2026 BCBS Medical Options Attachment

This document is intended to supplement the 2026 Employee Flexible Benefits Guide. Please read this document carefully to become familiar with your benefits under the BCBS Medical Options.

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OVERVIEW

This 2026 BCBS Medical Options Attachment ("2026 BCBS Attachment") contains the terms and conditions of the coverage provided to Union Pacific Employees and their Dependents under the following medical options, which collectively are referred to as the "BCBS Medical Options":

- BlueCross/BlueShield High Deductible Health Plan Option 1 ("BCBS HDHP1 Option");
- BlueCross/BlueShield High Deductible Health Plan Option 2 ("BCBS HDHP2 Option"); and
- BlueCross/BlueShield Non-High Deductible Preferred Provider Organization ("BCBS Non-HDHP PPO Option").

As used in this 2026 BCBS Attachment, the terms "Employee," "Spouse," "Child" and "Dependent" have the same meaning as these terms are defined beginning on page 7 of the 2026 Flexible Benefits Guide ("Flex Guide") for purposes of the Medical Care Program. The Employee and each person the Employee elects to cover under a BCBS Medical Option is considered a "Covered Person."

BCBS MEDICAL OPTIONS: COMPONENTS AND NETWORK INFORMATION

Each of the BCBS Medical Options, whether a BCBS HDHP Option or the BCBS Non-HDHP PPO, consists of three components, and each component has its own network of Preferred Providers:

1. ***Medical Benefits*:** These benefits are self-insured by Union Pacific. Union Pacific has contracted with Quantum Health and Highmark BCBS to administer the BlueCard Network and to administer claims and medical management services. In order to carry out their specific responsibilities under BCBS Medical Options, Quantum Health and Highmark BCBS have been granted discretionary authority to make factual findings and interpret terms of the medical benefits portion of the Plan and to determine entitlement to Plan benefits in accordance with the terms of the Plan.
2. ***Mental Healthcare and Substance Use Disorder Treatment Benefits:*** These benefits are self-insured by Union Pacific and are administered by Quantum Health and BCBS. In order to carry out their specific responsibilities under BCBS Medical Options, Quantum Health and Highmark BCBS have been granted discretionary authority to interpret the terms of Mental Healthcare and Substance Use Disorder Treatment benefits portion of the Plan and to determine entitlement to Plan benefits in accordance with the terms of the Plan.
3. ***Pharmacy Benefits:*** These benefits are self-insured by Union Pacific and are administered by OptumRx. In this capacity, OptumRx has been granted discretionary authority to make factual findings and interpret the terms of the pharmacy benefits portion of the Plan and to determine entitlement to Plan benefits in accordance with the terms of the Plan. Although OptumRx administers the pharmacy benefits, Quantum Health serves as the primary point of contact for you and your covered Dependents to answer questions and provide information about your pharmacy benefits. For more information about pharmacy benefits, refer to the "Pharmacy Program" section on page 63 of this document.

PREFERRED PROVIDER NETWORK

The BCBS Medical Options offer health benefits through a PPO Network. Highmark BCBS is the contract administrator for these benefits. BCBS, including BCBS plans in other states, has contracted with a PPO network of Hospitals, Doctors and other Healthcare Providers, each in their own geographical area. All BCBS plans participate in a national program called the BlueCard Program. Each plan has a network of providers who specifically have agreed to participate as a member of the BlueCard Program provider network. The providers in the BlueCard Program network will be referred to collectively in this document as "Preferred Providers."

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

It is the Employee's or Dependent's responsibility to verify that his/her provider is a Preferred Provider for each visit to ensure that the status of the provider has not changed. Generally, if the provider's status has changed and is no longer in the BCBS PPO Network, out-of-network criteria will apply. However, it is possible that a Preferred Provider may cease being in the BCBS PPO Network during the course of you receiving Covered Services from such provider. Should this occur, you have the right, in circumstances provided by law, to continue receiving certain Covered Services from that provider for a limited period time after the provider ceases being a Preferred Provider and have those Covered Services be considered as provided In-Network. Quantum Health will notify you in the event you become eligible to elect this continuity of care. Such notice will identify the affected provider, describe the course of treatment and/or Covered Services

being furnished by such provider that will be considered as provided In-Network, and indicate the time period during which these Covered Services may be considered as provided In-Network. Note that this continuity of care right does not apply if the provider is no longer included in the BCBS PPO Network because he or she fails to satisfy BCBS PPO Network credentialing requirements or has engaged in fraud.

Information regarding negotiated service rates between BCBS and its In-Network PPO Providers, along with Out-of-Network allowed amounts can be found at https://www.up.com/employee/ and clicking "more" in the drop-down menu. This information is provided in an electronic format required under federal law.

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

- Preferred Providers accept your Deductible and/or Coinsurance amount(s) plus this Plan's benefit payment as payment in full for a Covered Service (unless an Annual Benefit Maximum has been met); therefore, you have a lower out-of-pocket expense in most cases.
- Lower Coinsurance requirements in most cases. (Coinsurance is the percentage of each allowable charge which you must pay after any applicable Deductible amount has been met.)
- Lower Medical Coinsurance Maximums in most cases. (After your Medical Coinsurance Maximum has been met, most benefits are payable at 100% of the allowable charge.)
- When this Plan pays benefits for services provided to you, it pays directly to the Preferred Provider.
- Because of this, you may only have to pay a Preferred Provider your Deductible and/or Coinsurance amount(s) at the time Covered Services are provided.
- Preferred Providers also file your claims for you.

Who is Your BCBS BlueCard Network?
BCBS has contracted with a great number of Providers to provide healthcare services for you and your eligible Dependents. You can search for network providers by accessing Quantum Health at www.upquantumhealth.com or by calling Quantum Health at (855) 649-3855. BCBS is solely responsible for the selection, credentialing, and monitoring of Providers in the BCBS BlueCard Network. All Providers selected by BCBS are independent contractors. Union Pacific and its participating subsidiaries do not guarantee the quality of care provided by the BCBS BlueCard Network. You are responsible for choosing a Physician or Hospital for your care and determining the appropriate course of medical treatment.

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

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

The final choice of Healthcare Providers is yours. However, if you receive services from a Healthcare Provider included in the BCBS BlueCard Network, the Plan's Coinsurance may be increased, which may decrease the amount you must pay. The benefits are outlined in the Schedule of Benefits beginning on page 12.

You can select the Doctors of your choice that are In-Network. The BCBS Medical Options allow (but don't require) the designation of a primary care Provider in order to receive benefits. However, it is still recommended that you select and contact a Doctor prior to requiring medical services. You have the right to designate any primary care Provider who participates in the BCBS BlueCard Network and who is available to accept you or your covered Dependent(s). For Children, you may designate a pediatrician as the primary care Provider. Quantum Health will assist you in finding Hospitals, Doctors, and other providers that are In-Network. For information on how to select a primary care Provider, and for a list of the primary care Preferred Providers, contact Quantum Health at (855) 649-3855 or at Quantum Health at www.upquantumhealth.com.

You do not need prior authorization from a BCBS Medical Option in which you are enrolled or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the BCBS BlueCard Network who specializes obstetrics or gynecology. The health care professional, however,

may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Preferred Providers who specialize in obstetrics or gynecology, contact Quantum Health at (855) 649-3855 or access Quantum Health at www.upquantumhealth.com.

BLUECARD PROGRAM (NATIONAL)

Inter-Plan Arrangements:
BCBS has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "inter- plan arrangements." These inter-plan arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever members access health care services outside the geographic area BCBS serves, the claim for those services may be processed through one of these inter-plan arrangements, as described generally below.

Out-of-Area Services:
Typically, when accessing care outside the BCBS area, members obtain care from health care providers that have a contractual agreement ("Preferred Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Preferred Providers") with the Host Blue. The Plan remains responsible for fulfilling its contractual obligations to you. The Plan's payment practices in both instances are described below.

Liability Calculation Method per Claim:
Unless subject to a fixed dollar copayment, the calculation of your liability on claims for Covered Services will be based on the lower of the Preferred Providers billed charges for Covered Services or the negotiated price made available to BCBS by the Host Blue. Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The negotiated price made available to the Plan by the Host Blue may be represented by one of the following:

- an actual price - An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or
- an estimated price - An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives, or
- an average price - An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Special Cases – Value-Based Programs:
If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBS through average pricing or fee schedule adjustments.

Return of Overpayments:
Recoveries of overpayments from a Host Blue or its Preferred and Non-Preferred Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/health care provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to BCBS, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

Submitting a Blue Cross Blue Shield Global Core Claim:
When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available on the Quantum Health website at www.upquantumhealth.com or by calling Quantum Health at (855) 649-3855.

Notice: If you receive services from a Preferred Provider, your liability will generally be less than if you receive services from a Non-Preferred Provider. You may contact Quantum Health by calling (855) 649-3855 or by going to Quantum Health at www.upquantumhealth.com to obtain information on Preferred Providers.

PLAN FEATURES

The sections that follow describe the BCBS Medical Options, the benefits provided under each, how to file claims for benefits, the Appeal procedures to be used if you are denied benefits, and the coordination of benefit provisions.

COST SHARING FEATURES OF THE BCBS MEDICAL OPTIONS

This section describes the cost sharing features of the BCBS HDHP Options and the BCBS Non-HDHP PPO, each hereafter referred to separately as "the Plan."

"Cost sharing features" is a term that refers to the ways in which the Plan and the Employee each pays for a portion of the cost of medical care coverage. Under the HDHPs and the Non-HDHP PPO, cost of medical coverage is shared through a combination of premium contributions and subsidies, as well as through pay-as-you-go Deductibles and/or Coinsurance. All Annual Benefit Maximums, Coinsurance Maximums and Medical Deductibles accumulate during the Calendar Year. Each of these features is described in the paragraphs that follow.

Premium Contribution:

You pay a portion of the cost of your medical coverage in the form of a premium contribution. Your premium contribution is a before-tax deduction from your monthly pay, unless you are receiving long-term disability benefits, then you will pay the premium contribution on an after-tax basis. The amount of the premium contribution depends on both the BCBS Medical Option in which you are enrolled and your coverage level (i.e., Employee Only, Employee + Spouse, Employee + Child(ren), or Employee + Family). The services of an actuary and/or underwriter are used to determine premiums for each BCBS Medical Option.

Deductible:

The Deductible is the amount you pay each year before expenses are paid by the Plan. Under each BCBS HDHP Option, there is a single Deductible for medical expenses (including mental healthcare and Substance Use Disorder Treatment) and pharmacy expenses. Under the BCBS Non-HDHP PPO, there is only a Deductible for medical expenses (including mental healthcare and Substance Use Disorder Treatment). The BCBS Non-HDHP PPO pays a portion of all expenses for Prescription Drug Products, which are those Prescription Drug Products on the Prescription Drug List. (See the "Pharmacy Program Definitions" on page 82 for the definition of "Prescription Drug Product" and Prescription Drug List").

If you are enrolled at an Employee + Dependent(s) Coverage level, each Covered Person must satisfy the Employee + Dependent(s) Coverage per person annual Deductible or a combination of Covered Persons must satisfy the Employee + Dependent(s) Coverage combined annual maximum Deductible before Coinsurance applies. The annual Deductible for you and your covered Dependents is capped regardless of the number of Covered Persons in your family. The per person Deductible will be satisfied for all Covered Persons of the family for the remainder of the Calendar Year once two or more Covered Persons of your family incur expenses which together equal the Employee + Dependent(s) Coverage combined annual maximum Deductible.

- The amounts you pay for contracted rates with a Preferred Provider for Covered Services (page 20) are applied against the Deductible. In situations in which you receive Covered Services from Non-Preferred Provider and the Balance Billing protections described on page 11 apply, your Deductible will be based on the amount the Plan would pay a Preferred Provider for the Covered Service. Otherwise, if a Non-Preferred Provider is used to receive Covered Services, only the amount you pay up to the Maximum Benefit Amount for Covered Services are applied against the Deductible.
- If you are enrolled in a BCBS HDHP Option, the amount paid at an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Deductible. If you obtain a Prescription Drug Product from an Out-of-Network Retail Pharmacy, only the amount you pay up to the Predominant Reimbursement Rate for a Prescription Drug Product on the Prescription Drug List are applied against the HDHP Deductible. Medications not listed on the Pharmacy Drug List are excluded from coverage.
- Amounts paid for over-the-counter drugs and dental or vision care Copayments do not count toward your Deductible.
- Each BCBS Medical Option has a higher Deductible to meet if Non-Preferred Providers are used and the Balance

Billing protections do not apply to the Covered Service received. Any eligible expenses incurred will apply to either or both the In-Network and Out-of-Network Deductible amounts.

Specific Deductible features of each BCBS Medical Option are presented in the Schedule of Benefits, beginning on page 12.

Craft Professional Employee Transfers: If you transfer from a Union Pacific Craft Professional position to a Management position during a Calendar Year and elect coverage under any of the BCBS Medical Options, the amounts counted during the same Calendar Year against your Deductible under the Railroad Employees National Health and Welfare Plan may be credited toward your Deductible under the newly elected Management medical plan option. To initiate this process, you must submit a ticket to Union Pacific Employee Benefits.

Coinsurance Amount:

BCBS HDHP Options: After the HDHP Deductible is met, the Plan pays a specified portion of the Covered Services and covered Prescription Drug Products for the Calendar Year, and you pay the remaining portion, up to the Coinsurance Maximum.

- The medical Coinsurance is a percentage of the contracted rate if a Preferred Provider is used. In situations in which you receive Covered Services from a Non-Preferred Provider and the Balance Billing protections described on page 11 apply, your medical Coinsurance will be based on the amount the Plan would pay a Preferred Provider for the Covered Health Service. Otherwise, if a Non-Preferred Provider is used, a lower percentage of the Maximum Benefit Amount for Covered Services applies. Medical Coinsurance payments are capped by the Annual HDHP Coinsurance Maximum.
- The pharmacy Coinsurance level depends on the Plan's Prescription Drug List. The member pays a small flat dollar amount for Tier-1 (typically Generic drugs), a percentage for Tier-2 (typically Preferred Brand-Name drugs), and a higher percentage for Tier-3 (typically Non-Preferred Brand Name drugs). The lesser of actual costs or a minimum pharmacy Coinsurance amount applies and for each Tier-2 and Tier-3 prescription or refill, a maximum pharmacy Coinsurance applies. In addition, the pharmacy Coinsurance is a portion of the Prescription Drug Cost if the prescription is dispensed by an In-Network Pharmacy. If an Out-of-Network Retail Pharmacy is used, the pharmacy Coinsurance is a portion of the Prescription Drug Product's Predominant Reimbursement Rate. Pharmacy Coinsurance Payments are capped by the Annual HDHP Coinsurance Maximum.

BCBS Non-HDHP PPO: After the Deductible is met, the BCBS Non-HDHP PPO pays a specified percentage of the Covered Services for the rest of the Calendar Year and you pay the remaining percentage. The medical Coinsurance is a percentage of the contracted rate if a Preferred Provider is used. In situations in which you receive Covered Services from a Non-Preferred Provider and the Balance Billing protections described on page 11 apply, your medical Coinsurance will be based on the amount the Plan would pay a Preferred Provider for the Covered Service. Otherwise, if a Non-Preferred Provider is used, a lower percentage of the Maximum Benefit Amount for Covered Services applies.
Medical Coinsurance payments are capped by the Annual Coinsurance Maximum.

Participants in the BCBS Non-HDHP PPO pay a pharmacy Coinsurance amount for Prescription Drug Products on the Prescription Drug List. No prescription drug Deductibles apply. Cost sharing through pharmacy Coinsurance begins with the first prescription. Pharmacy Coinsurance Payments are capped by the Annual Coinsurance Maximum. The Pharmacy Coinsurance does not count toward the Deductible.

The pharmacy Coinsurance level depends on the Plan's Prescription Drug List, with the member paying a small flat dollar amount for Tier-1 (typically Generic drugs), a percentage for Tier-2 (typically preferred Brand- Name drugs), and a higher percentage for Tier-3 (typically Non-Preferred Brand Name drugs). The lesser of actual costs or a minimum pharmacy Coinsurance amount applies and for each Tier-2 and Tier-3 prescription or refill, a maximum pharmacy Coinsurance applies.

Specific medical Coinsurance features of each BCBS Medical Option are presented in the Schedule of Benefits, beginning on page 12.

Specific pharmacy Coinsurance levels, minimum and maximum costs, and Annual out-of-pocket limit features are presented in the Schedule of Benefits beginning on page 12.

Coinsurance Maximum:

The Coinsurance Maximum is the amount you pay each year before the BCBS Medical Option in which you are enrolled pays 100% of the contracted Preferred Provider rate or the Maximum Benefit Amount for Covered Services and 100% of the Prescription Drug Cost or Predominant Reimbursement Rate for covered Prescription Drug Products, for the remainder of the Calendar Year. Under all BCBS Medical Options, there is a single Coinsurance Maximum for medical and pharmacy expenses.

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

If you are enrolled at an Employee + Dependent(s) Coverage level, each Covered Person must satisfy the Employee + Dependent(s) Coverage per person annual Coinsurance Maximum or a combination of Covered Persons must satisfy the Employee + Dependent(s) Coverage combined annual Coinsurance Maximum. The annual Coinsurance Maximum for you and your covered Dependents is capped regardless of the number of Covered Persons in your family. The per person Coinsurance Maximum will be satisfied for all Covered Persons of the family for the remainder of the Calendar Year once two or more Covered Persons of your family incur expenses which together equal the Employee + Dependent(s) Coverage combined annual Coinsurance Maximum..

Specific Coinsurance Maximum features of each BCBS Medical Option are presented in the Schedule of Benefits, beginning on page 12.

Provider Charges:

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

Use of Preferred Providers:

The Plan offers a broad network of providers and provides the highest level of benefits when Covered Persons utilize Preferred Providers. These networks will be indicated on your Plan identification card. Specific benefit levels are shown in the Schedule of Benefits beginning on page 12.

Use of Out-of-Network Providers:

Generally speaking, if you are in an area where the BCBS PPO Network or a provider in the BCBS Preferred Provider Program is available and a Non-Preferred Provider is used, a higher Deductible will apply. You will receive lower Medical Care Program Medical Coinsurance after the Deductible is met. Eligible expenses for Covered Health Services received from Out-of-Network Providers are determined by Highmark BCBS (and in accordance with applicable requirements under the No Surprises Act) at the billed rate up to the Maximum Benefit Amount. Amounts charged above Maximum Benefit Amount are not "covered" expenses and do not count toward Deductibles or Coinsurance Maximums, and you may be subjected to Balance Billing (unless the *Protection from Balance Billing* section below applies). Balance Billing is the practice of the Non-Preferred Provider billing for the difference between his/her bill and the amount paid by the Plan, which is determined by BCBS based on the Maximum Benefit Amount. The lower Medical Care Program Medical Coinsurance will be calculated as a percent of the Maximum Benefit Amount. In addition, the Coinsurance Maximum will be higher if a Non-Preferred Provider is used.

Occasionally a provider in a particular specialty is not readily available. To accommodate these cases, whenever a Preferred Provider is not available within a 30-mile radius of an Employee's residence, the Employee may use a Non- Preferred Provider and still obtain the network level of benefits (i.e., lower Deductibles and higher Medical Care Program Coinsurance, if applicable). However, since the Non-Preferred Provider does not have a contract with BCBS, Medical Care Program benefits payable will be based on the Maximum Benefit Amount and balance billing may occur (unless the *Protection from Balance Billing* section below applies).

If an eligible Dependent does not reside with the Employee, his/her residence is deemed to be the same as the Employee's residence. **To qualify for coverage of Out-of-Network expenses at the In-Network benefit level, the participant must**

contact Quantum Health at (855) 649-3855 BEFORE services are rendered to verify that the Non- Preferred Provider Doctor/specialist qualifies for coverage at the network level and to facilitate the appropriate payment of applicable claim(s).

Maximum Benefit Amount:

The Maximum Benefit Amount is a maximum amount determined by BCBS for Covered Services. The Maximum Benefit Amount will be the amount agreed upon between BCBS and Preferred Providers for the Covered Service. If the provider does not participate with BCBS then the Maximum Benefit Amount may be a negotiated amount. In the event the negotiations with a Non-Preferred Provider are unsuccessful, then the Maximum Benefit Amount will be based on pricing determined by a national database or at the out-of-network rate under the No Surprises Act.

Cost Sharing and Price Comparison Tools:

Information regarding a participant's cost sharing liability for designated items/services furnished by providers can be found at the Quantum Health site at www.upquantumhealth.com. Also, cost sharing information is available in paper form upon request.

Protection from Balance Billing:

If you have an Emergency medical condition and get Emergency services from a Preferred or Non-Preferred Provider or facility, the most the provider or facility may bill you is the In-Network Deductible and medical Coinsurance under the BCBS Medical Option in which you participate. You can't be balance billed for these Emergency services. This includes the services you may get after you're in stable condition, unless, in the case of Non-Preferred Provider, you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Also, when you receive Covered Services from an In-Network Hospital or ambulatory surgical center, certain providers there may be Out-of-Network. In these cases, the most those providers can bill you is the In-Network Deductible and medical Coinsurance under the BCBS Medical Option in which you participate. This applies to Emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These Non-Preferred Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these In-Network facilities, Non-Preferred Providers can't balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also aren't required to get care Out-of- Network. You can choose a provider or facility in the BCBS PPO Network.

In situations in which Balance Billing isn't allowed, you have the following protections:

- You are only responsible for paying the In-Network Deductible and Coinsurance you would pay if the provider or facility was In-Network. The Plan will pay any additional costs to the Non-Preferred Provider or facility directly.
- Generally, the Plan must:
    - Cover Emergency Covered Services without requiring Prior Authorization;
    - Cover Emergency Covered Services furnished by a Non-Preferred Provider or facility;
    - Base your Deductible and medical Coinsurance amount you owe to the Non-Preferred Provider on the amount the Plan would pay a Preferred Provider or facility for the Covered Services and show that amount on your explanation of benefits; and
    - Count the amount you pay for Emergency or Out-of-Network Covered Services toward your In- Network Deductible and Coinsurance Maximum, as applicable.

If you think you've been wrongly billed, you should contact Quantum Health at (855) 649-3855. The federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law

Overall Maximum Benefit:

Except as otherwise indicated in the "Covered Services" section beginning on page 20, there is no overall maximum benefit for essential Covered Services.

NOTE: Additional limitations that apply to specific benefits are described throughout this 2026 BCBS Attachment.

PLAN BENEFITS OFFERED

Benefits are payable under the BCBS Medical Options for Covered Services performed and supplies prescribed by a Doctor, which are deemed Medically Necessary as determined by the Claims Administrator for medical services, medical supplies, mental healthcare/Substance Use Disorder Treatment or by OptumRx for prescription drugs. Such services and supplies must be provided while coverage is in effect.

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

Schedule of Benefits

2026 SCHEDULE OF BENEFITS						
HEALTHCARE						
	BCBS HDHP1		BCBS HDHP2		BCBS Non-HDHP PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible						
Employee Only	$3,400	$6,800	$4,900	$9,800	$750	$1,500
Employee + Dependent(s) Coverage						
- Per Person	$3,400	$6,800	$4,900	$9,800	$750	$1,500
- Annual Maximum	$6,800	$13,600	$9,800	$19,600	$1,500	$3,000
HSA+* MAXIMUM COMPANY CONTRIBUTIONS						
Employee Only	$900		$900		N/A	
Employee + Spouse	$1,800		$1,800		N/A	
Employee + Child(ren)	$1,800		$1,800		N/A	
Employee + Family	$2,700		$2,700		N/A	
Medical Coinsurance After Deductible						
Plan Pays	85%	65%	85%	65%	85%	65%
Employee Pays	15%	35%	15%	35%	15%	35%
Coinsurance Maximum (Annual Limit after Deductible)						
Employee Only	$2,000	$4,000	$1,500	$3,000	$2,750	$5,500
Employee + Dependent(s) Coverage						
- Per Person	$2,000	$4,000	$1,500	$3,000	$2,750	$5,500
- Annual Maximum	$4,000	$8,000	$3,000	$6,000	$5,500	$11,000
Preventive Care (As outlined under "Health Management Programs" and "Preventive Pharmacy Benefits")	Paid at 100%	No benefits are paid for an Out-of-Network Provider	Paid at 100%	No benefits are paid for an Out-of-Network Provider	Paid at 100%	No benefits are paid for an Out-of-Network Provider
Maximum Lifetime Benefit	Unlimited, except as otherwise indicated in the "Covered Services" section beginning on page 20.					

[+]A Health Savings Account (HSA) is not an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, amended (ERISA).
[*]The HSA contributions reflected in this Schedule of Benefits are intended only to illustrate how amounts contributed to an HSA may be used to offset HDHP Deductibles. These amounts would apply for a full-year participant who receives the maximum annual Union Pacific HSA contribution.

PHARMACY PROGRAM			
	BCBS HDHP1	**BCBS HDHP2**	**BCBS Non-HDHP PPO**
RETAIL			
Annual Deductible	Combined Medical and Pharmacy Deductible See "Deductible"	Combined Medical and Pharmacy Deductible See "Deductible"	N/A
Pharmacy Coinsurance	Up to 31-day Supply*		
You Pay	After the Deductible	After the Deductible	No Deductible
Tier 1 – Generic	$10 Copay	$10 Copay	$10 Copay
Tier 2 – Preferred	30%	30%	30%
Tier 3 – Non-Preferred	40%	40%	40%
Pharmacy Coinsurance Minimums/Maximums per Script**	After the Deductible	After the Deductible	No Deductible
Tier 1 – Generic	N/A	N/A	N/A
Tier 2 – Preferred	$30/$90	$30/$90	$30/$90
Tier 3 – Non-Preferred	$60/$150	$60/$150	$60/$150
MAIL ORDER			
Annual Deductible	Combined Medical and Pharmacy Deductible See "Deductible"	Combined Medical and Pharmacy Deductible See "Deductible"	N/A
Pharmacy Coinsurance	Up to 90-day Supply		
You Pay:	After the Deductible	After the Deductible	No Deductible
Tier 1 – Generic	$25 Copay	$25 Copay	$25 Copay
Tier 2 – Preferred	25%	25%	25%
Tier 3 – Non-Preferred	40%	40%	40%
Pharmacy Coinsurance Minimums/Maximums per Script**	After the Deductible	After the Deductible	No Deductible
Tier 1 – Generic	N/A	N/A	N/A
Tier 2 – Preferred	$75/$225	$75/$225	$75/$225
Tier 3 – Non-Preferred	$150/$375	$150/$375	$150/$375
Pharmacy Coinsurance Maximum	Combined Medical and Pharmacy Coinsurance Maximum See "Coinsurance Maximum"		
* Certain Generic drugs may be purchased at a Retail Pharmacy for a supply up to 90-days. ** If the actual cost of the drug is less than the stated minimum, the member will pay the actual drug cost.			

OUT-OF-POCKET MAXIMUM						
Annual Deductible and Coinsurance Maximum	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Employee Only	$5,400	$10,800	$6,400	$12,800	$3,500	$7,000
Employee + Dependents(s) Coverage						
- Per Person	$5,400	$10,800	$6,400	$12,800	$3,500	$7,000
- Annual Maximum	$10,800	$21,600	$12,800	$25,600	$7,000	$14,000

CARE COORDINATION PROCESS

Introduction

The Plan incorporates a "Care Coordination" process by Quantum Health. This process includes a staff of Care Coordinators who receive a notification regarding most healthcare services sought by Covered Persons, and coordinate activities and information flow between the providers.

Care Coordination is intended to help Covered Persons obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and for early identification of complex medical conditions. The Care Coordinators are available to Covered Persons and their providers for information, assistance, and guidance, and can be reached toll-free by calling (855) 649-3855.

Process of Care Requirements

In order to receive the highest benefits available in the Plan, Covered Persons must follow the "Care Coordination Process" outlined in this section as well as other provisions in the Plan. In some cases, failure to follow this process of care can result in penalties. The process of care generally includes:

- Designating a coordinating Primary Care Physician (PCP). This is encouraged but not required.
- Review and coordination process, including:
  - Prior Authorization of certain procedures
  - Utilization Review
  - Concurrent Review of hospitalization and courses of care
  - Case Management
  - Chronic Condition Management/Disease Management

As described below, Prior Authorizations are generally requested by the providers on behalf of their Covered Persons. If Prior Authorization for a Covered Health Service is required, the Covered Person is responsible for obtaining Prior Authorization if services requiring Prior Authorization are provided by an Out-of-Network Provider. If such services are provided by a Preferred Provider, the provider is generally responsible for obtaining Prior Authorization.

Designated Coordinating Physician

All Covered Persons are asked to designate a coordinating Primary Care Physician (PCP) for each Covered Person of their family when registering for the Quantum Health site or talking with a Care Coordinator. While such designation is not mandatory, it is strongly recommended. **To ensure the highest level of benefits, and the best coordination of your care, all Covered Persons are encouraged to designate an In-Network Primary Care Physician (PCP) to be their coordinating Physician.**

The care coordination process generally begins with the "**coordinating Physician**," who is a Preferred Provider Primary Care Physician who maintains a relationship with the Covered Person and provides general healthcare guidance, evaluation, and management. The following types of physicians are typically selected by Covered Persons as their coordinating PCP:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrician (for Children)
- OB/GYN may serve as the primary care physician ONLY during the course of a woman's pregnancy

Covered Persons are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP, who will guide patients as appropriate. In addition to providing care coordination and submitting referral and Prior Authorization requests, the PCP may also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Care Coordinators may be able to assist you by providing a list of available PCPs and even contacting PCP offices on your behalf. Please contact the Care Coordinators at (855) 649- 3855.

Review and Coordination Process
The Care Coordination process includes the following components:

Prior Authorization of Certain Procedures

To be covered at the highest level of benefit and to ensure complete care coordination, the Plan requires that certain care, services and procedures receive approval (i.e., Prior Authorization) before they are provided. Prior Authorization requests must be submitted to the Care Coordinators by a specialty Physician, designated PCP, other PCP, or other healthcare provider, including an Out-of-Network Provider, providing the care, service or procedure. Your Plan identification card includes instructions. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the need for the Prior Authorization request and to ensure that the care, service and/or procedure meet Plan criteria. If a Prior Authorization request does not meet Plan criteria, the Care Coordinators will contact the Covered Person and healthcare provider and assist in redirecting care if appropriate.

The following services require Prior Authorization, provided it is not an Emergency*:

- Inpatient and Skilled Nursing Facility Admissions
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy and radiation therapy)
- Genetic Testing
- Home Health Care
- Hospice Care
- DME – all rentals and any purchase over $1500
- Organ, Tissue and Bone Marrow Transplants
- Dialysis
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Abuse

***"Emergency" admissions and procedures**
Any Hospital admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the patient's health is considered an emergency and does not require Prior Authorization.

Penalties for Not Obtaining Prior Authorization:

A non-Prior Authorization penalty is the amount you must pay if Prior Authorization is not obtained for Covered Service listed above prior to receiving the service. A penalty of $300 will be applied if a Covered Person receives but did not obtain Prior Authorization for a Covered Service for which Prior Authorization is required.

The phone number to call for Prior Authorization is listed on the Plan identification card.

- ## Utilization Review
  The Care Coordinators will review each Prior Authorization request to evaluate whether the care, requested procedures, and requested care setting all meet utilization criteria established by the Plan. The Plan has adopted the utilization criteria in use by the Care Coordinators. If a Prior Authorization request does not meet these criteria, the request will be reviewed by one of the medical directors for Quantum Health, who will review all available information and if needed consult with the requesting provider. If required, the medical director will also consult with other professionals and medical experts with knowledge in the appropriate field. He or she will then provide, through the Care Coordinators, a recommendation to Highmark BCBS whether the request should be approved or denied. In this manner, the Plan ensures that Prior Authorization requests are reviewed according to nationally accepted standards of medical care, based on community healthcare resources and practices.

- ## Concurrent Review
  The Care Coordinators will regularly monitor a hospital stay, other institutional admission, or ongoing course of care for any Covered Person, and examine the possible use of alternate facilities or forms of care. The Care Coordinators will communicate regularly with attending Physicians, the utilization management staff of facilities providing services, and the Covered Person and/or family, to monitor the patient's progress and anticipate and initiate planning for future needs (discharge planning). Such concurrent review, and authorization for Plan coverage of hospital days, is conducted in accordance with the utilization criteria adopted by the Plan and Quantum Health.

- **Case Management**

  Case Management is ongoing, proactive coordination of a Covered Person's care in cases where the medical condition is, or is expected to become catastrophic, chronic, or when the cost of treatment is expected to be significant. Examples of conditions that could prompt case management intervention include but are not limited to, cancer, chronic obstructive pulmonary disease, multiple trauma, spinal cord injury, stroke, head injury, AIDS, multiple sclerosis, severe burns, severe psychiatric disorders, high risk pregnancy, and premature birth.

  Case Management is a collaborative process designed to meet a Covered Person's health care needs, maximize their health potential, while effectively managing the costs of care needed to achieve this objective. The case manager will consult with the Covered Person, their family (if requested), the attending Physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care which provides the most appropriate health care and services in a timely, efficient and cost-effective manner.

  During the process of Case Management, services may be recommended that are subject to Clinical Review determinations. These functions are the sole responsibility of Quantum Health. The case manager will assist providers and Covered Persons with ensuring that this is coordinated and timely.

  "Clinical Review" means a process in which information about the Covered Person is collected and reviewed against established criteria to determine if the service, treatment or supply is Medically Necessary and is a Covered Health Service.

  If the case manager, Covered Person, his or her provider and Highmark BCBS all agree on alternative care that can reasonably be expected to achieve the desired results without sacrificing the quality of care provided, Highmark BCBS may alter or waive the normal provisions of this Plan to cover such alternative care, at the benefit level determined by Highmark BCBS.

  In developing an alternative plan of treatment, the case manager will consider:
  - The Covered Person's current medical status;
  - The current treatment plan;
  - The potential impact of the alternative plan of treatment;
  - The effectiveness of such care; and
  - The short-term and long-term implications this treatment plan could have.

  Quantum Health retains the right to review the Covered Person's medical status while the alternative plan of treatment is in process, and to discontinue the alternative plan of treatment with respect to medical services and supplies which are not Covered Services under the Plan if:
  - The attending physician does not provide medical records or information necessary to determine the effectiveness of the alternative plan of treatment
  - The goal of the alternative care of treatment has been met
  - The alternative plan of care is not achieving the desired results or is no longer beneficial to the Covered Person as determined by the Claims Administrator.

- **Chronic Condition Management**

  Chronic Condition Management (also referred to as Disease Management) is specialized support and coordination for Covered Persons with lifelong, chronic conditions such as diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and asthma. Chronic Condition Management is a collaborative process that is designed to help Covered Persons with such conditions self-manage based on care pathways with respect to such disease state, including but not limited to assisting Covered Persons in understanding the care pathway, assisting Covered Persons in setting goals, facilitating dialog with physicians if there are complications or conflicts with the patient's care, evaluating ways to eliminate barriers to successful self-management and generally maximize their health. Covered Persons who are identified from claims or other sources will be assessed for level of risk for each disease state and may be contacted proactively by a Chronic Condition Case Manager (also referred to as Disease Manager). Covered Persons whose information indicates they are high risk will be contacted by a Chronic Condition Case Manager for an assessment and ongoing assistance and will be asked to update their care pathway information bi-annually. Covered Persons who are low or moderate risk may request assistance of a Chronic Condition Case Manager and will also be asked to update their care pathway information on a bi-annual basis.

Participation in chronic condition care management is voluntary, but participants may receive various prescription medications and/or supplies at a reduced cost or may be entitled to benefits that non-participants do not receive.

GENERAL PROVISIONS FOR CARE COORDINATION

Care Coordination Representative
The Covered Person is ultimately responsible for ensuring that all Prior Authorizations are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual Prior Authorization process will be executed by the Covered Person's Physician(s) or other providers. By enrolling in this Plan, the Covered Person authorizes the Plan and its designated service providers (including Quantum Health, Highmark BCBS and others) to accept healthcare providers making Prior Authorization submissions, or who otherwise have knowledge of the Covered Person's medical condition, as their care coordination representative in matters of Care Coordination.
Communications with and notification to such healthcare providers shall be considered notification to the Covered Person.

Time of Notice
Prior Authorization requests and other required notifications should be made to the Care Coordinators within the following timeframe:

- At least **three business days,** before a scheduled (elective) Inpatient Hospital admission
- By the next business day after, an emergency Hospital admission
- Upon being identified as a potential organ or tissue transplant recipient
- At least three business days before receiving any other services requiring Prior Authorization

Maternity Admissions
A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the care coordination process complies with all state and federal regulations regarding utilization review for maternity admissions. This Plan complies with the Newborns and Mothers Health Protection Act. The Plan will not restrict benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require Prior Authorization for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the Plan will only consider benefits for the actual length of the stay. The Plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48 or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Care Coordination is not a guarantee of payment of benefits
The Care Coordination process does not provide a guarantee of payment of benefits. Approvals of Prior Authorization notices for specialty visits, procedures, hospitalizations and other services, indicate that the medical condition, services, and care settings meet the utilization criteria established by the Plan. The Care Coordination approvals do not indicate that the service is a covered benefit, that the Covered Person is eligible for such benefits, or that other benefit conditions such as co-pay, deductible, co-insurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

Result of Not Following the Coordinated Process of Care
Failure to comply with the care coordination "process of care" may result in reduction or loss in benefits. The Penalties for Not Obtaining Prior Authorization section specifies applicable penalties. Charges you must pay due to any penalty for failure to follow the care coordination process do not count toward satisfying any Deductible, Coinsurance or out- of-pocket limits of the Plan.

Appeal of Care Coordination Determinations
Covered Persons have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of benefits and penalties. The appeal process is detailed in the Claims and Appeal Procedures section within this document.

It is important to refer to other sections of this document which defines terms, covered benefits, exclusions and other important information. If you need help locating information in the document, please contact a Care Coordinator and we would be happy to assist you.

Care Coordinators: 1-855-649-3855

MEDICAL AND MENTAL HEALTHCARE COVERED SERVICES

This section generally describes the Covered Services, and limits that may apply to the benefits provided by the BCBS Medical Options which are administered by Quantum Health and Highmark BCBS. To obtain information about a specific medical service or supply, call Quantum Health at (855) 649-3855.

This Plan does not claim to cover all medical expenses that you may incur. To be covered by the Plan, the Claims Administrator must determine that the services and supplies are Medically Necessary, and given for the diagnosis or treatment of an accidental Injury or Illness. (See, "Medical Claims & Appeals" beginning on page 45, which explains the types of claims for which either Quantum Health or Highmark BCBS serves as the "Claims Administrator.") These requirements apply whether or not you receive services or supplies from Preferred or Non-Preferred Providers.

Important: You and your Doctor decide which services and supplies are given, but this Plan only pays for Covered Services and supplies which are deemed Medically Necessary as determined by the Claims Administrator.

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

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

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

The Claims Administrator will determine whether a service is Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a treating Doctor.

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

Custodial Care:
The Plan does not provide benefits for services and supplies that are furnished primarily to provide Custodial Care. An Alternate Facility may also provide Mental Healthcare or Substance Use Disorder Services on an Outpatient basis or Inpatient basis (for example a Residential Treatment Facility).

COVERED SERVICES

Benefits paid for the Covered Services shown in the chart below depend on the BCBS Medical Option in which you are enrolled and the In-Network status of the provider. What you pay and what the Plan pays is described in more detail in the "Schedule of Benefits" beginning on page 12.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Acupuncture	Acupuncture services provided in an office setting by a provider who is practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body: Doctor of Medicine, Doctor of Osteopathy, Chiropractor, or Acupuncturist. Limited to 20 visits per year.	Acupuncture services by a non-qualified provider or in excess of 20 visits per year.
Allergy Care	Testing in a Doctor's office and treatment (including injection administered by a Nurse).	
Ambulance Services	**Emergency Only:** Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. **Non-Emergency:** Local transportation by professional ambulance, other than air ambulance, to and from a medical facility. Longer distance transportation by ambulance or air ambulance, to the nearest medical facility qualified to give the required treatment where Medically Necessary. Air ambulance transport is covered in the following circumstances: Patient requires transport to a Hospital or from one Hospital to another because the first Hospital does not have the required services and/or facilities to treat the patient, and ground ambulance transportation is not Medically Necessary because of the distance involved, or because the patient has an unstable condition requiring medical supervision and rapid transport.	Air ambulance benefits in excess of a $25,000 maximum per occurrence will not be paid.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Ambulance Services (Cont.)	**Air Ambulance:** Air ambulance transport is covered, up to a maximum $25,000 per occurrence, in the following circumstances: Patient requires transport to a Hospital or from one Hospital to another because the first Hospital does not have the required services and/or facilities to treat the patient, and ground ambulance transportation is not Medically Necessary because of the distance involved, or because the patient has an unstable condition requiring medical supervision and rapid transport. Covered Health Services for air ambulance transport is considered In-Network for purposes of determining cost sharing (i.e., Deductible and medical Coinsurance), regardless of the network status of the air ambulance service provider.	
Anesthesia	Anesthesia and related services provided in connection with a covered surgical procedure. Dental anesthesia fees and related facility fees at outpatient hospital, Inpatient hospital or ambulatory surgical center for the following: • Children under the age of 8, or • Developmentally disabled (any age) – the patient's physician will determine whether the patient qualifies as developmentally disabled.	For dental anesthesia services, no coverage for dentist professional fees.
Audiologists	Charges by a licensed or certified audiologist for Doctor prescribed hearing evaluations to determine the location of a disease within the auditory system; for validation or organicity tests to confirm an organic hearing problem.	
Breast Pumps	Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following: • Which pump is the most cost effective; • Whether the pump should be purchased or rented; • Duration of a rental; and • Timing of an acquisition. Benefits are only available if breast pumps are obtained from a DME provider or Physician.	

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Breast Reconstruction	Breast reconstruction required as a result of a mastectomy. **Special Notice Regarding Mastectomies:** If you or your Dependent receives a mastectomy, the covered benefits for the patient also include coverage for: a) all stages of reconstruction of the breast on which the mastectomy has been performed, b) surgery and reconstruction of the other breast to produce a symmetrical appearance, c) prostheses including mastectomy bras and lymphedema stockings for the arm, d) treatment of physical complications in all stages of mastectomy, including lymphedemas, e) replacement of an existing breast implant if the initial breast implant followed mastectomy, and f) other services required by the Women's Health and Cancer Rights Act of 1998, including breast treatment of complications. Benefits payable will be determined in a manner in consultation with the attending Doctor and patient. Such coverage is subject to Annual Deductibles, Coinsurance, and other provisions that are applicable to other benefits of the BCBS Medical Options.	Breast Reconstruction, other than in conjunction with a mastectomy, that does not meet the criteria established through the Prior Authorization process.
Breast Reduction	Breast reduction Surgery is a Covered Service with documentation of the following functional impairments: 1) Shoulder grooving or excoriation resulting from the brassiere shoulder straps, due to the weight of the breasts; AND 2) Documentation from medical records of medical services related to complaints of the shoulder, neck or back pain attributable to macromastia. In addition, the Surgery must be determined not to be Cosmetic Treatment by the Claims Administrator. Breast reduction Surgery is covered when a reconstruction has been performed on the other breast (see **Special Notice Regarding Mastectomies**, above).	Breast reduction Surgery is NOT a Covered Health Service when performed to improve appearance or for the purpose of improving athletic performance.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Cardiac and Pulmonary Rehabilitation Services	Services must be performed by a licensed therapy provider under the direction of a Doctor. Benefits are available only for the rehabilitation services that are expected to result in significant physical improvement in the patient's condition within 2 months of the start of treatment. The primary intent is to improve the functional capacity of the heart and/or lungs and provide the necessary skills for self-monitoring of unsupervised exercise. Limited to 36 visits per year. Additional visits beyond the 36 visit limit may be available if Medically Necessary.	Memberships to health clubs or equipment to use at home are not covered. The Medical Care Program excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
Chiropractic Care/Spinal Manipulation	Services of a spinal treatment specialist in the specialist's office for chiropractic and osteopathic manipulative therapy, including diagnosis and related treatment. Limited to 30 visits per Calendar Year.	Massage therapy is NOT covered. The Medical Care Program excludes treatment that ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.
Clinical Trials	Approved Clinical Trials for qualified individuals, as described in the PPACA. **Approved Clinical Trials:** A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life- threatening disease or condition and is one of the following: • A federally funded or approved trial. • A clinical trial conducted under an FDA Investigational new drug application. • A drug trial that is exempt from the requirement of an FDA investigational new drug application.	
Cochlear Implant	Covered if diagnosis of severe to profound bilateral sensorineural hearing loss and severely difficult speech discrimination, or post-lingual sensorineural deafness in an adult.	
Congenital Heart Disease Surgery	See Surgery	
Cosmetic Services	The following cosmetic procedures are covered, provided the procedure has been determined to be reconstructive rather than cosmetic: • Correction of a congenital anomaly. • Repair, following accidental injury or sickness. • Reconstructive Surgery (See Surgery)	Cosmetic services that do not meet the criteria listed will not be covered.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Dental Services	The following services and supplies are covered only if needed because of accidental injury to natural teeth: • Oral Surgery • Full or partial dentures • Fixed bridgework • Prompt repair to natural teeth • Crowns • Required anesthesia to perform covered dental services Accident/Injury must have occurred while coverage is in effect. Dental treatment is covered only if needed because of accidental Injury to natural teeth. Services must be: • Provided by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). • As a result of damage that is severe enough that the initial contact with the Doctor or Dentist occurred within 72 hours of the accident. Benefits are available only for treatment of sound, natural teeth. The Dentist must certify that the Injury to the tooth was a virgin or unrestored tooth; has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally during chewing and speech. Services for final treatment to repair the damage must be completed within 12 months of the Accident.	Dental services that are not a result of an Accident. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of teeth.
Diabetic Supplies	Diabetic supplies including syringes, test strips, lancets and Omnipod 5 devices/supplies are covered under the Pharmacy Program (beginning on page 63). Insulin pump (excluding Omnipod 5) and Glucose Monitors are covered under Durable Medical Equipment.	
Dialysis	See Therapeutics - Outpatient	
Disposable Medical Supplies	Must be prescribed by Doctor, including ostomy supplies.	Non-prescribed supplies.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Doctor Services	Medical care and treatment by a Doctor including Hospital, office and home visits, Telehealth, and emergency room services. Covered Health Services received in a Doctor's office including: • Treatment of a sickness or injury. Preventive medical care. • Voluntary family planning. • Well-baby and well-child care. • Routine well woman examinations, including pap smears, pelvic examinations, and mammograms. • Routine physical examinations, including hearing screenings. • Immunizations.	
Durable Medical Equipment	Durable Medical Equipment that meets each of the following criteria: 1) Ordered or provided by a Doctor for outpatient use; 2) Used for medical purposes 3) Not consumable or disposable; and 4) Not of use to a person in the absence of a disease or disability. **If more than one piece of Durable Medical Equipment can meet the patient's functional needs, DME benefits are available only for the most cost-effective piece of equipment.** Examples include: • Equipment to assist mobility such as wheelchairs and Hospital-type beds, oxygen concentrator units and the purchase or rental of equipment to administer oxygen (including tubing and connectors). • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure is covered. • Burn garments • Insulin pumps (excluding Omnipod 5) • Cranial banding. Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that treat curvature of the spine are covered under the DME benefit. The Medical Care Program also covers tubings, nasal cannulas, connectors and masks used in connection with DME.	A brace that straightens or changes the shape of the body part is an Orthotic Appliance and is not covered under the DME benefit, except for cranial banding. Dental braces are also excluded from coverage. Air conditioners, humidifiers, dehumidifiers, air purifiers, and filters are not covered. All rentals or purchases of any DME expense over $1,500 is subject to the Prior Authorization requirements**.**
Emergency Health Services (i.e. Emergency Room)	A true emergency is paid at the In-Network level regardless of the network status of the facility that provides the emergency health services. A true emergency is defined as a serious medical condition or symptom resulting from Injury, sickness or mental Illness which arises suddenly, and in the judgment of a reasonable person requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.	

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Emergency Health Services (i.e. Emergency Room) (Cont.)	Notification should be provided to a Quantum Health Coordinator within 24 hours of the first business day after receiving Emergency care and a subsequent and corresponding Hospital admittance.	
Enteral Nutrition	Defined as the delivery of nutrients in liquid form directly into the stomach, duodenum, or jejunum and used when the patient's condition precludes oral intake. Enteral nutrition is covered when it is the sole source of nutrition or when a certain nutritional formula treats inborn error of metabolism.	
Family Planning	See Reproductive Services.	
Gender Dysphoria	The Medical Care Program covers certain services for genital surgery and surgery to change secondary sex characteristics. Contact Quantum Health at (855) 649-3855 for details on what services may be covered and related criteria used to determine whether the services are Medically Necessary.	Contact Quantum Health at (855) 649-3855 for details on what services are not covered including, but not limited to, those services determined to be not Medically Necessary.
Hearing Aids and Related Services	Diagnostic testing, audiometric examination and the purchase/fitting/adjustments of hearing aid devices, when prescribed by a professional Provider. **Limits:** Hearing aids – one (1) pair every three (3) Calendar Years. Dollar Limit - $5,000 every three (3) Calendar Years	
Home Healthcare	Services received from a Home Healthcare Agency that are both ordered by a Doctor and provided by or supervised by a registered Nurse in your home. Benefits are available only when the Home Healthcare Agency services are provided on a part-time, intermittent schedule and when skilled home healthcare is required. Skilled home healthcare is skilled nursing, skilled teaching, and skilled rehabilitation services when the care: 1) Is administered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; 2) Is ordered by the Doctor; 3) Is not delivered for the purpose of assisting with the activities of daily living; 4) Requires clinical training in order to be delivered safely and effectively; and 5) Is not Custodial Care. The Claims Administrator will decide if skilled home healthcare is required by reviewing both the skilled nature of the service and the need for Doctor- directed medical management. Limited to any combination of 40 In-Network and Out- of-Network visits per Calendar Year.	Custodial Care or care for the purpose of assisting with the activities of daily living, including (but not limited to) dressing, feeding, bathing, or transferring from a bed to a chair, are not covered. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Hospice Care	Hospice care that is recommended by a Doctor. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and for short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. The following Hospice care benefits are covered: • Room and board charges in a hospice facility, except for charges that exceed the Hospital's most common semi-private room rate for any day you are Hospital confined or charges that exceed the hospice facility's most common semi-private room rate for any day you are confined in a freestanding hospice facility. • A hospice facility must offer a hospice program that is approved by the Claims Administrator and must either be a Hospital, a freestanding hospice facility that provides Inpatient care, or an organization that provides healthcare services in your home. The facility can provide these services using its own staff or by contracting with other organizations; • Skilled nursing or home health aide services provided by a Nurse or a licensed practical Nurse; • Counseling to enhance your peace of mind if your Doctor determines that your mental state is caused by your terminal illness. Such counseling is also covered for members of your family for up to 6 months after your death; • Up to 7 visits of respite care when part of an integrated hospice program; • Physical, respiratory, or speech therapy; Services of a licensed nutritionist or dietician if needed as part of your hospice care; • Local ambulance or special transport service between your home and the hospice facility; and • Other services which your Doctor, The Claims Administrator determine to be Medically Necessary and which are provided through the hospice program, such as medical supplies, medicines, drugs, Doctor's services, and the rental or purchase of durable medical equipment, whichever is less expensive.	Volunteer services or services normally provided at no charge. Private Duty Nursing. Legal or financial advice. Counseling by clergy or any volunteer group not specifically rendered by and charged for by the hospice. Services provided by a person who lives in your home or who is a member of your immediate family.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Hospital – Inpatient Stay	Benefits available for services and supplies (including room and board) received during the Inpatient stay in a semi-private room (two or more beds). Private rooms are covered up to the highest semi- private room rate for that facility, except that the extra costs of a private room can be covered: • When the Hospital is an all private room Hospital; • When the Hospital's semi-private rooms are filled and only a private room is available; or • When a private room must be used to keep the patient isolated because of the patient's diagnosis.	Charges over and above the highest semi- private room rate are not covered, except as noted in the adjacent covered benefits paragraph.
Inpatient Prescription Drugs	See Prescribed Drugs and Medicines within this Covered Services chart, below.	
Laboratory Services	Laboratory tests for diagnosis or treatment are covered expenses.	
Maternity Care	See Reproductive Services.	
Medical Supplies	Surgical supplies (such as bandages and dressings). Supplies provided during surgery or a diagnostic procedure is included in the overall cost for that surgery or diagnostic procedure. Blood or blood derivatives only if not donated or replaced. Ostomy supplies.	
Mental Healthcare Benefits	Mental Healthcare Services include those received on an Inpatient basis in a Hospital or Alternate Facility, and those received on an Outpatient basis in a provider's office or at an Alternate Facility. Benefits for Mental Healthcare Services include: • Mental health evaluations and assessment; • Diagnosis; • Treatment planning; • Referral services; • Medication management; • Inpatient services; • Partial Hospitalization/Day Treatment; • Intensive Outpatient Treatment; • Services at a Residential Treatment facility; • Individual, family and group therapeutic services; • Crisis intervention; and • Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses. • Eating disorders; and • Marriage counseling if part of a treatment plan for a mental health/substance use disorder diagnosis The Claims Administrator will determine if an Inpatient stay is Medically Necessary. If an Inpatient stay is required, it is covered on a Semi-private Room basis; except: • When the Hospital is an all private room Hospital; • When the Hospital's semi-private rooms are filled and only a private room is available; or • When a private room must be used to keep the patient isolated because of patient's diagnosis.	• Personality disorders • Behavior and impulse control disorders • "Z" codes (please call Quantum Health for further explanation) In addition, wilderness therapy (including Outward bound wilderness camping, tall ship programs and other similar activities) is excluded under the Medical Care Program as it is Unproven and not Medically Necessary for the treatment of emotional, addiction, and/or psychological problems including, but not limited to: • Adjustment disorders • Mood disorders • Anxiety disorders • Conduct disorders • Impulse disorders • Social functioning disorders • Substance related disorders; and • Attention-deficit hyperactivity disorder

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Mental Health Services (Cont.)	You are encouraged to contact Quantum Health for referrals to providers and coordination of care. Mental Healthcare services and supplies are subject to Deductibles and Coinsurance as presented in the Schedule of Benefits on page 12.	
Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders	The Medical Care Program pays benefits for psychiatric services for Autism Spectrum Disorders that are both of the following: • Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and • Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning. These benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which benefits are available under the applicable medical Covered Health Services categories as described in this section. **Benefits include:** • Diagnostic evaluations and assessment; treatment planning; • Referral services; medical management; • Inpatient/24-hour supervisory care; • Partial Hospitalization/Day Treatment; • Intensive Outpatient Treatment; • Services at a Residential Treatment Facility; • Individual, family, therapeutic group and provider-based case management services; • Applied behavioral analysis (ABA) • Psychotherapy, consultation and training session for parents and paraprofessional and resource support to family; and • Crisis intervention. Covered Services include enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are "habilitative" in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. ("Habilitative" services are healthcare services that help a Covered Person keep, learn or improve skills and functioning for daily living.) Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA)).	• Personality disorders • Behavior and impulse control disorders • "Z" codes (please call Quantum Health for further explanation) In addition, wilderness therapy (including Outward bound wilderness camping, tall ship programs and other similar activities) is excluded under the Medical Care Program as it is Unproven and not Medically Necessary for the treatment of emotional, addiction, and/or psychological problems including, but not limited to: • Adjustment disorders • Mood disorders • Anxiety disorders • Conduct disorders • Impulse disorders • Social functioning disorders • Substance related disorders; and • Attention-deficit hyperactivity disorder

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders (Cont.)	You are encouraged to contact Quantum Health for referrals to providers and coordination of care. Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorder services and supplies are subject to Deductibles and Coinsurance as presented in the Schedule of Benefits on page 12.	
Nutritional Counseling	Covered Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus, • Coronary artery disease, • Congestive heart failure, • Severe obstructive airway disease, • Gout, • Renal failure, • Phenylketonuria, and • Hyperlipidemias. When nutritional counseling services are billed as a preventive care service, these services will be paid as described under Preventive Care.	Nutritional counseling for: • Weight loss/obesity; • Conditions which have not been shown to be nutritionally related, including (but not limited to) chronic fatigue syndrome; and • hyperactivity. Benefits are limited to three individual sessions during a Covered Person's participation in the Medical Care Program. This limit applies to non-preventive nutritional counseling services only.
Obesity Surgery	See Surgery.	
Organ/Tissue Transplants	Services and supplies for organ or tissue transplants are covered subject to the following limitations. **Donor Charges for Organ/Tissue Transplants:** Donor charges are considered covered expenses ONLY if the recipient is a Covered Person under the Medical Care Program. If the recipient is not a Covered Person, no benefits are payable for donor charges. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Service unless the search is made in connection with a transplant procedure arranged by a designated transplant facility. (See **Transplant Management Program** for additional covered benefits for certain qualified transplant procedures, page 44).	
Orthognathic Surgery	See Surgery.	

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Outpatient Therapy	Short-term outpatient rehabilitation services (including "habilitative services" (as defined below)) limited to 30 visits per year for the combination of: • Physical Therapy, • Occupational therapy, and • Speech therapy. Rehabilitation services must be provided by a licensed therapy provider, under the direction of a Doctor when required by state law. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. The therapy must be ordered and monitored by a Doctor as part of a Medically Necessary course of treatment for a bodily injury or disease. The therapy must be provided in accordance with a written treatment plan approved by a Doctor. Benefits for Speech Therapy are available only when the speech impediment or speech dysfunction results from injury, stroke, a congenital anomaly, or if such therapy is considered "habilitative services." "Habilitative services" are healthcare services that help a Covered Person keep, learn or improve skills and functioning for daily living. Additional visits beyond the 30 visit limit may be available if Medically Necessary.	The Medical Care Program excludes any type of therapy, service, or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Vocational rehabilitation is not covered.
Physical Therapy	See Outpatient Therapy.	
Prescribed Drugs and Medicines	Prescribed drugs and medicines for Inpatient services are covered under the medical plan provisions.	
Preventive Care	See Preventive Care under "Health Management Programs" on page 43.	
Prosthetic Devices	Benefits are paid by the Medical Care Program for prosthetic devices and appliances that replace a limb or body part or help an impaired limb or body part work. Examples include, but are not limited to: • Artificial limbs, and • Artificial eyes. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The device must be ordered or provided either by a Doctor, or under a Doctor's direction.	

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Pulmonary Rehabilitation	See Cardiac and Pulmonary Rehabilitation Therapy.	
RAPL (Radiology, Anesthesiology, Pathology and Lab)	Services performed by radiologists, anesthesiologists, pathologists, and laboratory.	
Reconstructive Surgery	See Surgery.	
Reproductive Services	**Abortion Services:** Termination of pregnancy; surgically or non-surgically or drug induced Services for the care and treatment of spontaneous abortions (miscarriage). Must meet current federal and state guidelines.	
Reproductive Services	**Family Planning:** Norplant, diaphragms, IUDs and Depo-Provera are covered under the medical plan provisions. When reproductive services are billed as a preventive care service, these services will be paid as described under Preventive Care.	Oral contraceptives are not covered under this medical program but are covered under the Pharmacy Program (see page 63).
	Fertility: Covered Assisted Reproductive Technology (ART) Treatment services for Covered Persons are listed below, including confinement in a Hospital or specialized facility in connection with treatments. • Intrauterine insemination (IUI) • In vitro fertilization (IVF), • Artificial insemination (AI), • The use of donor ovum and donor sperm related costs, including collection and preparation, • Embryo transfer, • Gamete intrafallopian transfer (GIFT), • Zygote intrafallopian transfer (ZIFT), • Tubal ovum transfer (TOT), • Surgery, and • Injectable-drug-therapy administered within the Doctors office. • Expenses for embryo cryopreservation and short-term temporary storage are covered for IVF, AI, GIFT and ZIFT • Male factor infertility related services, excluding reversal of sterilization.	Injectable drug therapy that is self-administered is not covered under this medical program but is covered under the Pharmacy Program. (See "Pharmacy") Freezing or storage of embryo, eggs, or semen (including, but not limited to, oocyte cryopreservation) beyond one year is not covered by the Medical Care Program. The Medical Care Program will not pay for any fertility services provided to an individual who is not a Covered Person. Reversal of sterilization.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Reproductive Services (Continued)	**Maternity Care:** Benefits for pregnancy will be paid at the same level as benefits for any other condition, sickness or injury, unless the services are considered to be preventive services, which are payable at 100% of In-Network covered expenses. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. The Medical Care Program will pay benefits for an Inpatient stay for the birth of a child of at least 48 hours for the mother and newborn child following a normal vaginal delivery and 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. For Inpatient care (for either the mother or child) which continues beyond the 48/96 hour limits, Prior Authorization must be received as soon as possible.	
	Sterilization: Covered Health Services include vasectomy and tubal ligation.	Reversals are not covered.
Second/Third Opinions	See Surgery.	
Sexual Function	Diagnostic services in connection with treatment for male or female impotence. This would include office visits and diagnostic testing.	Non-surgical and surgical procedures and Prescription Drug Product (unless covered under the Pharmacy Program) in connection with treatment for male or female impotence. This would include any medications, oral or other, used to increase sexual function or satisfaction or penile pumps and erect aid devices.
Skilled Nursing Facility/ Inpatient Rehabilitation Facility	Skilled Nursing Facility/Inpatient Rehabilitation Facility benefits are payable for room and board charges for up to 45 days of confinement in a Skilled Nursing Facility/Inpatient Rehabilitation Facility if the charges are incurred while you are confined in the Facility and while coverage is in effect. Such confinement must be due to an injury or illness covered by the Medical Care Program. The stay must: 1. Be for convalescent care; 2. Start immediately after the end of a Hospital stay that lasted at least 5 days and for which benefits are payable under the Medical Care Program; and 3. Be for the same or related conditions as the Hospital stay.	

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Sleep Disorders	See Surgery for sleep apnea surgery. See Laboratory Services for sleep studies.	
Speech Therapy	See Outpatient Therapy.	
Sterilization	See Reproductive Services.	
Substance-Related and Addictive Disorders Treatment Services	Substance-Related and Addictive Disorders Treatment Services include those received on an Inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits for Substance-Related and Addictive Disorders Treatment Services include: • Substance-Related and Addictive Disorders Treatment or chemical dependency evaluations and assessment; • diagnosis; • treatment planning; • detoxification (sub-acute/non-medical); • Inpatient services; • Partial Hospitalization/Day Treatment; • Intensive Outpatient Treatment; • services at a Residential Treatment Facility; • referral services; • medication management; • crisis intervention; and • individual, family and group therapeutic services; and • Marriage counseling if part of a treatment plan for a mental health/substance use disorder diagnosis The Claims Administrator will determine whether an Inpatient stay is Medically Necessary. If an Inpatient stay is required, it is covered on a Semi-private Room basis; except: • When the Hospital is an all private room Hospital; • When the Hospital's semi-private rooms are filled and only a private room is available; or • When a private room must be used to keep the patient isolated because of the patient's diagnosis. You are encouraged to contact Quantum Health for referrals to providers and coordination of care.	Wilderness therapy (including Outward bound wilderness camping, tall ship programs and other similar activities) is excluded under the Medical Care Program as it is Unproven and not Medically Necessary for the treatment of emotional, addiction, and/or psychological problems including, but not limited to: • Adjustment disorders • Mood disorders • Anxiety disorders • Conduct disorders • Impulse disorders • Social functioning disorders • Substance related disorders; and • Attention-deficit hyperactivity disorder Substance-Related and Addictive Disorders services and supplies are subject to Deductibles and Coinsurance as presented in the "Schedule of Benefits (page 12).

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility)	Professional fees for surgical procedures and other medical care related to the surgical procedure received from a Doctor in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, outpatient surgery facility, or Birthing Center, or via a Doctor house call. Benefits include the facility charge and the charge for required services, supplies, and equipment.	
	Reconstructive Surgery: Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following: • Birth defect, • Sickness, • Surgery to treat a sickness or accidental injury, • Accidental injury, • Reconstructive breast surgery following a mastectomy, and • Reconstructive surgery to remove scar tissue on the neck, face or head if the scar tissue is due to sickness or accidental injury. Note: Replacement of an existing breast implant is a covered expense if the initial breast implant followed mastectomy. **Special Notice Regarding Mastectomies:** If you or your Dependent receives a mastectomy, the covered benefits for the patient will also include coverage for the following, in a manner determined in consultation with the attending Doctor and the patient: • All stages of reconstruction of the breast on which the mastectomy has been performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; • prostheses including mastectomy bras and lymphedema stockings for the arm; • treatment of physical complications in all stages of mastectomy, including lymphedemas; • replacement of an existing breast implant if the initial breast implant followed mastectomy, and • other services required by the Women's Health and Cancer Rights Act of 1998, including breast treatment of complications. Such coverage is subject to annual Deductibles, Coinsurance, and other provisions applicable to the other benefits of the UHC Medical Options.	Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Treatment procedure.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (Cont.)	**Assistant Surgeon Services:** Covered expenses for assistant surgeon services are limited to one-fifth (20%) of the amount of covered expenses for the surgeon's charge for the surgery. An assistant surgeon must be a Doctor.	
	Second Surgical Opinion Program: This voluntary program applies when a Doctor recommends that you or a covered Dependent undergo any elective or non- Emergency surgical procedure. You may voluntarily obtain a second surgical opinion for any non-Emergency surgical procedure. The purpose of the second surgical opinion is advisory only. It is the patient's decision whether or not to undergo the surgery. Benefits for the Second Surgical Opinion are subject to the cost sharing features of the Medical Care Program, such as Deductible and Coinsurance. Benefits will be payable for a third opinion on the same basis as benefits for the second opinion. The Doctor who gives the second opinion must: 1) Be qualified to render an opinion on the specific surgical procedure in question, and 2) Examine you in person.	The following are not covered by the Second Surgical Opinion Program: • An opinion on a surgical procedure that would not be covered under the UHC Medical Options; • Any charges in connection with a surgical procedure, if they are payable under other provisions of the UHC Medical Options; and • Surgery that is then performed by the same Doctor who rendered the second surgical opinion. More than two opinions per surgical procedure after the initial recommendation for surgery.
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (Cont.)	**Obesity Surgery:** Surgical treatment for severe/morbid obesity, as defined by NIH (National Institutes on Health) must meet the following: • Severe Obesity: BMI of 35-40 with co-morbidities; or Morbid Obesity: BMI of 40 or greater. In addition, the patient's medical history must demonstrate that dietary attempts at weight control have been ineffective, and that there is no specifically correctable cause for obesity (e.g., an endocrine disorder).	Non-surgical treatment of obesity, including morbid obesity, is not covered. **Note:** Abdominoplasty and panniculectomy are not covered, even when recommended as a result of approved obesity surgery services.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (Cont.)	**Orthognathic surgery** is covered in the following situations: • A jaw deformity resulting from facial trauma or cancer; or • A skeletal anomaly of either the maxilla or mandible that demonstrates a functional medical impairment such as one of the following: o Inability to incise solid foods; or choking on incompletely masticated solid foods; o Damage to soft tissue during mastication; o Speech impediment determined to be due to the jaw deformity; or o Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.	Orthognathic surgery is not covered for the following symptoms: • Myofacial, neck, head and shoulder pain, • Irritation of head/neck muscles, • Popping/clicking of Temporo Mandibular Joint(s), • Potential for development or exacerbation of Temporo Mandibular Joint dysfunction, • Teeth grinding, and • Treatment of malocclusion.
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (Cont.)	**Gender Dysphoria Surgery:** The Medical Care Program covers certain services for genital surgery and surgery to change secondary sex characteristics. Contact Quantum Health at (855) 649-3855 for details on what services may be covered and related criteria used to determine whether the services are Medically Necessary.	Contact Quantum Health at (855) 649-3855 for details on what services are not covered including, but not limited to, those services determined to be not Medically Necessary.
Therapeutics – Outpatient	Covered Health Services includes therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including: • dialysis (both hemodialysis and peritoneal dialysis), • intravenous chemotherapy, • intravenous infusion, • radiation oncology, • intensity modulated radiation therapy, and • MR-guided focused ultrasound. Benefits include the charges for the facility, related supplies and equipment, and physician services for anesthesiologists, pathologists and radiologists. Covered Health Services also include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when: • Education is required for a disease in which patient self-management is an important component of treatment, and • There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.	

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Therapeutics – Outpatient (Cont.)	Note - dialysis is subject to coordination with Medicare for End Stage Renal Disease.	
Transplants	See Organ/Tissue Transplants	
Travel & Lodging Reimbursement	If an In-Network provider for a Covered Service does not exist within 150 miles of the Covered Person's home address, reimbursement of travel and lodging expenses (related to receiving the Covered Service beyond the 150 miles) is available up to $2,500 per Calendar Year, per Covered Person, and subject to the In-Network Deductible and Coinsurance. A travel and lodging reimbursement form must be completed and submitted along with receipts to the Claims Administrator for reimbursement to be considered. The form can be found at www.upquantumhealth.com. **Covered Travel Expenses:** • Lodging – a per diem rate, up to $50/day, for the patient or the caregiver if the patient is in the Hospital. A per diem rate, up to $100/day, for the patient and one caregiver if the patient is not in the Hospital. When a Child is the patient, two persons may accompany the Child. • Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the provider's facility. • Taxi fares/standard Uber and Lyft rider (not including limos or car services). • Economy or coach airfare only • Parking • Trains • Boats • Bus • Tolls	• Alcoholic beverages • Groceries • Meals • Over-the-counter dressings or medical supplies • Personal or cleaning supplies • Phone calls, newspapers, movie rentals • Utilities and furniture rental, when billed separate from the rent payment • Deposits

ADDITIONAL EXCLUSIONS

The BCBS Medical Options do not cover any expenses incurred for services, treatments, items or supplies described in this section, even if either or both of the following are true:

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

The services, treatments, items, or supplies listed in this section are not Covered Services, except as may be specifically provided for in the "Covered Services" section beginning on page 20 of this document. Note also the exclusions stated in the "Covered Services" section under the column headed "What's Not Covered."

Additional Exclusions	
Type of Service	**What's Not Covered**
Alternative Treatments	• Acupressure. • Aromatherapy. • Hypnotism. • Massage therapy. • Rolfing. • Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
Comfort or Convenience	• Television. • Telephone. • Beauty/barber service. • Guest service. • Supplies, equipment, and similar incidental services and supplies for personal comfort (i.e., air conditioners, air purifiers and filters, batteries and battery charges, dehumidifiers, humidifiers). • Devices and computers to assist in communication and speech. • Home remodeling to accommodate a health need, such as (but not limited to) ramps and swimming pools.
Cosmetic Treatment Services	• All cosmetic services, except those described under "Covered Services" beginning on page 20 of this document.
Dental under the Medical Plans	• Dental care, except as described under "Covered Services" beginning on page 20 of this document. • Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums (i.e., extraction, restoration and replacement of teeth, medical or surgical treatments of dental conditions, services to improve dental clinical outcomes). • Dental implants. • Dental braces. • Dental x-rays, supplies and appliances, and all associated expenses, including Hospitalizations and anesthesia. The only exceptions to this are for transplant preparation, initiation of immunosuppressives or the direct treatment of acute traumatic Injury, cancer, or cleft palate; in which case, the treatment and required anesthesia to perform the treatment are Covered Services. • Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
Drugs under the Medical Plans	• Prescription drug products for Outpatient use that are filled by a Prescription Order or Refill. • Self-injectable medications. • Non-injectable medications provided in a Doctor's office, except as required in an Emergency. • Over-the-counter drugs and treatments. • Coordination of Benefits as a secondary payment for Prescription Drugs purchased through a non-Union Pacific Health Plan.
Experimental, Investigational, or Unproven Services	Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following: • not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; • subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.); or • the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight. Exceptions: • Clinical Trials for which benefits are available as described in the *Covered Health Services* section or • If you are not a participant in a qualifying Clinical Trial as described in the *Covered Health Services* section, and have a sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Additional Exclusions	
Type of Service	**What's Not Covered**
Foot Care	• Except when needed for severe systemic disease, routine foot care (including the cutting or removal of corns and calluses) and nail trimming, cutting, or debriding. • Hygienic and preventive maintenance foot care (i.e., cleaning and soaking the feet, applying skin creams in order to maintain skin tone, other services that are performed when there is not a localized Illness, Injury or symptom involving the foot). • Treatment of flat feet. • Treatment of sublaxation of the foot. • Shoe orthotics. • Shoes (standard or custom), lifts and wedges. • Shoe inserts. • Arch supports.
International Coverage	• Health services provided in a foreign country unless required as Emergency health services.
Mental Healthcare/Substance Use Disorders	• Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. • Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. • Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder. • Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. • Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act. • Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. • Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. • Transitional Living services • Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless authorized by Quantum Health. • Services or supplies for the diagnosis or treatment of mental Illness, alcoholism, or substance use disorders that, in the reasonable judgment of Quantum Health, are any of the following: o Not consistent with prevailing national standards of clinical practice for the treatment of such conditions. o Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental. o Do not typically result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective. o Not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. o Not consistent with Quantum Health guidelines or best practices as modified from time to time. • Mental Healthcare Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. • Mental Healthcare Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. • Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) **Note:** Quantum Health may consult with professional clinical consultants, peer review committees, or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

Additional Exclusions	
Type of Service	**What's Not Covered**
Nutrition	• Megavitamin and nutrition based therapy. • Except as described under "Covered Services" beginning on page 20 enteral feedings and other nutritional and electrolyte supplements (including infant formula and donor breast milk – infant formula available over the counter is always excluded), dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat/cholesterol), oral vitamins, and oral minerals except when the sole source of nutrition. **Note:** Limited nutritional counseling services are covered as described under "Covered Services" beginning on page 20.
Physical Appearance	• Cosmetic procedures including, but not limited to: o Pharmacological regimens, nutritional procedures, or treatments. o Scar or tattoo removal or revision procedures (such as salabrasion, chemoSurgery, and other such skin abrasion procedures). o Skin abrasion procedures performed as a treatment for acne. • Physical conditioning program (such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation). • Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. • Wigs regardless of the reason for the hair loss, except for loss of hair resulting from treatment of a malignancy, hair loss due to alopecia or similar conditions, or permanent loss of hair from an accidental Injury.
Providers	• Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Doctor or other provider. Services which are self-directed to a freestanding or Hospital-based diagnostic facility. Services (excluding mammography testing) ordered by a Doctor or other provider who is an Employee or representative of a free-standing or Hospital-based diagnostic facility, when that Doctor or other provider: o Has not been actively involved in your medical care prior to ordering the service, or o Is not actively involved in your medical care after the service is received. • Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent, or Child. This includes any service the provider may perform on himself or herself. • Services performed by a provider with your same legal residence. • Services of a provider or facility beyond the scope of their medical license.
Services provided under Another Plan	• Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes (but is not limited to) coverage required by Workers' Compensation, no-fault auto insurance, or similar legislation. If coverage under Workers' Compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any Injury, sickness, or mental Illness that would have been covered under Worker's Compensation or similar legislation had that coverage been elected. (Note: Medical services, that are Covered Services, provided to treat an on-duty Injury, where the company is not at fault and no FELA claim will be filed, will be allowed to be paid by the Plan.) • Health services for treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you. • Health services while on active military duty.
Transplants	• Health services for organ and tissue transplants, except those described under the "Transplant Management Program" on page 44. • Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (donor costs for removal are not a Covered Service under the Plan). • Health services for transplants involving mechanical or animal organs. • Any solid organ transplant that is performed as a treatment for cancer. • Any multiple organ transplants not listed as a Covered Service.
Vision	• Purchase cost of eyeglasses or contact lenses. (See the "Vision Care Program" section of the Flex Guide for a description of the vision plan. • Fitting charge for eyeglasses or contact lenses. • Surgery that is intended to allow you to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, radial keratotomy, laser, and other refractive eye Surgery.

Additional Exclusions	
Type of Service	**What's Not Covered**
All Other Exclusions	• Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing. • Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply, or equipment. • Any charges for services, supplies, or equipment advertised by the provider as free. • Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency. • Any charges prohibited by federal anti-kickback or self-referral statutes. • Any charges by a resident in a teaching Hospital where a faculty Doctor did not supervise services. • Any additional charges submitted after payment has been made and your account balance is zero. • Any Outpatient facility charge in excess of payable amounts under Medicare. • Appliances for snoring. • Breast reduction Surgery, except as described under "Covered Services" beginning on page 20. • Charges in excess of eligible expenses or in excess of any specified limitation. • Custodial Care or care for the purpose of assisting with the activities of daily living, including (but not limited to) dressing, feeding, bathing, or transferring from a bed to a chair. • Domiciliary care. • