinsurance applicable to the Specialty Pharmacy Benefit will apply.

To begin ordering this type of medication, contact the UHPS Specialty Pharmacy referral line at 1-866-429-8177.

What's Not Covered - Exclusions:
The following exclusions apply to the Pharmacy Program (Note - Some items excluded here may be covered under the Medical Program):

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Prescription Drug Products that are prescribed, dispensed, or intended for use while you are an inpatient (e.g., a Hospital, Skilled Nursing Facility, etc.).
- Experimental, investigational, or unproven services and medications; medications used for experimental indications and/or dosage regimens determined by UHPS/Medco to be experimental, investigational or unproven
- 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 or Specialty Pharmacy Program when dispensed at a Retail Pharmacy following the three prescription transition period, and any Prescription Drug Product classified by the PDL Management Committee as a self-injectable infertility drug that is not dispensed through a Specialty Pharmacy.
- 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.
- Prescription Drug Products prescribed to treat an on-duty injury, regardless of fault.
- 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 UHPS, must typically be administered or supervised by a qualified Provider or licensed/certified health professional in an outpatient setting. 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 67). Certain Durable Medical Equipment may be covered under the UHC HDHP PPO Program.
- Coordination of benefits on Prescription Drug Products, including prescriptions on the UHPS/Medco Prescription Drug List.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride and single entity vitamins. Examples of single entity vitamins covered with a prescription include Intranasal Vitamin B12, Aminobenzoate Potassium, Vitamin D, Vitamin K, and Folic Acid 1mg.
- 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.
- Prescription Drug Products for tobacco dependency.
- 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.
- New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
- 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 are otherwise provided under this Plan or under any other plan to which your employer sponsors or contributes.
- Prescription Drug Products for which the prescription is more than one year old.

- Injectable Prescription Drug Products. (This exclusion does not apply to insulin or self-administered injectables that can be injected subcutaneously which are covered. Which drugs are considered "self-administered injectables" is determined by UHPS/Medco. To verify if an injectable drug is considered a self-administered injectable, go to www.myuhc.com or call UHPS/Medco at 1-800-331-4370.
- 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.
- Prescription Drug Products not obtained through a Specialty Pharmacy or Mail Order Pharmacy Service as required by the Pharmacy Program.

How to File Pharmacy Claims:

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 UHPS, within 12 Calendar Months of the date you fill the Prescription Order or Refill. UHPS 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 1-800-331-4370 or visit the "Pharmacies & Prescriptions" section of www.myuhc.com. You will usually be reimbursed for a Covered Prescription Drug Product within 21 days after receipt of your claim form. The completed claim form, along with the prescription receipt, must be sent to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington KY 40512

If you have a claim for urgent care, UHPS will review your claim as an urgent care claim. You, your physician or your pharmacist must submit your urgent care claim by calling UHPS at 1-800-331-4370. An urgent care claim is a claim for care that without such care could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 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 within 24 hours after receipt of your claim, of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information.

For all other claims, a decision regarding your claim will be sent to you within 30 days of receipt of your claim.

If your claim is denied, UHPS 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 in writing within 180 days of receipt of notice of the initial coverage decision.

Appeal of Non-Urgent Pharmacy Claims: To initiate an appeal for coverage, you or your physician must provide in writing, your name, member ID, physician 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 National Appeals Center-ASO, UnitedHealthcare – Appeal, PO BOX 30432, Salt Lake City, UT,

84130-0432. UHPS will review your appeal and a decision regarding your appeal will be sent to you within 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 appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. To initiate a second level appeal, you or your physician must provide in writing, your name, member ID, physician 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 appeal. This information must be mailed to National Appeals Center-ASO, UnitedHealthcare –Appeal, PO BOX 30432, Salt Lake City, UT, 84130-0432. Your second level appeal will be reviewed by UHPS. UHPS will notify you and your Doctor in writing within 30 days of receipt of your written request for appeal. The decision of UHPS 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 the Employee Retirement Income Security Act ("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 physician may call UHPS at 1-800-331-4370 or write to National Appeals Center-ASO, UnitedHealthcare –Appeal, PO 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 UHPS. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 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 within 24 hours after receipt of your claim, of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. The decision of UHPS 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 the Employee Retirement Income Security Act ("ERISA") if your urgent care appeal is denied.

Pharmacy Appeals Process: UHPS 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 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. 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. 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. If the initial denial is based in whole or in part on a medical judgment, UHPS 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 UHPS obtained advice from medical or vocational experts with respect to your claim, these experts will be identified, regardless of whether UHPS relied on their advice when deciding your claim.

For all claims and appeals for Pharmacy Program benefits provided under the UHC HDHP PPO Program, Union Pacific has delegated to UHPS the exclusive and discretionary right to interpret and administer the provisions of the Plan. The decisions of UHPS are conclusive and binding.

Pharmacy Benefit Defined Terms:

Annual HDHP Deductible: See definition in the Medical Section, Page 13.

Annual HDHP Coinsurance Maximum: See definition in the Medical Section, Page 14.

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 UHPS identifies as a brand-name product, based on available data resources including, but not limited to, First DataBank, 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 Physician 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 UHPS identifies as a Generic product based on available data resources including, but not limited to, First DataBank, 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 physician may not be classified as a Generic by the Plan.

