SUMMARY PLAN DESCRIPTION

FOR

BURLINGTON NORTHERN SANTA FE GROUP BENEFITS PLAN

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BNSF MEDICARE-ELIGIBLE RETIREE MEDICAL PROGRAM

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INTRODUCTION

Burlington Northern Santa Fe, LLC (the "Sponsor") has established a Health Reimbursement Arrangement (this Program, or the "Plan") under the Burlington Northern Santa Fe Group Benefits Plan for the benefit of its retirees and the retirees of its participating affiliates. (The Sponsor and participating affiliates are collectively referred to herein as the "Employer.") The purpose of the Plan is to reimburse eligible retirees for certain medical expenses which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

The material provisions of the Plan as of the Effective Date are summarized below, but this summary plan description ("SPD") is qualified in its entirety by reference to the full text of the formal plan document, a copy of which is available for inspection at the Sponsor's offices. In the event of any conflict between the terms of this SPD and the terms of the plan document, the terms of the plan document will control. Participants seeking to obtain additional information about the Plan should contact the Sponsor.

Note that capitalized terms used in this SPD are defined the first time they are used. Please note that "you," "your" and "my" when used in this SPD refer to you, the retiree.

PART I
GENERAL INFORMATION ABOUT THE PLAN

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to reimburse Participants (as defined in Q-2, Q-3 and Q-4) for Eligible Medical Expenses (as defined in Q-6) which are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Medical Expenses paid by the Plan generally are excludable from the Participant's taxable income.

Q-2. Who can participate in the Plan?

You are eligible to participate in the Plan (an "Eligible Retiree") if you are eligible for Medicare and you satisfy one of the following two requirements:

- You were a regularly assigned, salaried employee of Santa Fe Pacific Corporation or its participating affiliates on or before September 22, 1995 and you continuously remained a salaried employee of Santa Fe Pacific Corporation, its successor or affiliates until your retirement date; or
- Your retirement date was after June 1, 1994 and you had ten or more years of service with Santa Fe Pacific Corporation, its successor or affiliates after reaching age 45;

and you satisfy the following requirements:

- If you were not eligible for Medicare when you retired, you elected and maintained your coverage under the BNSF Medical Program for Pre-Medicare Retirees until you became eligible for Medicare;

- You were a U.S. resident at the time of your retirement and continue to be a U.S. resident; and

- One of the following two statements are true:

    - You began receiving your benefit under the BNSF Retirement Plan immediately after you left active employment with the Employer; or

    - You were employed by IBM or an IBM affiliate after your termination of employment with the Employer, your employment was terminated other than for cause as a result of the Comprehensive Outsourcing Agreement between BNSF and IBM, such termination happened after you reached age 40, and you signed a release prepared by the Employer.

Eligible Retirees and Eligible Dependent spouses (as defined in Q-3) who become covered under the Plan, as explained in Q-4, are called "Participants."

Retirees who entered salaried employment with BNSF as a result of a transfer, initial hire or rehire after September 22, 1995, are not eligible for benefits under this Program. Note that certain self-employed persons, leased employees, and independent contractors may not participate in the Plan. In addition, you are not eligible to participate in the Plan unless you are classified by the Employer as a former employee who satisfies the eligibility requirements, even if you are later determined by a court or governmental agency to be or to have been a former common law employee of the Employer. Retirees who were covered under a collective bargaining agreement are not eligible to participate in the Plan unless the terms of the collective bargaining agreement specifically include Plan participation.

Q-3. Can my dependents participate in the Plan?

You may seek reimbursement from your HRA Account (as defined in Q-5, below) for the Eligible Medical Expenses incurred by all of your Eligible Dependents. However, only your Eligible Dependent spouse may be a Participant in the Plan. You should keep the Plan Administrator apprised of any changes in family status by calling the BNSF Benefits Center at 877-451-2363. Your Eligible Dependents include:

- **Your Spouse.** You may cover that person who, at the time you commence benefits under this Plan or under the BNSF Medical Program for Pre-Medicare Retirees, is your legal spouse of the opposite sex and who is eligible for Medicare. You may not cover a spouse you marry after commencement of benefits or cover an ex-spouse from whom you are legally separated or divorced.

