Burlington Northern Santa Fe

Vision Care Program

Summary Plan Description

Effective January 1, 2006

Contents

BNSF

Vision Care Program

The BNSF Vision Care Program offers you coverage for vision exams and eyewear.

You contribute the full cost of Vision Care coverage. BNSF does not share in the cost of coverage. Employee's contributions will be paid on a before-tax basis through the BNSF Internal Revenue Code Section 125 cafeteria plan. For Retirees, payment for the level of coverage elected will be withheld from their pension check unless arrangements are made with Your Benefits Resources (YBR) for direct bill and payment. Retirees are not eligible for a pre-tax contribution election under the BNSF Internal Revenue Code Section 125 cafeteria plan.

This Summary Plan Description (SPD) covers benefits available under the EyeMed Vision Care Policy only. The Vision Care Program is covered under ERISA as described in the section of this SPD titled "Your Rights Under ERISA." You should read through this SPD carefully to be certain you understand your Vision Care Program coverage and your rights under ERISA. If you have any questions you can contact the Vision Care Program at 1-800-843-3272 or log on to their web site at www.eyemedvisioncare.com. You can also contact Your Benefits Resources (YBR) at 1-877-847-2436.

Eligibility and Enrollment

Your Eligibility for Coverage

You are eligible to enroll in the Vision Care Program if you are a regularly assigned, salaried employee of BNSF or a Participating Affiliated Company. Employees covered under a collective bargaining agreement that does not provide for participation in the Vision Care Program are not eligible to enroll. Vision Care Program coverage is not available to other employees or service providers, such as leased employees or independent contractors, unless otherwise specified in the Program document.

Retired employees who meet the eligibility requirements for Retiree Medical Benefits are also eligible to enroll in the Vision Care Program.

Dependent Eligibility

Family members you may cover as eligible dependents under the Vision Care Program include:

• Your legal spouse, unless you are legally separated or divorced.

• Your unmarried children under age 19 (or age 23 if the child is a full-time student at an accredited institution) and dependent primarily on you for financial support. Eligible children must live with you in a parent-child relationship, and include:

– your unmarried natural children;

– your stepchildren, legally adopted children, children placed for adoption, or children placed under the full legal guardianship of you or your spouse; and

– children related to you by blood or marriage, including grandchildren (for grandchildren, a parent-child relationship does not exist if the child's natural parent lives in the same home).

• A child who is the subject of a Qualified Medical Child Support Order (QMCSO) issued under ERISA Section 609, as determined by BNSF. You may request copies of the BNSF QMCSO policies and procedures free of charge through your Benefits Department in Fort Worth, or you may contact YBR.

Your children are considered to depend primarily on you for financial support if you provide more than 50% of their support and they are eligible to be claimed as dependents on your federal income tax return. Coverage ends on the first to occur of the following:

• the end of the month in which a child who is not a full-time student turns 19;

• the date that the child over 19 graduates or ceases to be a full-time student;

• the end of the month in which a child who is a full-time student reaches age 23;

• the child's marriage; or

• the date the child ceases to be a dependent for income tax purposes.

To be considered a full-time student at an accredited institution, your child must be registered as a full-time student in a high school, college, university, trade school, professional school, school in a foreign

country or remedial education facility. YBR will require proof of whether a child qualifies as a full-time student.

Eligible enrolled children who are mentally or physically disabled may retain coverage beyond age 19 (or age 23, if they are full-time students when they become disabled) if their disability occurred before reaching the Vision Care Program's maximum age. To be eligible for continued coverage, the child must legally reside with you, must be unmarried and incapable of self-sustaining employment and must be primarily dependent on you for financial support. To continue coverage for a disabled child, you must provide the Claims Administrator with proof of the disability within 60 days of the date the child turns age 19 (or age 23 if the child is a full-time student) and as requested from time to time thereafter.

First Enrollment

If you are a newly hired employee you must enroll within 31 days of your first day of employment. Your coverage will begin on the first day of employment provided you enroll on time. For newly eligible employees (e.g., employees promoted from union to salaried exempt positions), the effective date of coverage is the first day of the month following 30 days' classification as a regularly assigned salaried employee. An exception applies to newly promoted salaried exempt employees whose promotion date is February 1. This group of employees will be covered effective March 1, provided the employee enrolls on time.

If you do not enroll within 31 days of your eligibility, your vision coverage will default to "no coverage".

Annual Enrollment

Each year you have the opportunity to change your Vision Care Program coverage option election during Annual Enrollment. If you did not previously opt out of Vision Care Program coverage and you continue to be eligible for coverage, your Vision Care Program enrollment will be renewed during each Annual Enrollment unless you change your election through YBR. If the Vision Care Program option you were enrolled in is no longer available and you fail to make a new election, you will not be covered by any Vision Program option.

If you opted out of Vision Care Program coverage, you must show a Family Status Event in order to enroll in the Vision Care Program before the next Annual Enrollment. If you have a Family Status Event you must enroll through the YBR web site or by phone through the YBR automated Resource Line within 31 days of the Family Status Event.

Changing Your Election During the Year

Your enrollment elections will remain in place for the calendar year in which you enroll. You are allowed to make a change only if you experience a Family Status Event as described below. Otherwise, you must wait until the next Annual Enrollment period to make a change.

Family Status Event

Eligible changes in family or employment status include:

• Your marriage, legal separation, divorce or annulment;

• The birth, placement for adoption or adoption of a child;

• The death of a dependent (including your spouse);

• The termination or commencement of your spouse's employment, a change in hours worked, or an unpaid leave of absence taken by you or your spouse resulting in a change in eligibility for medical coverage;

• A dependent satisfies or ceases to satisfy eligibility requirements;

• A significant change in your spouse's group medical coverage, as determined by the Program Administrator; or

• Service of a Qualified Medical Child Support Order (QMCSO) issued under ERISA Section 609, as approved by the Program Administrator.

If you experience one of the qualifying family status change events noted above, any changes to your benefit selections will be based on the type of event you experience. **You can make only those changes that directly relate to the event and are consistent with the event.**

You must request enrollment or a change in enrollment within 31 days of your Family Status Event.

Giving Notice of a Family Status Event

If you have a Family Status Event, you can log on to YBR's web site at www.ybr.com/benefits. You can also link to YBR's web site from the BNSF Intranet site to make changes. If you prefer to use the phone, you can use the YBR Resource Line by dialing 1-877-847-2436. If you do not request the change within 31 days of the event, you will not be allowed to make any changes until the next Annual Enrollment period.

Vision Care Program Benefits

The Vision Care Program offered through EyeMed Vision Care in conjunction with Fidelity Security Life, includes a network of providers who offer discounted fees and prices for eye exams, lenses and frames. When you use a Vision Care Program network provider, you do not have to submit any paper claims. You simply show your Vision Care Program identification card, and pay your copayment and any expenses that are not covered under the Program. The network provider will obtain reimbursement through the Vision Care Program.

You may also choose to use out-of-network vision care providers. There are no discounted fees or prices when out-of-network vision care providers are used. The Program does reimburse, on a set fee basis, a portion of the out-of-network provider's charge. The Program reimburses the lesser of the actual cost of the out-of-network provider service or the set fee shown on the Schedule of Benefits for the applicable Vision Care Program election. You must pay in full at the time you use an out-of-network provider and then submit your receipts and claim form to EyeMed Vision Care. You do not need a claim form to be reimbursed. Just follow the instructions on the back of your Vision Care identification card to submit expenses for reimbursement.

There are two levels of Vision Care Program benefits from which you can choose: Premier Plus Plan B and Premier Plus Plan C. Both levels work the same way. The only difference is the benefits provided for certain services. The Schedule of Benefits on the following page illustrates the benefits available on an in-network and out-of-network basis under each of the levels of benefits.

Vision Care Schedule of Benefits

Vision Care Services	Premier Plus B Plan		Premier Plus C Plan	
	In-Network	Out-of-Network Allowance	In-Network	Out-of-Network Allowance
Examination	$10 Copay	Up to $35	$10 Copay	Up to $35
Standard Plastic Lenses:				
Single Vision	$20 Copay	Up to $25	$20 Copay	Up to $25
Bifocal	$20 Copay	Up to $40	$20 Copay	Up to $40
Trifocal	$20 Copay	Up to $55	$20 Copay	Up to $55
Lenticular	$20 Copay	Up to $55	$20 Copay	Up to $55
Frames: Any frame available at provider location	$20 Copay; $130 allowance plus 20% off balance over $130	Up to $60	$20 Copay; $130 allowance plus 20% off balance over $130	Up to $60
Contact Lenses:				
Medically Necessary	$250 allowance	Up to $200	$250 allowance	Up to $200
Elective	$130 allowance	Up to $110	$130 allowance	Up to $110
Laser Vision Correction: Lasik or PRK from U.S. Laser Network	15% off retail price; or 5% off promotional price	N/A	15% off retail price; or 5% off promotional price	N/A
Frequency:				
Examination	Once every 12 Months		Once every 12 Months	
Frame	Once every 24 Months		Once every 12 Months	
Lenses or Contact Lenses	Once every 12 Months		Once every 12 Months	

Notes on EyeMed Options:

- Only one copay applies to materials when lenses and frames are purchased at the same time.
- Contact Lenses in lieu of frames/lenses; if Medically Necessary, must be **preauthorized**.
- Contact lens evaluation and fitting fees may not be covered; however, a discount for these services may be available when provided by in-network providers.

