



Employee Assistance Program (EAP)  
For  
Nonagreement Employees of  
Union Pacific Corporation & Affiliates

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## **OVERVIEW**

Through a contract with United Behavioral Health (UBH), Union Pacific Corporation (the “Company”) offers the Union Pacific Corporation Employee Assistance Program (“EAP” or “Plan”), effective January 1, 2008 (“Effective Date”).

### **Eligibility:**

You are eligible to participate in the EAP if you are an Employee. For purposes of the EAP, the following definitions apply:

- An “Employee” means:
  1. An active, nonagreement person (other than any person classified as a co-op or intern) employed by Union Pacific Corporation or Union Pacific Railroad Company; or
  2. Any other classification of employees specified by any other Union Pacific affiliate that becomes a participating employer in the EAP.

The term “Employee” shall not include a person who is classified by Union Pacific Corporation, Union Pacific Railroad, or any other Union Pacific affiliate that becomes a participating employer in the EAP (“EAP Employer”) as an independent contractor or a person who is not treated by an EAP Employer as an employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding. If an individual is engaged in an independent contractor or similar capacity and is subsequently classified by an EAP Employer, a governmental body or the judiciary as an employee, such person, for purposes of the EAP, shall be deemed to be an employee from the actual (and not effective) date of such classification by an EAP Employer or the date as of which such classification by the governmental body or judiciary is final and not appealable.

- A “Dependent” means the Employee’s Spouse, if not legally separated from the Employee, or a Child.
- “Spouse” means the person to whom the Employee is married in accordance with the law of the jurisdiction in which the Employee 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 EAP, 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 Employee 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 Employee:
      - 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 Employee (or the Employee’s Spouse, if filing jointly) 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 Employee and his/her other parent,
      - 2) Is in the custody of the Employee 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 Employee’s home and if the Employee 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 Employee is required to cover the individual pursuant to a Qualified Medical Child Support Order (QMCSO).
- A “Disabled Child” means any 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 Employee 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. Employees will be required to provide evidence of "Full-Time Student" status, 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 a 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 Employee and each alternate recipient, describe the coverage to be provided, identify the period for which the coverage is to be provided, and specify the plan to which the QMCSO applies. Additional information may be obtained by calling the Union Pacific HR Service Center (toll free at 1-877-275-8747, Option 1, Monday through Friday from 9:00 AM to 4:00 PM Central Time, excluding holidays).

**Note: A "Calendar Year" is a twelve-month period beginning on January 1 and ending on December 31.**

The Plan Administrator may require written documentation to verify that individuals identified by the Employee as Dependents satisfy the Plan's definition of Dependent.

## **EFFECTIVE DATE OF COVERAGE**

If you are an Employee on the Effective Date, your EAP coverage is effective as of that date.

### **Newly Eligible during the Year:**

If you are not an Employee on the Effective Date, your EAP coverage is effective the date you become an Employee. As an Employee, EAP coverage is provided to you automatically, and regardless of the medical coverage option, if any, you elected under the Union Pacific Corporation Group Health Plan.

### **Dependent Coverage:**

Coverage for your Dependents under the EAP will begin at the same time your coverage is effective, assuming you have notified Union Pacific that the individual is your Dependent. Generally, this means those individuals you listed as your Dependents when enrolling in other Union Pacific sponsored benefit plans have coverage under the EAP. If you have a Dependent and you have not notified Union Pacific about such Dependent, EAP coverage will be provided for your Dependent as of the first day of the month following the date on which you notify the Union Pacific HR Service Center that the individual is a Dependent. There is no open enrollment period applicable for the Plan. However, if you notify the Union Pacific HR Service Center about your Dependents during the open enrollment period for the Union Pacific Flexible Benefits Program, EAP coverage will be provided for your Dependent as of the first day of the month following the date on which you notify the Union Pacific HR Service Center.

However, EAP coverage resulting from a birth, adoption, or placement for adoption of a Dependent Child will be effective as of the event date if the Union Pacific HR Service Center is notified within 31 days of the event date. If you notify the Union Pacific HR Service Center after the end of this 31 day period, coverage resulting from a birth, adoption, or placement for adoption of a Dependent Child will be effective as of the first day of the month following the date on which you provide notice to the Union Pacific HR Service Center.

The Plan is required to inform you of rights related to coverage under Medicaid and State Child Health Insurance Plans (SCHIP). Effective April 1, 2009, if you or your Dependent:

- Are covered under a Medicaid plan under Title XIX of the Social Security Act, or under a State Child Health Insurance Plan (SCHIP) under Title XXI of such Act, and your coverage under the Medicaid or SCHIP plan is terminated as a result of loss of eligibility for such coverage; or
- Become eligible for Medicaid or SCHIP plan assistance with respect to coverage under a Medical Care Program option,

Then you and your Dependent may be covered under the Plan. Your coverage will be effective the first day of the month following the date you provide notification of the event.

To notify the Union Pacific HR Service Center about your Dependents or confirm that you have previously notified Union Pacific about your Dependents, you can call the Union Pacific HR Service Center at 1-877- 275-8747, Option 1, or, in the event of a marriage, birth or adoption, you can use My Benefits located on the UP Employee Web site, Human Resources.

## **CHANGES IN EMPLOYMENT STATUS**

### **Termination or Transfer to an Ineligible Status:**

Coverage under the EAP will cease at the end of the month in which you terminate or become ineligible to continue participation. If you are rehired or return to eligible status, you will be automatically re-enrolled in the EAP. Your Dependents for which you have previously notified Union Pacific regarding their status as your Dependents will also be re-enrolled in coverage as long as they still satisfy the Plan's definition of Dependent.

### **Leaves of Absence:**

***Unpaid Leave of Absence:*** If you go on an unpaid leave of absence, your EAP coverage terminates at the end of the calendar month in which the unpaid leave begins unless such leave is (1) family and medical leave under the terms of a policy adopted by Union Pacific Corporation or a Union Pacific affiliate that is a participating employer in the EAP that complies with the Family and Medical Leave Act or a family military leave law enacted by the state in which you reside, (2) leave under the Uniformed Services Employment and Reemployment Rights Act of 1994, or (3) pursuant to the Unpaid Sabbatical Pilot Program for Nonagreement Employees. If you return from an unpaid leave you will be automatically re-enrolled in the EAP. Your Dependents for which you have notified Union Pacific regarding their status as your Dependents will also be re-enrolled in coverage.

***Unpaid Family and Medical Leave:*** If you go on family and medical leave under the terms of a policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating employer in the EAP) that complies with the terms of the Family and Medical Leave Act, your coverage under the EAP will continue for the duration of such leave.

***Unpaid Family Military Leave:*** If you go on an unpaid leave of absence under the terms of a policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating employer in the EAP) that complies with a family military leave law enacted by the state in which you reside, coverage under the EAP will continue for the duration of such leave.

***Unpaid Sabbatical Program and Unpaid Vacation:*** If you go on an unpaid sabbatical or take unpaid vacation under the terms of the Unpaid Sabbatical Program or Unpaid Vacation Policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating employer in the EAP), coverage under the EAP will continue for the duration of such leave or vacation.

***Unpaid Military Leave:*** If you go on an unpaid leave due to military service (not including Reservists and National Guard Members called to active duty during Operation Enduring Freedom, Operation Iraqi Freedom, or other military operations related to national security designated by Union Pacific) for less than 31 days, coverage under the EAP will continue for the duration of the military leave.

If you go on an unpaid leave due to military service (not including Reservists and National Guard Members called to active duty during Operation Enduring Freedom, Operation Iraqi Freedom, or other military operations related to national security designated by Union Pacific) for more than 30 days, you will be permitted to continue your EAP coverage on an after-tax basis. Upon being notified of your military leave, Union Pacific will notify the Plan Administrator of your military leave and you will be offered the right to continue this coverage. You will have the right to elect to continue this coverage on behalf of you, your Spouse and other Dependents, if any. You must make your election no more than 60 days after receiving the Plan Administrator's notice of the right to continue such coverage.

Your right to continue this coverage is temporary. You may continue this coverage until the earlier of: (1) 24 months following the date on which your leave began; or (2) the date you fail to return to work or apply for re-employment within the time period prescribed by USERRA. Your coverage may be cut short if Union Pacific no longer provides group health coverage for any of its employees or the premium for your coverage is not paid within 30 days of the date due. You will be charged 102% of the full premium cost for coverage. The 102% of full premium cost will be effective on the first day of the month following the start of your military leave. You will be notified as to the amount of your required premium when you receive the notice of your right to continue coverage. The required premium may be adjusted each plan year to reflect actual and anticipated claims experience; thus, your required contribution may change during the continuation period. There is a grace period of 30 days for payment of the regularly scheduled premium. If you discontinue your coverage during military leave and you return from your military leave, you will be automatically re-enrolled in the EAP. Your Dependents for which you have notified Union Pacific regarding their status as your Dependents will also be enrolled in coverage.