- **Your Children.** You may cover your child who is eligible for Medicare and is under age 26 (or the age set by law in your state for the HMO Program for Medicare-Eligible Retirees). This includes your natural child, adopted child, stepchild, foster child, or a child for whom you and/or your spouse has legal custody.

- **Your Grandchildren and Other Children.** You may cover your grandchild (or other child related by blood or marriage) who is eligible for Medicare and is:

    - Under age 19 (or under age 23 if a full-time student);

- Unmarried;
- Living with you (unless a full-time student); and
- Eligible to be claimed as a dependent on your federal income tax return.

- **Your Disabled Child**. You may cover your child who is eligible for Medicare and is incapable of self-support due to a physical or mental disability, so long as the child became disabled before reaching a program's maximum age. To be eligible for continued coverage, the child must be unmarried, incapable of self-sustaining employment, and must not provide more than one-half of his or her own financial support. To continue coverage for a disabled child, *you must call* the BNSF Benefits Center at 877-451-2363 with proof of the disability *within 60 days* of the child reaching the applicable age limit.

- **A Child Covered by Child Support.** You may cover a child who is eligible for Medicare and who is the subject of a Qualified Medical Child Support Order (a "QMSCO") issued under the Employee Retirement Income Security Act of 1974 ("ERISA") Section 609, as determined by the Plan Administrator, or another court order or decree, such as a divorce decree. You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting the Plan Administrator at the address listed in the Plan Information Appendix.

Note that if both you and your spouse are retired salaried employees of BNSF, you cannot both take coverage for your otherwise eligible spouse and/or children under the Plan.

The following dependents (whether your spouse or children) are not eligible for coverage under the Plan:

- A person who is serving on active duty in the military;
- A person who lives outside of the U.S. or Canada (unless he or she is enrolled as a full-time student in an accredited foreign school and has a permanent address in the U.S. or Canada);
- A child who is a regularly assigned employee of the Employer; and
- A child who has reached a program's age limit or otherwise does not meet eligibility requirements.

To be considered a full-time student, your child must be registered as a full-time student at an accredited high school, college, university, trade school, professional school, school in a foreign country or remedial education facility. The Plan Administrator may require proof that a child is registered as a full-time student. If a child older than age 18 whose eligibility depends on being a full-time student at a post-secondary educational institution takes a medically necessary leave of absence from the educational institution while suffering from a serious illness or injury, his or her coverage will continue at least until one year after the earlier of: one year after the start of the medically necessary leave of absence, or the date on which coverage would otherwise end due to eligibility requirements. For the child to be eligible for continued coverage due to a medically necessary leave of absence, you must contact the BNSF Benefits Center at 877-451-2363. You may be required to submit a written certification from the child's treating physician.

You may be required to provide proof of dependent status upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay in benefits provided under the Plan.

Q-4. When do I actually become a Participant in the Plan?

An Eligible Retiree or an Eligible Dependent spouse actually becomes a Participant in the Plan on the later of January 1, 2013 or the date that he or she has satisfied all of the following requirements:

- He or she has become eligible for Medicare;
- He or she has obtained an individual medical insurance policy through Extend Health, Inc. (or any of its affiliates), or he or she has provided satisfactory evidence to the Plan Administrator that he or she has other coverage permissible to the Plan Administrator (for example, his or her spouse's employer-provided benefits); and
- He or she has completed any enrollment forms or procedures required by the Plan Administrator.

If you were eligible to enroll prior to December 31, 2012 but did not make an election by December 31, 2012 to enroll or defer enrollment, you permanently forfeited your Employer-provided medical benefits. In addition, if you do not enroll in retiree medical coverage with the Employer when you are first eligible, and you do not have other employer group medical plan coverage available, you forfeit eligibility to enroll in retiree medical coverage permanently and cannot enroll at a later date.

Q-5. How does the Plan work?

One Health Reimbursement Arrangement account (an "HRA Account") will be established for an Eligible Retiree and his or her Eligible Dependents. For 2013, the Employer will credit to the HRA Account $2,500.00 for an Eligible Retiree Participant and $2,500.00 for an Eligible Dependent spouse who is a Participant in the Plan, prorated for the number of months of participation in the year. (The Employer will not make any credits to an HRA Account for any other Eligible Dependents.) For each future year, the Employer will determine the level of HRA funding on an annual basis. These credits are your "Benefit Credits."