In-Network Copayments

If you use an in-network provider you must pay a copayment for your vision exam. There is also a copayment for materials such as frames and lenses. However, only one "materials" copayment is required when lenses and frames are purchased at the same time.

Contact Lens Benefits

You may apply an allowance (subject to a copayment) toward cosmetic contact lenses in place of the frame and/or lens benefit. A covered person may not receive both a frame and/or lens and a contact lens benefit under the Program. If your contact lenses are medically necessary, as determined by the Vision Care Claims Administrator, the benefit allowance is higher, subject to the applicable Program copayment. You are required to pay the remainder of the cost that exceeds the allowance and the copayment. The contact lens benefit is available once every 12 months.

Contact lens evaluation and a professional fitting fee may not be covered. You will be responsible for payment of this fee, should it be charged.

Limitations on Benefits

The Vision Care Program is intended to cover only eye examinations and corrective eyewear. Medical or surgical treatment of eye disease or injury is not provided under the Vision Care Program. Coverage may not exceed the lesser of actual cost of covered services and materials or the limits listed on the Schedule of Benefits on page 6.

Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the Program option design; however, these materials and any items not covered below may be purchased at Preferred Pricing from an EyeMed Provider. In addition, benefits are payable only for expenses incurred while the coverage is in force.

The Vision Care Program does not cover the following vision care services:

- Orthoptics or vision training and any supplemental testing;
- Plano (non-prescription) lenses;
- Two pair of eyeglasses in lieu of bifocals or trifocals;
- Medical or surgical treatment of the eyes;
- An eye exam or corrective eye wear required by an employer as a condition of employment;
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related;
- Program or prescription sunglasses or tinted lenses, and no-line bifocals and blended lenses;
- Sub-normal vision aids;
- Charges in excess of Usual and Customary for services and materials;
- Experimental or non-conventional treatments or devices;
- Safety eyewear; and
- Spectacle lens styles, materials, treatments or "add-ons" not shown in the Schedule of Benefits on page 6.

Laser Vision Correction

The Vision Care Program does not cover laser vision correction. However, Vision Care Program participants may access providers who have agreed to offer laser vision correction at preferred pricing to Vision Care Program participants. Laser vision surgery is an elective procedure that may involve potential risks to patients. The Vision Care Program does not guarantee the outcome of any refractive surgical procedure or a total elimination of the need for glasses or contacts. The Vision Care Program has only made arrangements for a reduced price on the procedure in the event a Program participant elects laser vision correction.

Selecting Vision Care Program Providers

If you elect Vision Care Program coverage, you may find network vision care providers by logging on to www.eyemedvisioncare.com or by calling 1-800-843-3272. You can also contact YBR for more information on the Vision Care Plan at 1-877-847-2436 or log onto YBR's website at **www.ybr.com/benefits.**

How The In-Network Vision Care Program Works

1. Call 1-800-843-3272 or visit www.eyemedvisioncare.com to find a provider near you.
2. Schedule an appointment with your EyeMed provider, identifying yourself as an EyeMed member.
3. Present your EyeMed card for *Easy Access* to your benefits at your EyeMed Provider. No paperwork is involved; you simply pay your copayment and any expenses that are not covered.

What You Should Know About The Vision Care Program

The Vision Care Program is subject to the same COBRA Continuation rules and the same ERISA claim appeal rules as the Medical Program. The COBRA election for Vision Care Program coverage is separate from any COBRA election for Medical Program coverage. The name of the ERISA fiduciary for claim review purposes can be found under the Vision Care Program Information at the end of this Summary Plan Description under the heading "Administrative Information".

Claims Procedures

Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Vision Care Program. The procedures described on the following pages are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

The Company has delegated the discretionary authority to interpret BNSF Vision Care Program terms and to make both initial claim determinations and final claim review decisions on ERISA appeals to EyeMed Vision Care (Claims Administrator). The BNSF Employee Benefits Committee retains the discretionary authority to determine whether you and/or your dependents are eligible to enroll for coverage and/or to continue coverage under Program terms.

How to File a Claim

*N*o claim forms are necessary when you or a dependent receives services at a participating EyeMed Provider location. At the time services are rendered, you will have to pay the cost of any services or eyewear that exceeds any allowances, applicable co-payments, and any expenses not covered under the Vision Care Program.

If you or a dependent uses an out-of-network provider for vision care services you must pay the bill first. Reimbursement will be made according to the Schedule of Benefits on page 6. You must submit the original fully itemized bill, along with your member's group number and a copy of the prescription to the Claims Administrator.

You must submit separate reimbursement requests for yourself and each of your covered dependents who have incurred vision expenses. Incomplete claim requests will not be processed.

Timeframe for Deciding Claims

There are no urgent care or pre-service claims; therefore, only post-service claims shall be submitted to the Claims Administrator for payment. Post-service claims are claims that involve only the payment or reimbursement of the cost for services that have already been provided.

The Claims Administrator will notify you or your representative of the determination within 30 days after receiving the claim. However, if more time is needed to make a determination due to matters beyond the Claims Administrator's control, the Claims Administrator will notify you or your representative within 30 days after receiving the claim. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the claim. If more time is needed because necessary information is missing from the claim, the notice will also specify what information is needed and you or your representative must provide the specified information with 45 days after receiving the notice. The timeframe for deciding the claim will be suspended from the date the extension notice is sent until the date the missing necessary information is provided to the Claims Administrator.

Notification of Benefit Determination

Each time a claim is submitted, you or your representative will receive a written Explanation of Benefits (EOB) form that will explain how much was paid towards the claim, or whether the claim was denied, in whole or in part. If a claim for reimbursement is denied, in whole or in part, the Claims Administrator will give you or your representative a written notice of the denial and the reason for the denial. The Claim Denial Notice will:

- Explain the specific reason(s) for the denial;

- Provide the specific reference to pertinent Vision Care Program provisions on which the denial was based;

- Provide a description of any additional information that you could provide to reverse the denial, or in the case of an incomplete claim; perfect your claim;

- Provide an explanation of the Vision Care Program's claim review procedures and applicable time limits; and

- If the Claims Administrator used or relied on internal guidelines, protocols, or other criteria, the letter will specify the criterion; and a copy of such rule, guideline, protocol or other criteria, and reasonable access to relevant documents, records and other information relevant to the Claim will be provided free of charge on request.

If Your Claim is Denied

The Vision Care Program is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA has special rules that must be followed when you choose to appeal an adverse benefit decision (denied claim).

You have a right to appeal any claim denial. It does not make any difference whether the denial is a complete denial or a partial denial. You or your representative should file a written request for appeal as soon as you receive a denial of benefits that you believe should be covered under the Vision Care Program but no later that **180** days from the date you receive notice that your claim has been denied. Failure to comply with this important deadline may cause you to forfeit any right to appeal the denial.

A person who did not make the initial decision shall decide your appeal. The review on appeal will not give any deference to the initial decision and will take into account all information submitted by you, regardless of whether it was submitted or considered in the initial decision.

Along with a written request for a review, you may submit any additional documents and written issues and comments you believe should be considered during the review. You should also include any clinical documentation from your physician that would substantiate coverage of the denied claim.

Upon request, you or your representative will be provided reasonable access to and copies of all documents, records and other information relevant to your claim, free of charge, including:

- information relied upon in making the benefit determination;
- information submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon in making the benefit determination;
- descriptions of the administrative processes and safeguards used in making the benefit determination;
- records of any independent reviews conducted by the Claims Administrator;
- if the claim was based on a medical judgment, including determinations about whether a particular service is experimental, investigational or not medically necessary or appropriate, an explanation of the scientific or clinical judgment for the decision applying the term of the Program, or an explanation for the denial; and
- expert advice and consultation obtained by the Claims Administrator in connection with your denied claim, whether or not the advice was relied upon in making the benefit determination.

Your request for an appeal should be addressed to:

EyeMed Vision Care, L.L.C.
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, Ohio 45040

Timeframes for Deciding Benefits Appeals

The Claims Administrator will decide the appeal of a post-service claim within 60 days after receipt of the appeal.

Notification of Decision on Appeal

The Claims Administrator will notify you, in writing, of its final decision and will include the following:

- the specific reasons for the appeal decision;
- a reference to the specific Vision Care Program provision(s) on which the decision was based;
- a statement that the claimant is entitled to receive, upon request and without charge, reasonable access to or copies of all documents, records, and other information relevant to the determination (see prior page for a list of such documents); and
- a statement indicating entitlement to receive, upon request and without charge, a copy of any internal rule, guideline, protocol or similar criterion relied on in making the adverse decision regarding your appeal, and/or an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

The Claims Administrator's decision on appeal is final and binding. Benefits under this Program will be paid only if the Claims Administrator decides, in its sole discretion, that you are entitled to them. If you continue to disagree with the decision, you may exercise "Your Rights under ERISA" as explained on page 24 of this SPD.

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When Coverage Ends

Coverage for you and your covered dependents will end on the *first* to occur of the following:

• The date your employment terminates;

• The date the Vision Care Program is terminated or, if you work for a BNSF Participating Affiliated Company, the date the BNSF affiliate terminates its participation in the Vision Care Program;

• The date you are no longer eligible for coverage under Vision Care Program rules; or

• The first day of the payroll period for which you fail to make the required contributions for Vision Care Program coverage.

Dependents will lose their coverage on the *first to occur* of the following:

• The date you are no longer eligible for Vision Care Program coverage for any reason; or

• The date your dependent no longer meets the Vision Care Program's eligibility rules for dependent coverage. (Dependent eligibility is described on page 2 of the SPD.)

Continuation of Coverage

Family and Medical Leaves of Absence

Under the Family and Medical Leave Act of 1993 (FMLA), you may be entitled to up to a total of 12 weeks of unpaid, job-protected leave during each calendar year for the following:

• For the birth of your child, to care for your newborn child, or for placement of a child in your home for adoption or foster care;

• To care for your spouse, child or parent with a serious health condition; or

• For your own serious health condition.

If your FMLA leave is a paid leave, your pay will be reduced by your before-tax contributions as usual for the coverage level in effect on the date your FMLA leave begins. If your FMLA leave is unpaid, you are required to send your contributions to YBR while on leave.

If you notify your Employer that you are terminating employment during your FMLA leave, your Vision Care Program coverage will end on the date of your notification. If you do not return to work on your expected FMLA return date, and you do not notify your Employer of your intent either to terminate your employment or to extend the period of leave, your Vision Care Program coverage will end on the date you were expected to return. You will receive notice of any right you may have to continue Vision Care Program coverage under COBRA when your Program coverage ends.

You may not change your Vision Care Program elections during your FMLA leave unless an Annual Enrollment occurs, or unless you are on a paid FMLA leave and you have a Family Status Event.

Other Approved Leaves of Absence

If you take an approved leave of absence other than an FMLA leave and your leave is a paid leave, for the first 90 days, your pay will be reduced by the contribution required for the Vision Care Program coverage in effect on the date prior to the start of your leave. If your leave exceeds 90 days, your Vision Care Program coverage will end and you will receive a COBRA continuation notice.

If your approved leave is unpaid, your coverage will continue for 90 days. You will be required to pay your contributions directly to YBR until you return to active pay status. If your leave exceeds 90 days, Vision Care Program coverage will end and you will receive a COBRA continuation notice.

Military Leaves

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires the Employer to provide COBRA coverage for up to 24 months from the first day of absence, or if earlier, until the day after the date you are required to apply for or return to active employment with your Employer. However, BNSF provides that if you are absent from work due to military service, you may elect to continue coverage under the Program (including coverage for enrolled dependents) for the duration of your military leave. Your contributions for continued coverage will be the same as for similarly situated active participants in the Program.

Whether or not you continue coverage during military service, you may reinstate coverage under the Program on your return to employment under USERRA. The reinstatement will be without any waiting

period otherwise required under the Program, except to the extent that you had not fully completed any required waiting period prior to the start of military service.

Continuation of Coverage Under COBRA

(Consolidated Omnibus Budget Reconciliation Act of 1985 as Amended)

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the BNSF Medical Program. The information that follows 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. COBRA continuation coverage can become available to you when you would otherwise lose your BNSF Medical Program coverage due to a "qualifying event". It can also become available to other members of your family who are covered under the BNSF Medical Program when they would otherwise lose their BNSF Medical Program coverage because of a qualifying event.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of BNSF Medical Program coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your eligible dependents could become qualified beneficiaries if coverage under the BNSF Medical Program is lost because of a qualifying event.

Eligibility

You or your covered dependents will become eligible for COBRA continuation coverage after any of the following qualifying events result in the loss of BNSF Medical Program coverage:

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the BNSF Medical Program 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 BNSF Medical Program 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 both); or

• You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the BNSF Medical Program 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 both); or

• The child stops meeting the eligibility requirements for a "dependent child."

Notification

The BNSF Medical Program will offer COBRA continuation coverage to you and your family as qualified beneficiaries only after the COBRA Administrator, Your Benefits Resources ("YBR"), has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or your death, your employer must notify YBR of the qualifying event. YBR will send you an election form. To continue Medical Program coverage, you must return the election form within 60 days from the later of:

• the date you receive the form; or

• the date your coverage ends due to a qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse, your entitlement to Medicare (under Part A, Part B or both) or a dependent child's losing eligibility for coverage as a dependent child), you or your covered dependent must notify YBR's Customer Care Service by phone that a qualifying event has occurred. This notification must be received by YBR within 60 days after the later of:

• the date of such event; or

• the date you or your eligible dependent would lose coverage on account of such event.

Failure to promptly notify YBR of these events will result in loss of the right to continue coverage for you and your dependents. After receiving this notice, YBR will send you an election form within 14 days. If you or your dependents wish to elect continuation coverage, the election form must be returned to YBR within 60 days from the later of:

• the date you receive the form; or

• the date your coverage ends due to the qualifying event.

Once YBR 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. You may elect COBRA continuation coverage on behalf of your spouse, and parents may elect COBRA continuation coverage on behalf of their children.

If you are eligible for trade adjustment assistance (TAA) pursuant to the Trade Act of 1974 and you did not elect continuation coverage within the initial 60-day election period, you may elect continuation coverage within 60 days of the first day of the month in which you become eligible for TAA, but no later than 6 months from the date health coverage is lost. If you elect continuation coverage during this second election period, your coverage will begin on the first day of the second election period, rather than the date health coverage is lost. The period between the loss of coverage and the beginning of the second

election period does not count as a break in coverage for purposes of the coverage rules under HIPAA (as described in the section titled “Electing the Opt-Out Option” on page 3).

Cost of Coverage

If you elect to continue coverage, you must pay the entire cost of coverage (BNSF’s contribution and the active employee portion of the contribution), plus a 2% administrative fee for the duration of COBRA continuation.

If you or your covered dependent is Social Security disabled as defined by Title II or Title XVI of the Social Security Act within 60 days of loss of coverage due to your termination of employment or reduction in hours, you may elect to continue coverage for the disabled person only or for some or all of COBRA eligible family members for up to 29 months. You must pay 102% for the first 18 months of COBRA continuation and 150% for the 19th through the 29th month of coverage.

For COBRA coverage to remain in effect, payment must be received by YBR by the first day of the month for which the payment is due, subject to a 30-day grace period. (Your first payment is due no later than 45 days after your election to continue coverage, and it must cover the period of time back to the first day of your COBRA continuation coverage.)

Duration

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is your death, your entitlement to Medicare benefits (under Part A, Part B, or both), 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 your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement.

> For example: if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your 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 your employment or reduction of your 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 the BNSF Medical Program is determined by the Social Security Administration to be disabled and you notify YBR of the disability before the end of the initial 18 months of COBRA continuation coverage and within 60 days following the date you or a covered dependent is determined to be disabled by the Social Security Administration, 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. 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.

If the disabled individual should no longer be considered to be disabled by the Social Security Administration, you must notify YBR within 30 days following the end of the disability. Coverage that has exceeded the original 18-month continuation period will end when the individual is no longer Social Security 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 YBR. 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 both), or gets divorced or legally separated, or if the dependent child stops being eligible under the BNSF Medical Program as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the BNSF Medical Program had the first qualifying event not occurred.

The COBRA beneficiary must experience the second qualifying event during the first 18 months of COBRA continuation, and must provide notice to the COBRA Administrator within the required time period. COBRA continuation coverage will end sooner if the BNSF Medical Program terminates and BNSF does not provide replacement medical coverage, or if a person covered under COBRA:

• First becomes covered under another group health plan after the loss of coverage due to your termination or reduction in hours, unless the new group coverage is limited due to a pre-existing condition exclusion. This Program will be primary for the pre-existing condition and secondary for all other eligible health care expenses, provided contributions for COBRA coverage continue to be paid. Coverage may only continue for the remainder of the original COBRA period;

• Fails to make required contributions when due;

• First becomes entitled to Medicare benefits after the initial COBRA qualifying event; or

• Is extending 18-month coverage because of disability and is no longer disabled as defined by the Social Security Act.

If You Have Questions

Questions concerning the BNSF Medical Program 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 website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the BNSF Medical Program Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA 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 COBRA Administrator. You can contact the COBRA Administrator at the below address:

Your Benefits Resources
2300 Discovery Lane
Orlando, Florida 32826
Phone: 1-877-847-2436

General Information Affecting Your Right to Program Benefits

Recovery of Overpayments

If you or a Program beneficiary should receive a benefit payment from this Program in excess of the payment that should have been received, the Claims Administrator has the right to recover the amount of the overpayment. If the overpayment is not returned, the Claims Administrator reserves the right to deduct the overpayment from future Vision Care Program benefits payable to you if the overpayment was made to you. If the overpayment was made to any other beneficiary under the Program, the excess payment may be deducted from future Vision Care Program benefits payable to that beneficiary

No Assignment of Benefits

The Program will not prevent a Vision Care provider from receiving payment for eligible charges for covered services if there is a valid assignment of benefits. The Program Administrator has the discretionary authority to determine whether an assignment of benefits to a Vision Care provider is valid. You may not commit benefits payable to you to pay your personal debts or other obligations that are not otherwise covered under a valid assignment of Program benefits. You may not sell any right or interest you or a covered dependent may have in any benefit under this Program.

Right to Information

You must provide the Program Administrator and the Claims Administrator with any information they consider necessary to administer the Vision Care Program. If the information you give on an enrollment form or claim application is wrong, or if you omit important information, your Program coverage may be canceled or your claim may be denied. If your address should change, or if a spouse's or dependent child's address should change, you must notify YBR immediately.

No Guarantee of Employment

Participation in this Program does not guarantee your employment with BNSF or any related BNSF Employer. Neither does it guarantee your right to any benefit under the Program.

Program Termination and Amendment

The Vision Care Program may be amended or terminated by BNSF at any time and for any reason. BNSF reserves the right to amend, modify or terminate the Program, including any benefits provided under the Program or the amount of any required employee contributions, at any time and for any reason. If any change in the Program should occur, you will be notified within a reasonable amount of time.

No Vested Rights

Your Program benefits are not vested. Your right to benefits is limited to claims incurred before the first to occur of the following events.

- Amendment of the Program;
- Termination of the Program;
- Expiration of the period that claims can be accepted by the Claims Administrator;
- Termination of your eligibility to participate; or
- Your failure to pay any required contributions.

Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 and its applicable regulations (HIPAA) is a federal law that, in part, requires group health plans, like the Burlington Northern Santa Fe Group Vision Care Program to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the Vision Care Program is subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Vision Care Program will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, program administration or as required or permitted by law. A description of the Vision Care Program's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Notice of Privacy Practices, which will be furnished to you and can also be accessed on the BNSF intranet site at http://bnsfweb.bnsf.com/departments/hr/index.html. You can also receive a copy of the Notice of Privacy Practices by contacting the BNSF Privacy Official at the following address:

2500 Lou Menk Drive
Fort Worth, Texas 76131
Phone: 800-234-1283

Administrative Information

Program Costs

Vision Care Program benefits are provided through EyeMed Vision Care under insurance policies fully underwritten by Fidelity Security Life Insurance Company. The employee pays the full cost of Vision Care Program coverage on a before-tax basis under the BNSF Internal Revenue Code Section 125 cafeteria plan. Employee contributions are deposited in a tax-qualified Internal Revenue Code Section 501(c)(9) trust, commonly called a VEBA. The EyeMed insurance premiums are paid through the VEBA. The cost of Vision coverage is withheld pro-rata from the employee's earnings each pay period. .

Program Name and Plan Number

The Vision Care Program is a participating Program in Burlington Northern Santa Fe Group Benefits Plan, a consolidated welfare benefits program under ERISA that files its annual returns under Plan Number 501.

Company and Employer

The terms "BNSF," "Company," and "Employer" as used in this SPD refer to Burlington Northern Santa Fe Corporation or a Participating Affiliated Company of BNSF whose employees are eligible to participate in the Vision Care Program.

Company Name and Identification Number

The Vision Care Program is sponsored by Burlington Northern Santa Fe Corporation, Employer Identification Number 41-1804964.

Program Administrator and Agent for Service of Legal Process

The Vision Care Program Administrator's name, address and telephone number are as follows:

Employee Benefits Committee
c/o BNSF Railway Company
2500 Lou Menk Drive
Fort Worth, Texas 76131
800-234-1283

The agent for service of legal process is:

Mr. Jeffrey R Moreland
Executive Vice President Law & Government Affairs and Secretary
2500 Lou Menk Drive
Fort Worth, Texas 76131

The Burlington Northern Santa Fe Employee Benefits Committee is the Program Administrator. The Program Administrator has delegated the discretionary authority to interpret Program provisions relating to the payment of benefits to the Claims Administrator for both initial claims processing and for ERISA appeals requested in writing by Program participants and beneficiaries. BNSF Employee Benefits Committee retains the discretionary authority to determine whether an Employee or dependent is eligible for initial or continued enrollment in the Program. The discretionary authority delegated to the Claims

Administrator includes the authority to interpret the provisions of the Program for purposes of resolving any inconsistency or ambiguity, correcting any error, or supplying information to correct any omission.

Claims Administrator for the Vision Care Program

The Claims Administrator for the Vision Care Program is:

EyeMed Vision Care
4000 Luxottica Place
Mason, Ohio 45040
Phone: 800-521-3605

Named Fiduciary

Security Life Insurance Company of America is the Named Fiduciary under ERISA for all ERISA appeals regarding Program benefit matters. The BNSF Employee Benefits Committee retains discretionary authority to determine eligibility and enrollment rights under the Program.

COBRA Administrator

The COBRA Administrator for the Vision Care Program is:

Your Benefits Resources
2300 Discovery Lane
Orlando, Florida 32826
Phone: 1-877-847-2436

Program Year

The Program Year is the calendar year.

Your Rights Under ERISA

As a participant in the BNSF Vision Care Program, you are entitled to certain rights and all Vision Care Program participants will be entitled to:

Receive Information About Your Vision Care Program Benefits

• Examine, without charge, at the Program Administrator's office and other locations, such as worksites and union halls, all documents governing the Vision Care Program, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

• Obtain, upon written request to the Program Administrator, copies of documents governing the operation of the Program, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) an updated summary plan description. The Program Administrator may make a reasonable charge for the copies.

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

Continue Vision Care Program Coverage

• Continue vision care coverage for yourself or your dependents if there is a loss of coverage under the Vision Care Program as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Vision Care Program for the rules governing your COBRA continuation coverage rights.

• Reduction or elimination of exclusionary periods, if any, for coverage for preexisting conditions under your group health coverage, if you have creditable coverage from another health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage, 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment in some group health plans.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Program participants, ERISA imposes duties upon the people who are responsible for the operation of this Vision Care Program. The people who operate the BNSF Vision Care Program, called *fiduciaries* of the Program, have a duty to do so prudently and in the interest of you and other Program 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. After completion of the appeal process (see pages 9 -11) you have the right to bring a civil action under ERISA Section 502(a).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Program Administrator 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 Program Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Program 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 Program'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 Program fiduciaries misuse the Program'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 — for example, if it finds your claim is frivolous.

You and the Program may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Assistance With Your Questions

If you have any questions about the Program, you should contact the Program Administrator.

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

The next page lists the EBSA area offices.

Offices of the Employee Benefits Security Administration
U.S. Department of Labor

Atlanta Regional Office
61 Forsyth Street, S.W.
Suite 7B54
Atlanta, GA 30303
Phone: 404/562-2156

Boston Regional Office
One Bowdoin Square
7th Floor
Boston, MA 02114
Phone: 617/424-4950

Chicago Regional Office
200 W. Adams Street
Suite 1600
Chicago, IL 60606
Phone: 312/353-0900

Cincinnati Regional Office
1885 Dixie Highway
Suite 210
Ft. Wright, KY 41011-2664
Phone: 606/578-4680

Dallas Regional Office
525 Griffin Street
Room 707
Dallas, TX 75202-5025
Phone: 214/767-6831

Detroit District Office
211 W. Fort Street
Suite 1310
Detroit, MI 48226-3211
Phone: 313/226-7450

Kansas City Regional Office
City Center Square
1100 Main
Suite 1200
Kansas City, MO 64105-2112
Phone: 816/426-5131

Los Angeles Regional Office
790 E. Colorado Boulevard
Suite 514
Pasadena, CA 91101
Phone: 818/583-7862

Miami District Office
111 N.W. 183rd Street
Suite 504
Miami, FL 33169
Phone: 305/651-6464

New York Regional Office
1633 Broadway, Room 226
New York, NY 10019
Phone: 212/399-5191

Philadelphia Regional Office
Gateway Building
3535 Market Street
Room M300
Philadelphia, PA 19104
Phone: 215/596-1134

St. Louis District Office
815 Olive Street
Room 338
St. Louis, MO 63101-1559
Phone: 314/539-2691

San Francisco Regional Office
71 Stevenson Street
Suite 915
P.O. Box 190250
San Francisco, CA 94119-0250
Phone: 415/975-4600

Seattle District Office
1111 Third Avenue
Suite 860
MIDCOM Tower
Seattle, WA 98101-3212
Phone: 206/553-4244

Washington, D.C. District Office
1730 K Street, N.W.
Suite 556
Washington, DC 20006
Phone: 202/254-7013

Who to Call About Your Benefits

For questions regarding the enrollment process or Vision Care Program benefits, call YBR at 1-877-847-2436.

For questions regarding the services in the Vision Care Program, call Customer Service at 1-800-521-3605.

This SPD is only a summary of the BNSF Vision Care Program. It does not constitute a contract. This Program has been established under a Plan document. If there are any differences between this SPD and the Plan document, the Plan document will control.