Network Pharmacy: A pharmacy that has:

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

A Network Pharmacy can be a Retail, Specialty 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. UHPS calculates the Predominant Reimbursement Rate using the UHPS Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Cost*:* The rate UHPS 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 UHPS (generally quarterly). You may determine to which tier a particular Prescription Drug Product has been assigned at www.myuhc.com or by calling UnitedHealthcare at 1-800-331-4370.

Prescription Drug List Management Committee*:* The committee that UHPS 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.

UHC HDHP PPO PROGRAM: VISION CARE BENEFITS

As a participant in the UHC HDHP PPO Program, 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	$50
Bifocal	$70
Trifocal	$105
Frames	Any frame available at Provider location: 35% off retail price
Lens Options:	
UV Coating	$15
Tint (Solid and Gradient)	$15
Standard Scratch-Resistance	$15
Standard Polycarbonate	$40
Standard Progressive(Add-on to Bifocal)	$65
Standard Anti-Reflective Coating	$45
Other Add-Ons and Services	20% discount
Contact Lens Materials: (Discount applied to materials only)	
Disposable	0% off retail price
Conventional	15% off retail price
Laser Vision Correction: Lasik or PRK	15% off retail price or 5% off promotional price
Frequency:	
Examination	Unlimited
Frame	Unlimited
Lenses	Unlimited
Contact Lenses	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.

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 1-866-723-0513. Representatives are available Monday through Saturday from 8:00 AM to 11:00 PM, and Sunday from 11:00 AM to 8:00 PM 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 Web site at www.eyemedvisioncare.com.
2. Click on the "Member Access" menu.
3. Follow the registration instructions on the page to set up a user name and password.
4. Once you have registered and logged into the site, click on the Provider Locator button to perform a search.

For Retirees who are not currently an EyeMed Vision Care member, go to www.enrollwitheyemed.com and click on the Provider Locator button to perform a search.

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:

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 1-866-939-3633. 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 (ERISA) as amended, please refer to the ERISA section beginning on Page 87 of this document.

For all claims and appeals for vision care benefits under the UHC HDHP PPO Program, Union Pacific has delegated to EyeMed Vision Care the exclusive and discretionary right to interpret and administer the provisions of the Plan. The decisions of EyeMed Vision Care are conclusive and binding.

CONVERSION COVERAGE FOR MEDICAL PLAN

If your group health coverage stops under the UHC HDHP PPO Program, you may buy individual health insurance (called "Conversion Coverage"). Proof of insurability will not have to be given.

If you have healthcare coverage for your Dependent(s) when the group coverage stops, the Conversion Coverage will be for you and all covered Dependents on the day such coverage stops. You must apply for Conversion Coverage on the same basis as the medical coverage you have under the UHC HDHP PPO Program. You cannot apply for single Conversion Coverage unless you are enrolled for Retiree Only coverage under the UHC HDHP PPO Program. A Dependent Child over 19 will be issued single Conversion Coverage because only Dependent Children under 19 are covered as family members under Conversion Coverage.

Individual conversion policies are available in a number of states. In other states, conversion coverage is provided through The Group Conversion Trust. Contact UnitedHealthcare at 1-800-331-4370 for additional information about what form of conversion coverage is currently available in your state.

See "Conversion Coverage for Medicare Eligibles" at the end of this provision if you or your covered Dependent is Medicare eligible.

Conditions for Conversion:

For Covered Retirees: The UHC HDHP PPO Program must be in force and the coverage has to stop for either of the following reasons:

- Your entire entitlement under COBRA has been exhausted.
- The Plan ends and is not replaced within 31 days.

If your health coverage stops because the UHC HDHP PPO Program ends and is replaced within 31 days, you will not have the right to buy Conversion Coverage.

For Covered Dependents: If you die, your Spouse or any guardian of your covered Dependent Children may buy Conversion Coverage for the covered Dependents. If your marriage is dissolved, your former Spouse may buy Conversion Coverage. This can happen at either of the following times:

- When the marriage is dissolved; or
- At the end of any period of continuation of coverage under the UHC HDHP PPO Program, but only if the UHC HDHP PPO Program is in force on that date.

Any of your covered Dependents may buy Conversion Coverage if one of the following is true:

- The Dependent stops being eligible; or
- The Dependent is 19 or older when you buy Conversion Coverage. (Only Dependent Children under 19 are eligible under a covered Retiree's new family coverage.)

How to Apply:

Application must be made within 31 days after the group coverage stops. Contact UnitedHealthcare at 1-800-331-4370 to obtain an application.

The first premium must be paid before Conversion Coverage can be put in force. Conversion Coverage will be effective on the date that the group coverage stops. Contact UnitedHealthcare for premium information.

In some cases, your covered Dependents may be able to choose to continue their group coverage after your death. In these cases, Conversion Coverage will go into effect when the continued coverage stops but only if this plan is in force on that date.

If you die within the 31-day conversion period, your Spouse or any guardian of your covered Dependents may apply for Conversion Coverage for those covered Dependents.

Limitations:

Conversion Coverage may have greatly reduced benefits at a much higher cost. In most cases, the benefits will be limited to Hospital and surgical benefits only. The benefit amounts for Conversion Coverage will be governed by the following:

- The rules of UnitedHealthcare.
- The laws of the state or jurisdiction where the person lives when he or she applies.

A copy of the individual policy or Certificate of Insurance is on file with the state insurance authority, where required. A copy may also be obtained from UnitedHealthcare.

UnitedHealthcare might limit the benefit of, or refuse to issue, Conversion Coverage because the covered Retiree or a Dependent has other health coverage.

Application for Individual Conversion Coverage must be made within 31 days after the group coverage stops. Contact UnitedHealthcare at 1-800-331-4370 to obtain an application.

RETIREE HRA FOR MEDICARE ELIGIBLE RETIREES AND DEPENDENTS

Retiree HRA Components:

Effective January 1, 2010, 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 Extend Health. A Retiree HRA is an account used to pay certain medical expenses 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 Extend Health 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 expenses 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 2010 Calendar Year with $1,200 if you or your Spouse is the only Medicare eligible participant enrolled in the Retiree Medical Program ("Single Retiree HRA Coverage"). Your HRA will be credited for the 2010 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 or your Spouse 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 or your Spouse first become Medicare eligible on June 22, 2010, 7/12 of $1,200 (the Single Retiree HRA Coverage amount) will be placed 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 2010 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, 2010, an additional $330 will be credited to your Retiree HRA. This additional amount is 6/12 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 75, 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 allowable for reimbursement from the Retiree HRA for 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 74.) Amounts in your Retiree HRA that are not used to pay for eligible expenses incurred in the Calendar Year are carried over and can be used to pay for eligible expenses incurred in the following Calendar Year(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 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 of your divorce or legal separation. 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 Dependent continues Retiree HRA coverage under the 6-Month Rule or as a result of being on a Medically Necessary Leave of Absence, in the event your 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 a Full-Time Student and is not on a Medically Necessary Leave of Absence, a separate Dependent Retiree HRA will be established for such Dependent and coverage under the Retiree HRA will begin the first of the month following the month in which such Dependent is no longer eligible to continue coverage under the 6-Month Rule. 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 under the 6-Month Rule. Coverage under such Retiree HRA will continue until 36 months after the end of the month in which your Dependent's Retiree HRA coverage under the 6-Month Rule terminated.

If your Dependent is no longer your Dependent because he/she is no longer a Full-Time Student 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 be established for such Dependent. Coverage under the 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 the 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 1-877-275-8747, Option 1. 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 Extend Health to provide you with the option of the insurance carrier submitting claims on your behalf through a process called **"**Auto Reimbursement.**"** Extend Health 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 Extend Health and thereby generate an HRA claim on your behalf in the amount of the premiums you have paid. Upon claim approval, Extend Health 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. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

To receive a reimbursement from your Retiree HRA, you must file a claim, along with appropriate proof of expenses. Retiree HRA claim forms are available online at www.extendhealth.com/unionpacific or by calling Extend Health at 1-800-935-7780.

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.
3. Sign and date your form.
4. Submit your claim(s) by mail or fax:
    a. Mail your claim form and supporting documents to:
        Your Spending Account
        P.O. Box 785050
        Orlando FL 32878-5040
    b. Fax your claim form and supporting documents to 1-888-211-9900. 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 www.extendhealth.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. Once you are in your account, select **Funds**, where you will see a list of your HRA funds.
4. Click on **Go to Your Account**. This will bring you to the **Your Spending Account™** home page**.**
5. Click on the **Your Spending Account** home page and choose **Submit Claims** to the right of your account balance.
6. Enter the claim information for your eligible expenses and select **Review Claims**.

7. Once reviewed, select **Create Fax Cover Sheet**. If you prefer to mail your documentation, select **Mail Your Documentation**.
8. 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.
9. Sign and date your form.
10. To complete the online claim submission process, you must fax or mail in the copy of the signed claim form that you completed on the **Your Spending** Account Web site along with your receipts:
    a. Mail your claim form and supporting documents to:
    b. Your Spending Account
        P.O. Box 785050
        Orlando FL 32878-5040
    b. Fax your claim form and supporting documents to 1-888-211-9900. 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.

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 Extend Health Web site at www.extendhealth.com/unionpacific for the most current status of your claim.

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 medical condition	Yes	
Additional card expense - Additional Card Expense	No	

Expense Item	Eligible?	Claim Details
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 pregnancy tests, condoms, gels, and foams	Yes	
Blood donation - Costs associated with blood donation, including self-administered blood donations, storage fees, and processing fees	Yes	
Blood pressure monitors - Costs include electronic monitors and replacement blood pressure cuffs	Yes	
Body scans	Yes	
Bottled water	No	
Braille books and magazines - Costs are limited to those that exceed regular printed editions	Yes	You must provide a receipt or advertisement with the price of the regular printed version of the book or magazine and a receipt of the Braille material
Breast augmentation - Examples include implants and injections	No	Surgery or procedures that aren't medically necessary aren't eligible
Breast pumps - Pump prescribed by a doctor for a medical reason	Yes	Breast pumps used for nursing and routine post-partum care aren't eligible
Chelation therapy - Therapy used to treat a medical condition, such as lead poisoning	Yes	
Childbirth classes - Classes necessary to reduce pain during labor and delivery. An example is Lamaze	Yes	Expenses related to parenting techniques, infant CPR, and breast feeding are not covered
Chiropractor - Treatment for a medical condition	Yes	
Christian science practitioner - Medical expenses paid to a practitioner for medical care	Yes	