Benefit Credits will be credited to HRA Accounts by the Employer on or around January 1, which is the first day of the Plan Year. If you have an existing HRA account under the Employer's medical plan for active employees and pre-Medicare retirees, any remaining balance will be rolled into your new HRA Account. Note that the law does not permit Participants to make any contributions to their HRA Accounts.

The amount of Benefit Credits in an HRA Account will be reduced from time to time by the amount of any Eligible Medical Expenses for which the Participant is reimbursed under the Plan. At any time, the Participant may receive reimbursement for Eligible Medical Expenses up to the amount in his or her HRA Account. For your convenience, you can set up direct deposit from your HRA to your bank account in order to receive reimbursements as quickly as possible.

An HRA Account is merely a bookkeeping account on the Employer's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Employer's general assets.

Q-6. What is an "Eligible Medical Expense"?

An Eligible Medical Expense is an expense incurred by you or any Eligible Dependent for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease).

Some common examples of Eligible Medical Expenses include:

- Medications (in reasonable quantities);
  NOTE: Effective for expenses incurred in Plan Years beginning after December 31, 2010, medications are considered Eligible Medical Expenses only if they are prescribed by a doctor (without regard to whether the medication is available without a prescription) or is insulin.
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Birth control pills;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Premiums for medical, prescription drug, dental, vision or long-term care insurance.

Some examples of common items that are not Eligible Medical Expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items are and are not Eligible Medical Expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible." (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement account.) If you need more information regarding whether an expense is an Eligible Medical

Expense under the Plan, contact the Third Party Administrator as provided in the Plan Information Appendix.

Only Eligible Medical Expenses incurred while you and/or your Eligible Dependent spouse are Participant(s) in the Plan may be reimbursed from your HRA Account. (Note that, even though your other Eligible Dependents may not be Participants in the Plan and will not receive Benefit Credits from the Employer, you are entitled to obtain reimbursement from your HRA Account for Eligible Medical Expenses incurred by or on behalf of your Eligible Dependents.) Eligible Medical Expenses are "incurred" when the medical care is provided, not when you or your Eligible Dependent are billed, charged or pay for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA Account:

- expenses incurred for qualified long-term care services;
- expenses incurred *prior to the date* that you became a Participant in the HRA;
- expenses incurred *after the date* that you cease to be a Participant in the HRA; and
- expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

Q-7. When do I cease participation in the Plan?

If you are an Eligible Retiree, you will cease being a Participant in the Plan on the earlier of:

- the date you cease to be an Eligible Retiree for any reason;
- the date you are rehired by the Employer as an active employee;
- the date you cease to be eligible for Medicare;
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

If you are an Eligible Dependent spouse, you will cease being a Participant in the Plan on the earlier of:

- the date you cease to be an Eligible Dependent for any reason;
- the date you cease to be eligible for Medicare;
- the date you divorce the Eligible Retiree;
- the date of your death;
- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date your eligibility ceases. (For the definition of "incurred," see Q-6.) You have 180 days after your eligibility ceases, however, to request reimbursement of Eligible Medical Expenses you incurred before your eligibility ceased.

If an Eligible Dependent child ceases to be eligible only because he or she becomes ineligible for Medicare, the child may be covered under the BNSF Medical Program for Pre-Medicare Retirees. In addition, your Eligible Dependents may be eligible to continue coverage under the Plan beyond the date that their coverage would otherwise end if coverage is lost for certain reasons. Their continuation of coverage rights and responsibilities are described in Q-16 below.

Q-8. What happens if I do not use all of the credits allocated to my HRA Account during the Plan Year?

If you do not use all of the amounts credited to your HRA Account during a Plan Year, any remaining amounts will be carried over to subsequent Plan Years.

Q-9. How do I receive reimbursement under the Plan?

You must complete a reimbursement form and mail or fax it to the Claims Submission Agent (PayFlex) as provided in the Plan Information Appendix, along with a copy of your insurance premium bill, an "explanation of benefits" (an "EOB"), or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form from the Third Party Administrator identified in the Plan Information Appendix. Your claim is deemed filed when it is received by the Claims Submission Agent. (Do not mail your form to the Third Party Administrator as this may result in a delay in processing.)