Employees who are Reservists and National Guard Members and who are called to active duty during Operation Enduring Freedom, Operation Iraqi Freedom, or other military operations related to national security designated by Union Pacific should refer to the Nonagreement Benefits Policy for Reservists and National Guard Members Called to Active Duty, a copy of which may be found on the HR/Benefits page via the UP Employees Web site ([www.up.com](http://www.up.com)), for rules governing EAP coverage while on leave of absence.

***Absence Due To Disability:*** If you receive short-term disability benefits under the Union Pacific Short-Term and Long-Term Disability Plan, coverage under the EAP will continue for the duration of the short-term disability. If you receive long-term disability benefits under the Union Pacific Short-Term and Long-Term Disability Plan, coverage under the EAP will cease at the end of the month in which you begin receiving long-term disability benefits.

## **WHEN BENEFITS END**

EAP benefits for you and/or your Dependents will, unless otherwise stated, end as of the last day of the month in which:

- You terminate employment;
- You cease to be an eligible Employee;
- Your Dependent no longer meets the definition of an eligible Dependent; or
- This Plan ends.

Coverage under the EAP by Full-Time Students, 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 attending an accredited educational institution on a full-time basis in accordance with the institution's policies;
- The date such 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.\*

Effective January 1, 2010, 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.

\* In order for 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 Employee must provide notification to the Union Pacific HR Service Center within 31 days of the end of the 6-month period following such student losing Full-Time Student status.

\*\* 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 Employee’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.

**COBRA Continuation Coverage:**

If you, your Spouse, or other Dependents lose EAP coverage due to loss of eligibility, you and your Dependents may have rights to continue such coverage under COBRA. These rights are explained beginning on page 7 of this document.

**NETWORK INFORMATION**

The EAP is offered through a network of providers (“Network Providers”) maintained by UBH. UBH is solely responsible for the selection, credentialing, and monitoring of their providers. However, UBH does not assure the quality of the services provided. All providers selected by UBH are independent contractors.

Union Pacific and its participating subsidiaries do not guarantee the quality of care provided by providers in the UBH Network. Network Providers contracted with UBH to provide Covered Services under the EAP and EAP benefits are based on contracted rates. You will not be responsible for the difference, if any, between the amount that your Network Provider bills for Covered Services and the contracted rates.

**EAP BENEFITS**

The EAP offers outpatient mental health/substance abuse treatment services. The following table provides an overview of the EAP benefits. Certain limitations and exclusions apply. It is important that you refer to the provisions that follow for details about your benefits.

OUTPATIENT MENTAL HEALTH/SUBSTANCE ABUSE MAXIMUM	
Network	Non-Network
5 Counseling Visits per issue per Calendar Year* - EAP pays 100%	The EAP pays no benefits if a non-network provider is used.
* A “Calendar Year” is a twelve-month period beginning on January 1 and ending on December 31.	

The EAP offers the following Covered Services:

- Assessment, consultation and problem solving.
- Risk screening and crisis intervention.
- Advocacy to help you address your situation.
- Referral to a licensed network practitioner for up to five (5) individual and/or family coaching / counseling sessions (“Counseling Visits”) per Employee and/or covered Dependent per Calendar Year per issue (based on clinical necessity).
- Referral to community resources.
- Service planning to determine the type of service and counselor, and amount of visits needed for the Employee and covered Dependent.
- Educational materials specific to the Employee’s and/or covered Dependent’s issue.

The EAP only pays benefits for Covered Services provided:

- For mental health and substance abuse (MHSA) treatment;
- While the Employee and/or covered Dependent who receives the services is covered under this Plan; and
- By a Network Provider.

**EAP benefits are not automatically paid simply because mental health or substance abuse treatment services were prescribed by a provider. You must contact the EAP and obtain a referral to a Network Provider before receiving Covered Services. For more information regarding this referral process, see the section “How to Use Your Benefits” below.**

If you or your Dependent need mental health or substance abuse treatment that is not (or is no longer) a Covered Service under the EAP, you may wish to check whether any other medical coverage in which you and your Dependent are enrolled provides benefits for such treatment.

## **HOW TO USE YOUR BENEFITS**

You must call the EAP’s toll-free number 1-800-779-1212 before receiving mental health/substance abuse treatment in order to receive EAP benefits. Pioneer Behavioral Health (“Pioneer”) provides incoming call services on behalf of the EAP. Pioneer will transfer your call to a UBH clinician who will discuss your issue or concern with you and determine whether your mental health substance abuse issue is eligible for Counseling Visits under the Plan. If so, the UBH clinician will give you a list of Network Providers who work in areas related to your issue from which to choose. These services are available 24 hours-a-day, seven days-a-week.

**Note:** If, because of Department of Transportation requirements for job performance and safety you are required to receive mental health and/or substance abuse treatment before returning to work, such treatment may be a Covered Service under the EAP. You should contact the EAP’s toll-free number above for more details.

In addition to the other EAP benefits, there are educational materials that you can use without calling the toll-free number by accessing UBH’s web site at [www.liveandworkwell.com](http://www.liveandworkwell.com).

## **CHANGES TO NETWORK PROVIDERS**

The rapport between you and your Network Provider is an important relationship. With your initial authorization, you will receive a choice of three providers in your area to choose from to begin Counseling Visits under the EAP, if applicable. For any reason, if after the initial Counseling Visit you wish to select another Network Provider, you may call the EAP and ask for a referral to another Network Provider. You may select only one Network Provider referral at a time, but you can change more than once.

## **NOT COVERED - EXCLUSIONS**

The services, treatments, items, or supplies listed in this section are not Covered Medical Services. The following services and treatments are not Covered Services, regardless of whether the service or treatment described in this section is recommended or prescribed by your provider and/or the only available service or treatment option for your condition. In addition, the EAP does not cover any type of tangible supplies, equipment, devices or products (including, but not limited to prescription or over the counter drugs and treatments) even if such items are prescribed by your provider or are otherwise used as part of or in conjunction with Covered Services you receive.

The Plan does not cover services or treatments relating to, arising out of, or given in connection with the following:

- Treatment for mental health or substance abuse that, in the reasonable judgment of UBH are any of the following:
  - Not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - Not consistent with prevailing professional research demonstrating that the service or supplies will have a successful outcome.

- Treatment, except for the initial diagnoses, for a primary diagnoses of the following types of conditions as indicated by the following International Classification of Diseases (ICD) code(s): Mental Retardation (317, 318, 319), Learning, Motor Skills, and Communication Disorders (315), Pervasive Developmental Disorder (299), Conduct Disorder (312), Dementia (290, 294), Sexual, Paraphilia, and Gender Identity Disorders (302), and Personality Disorders (301), as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by UBH.
- Services that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service is the only available service for a particular condition will not result in it being a Covered Service if the service is considered to be unproven, investigational, or experimental.
- Neuropsychological testing when used for the diagnosis of attention deficit disorder.
- Homeopathic care, including forms of alternative treatment as defined by the Office of Alternative Medicine of National Institutes of Health.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision).
- Services rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure.
- Smoking cessation-related services.
- Detoxification services.
- 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 that the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as you.
- Services received prior to your being eligible for coverage under the Plan or after the date your coverage under the Plan ends.

## **CONTINUATION OF COVERAGE UNDER COBRA**

### **Introduction:**

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Union Pacific HR Service Center at 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 document. 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 a Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

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

- Your Spouse dies;

- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or Part D); or
- You become divorced or legally separated from your Spouse.

Your children who are Dependents will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or Part D);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

### **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 end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or Part D), the employer must notify the Plan Administrator of the qualifying event.

### **You Must Give Notice of Some Qualifying Events:**

For the other qualifying events (divorce or legal separation of the Employee and Spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days of the date on which coverage would end under the 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, Social Security number, a description of the qualifying event, the date the qualifying event occurred, and the names of the individual(s) losing coverage as a result of the qualifying event. The Employee, Spouse or Dependent, or any person representing any of these individuals can provide this notification. Notification by the Employee, 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 Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or Part D), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

***Disability Extension of 18-Month Period of Continuation Coverage:*** If you or anyone in your family covered under a Plan is determined by the Social Security Administration/Railroad Retirement Board to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. Notice must be made in writing and addressed as follows: Attn: Adjustments Department, ADP Benefit Services, P.O. Box 2998, Alpharetta, GA 30023-2998. The notice can also be faxed to 1-770-619-7160. The notice must be provided before the end of the 18-month

period of continuation coverage and no later than 60 days after the latest of the following dates: (1) the date of the Social Security Administration/Railroad Retirement Board determination of the disability; (2) the date on which the qualifying event occurs that gives rise to your right to elect COBRA; or (3) the date on which coverage is lost as a result of the qualifying event. The notice must contain your name, account or Social Security number, and include a copy of the Social Security Administration/Railroad Retirement Board determination. The Employee, Spouse or Dependent, or any person representing any of these individuals can provide this notice. Notification by the Employee, Spouse, or Dependent (or their representative) will satisfy this notice requirement with respect to all individuals who may extend continuation coverage because of this disability determination. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. During the additional 11 months of continuation coverage, the premium for that coverage will be approximately 50% higher than it was during the preceding 18 months.

The affected individual receiving extended continuation coverage because of a disability determination must also notify the Plan Administrator within 30 days of any final determination by the Social Security Administration/Railroad Retirement Board that the individual is no longer disabled. Notice must be made in writing and addressed as follows: Attn: Adjustments Department, ADP Benefit Services, P.O. Box 2998, Alpharetta, GA, 30023-2998. The notice can also be faxed to 1-770-619-7160. The notice must contain your name, account or Social Security number, and include a copy of the Social Security/Railroad Retirement determination. The Employee, Spouse or Dependent, or any person representing any of these individuals can provide this notice. Notification by the Employee, Spouse, or Dependent (or their representative) will satisfy this notice requirement with respect to all individuals who may lose continuation coverage because of the determination that the individual is no longer disabled.

***Second Qualifying Event Extension of 18-Month Period of Continuation Coverage:*** If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or Part D), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. If you experience an event that permits you to extend continuation coverage, you must provide the Plan Administrator with written notice of the event. The notice must be sent within 60 days from the date continuation coverage would end under the Plan because of such other event and must be addressed as follows: Attn: Adjustments Department, ADP Benefit Services, P.O. Box 2998, Alpharetta, GA, 30023-2998. The notice can also be faxed to (770) 619-7160. The Employee, Spouse or Dependent, or any person representing any of these individuals can provide this notice. Notification by the Employee, Spouse, or Dependent (or their representative) will satisfy this notice requirement with respect to all individuals who may extend continuation coverage because of the event. The notice must contain your name, account or Social Security number, and a description of the event, along with the following documentation, depending on the event:

- **Loss of Dependent Status** – If the individual no longer satisfies the Plan’s definition of Dependent because the individual marries, you must provide a copy of the marriage certificate. If the loss of Dependent status is for any other reason, you must indicate the reason in writing.
- **Divorce or Legal Separation** – A copy of the Divorce Degree or Legal Separation document.
- **Employee’s Medicare Entitlement** – A copy of the Employee’s Medicare card.
- **Death** – A copy of the death certificate.

#### **Premium for COBRA Continuation Coverage:**

You will be notified as to the amount of your required premium when you receive the notice of your right to continue coverage. The required premium may be 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 at least 30 days for payment of the regularly scheduled premium. At the end of the 18-month or 3-year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under a group health plan, if any.

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 Health Care 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 [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).

The American Recovery and Reinvestment Act, as amended, (“ARRA”) gives “Assistance Eligible Individuals” the right to pay reduced COBRA premiums for periods of coverage beginning on and after March 1, 2009, and can last up to 15 months.

To be considered an “Assistance Eligible Individual” and get reduced premiums you:

- Must have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at any time from September 1, 2008, through February 28, 2010;
- Must elect the continuation coverage;
- Must not be eligible for Medicare; and
- Must not be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer. This requirement does not apply if the other group health plan coverage for which you are eligible is limited to only dental, vision, counseling or referral services, or coverage under a health flexible spending account or coverage that is limited to treatment provided at an employer maintained on-site medical facility.

If you experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008, through February 16, 2009, and were offered, but did not elect, continuation coverage or elected continuation coverage and subsequently discontinued it, you may have an additional opportunity to elect continuation coverage. You must make this election no more than 60 days after the date the Plan Administrator furnishes you with a notice of this additional continuation coverage election right. Note that electing COBRA continuation coverage pursuant to this additional election right does not extend the period for which you are eligible for COBRA continuation coverage. For more information regarding the duration of COBRA coverage and when COBRA coverage may be terminated, see “How is COBRA Coverage Provided?” and “Termination of Continuation Coverage.”

You should be aware of the following regarding payment of reduced COBRA continuation coverage premiums:

- If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you must notify the Plan in writing. If you do not, you may be subject to a tax penalty.
- Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for such credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return), all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS Web site at [www.irs.gov](http://www.irs.gov).

For more information regarding the ARRA premium reduction or to notify the Plan of your ineligibility to continue paying reduced premiums, contact ADP COBRA Services at 1-800-526-2720.

If you are denied treatment as an “Assistance Eligible Individual,” you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA premium reduction, go to [www.dol.gov/COBRA](http://www.dol.gov/COBRA) or call 1-866-444-EBSA (1-866-444-3272).

### **Termination of Continuation Coverage:**

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

- The employer no longer provides group health coverage for any of its employees;
- The premium for your continuation coverage is not paid within 30 days of the date due;
- 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;
- You become entitled to Medicare benefits; or
- You have the special extended disability continuation coverage and are determined to be no longer disabled by the Social Security Administration or by the Railroad Retirement Board.

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

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

**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 or visit the EBSA Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or contact EBSA at 866-444-3272. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s 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, 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 the Plan (see Page 2 of the “Effective Date of Coverage” section for more information).

**COBRA, USERRA and HIPAA Administration:**

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

If you have any questions about your current COBRA or USERRA continuation coverage, please contact ADP COBRA Services at 1-800-526-2720. If you have additional benefits 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 Spouse have changed addresses while receiving continuation of benefits under COBRA or USERRA, you should notify ADP COBRA Services.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** Union Pacific has retained UBH to provide certain HIPAA services. In this capacity, UBH handles notifications and record keeping services. You may request a certificate of creditable coverage at any time while you are covered under the Plan and up to 24 months after such coverage ceases. To request a certificate of creditable coverage, please contact UBH at the following address:

United Behavioral Health  
425 Market Street  
San Francisco, CA 94105

If you have any questions about HIPAA or additional benefits questions, please contact the Union Pacific HR Service Center at 1-877-275-8747, Option 1.

## **CLAIMS INFORMATION**

You do not need to file claims for EAP Network Provider services. Network Providers will automatically record your Counseling Visit with the Plan. If you disagree with a determination regarding your request for benefits under the EAP, you may file an appeal as described below.

## **QUESTIONS OR CONCERNS ABOUT BENEFIT DETERMINATIONS**

If you have a question or concern about a benefit determination, you may informally contact UBH. If you are not satisfied with a benefit determination, you may appeal it as described below.

If you are appealing an urgent claim denial, please refer to the “Urgent Claim Appeals that Require Immediate Action” section below and contact UBH’s Appeals Unit immediately.

### **How to Appeal a Benefit Decision:**

If you disagree with a benefit determination, you can contact UBH in writing to formally request an appeal. If the appeal relates to a claim for payment, the request should include:

- The patient’s name and the identification number.
- The date(s) of service(s).
- The provider’s name.
- The reason the Covered Person believes the benefit should be allowed.
- Any documentation or other written information to support the request for benefit consideration.
- Your first level appeal request must be submitted to UBH within 180 days after the date of the benefit denial at the following address:

Grievance Coordinator  
United Behavioral Health  
425 Market Street, 15<sup>th</sup> Floor  
San Francisco, CA 94105  
(800) 888-2998

### **Appeal Process:**

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. Upon request and free of charge, you have the right to reasonable access to the copies of all documents, records, and other information relevant to your benefit determination.

***First Level Pre-service and Post-service Claim Appeals:*** You will be provided written or electronic notification of the decision on the appeal as follows. For appeals of pre-service requests for benefits identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of your request for appeal.

For appeals of post-service benefit determinations, as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of your request for appeal. For procedures associated with urgent claims, see “Urgent Claim Appeals that Require Immediate Action” below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal, see “Second Level Pre-Service and Post-Service Benefit Appeals” below.

Please note that the UBH decision is based only on whether or not EAP benefits are available for the proposed service.

***Second Level Pre-service and Post-service Benefit Appeals:*** If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. The second level appeal request must be submitted to UBH within 60 days from receipt of the first level appeal decision.

For appeals or pre-service request for benefits, the second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service benefit determinations, the second level appeal will be conducted and you will notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Union Pacific has delegated to UBH the exclusive and discretionary authority to interpret and administer the provisions of the EAP Plan. The UBH appeal decision is final and binding.

***Urgent Benefit Appeals that Require Immediate Action:*** An appeal may require immediate action if a delay in service could significantly increase the risk to your health, or the ability to regain maximum function. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your physician should call UBH as soon as possible at (800) 888-2998.
- UBH will provide you with a written or electronic determination within 72 hours following receipt of the request for review of the determination, taking into account the seriousness of your condition.

## **COORDINATION OF BENEFITS**

The EAP does not coordinate benefits with those of any other health plan.

## **ERISA INFORMATION**

This document describes your benefits under the EAP. It includes information about who is covered, the kinds of benefits provided, limitations or restrictions you should know about, and how to claim benefits. The EAP 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 EAP and ERISA.

### **Summary Plan Description:**

ERISA requires that you receive easily understood descriptions of your benefits, called summary plan descriptions. The information contained in this document constitutes the summary plan description for the EAP 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 employees 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 EAP is the Union Pacific Corporation Senior Vice President-Human Resources. The Plan Administrator administers the EAP 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  
1400 Douglas Street, 19<sup>th</sup> 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 the Plan and the Employees and Dependents who are covered by the Plan. Feel free to contact the Union Pacific HR Service Center with any questions. In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries, including UBH, 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 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 was arbitrary and capricious.

### **Your ERISA Rights:**

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

- You may examine free of charge all official documents related to the EAP. These include a copy of the insurance contract and latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. You can examine copies of these documents in the Human Resources Department in Omaha or at your Company Headquarters if copies are kept there.
- Copies of the documents governing the operation of the Plan, including the insurance contracts, 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 EAP's financial report.
- You may continue coverage for you and your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- You should be provided a certificate of creditable coverage, free of charge, from the EAP when you lose coverage under the 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 it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the EAP, 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 EAP 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 for more information.

If it should happen that fiduciaries misuse the EAP's money, if any, 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 Union Pacific HR Service Center at 1-877-275-8747, Option 1. 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 Regional or District Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, on EBSA's web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or contact EBSA at 1-866-444-3272 or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington,

D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

### **Serving Legal Process:**

If you or your beneficiary choose to take legal action against the EAP over terms of the EAP, legal process should be served on:

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

### **FUTURE OF THE EAP**

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

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

In carrying out their respective responsibilities under the EAP, the Plan Administrator and other Plan fiduciaries including UBH shall have discretionary authority to ascertain facts, to interpret the terms of the EAP, and to determine entitlements to benefits in accordance with the terms of the EAP. 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 EAP for the operation and administration of the EAP 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 Plan is a group health plan, which is a type of welfare plan. The name of the Plan is the Union Pacific Corporation Employee Assistance Program.

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.

The plan number for the EAP is 557. The plan year, that is, the twelve-month period for which the Company maintains financial records for the EAP, is January 1 – December 31. United Behavioral Health, 425 Market Street, San Francisco, CA 94105, administers the EAP. The Company has contracted with UBH to provide services to participants and their covered Dependents in accordance with the terms of the Plan in exchange for contributions made by the Company. The amount of the Company's contributions is determined based on the number of Employees. UBH is responsible for the financing and payment of the valid claims of the EAP and for the provision of benefits.

### **HIPAA INFORMATION**

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 apply to the EAP. The privacy

rules restrict the disclosure of Protected Health Information to the Company and its affiliated companies. The Company may use or disclose Protected Health Information it receives from the EAP only as provided in this Health Insurance Portability and Accountability Act of 1996 Section.

**Entity Responsible for HIPAA Compliance:**

UBH is responsible for complying with HIPAA’s privacy rules with respect to the Protected Health Information it creates, maintains, or receives. For more information about its obligations and your rights under the HIPAA privacy rules, you may contact UBH at the following address to request a copy of its Privacy Notice.

United Behavioral Health  
425 Market Street  
San Francisco, CA 94105

**Permitted Uses and Disclosure of Summary Health Information:**

The Plan, or a health insurance issuer with respect to 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, or a health insurance issuer with respect to the Plan, may disclose Plan enrollment and disenrollment information 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.