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

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

Expense Item	Eligible?	Claim Details
Hearing-impaired phone tools - Telephone equipment that allows a hearing-impaired person to communicate over a regular telephone	Yes	
Hearing-impaired TV equipment - Equipment that displays the audio part of television programs as subtitles for a hearing-impaired person	Yes	
Herbal remedies - Remedies that are prescribed by a doctor for a medical condition	Yes	You must provide a statement of medical necessity documenting that the herbal remedy is necessary to treat a medical condition, injury, or illness and is not for general health purposes
Hospital care - Inpatient care, including the cost of a private room	Yes	Fees for personal convenience items, such as a television, telephone, and concierge services, aren't eligible
Household help - Expenses for help with physical housework, even if recommended by a doctor, due to an inability of employee, dependent, or retiree	No	
Humidifiers - Cost of portable units prescribed by a doctor for treatment of a medical condition	Yes	
Hypnosis - Hypnosis prescribed for medical reasons	Yes	
Illegal medical treatment - Including surgery	No	
Immunizations	Yes	
Ineligible expense - Not covered	No	
Infertility - Treatments for infertility, including artificial insemination, in-vivo or in-vitro fertilization, embryo placement, egg and sperm storage, and ovulation monitors	Yes	
Laboratory and X ray fees	Yes	
Laetrile - Anti-cancer drug	No	
Language training - Training for a child with dyslexia or other learning disabilities. Fees for regular schooling aren't eligible	Yes	
LASIK surgery	Yes	
Lead-based paint removal - Costs for residences with children who have or had lead poisoning	Yes	
Legal fees - Fees paid to authorize treatment for mental illness, excluding guardianship or estate management fees	Yes	
Lens replacement insurance - Insurance to replace eyeglass or contact lenses	No	
Life insurance premiums - Premiums paid for the following policies: life insurance, repayment for loss of earnings, and accidental loss of life, limbs, or sight	No	
Lodging - Cost of lodging not provided in a hospital or similar institution while away from home if primarily for and essential to medical care (limited to $50 per person per night)	Yes	The $50 is applicable to only the patient and caregiver ($100 limit per night); you must provide a statement of medical necessity from a doctor documenting the medical condition
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

Expense Item	Eligible?	Claim Details
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 aren't eligible
Maternity clothes	No	
Mattresses - Mattresses prescribed by a doctor to treat a medical condition	Yes	You must provide a statement of medical necessity documenting that the mattress is necessary to treat a medical condition, injury, or illness and is not for general health purposes
Medic alert identifications - Bracelet or necklace prescribed by a doctor in connection with treating a medical condition	Yes	
Medical coinsurance - Amounts not covered by your or your spouse's medical plans	Yes	
Medical conference - Admission and transportation costs	Yes	
Medical contract fees - Annual contract costs for exclusive provider care	No	Itemized expenses for services provided are eligible
Medical copayments	Yes	
Medical debit card - Debit Card Medical Expense	No	
Medical deductibles - Deductibles under your or your spouse's medical plans	Yes	
Medical equipment - Costs to buy or rent durable equipment prescribed by a medical practitioner to alleviate or treat a medical condition. Examples include medical beds, nebulizers, and sleep therapy devices	Yes	
Medical information - Amounts paid to a medical information plan for storage and retrieval of medical information	Yes	
Medical reasonable/customary - Amounts not paid by a medical plan that exceed reasonable and customary limits	Yes	
Medical services - Services provided by doctors, surgeons, specialists, or other medical practitioners	Yes	
Medical supplies - Over-the-counter items such as bandages, thermometers, and heating pads	Yes	
Medicare Part B Premiums	Yes	
Medicare Part D Premiums	Yes	
Mental health - Includes psychoanalysis or amounts paid to a psychiatrist, psychologist, hospital, clinic, or mental health facility for medical care	Yes	

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

Expense Item	Eligible?	Claim Details
Post Tax Dental Premiums - Premiums paid on an after-tax basis for any type of dental insurance coverage, including premiums for private insurance not provided by an employer	Yes	
Post Tax Medical Premiums - Premiums paid on an after-tax basis for any type of medical insurance coverage, including premiums for private insurance not provided by an employer	Yes	
Post Tax Vision Premiums - Premiums paid on an after-tax basis for any type of vision insurance coverage, including premiums for private insurance not provided by an employer	Yes	
Premiums for medical insurance - Premiums paid on an after-tax basis for any type of medical insurance coverage, including premiums for private insurance not provided by an employer	Yes	You must provide indication that the medical premium is after-tax when a payroll or retirement statement is used to document the medical premium expense - handwritten or verbal confirmation won't be accepted
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 for cosmetic or general health purposes	Yes	
Prosthetics	Yes	
Psychiatric care - Medical costs for psychiatric care	Yes	
Psychiatric expenses - Includes psychoanalysis or amounts paid to a psychologist for medical care	Yes	
Sales taxes - Sales and service taxes on eligible medical care or products	Yes	
School (alternative) - Costs of sending a problem child to an alternative school for benefits the child may receive from the course of study and disciplinary methods	No	
School payments for disabled - Expenses paid to an alternative school for a child with a severe learning disability if the main reason is using the school's resources for relieving the disability	Yes	You must provide a statement of medical necessity documenting the school is necessary to relieve the child's learning disability
Shipping - Charges to ship an eligible medical product	Yes	
Social activities - Activities such as dancing or swimming lessons, even if recommended by a doctor for general health improvement	No	

Expense Item	Eligible?	Claim Details
Speech therapy - Speech therapy costs when prescribed as treatment for medical conditions such as autism, dyslexia, developmental delays, and rehabilitation.	Yes	
Sterilization - Costs of sterilization (vasectomy or tubal ligation) and reversal of sterilization operations	Yes	
Stop-smoking program	Yes	
Sunglasses - Sunglasses prescribed by an eye doctor for light sensitivity	Yes	You must provide a statement of medical necessity documenting that the sunglasses are necessary to treat a medical condition, injury, or illness and are not for general health purposes
Support hose - Hose prescribed by a doctor for a medical condition	Yes	The hose must be primarily manufactured and marketed for relief of a medical condition - however, hosiery primarily marketed for fashion isn't eligible
Taxes - Social Security and Medicare taxes paid for a nurse, attendant, or other person who provides medical care	Yes	
Teeth whitening or bonding - Costs include bleaching and special whitening toothpaste. These expenses are always considered cosmetic and aren't eligible	No	
Toothbrush - Any type of toothbrush even if recommended by a dentist or orthodontist	No	
Transportation expenses - Costs to receive medical care - including airfare, parking, tolls, taxis, rental cars, buses, gas for your car, or mileage	Yes	You must provide a statement of medical necessity from a doctor documenting the medical condition for any expense $100 or more if no diagnosis has been submitted previously
Tutoring - Tutoring fees, recommended by a doctor, for a child who has severe learning disabilities caused by a mental or physical impairment, including nervous system disorders	Yes	You must provide a statement of medical necessity from a doctor documenting the medical condition
Umbilical cord storage - Costs to collect, freeze and store umbilical cord blood only when a medical condition is present. Storage when no medical condition is present isn't eligible	Yes	You must provide a statement of medical necessity from a doctor documenting the medical condition
Uniforms	No	
Unknown debit card MCC Code - Medical Debit Card Expense	No	
UVR treatments - Ultraviolet radiation treatments recommended by a doctor for a medical condition, such as chronic psoriasis	Yes	
Vacation or travel - Time off or travel for general health purposes	No	
Vaccinations - Amounts paid for vaccinations or immunizations against disease	Yes	
Varicose vein surgery - Expenses associated with the removal of varicose veins prescribed by a doctor for treatment of a medical condition	Yes	You must provide a statement of medical necessity from a doctor documenting the medical condition

Expense Item	Eligible?	Claim Details
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	
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	
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).

Claims for reimbursement from the Retiree HRA may be filed as eligible expenses are incurred. 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, Extend Health will make a benefit determination as set forth in the "Benefit Determinations" section below.

If your claim is approved, Extend Health 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.

Extend Health 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 Extend Health at 1-800-935-7780 or through the Extend Health Web site at www.extendhealth.com/unionpacific.

If you have a question concerning your claim, you can contact Extend Health at 1-800-935-7780.

Benefit Determinations: If your claim is denied, you will receive a written notice from Extend Health within 30 days of receipt of the claim as long as all needed information was provided with the claim. Extend Health 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, Extend Health 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, Extend Health 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 Extend Health at 1-800- 935-7780 before requesting a formal appeal. If the Extend Health 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 74, you may appeal it as described below without first informally contacting Extend Health Customer Service. If you first informally contact Extend Health 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 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 ("ERISA") if your appeal is denied.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND OTHER FIDUCIARIES

In carrying out their respective responsibilities under the UHC HDHP PPO Program, the Retiree HRA Program, and the Plan, the Plan Administrator and other plan fiduciaries including UnitedHealthcare, United Behavioral Health, UnitedHealth Pharmaceutical Solutions (UHPS), and EyeMed Vision Care, shall have discretionary authority to make factual findings and to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the UHC 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 by intentional act or negligence, the third party's insurer or any other source (for example, funds recovered in a lawsuit, a settlement, an arbitration or a payment from the third party's insurance company, or uninsured/underinsured motorist coverage), the Plan has a right to funds obtained as a result of that recovery to the extent of the claims it has paid. This right comes first (prior to any claim by any other party against the recovery) even if the covered person has not been compensated for all of his/her injuries and even if the recovery is described as being for other than medical expenses (for example, pain and suffering or emotional distress). This right is not dependent upon the third party admitting responsibility, and is not dependent upon the execution of an agreement

by the covered person (or that person's legal representative) to the right of recovery. The Plan shall automatically have a lien against the proceeds of any such recovery to the extent of the claims it has paid.

By filing a claim under the Plan, you are accepting the terms of this subrogation provision. You must immediately give written notice to UnitedHealthcare (for UHC HDHP PPO Program medical benefits), United Behavioral Health (for UHC HDHP PPO Program mental health/substance abuse benefits), UHPS (for UHC HDHP PPO Program prescription benefits), EyeMed Vision Care (for UHC HDHP PPO Program vision care benefits), or Extend Health (for Retiree HRA benefits) if you pursue a recovery from a responsible third party. You must do nothing to prejudice a right of recovery, such as accept a settlement that is less than the reasonable value of the claim. The Plan is not responsible for any share of attorney fees incurred in pursuing or obtaining any recovery or settlement.

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

MEDICAID

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

UnitedHealthcare, United Behavioral Health, EyeMed Vision Care, UHPS or Extend Health have the right to a refund of any Medical, Mental Health/Substance Abuse, Vision Care, Prescription Benefits, or Retiree HRA benefits 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 UnitedHealthcare, United Behavioral Health, EyeMed Vision Care, UnitedHealth Pharmaceutical Solutions (UHPS) or Extend Health. 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, UnitedHealthcare, United Behavioral Health, EyeMed Vision Care, UHPS or Extend Health may, in addition to other rights they may have, reduce the amount of any future benefits payable under the UHC HDHP PPO Program 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 the information on the medical programs provided to certain retirees of Alton & Southern Railroad constitutes the Summary Plan Description under ERISA.