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

Q-10. What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement that you may bring a civil action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or

other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent, you may file a written appeal. Upon request and free of charge, you shall be provided all documents and other information relevant to your claim. You should file your appeal with the Plan Administrator at the address provided in the Plan Information Appendix no later than 180 days after receipt of the denial notice. You will lose the right to appeal if the appeal is not timely made. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim. The Plan Administrator shall consider the merits of your presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

Q-11 What happens if I die?

If the Eligible Retiree dies with no Eligible Dependent spouse who is a Participant in the Plan, his or her HRA Account is immediately forfeited upon death, but the deceased Eligible Retiree's estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her Eligible Dependents before his or her death. Claims must be submitted within 180 days of his or her death.

If the Eligible Retiree dies with an Eligible Dependent spouse who is a Participant, his or her HRA Account shall continue and the Eligible Dependent spouse who is a Participant can continue to submit Eligible Medical Expenses for reimbursement.

Q-12. Are my benefits taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Q-13. What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my HRA Account?

If it is later determined that you or your Eligible Dependent received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your Eligible Dependent will be required to refund the overpayment or erroneous reimbursement to the Employer.

If you do not refund the overpayment or erroneous payment, the Employer reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Employer. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Q-14. How long will the Plan remain in effect?

Although the Sponsor expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, the amount credited to HRA Accounts or to reduce or eliminate any amounts currently credited to a Participant's HRA Account.

Employers participating in the Plan other than the Sponsor (such as a related affiliate of the Sponsor) may terminate their participation in the Plan at any time upon 60 days written notice to the Sponsor and Plan Administrator.

Q-15. How does the Plan interact with other medical plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses, as described in Q-6, have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to this Plan for reimbursement.

Q-16. What is "continuation coverage" and how does it work?

Under a federal law called "COBRA," Eligible Dependents under the Plan who are the spouse, former spouse or dependent child of a Participant may elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Participant, or a dependent child ceasing to be an Eligible Dependent. These are called "qualifying events."

Note that the Eligible Dependents are required to notify the Plan Administrator in writing of a divorce or legal separation or a dependent child losing dependent status within 60 days of the event or they will lose the right to continue coverage under the Plan.

If an Eligible Dependent elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event. He or she may also be entitled to an increase in his or her HRA Account equal to the amounts credited to the HRA Accounts of similarly situated Participants (subject to any restrictions applicable to similarly situated Participants) so long as he or she continues to pay the applicable premium.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's HRA Account is exhausted;
- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- Any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The Employer ceases to provide any group health plan.

Q-17. What is alternative coverage?

The Sponsor may make available to a qualified beneficiary (as defined in Q-16 above) coverage in lieu of the continued coverage described in Q-16 above. The Sponsor will provide more information on any alternative coverage that may be available under the Plan upon the occurrence of a qualifying event (as defined in Q-16 above).

If the qualified beneficiary chooses the continuation coverage above, he or she waives the right to the alternative coverage. If the qualified beneficiary chooses the alternative coverage, he or she waives the right to continuation coverage as described above.

Q-18. Who do I contact if I have questions about the Plan?

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the Plan Information Appendix.

PART II
ERISA RIGHTS

This Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and

available at the Public Disclosure Room of the Employee Benefits Security Administration if a Form 5500 is required to be filed by the plan.

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Plan Coverage

Continue Plan coverage for your eligible spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, your spouse or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

PART III

LEGAL NOTICES

Newborns' and Mothers' Health Protection Act of 1996

The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her 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).

Women's Health And Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same terms and conditions applicable to other medical and surgical benefits provided under the Plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number provided at the end of this Summary Plan Description.

Health Insurance Portability And Accountability Act

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Section 1. Introduction

The Plan is dedicated to maintaining the privacy of your health information. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information or "Protected Health Information" ("PHI") and to inform you about:

- the Plan's uses and disclosures of PHI;
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" or "PHI" includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is changed, a revised version of this notice will be provided to all individuals then covered under the Plan for whom the Plan still maintains PHI. The revised notice will be provided by mail or by another method permitted by law.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Please note that the Plan Sponsor obtains summary PHI, enrollment and disenrollment, termination of coverage and specific appeals information from the Plan. Most records containing your PHI are created and retained by the Third Party Administrator for the Plan. In the event that the Plan Sponsor receives PHI, the Plan has been amended to require that the Plan Sponsor only use and disclose PHI received from the Plan for administrative plan purposes as permitted by federal law.