Plan Sponsorship:

The plan's coverage is sponsored by:

Union Pacific Corporation
1400 Douglas Street
Omaha NE 68179

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

Plan Administrator:

The official Plan Administrator of the Plan is the Union Pacific Corporation Senior Vice President - Human Resources. 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:

Senior Vice President - Human Resources
Union Pacific Corporation
1400 Douglas Street, 19th Floor
Omaha NE 68179
(402) 544-5000

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

Your ERISA Rights:

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

- You may examine free of charge all official documents related to the plan. These include insurance contracts and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. You can examine copies of these documents in the Human Resources Department in Omaha or at your Company Headquarters if copies are kept there.
- Copies of the documents governing the operation of the Plan, including insurance contracts, the latest annual report, and an updated summary plan description, can be acquired by writing to the Plan Administrator. You may have to pay a reasonable photocopying charge.
- You will automatically receive a yearly summary of the Plan's financial reports.
- For those medical programs that provide maternity or newborn infant coverage, those programs 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).
- For those medical programs that cover mastectomies, if you or your Dependent receives a mastectomy, the covered benefits for the patient will also include coverage for:
    - Reconstruction of the breast on which the mastectomy has been performed;
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
    - Prostheses; and
    - Physical complications in all stages of mastectomy, including lymphedemas,

  in a manner determined in consultation with the attending physician and the patient. Such coverage is subject to annual Deductibles, Coinsurance and Copay provisions, and other provisions that are applicable to the other benefits of the medical programs.
- You may continue healthcare coverage for you and your Dependents if there is a loss of group health coverage as a result of a qualifying event. You or your Dependents may have to pay for such coverage. You should review this summary plan description and the documents for your particular group health plan on the rules governing your COBRA continuation coverage rights.

- You will be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the group health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases (if you request it before losing coverage), or if you request a certificate up to 24 months after losing coverage.

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

No one, including your employer or anyone else, may discharge or discriminate against you in a way that would prevent you from obtaining benefits under the plan or exercising rights under ERISA.

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

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

You may file suit in a state or federal court if your claim for benefits is totally or partially denied or ignored. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical Child support order, you may file suit in federal court. However, before filing a lawsuit you must first exhaust all appeals required by the Plan. Please refer to the claims and appeals sections of the Plan.

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

If you have questions about your benefits, contact the Human Resources Department. If you have questions about your rights under ERISA or about this statement, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, 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 also can 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:

Senior Vice President Human Resources
Union Pacific Corporation
1400 Douglas Street, 19th Floor
Omaha NE 68179
(402) 544-5000

Future of the Plan:

While Union Pacific intends to continue the Plan indefinitely, it reserves the right to terminate or amend the Plan for any reason. If the Company terminates or amends the Plan, benefits under the Plan would cease or change. The Company may also increase the required employee or Retiree contributions at any time. Similarly, a participating employer can take such actions with respect to its employees or Retirees. 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 effort 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 13-2854458.

PLAN NAME	PLAN NO. & TYPE	INSURANCE CARRIER, ADMINISTRATOR OR TRUSTEE	CONTRACT OR POLICY NO.	PLAN YEAR	CONTRIBUTION SOURCES
Union Pacific Corporation Group Health Plan	502 Group Health Plan			1/1 - 12/31	Retirees and Employers
(a) Medical Benefits (1) UHC HDHP PPO Program – (a) Medical & Pharmacy		(1) (a) UnitedHealthcare Insurance Company 450 Columbus Blvd Hartford, CT 06115	183842 – Medical & Pharmacy		
(b) Mental Health/ Substance Abuse		(b) United Behavioral Health 425 Market Street San Francisco, CA 94105	183842 – Mental Health/ Substance Abuse		
(c) Vision Care		(c) EyeMed Vision Care LLC 4000 Luxottica Place Mason, OH 45040	9235524 – Vision Care		

PLAN NAME	PLAN NO. & TYPE	INSURANCE CARRIER, ADMINISTRATOR OR TRUSTEE	CONTRACT OR POLICY NO.	PLAN YEAR	CONTRIBUTION SOURCES
(2) Retiree HRA		(2) Extend Health, Inc. 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 "Plan"), including the Retiree Medical Program, 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 Plan only as provided in this Health Insurance Portability and Accountability Act of 1996 section.

Entities Responsible for HIPAA Compliance:

For all Plan benefits provided to Retirees, the Plan is responsible for complying with HIPAA's privacy rules with respect to the Protected Health Information the Plan creates, maintains, or receives.

Availability of Notice of Privacy Practices:

The Group Health Plan, with respect to benefits under the Group Health Plan self-insured by Union Pacific, have adopted a Notice of Privacy Practices ("Notice") which is available upon request to Plan participants. 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
1-877-275-8747, Option 1
(402) 544-4000, Option 1

Permitted and Required Uses and Disclosure of Protected Health Information:

Subject to the conditions of disclosure described below and obtaining written certification as described below, the Plan may disclose Protected Health Information to Union Pacific, provided Union Pacific does not use or disclose such Protected Health Information except to perform Plan administrative functions which Union Pacific performs for the Plan. "Plan administrative functions" are functions related to the payment and healthcare operations performed by Union Pacific on behalf of the Plan. Except as described below, Plan administrative functions do not include functions performed by Union Pacific in connection with any other benefit or benefit plan of Union Pacific, and they do not include any employment related functions.

Notwithstanding the provisions of this document to the contrary, in no event shall Union Pacific be permitted to use or disclose Protected Health Information in a manner that is inconsistent with the HIPAA regulations.

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, and information disclosed pursuant to a valid HIPAA authorization, Union Pacific shall:

a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.
b. Ensure that any agents, including subcontractors, 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,

except to the extent such other benefit plan, program or arrangement is part of an Organized Healthcare Arrangement (as defined in the HIPAA regulations) of which the Plan also is a part.

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.

Certification of Plan Sponsor:
The Plan shall disclose Protected Health Information to Union Pacific only upon the receipt of a Certification by Union Pacific that the Plan has been amended to incorporate the required provisions of the HIPAA regulations and that Union Pacific agrees to the conditions of disclosure set forth in this document.

Permitted Uses and Disclosure of Summary Health Information:
The Plan may disclose Summary Health Information to Union Pacific, provided such Summary Health Information is only used by Union Pacific for the purpose of:

a. Obtaining premium bids from health plan Providers for providing health insurance coverage under the Plan; or
b. Modifying, amending, or terminating the Plan.

Permitted Uses and Disclosure of Enrollment and Disenrollment Information:
The Plan may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to Union Pacific.

Permitted Uses and Disclosure of Protected Health Information Pursuant to an Authorization:
The Plan, or a health insurance issuer with respect to the Plan, may disclose protected health information to Union Pacific pursuant to a valid HIPAA authorization.

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:

- Union Pacific Corporation Senior Vice President-Human Resources
- 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
1-877-275-8747, Option 1
(402) 544-4000, Option 1

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 information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of healthcare to a participant; or the past, present, or future payment for the provision of healthcare to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased. The following components of a participant's information also 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. Biometric identifiers, including finger and voice prints;
n. Full face photographic images and any comparable images; and
o. 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

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

Alternate Medical Treatment Benefits are benefits for expenses that UnitedHealthcare has approved before they are incurred, in connection with a Specific Plan of Alternate Medical Treatment. Such expenses would not otherwise be payable as covered expenses in the other provisions of this Plan.

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

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

Cancer Resource Services Program is the UnitedHealthcare's program made available by the Employer to non-Medicare eligible Retirees. The Cancer Resource Services Program provides information to Retirees or their covered Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

Claims Administrator is UnitedHealthcare Insurance Company (as known as UnitedHealthcare), or its affiliate, that provides certain claims administration services for the UHC HDHP PPO Program.

Consultant is a medical Case Management Consultant who is a Nurse employed by UnitedHealthcare to coordinate the Medical Case Management Program.

Designated United Resource Networks Facility is a facility designated by the UnitedHealthcare to render necessary Covered Services and Supplies for Qualified Procedures for the Transplant Management Program and Cancer Resource Services under the UHC HDHP PPO Program.

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

Emergency is a serious medical condition or symptom resulting from injury, sickness, or mental illness which is both of the following:

- 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.

Emergency Admission is a Hospital confinement due to a Life-Threatening Condition, which reasonably requires immediate medical care.

Emergency Mental Healthcare or Substance Abuse Treatment is immediate Mental Healthcare or Substance Abuse Treatment when the lack of the care or treatment could reasonably be expected to result in the patient harming himself/herself and/or other persons.

Experimental/Investigational Services are medical, surgical, diagnostic, psychiatric, substance abuse, or other healthcare services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed used.
- Subject to review and approval by any institutional review board for the proposed used.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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

Extended Care Facility/Skilled Nursing Facility is a place that:

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

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

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

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

Level of Care is the intensity and/or magnitude of a Mental Health or Substance Abuse Care treatment setting, treatment plan or treatment modality including, but not limited to:

- Acute care facilities;
- Less intensive inpatient or outpatient alternatives to acute care facilities, such as residential treatment centers, group homes, or structured outpatient programs;
- Outpatient visits; or
- Medication management.

Life Threatening Condition is a condition such as:

- A major injury or illness, such as a heart attack or serious wound;
- Unconsciousness;
- Bleeding that will not respond to elevation or direct pressure;
- Stupor, drowsiness or disorientation that cannot be explained;
- Shortness of breath;
- Severe pain;
- Poisoning.

Medical ID Card is the identification card issued to you by your healthcare plan, which identifies your eligibility for benefits under the Medical Programs. Your healthcare plan may issue ID cards in the Retiree's name for use by both the Retiree and his/her Dependent(s).

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

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

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

If there are multiple diagnoses, only the treatment for the sickness which is identified in the DSM is considered Mental Healthcare or Substance Abuse Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered Mental Healthcare or Substance Abuse Treatment.

Network is using a Provider participating in one of the following Networks:

- UnitedHealthcare's Preferred Provider Organization (PPO) Network for medical services other than Mental Healthcare or Substance Abuse Treatment, Pharmacy services, or Vision Care services; or
- United Behavioral Health's Network of Mental Healthcare or Substance Abuse Treatment Providers; or
- UHPS' Network of participating pharmacies for retail or mail order pharmaceutical services; or
- EyeMed Vision Care's Network of participating Providers of Vision Care services and supplies

When a Preferred Provider is used, benefits are paid according to Network provisions. While some locations do not have a managed care Network available, all or nearly all locations have multiple Networks of Providers available.

Non-Emergency Admission is a Hospital confinement, which is not due to a Life-Threatening Condition.

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

Occupational Injury is an injury that happens in the course of any work you perform for wage or profit.

Occupational Sickness is a sickness that entitles you to benefits under a workers' compensation or occupational disease law.

Other Plans are any of the following types of plans which provide health benefits or services for medical care or treatment: Group Medical or Dental plans, Government plans or No Fault coverage.

Preferred Provider, with respect to medical care, means a Doctor or Hospital with which UnitedHealthcare has contracted to participate in the Preferred Provider Program. Preferred Providers are listed in the Preferred Provider Directory.

Preferred Provider Directory is a list of Doctors and Hospitals who are located in your area, and with which UnitedHealthcare has contracted to be Preferred Providers and part of the Preferred Provider Program. This list will be periodically updated.

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

Proposed Plan of Alternate Medical Treatment is a treatment plan that UnitedHealthcare develops for you, which will then be reviewed to determine if it can be approved as the Specific Plan of Alternate Medical Treatment.

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

Severe Personal Injury or Sickness is an injury or sickness for which a large amount of covered medical expenses are expected to continue over a long period of time. These include, but are not limited to the following:

- Amputations.
- Multiple Sclerosis.
- Multiple Fractures.
- Neonatal High-Risk.
- Spinal Cord Injury.
- Severe Burns.
- Cerebral Vascular Accident.
- Amyotrophic Lateral Sclerosis.
- Major Head Trauma.
- Severe Stroke.
- Acquired Immune Deficiency Syndrome (AIDS).
- Cancer (Terminal).
- High-Risk Pregnancy.
- Psychiatric Disorders.

Specific Plan of Alternate Medical Treatment is a Proposed Plan of Alternate Medical Treatment approved by UnitedHealthcare as the suggested plan for your Severe Personal Injury or Sickness.

Substance Abuse Care is care provided by an eligible therapist or facility for the treatment of a substance abuse or chemical dependency illness or condition that United Behavioral Health has determined:

- Is a clinically significant behavioral or psychological syndrome or pattern;
- Is associated with a painful symptom;
- Substantially or materially impairs a person's ability to function in one or more major life activities; and
- Is recognized by the American Psychiatric Association as a substance abuse or chemical dependency illness or condition.

Transplant Management Program is UnitedHealthcare's program made available by the UnitedHealthcare to Retirees enrolled in the UHC HDHP PPO Program. The Transplant Management Program offers access to a network of transplant centers.

UBH Therapist is a licensed or certified psychiatrist, psychologist, psychiatric social worker, or other licensed mental health practitioner who has entered into an agreement with United Behavioral Health as an independent contractor to provide covered services for Mental Healthcare and/or Substance Abuse Care to covered Retirees and Dependents.

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

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

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

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

Urgent Care Center is a medical facility where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate, non-Emergency care.

BENEFIT PHONE NUMBERS

Union Pacific HR Service Center — 9:00 a.m. to 4:00 p.m. (CT)
Toll-Free ..... 1-877-275-8747, Option 1
Fax Number ..... (402) 233-2736
Mailing Address..... 1400 Douglas Street, Stop 0320, Omaha, NE 68179

UnitedHealthcare (UHC) HDHP PPO Program
- Web site..... *www.uhc.com*
- Member only Web site ..... *www.myuhc.com*
- Coverage questions, claim forms and claim questions..... (800) 331-4370
- Pre-admission review and second opinions..... (800) 331-4370

United Behavioral Health (for Retirees enrolled in the UHC HDHP PPO Program)
- Web site..... *www.liveandworkwell.com*
- Coverage questions, claim forms and claim questions..... (800) 888-2998
- Pre-certification of mental health/substance abuse care..... (800) 888-2998

UHPS/Medco Prescription Benefits (for Retirees enrolled in the UHC HDHP PPO Program)
- Member only Web site ..... *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

Cancer Resource Services (for Retirees less than age 65, or otherwise not Medicare-eligible, enrolled in the UHC HDHP PPO Program)
- Web site..... *www.urncrs.com*
- To enroll..... (866) 936-6002

Nurtur/Disease Management Program (for Retirees less than age 65, or otherwise not Medicare eligible, enrolled in the UHC HDHP PPO Program)
- Web site..... *www.mynurturhealth.com*
- To enroll..... (888) 252-7708
- Information on a variety of health conditions ..... (888) 252-7708

Optum Connect 24 (for Retirees less than age 65, or otherwise not Medicare eligible, enrolled in the UHC HDHP PPO Program)
- Member Only Web site ..... *www.myuhc.com*
- Questions about general healthcare needs..... (888) 243-6948

EyeMed Vision Care (for Retirees enrolled in the UHC HDHP PPO Program)
- Web site..... *www.eyemedvisioncare.com*
- Provider directory (click on **Member Access**, then **Provider Locator**) ..... *www.eyemedvisioncare.com*
- To locate a participating Provider ..... (866) 723-0513
- Questions about vision benefits..... (866) 723-0513

Extend Health (for Medicare Eligible Participants)
- Web site..... *www.extendhealth.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.