Section 2. Notice of PHI Uses and Disclosures

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

A. Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

The Plan also will disclose PHI to the Plan Sponsor for administrative purposes permitted by law and related to treatment, payment or health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

The Plan contracts with business associates for certain services related to the Plan. PHI about you may be disclosed to the business associates so that they can perform contracted services. To protect your PHI, the business associate is required to appropriately safeguard the health information. The following categories describe the different ways in which the Plan and its business associates may use and disclose your PHI.

B. Uses and disclosures to carry out treatment, payment and health care operations

The Plan and its business associates will use PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating cardiologist the name of your treating physician so that the cardiologist may ask for your lab results from the treating physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

The Plan may also use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

C. Authorized uses and disclosures

You must provide the Plan with your written authorization for the types of uses and disclosures that are not identified by this notice or permitted or required by applicable law. In addition, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your mental health professional. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

Any authorization you provide to the Plan regarding the use and disclosure of your health information may be revoked at any time **in writing**. After you revoke your authorization, the Plan will no longer use or disclose your health information for the reasons described in the authorization, except for the two situations noted below:

- The Plan has taken action in reliance on your authorization before it received your written revocation; and
- You were required to give the Plan your authorization as a condition of obtaining coverage.

D. Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Uses and disclosures for which consent, authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice

would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The Plan may also disclose PHI when disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- For research, subject to conditions.
- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Section 3. Rights of Individuals

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations as required by law. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Plan at the address provided at the end of this Notice specifying the requested method of contact or the location where you wish to be contacted.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. *"Designated Record Set"* includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used by the Plan entity to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan at the address provided at the end of this Notice.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. Requests for amendment of PHI in a designated record set should be made to the Plan at the address provided at the end of this Notice.

D. Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to you about your own PHI; (3) prior to April 14, 2004; or (4) pursuant to your authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. You or your personal representative will be required to complete a form to request an accounting. Requests for an accounting should be made to the Plan at the address provided at the end of this Notice.

E. The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice at any time contact the Plan Administrator. The Notice is also posted on the Plan Sponsor's intranet site. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

F. A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Administrator. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan Administrator.

Section 6. Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

If you wish to exercise one or more of the rights listed in this Notice, contact the Plan Administrator.

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PLAN INFORMATION APPENDIX

GENERAL PLAN INFORMATION

Name of Plan:	Burlington Northern Santa Fe Group Benefits Plan
Effective Date:	Restatement effective January 1, 2011
Name, address, and telephone number of the Plan Sponsor:	Burlington Northern Santa Fe, LLC 2500 Lou Menk Drive Fort Worth, TX 76131
Name, address, and telephone number of participating Employers (other than Sponsor):	BNSF Railway Company 2500 Lou Menk Drive Fort Worth, TX 76131 (800) 234-1283 Los Angeles Junction Railway Company 2500 Lou Menk Drive Fort Worth, TX 76131 (800) 234-1283
Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	Vice President and Chief Human Resources Officer BNSF Railway Company 2500 Lou Menk Drive Fort Worth, TX 76131 (800) 234-1283
Agent for Service of Legal Process:	Vice President and Chief Human Resources Officer BNSF Railway Company 2500 Lou Menk Drive Fort Worth, TX 76131 (800) 234-1283
Sponsor's federal tax identification number:	27-1754839
Plan Number:	501
Plan Year:	Calendar Year

Third Party Administrator:	Extend Health, Inc. 10975 South Sterling View Drive Suite A-1 South Jordan, UT 84905 (855) 663-4219 www.ExtendHealth.com/employer

Claims Submission Agent: All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent. Forms should not be mailed to the Third Party Administrator.	**PayFlex Systems USA, Inc.** **Extend Health HRA** **P.O. Box 3039** **Omaha, NE 68103-3039** Fax: **(402) 231-4310**
Funding:	Benefits are paid through the BNSF Welfare Benefits Trust.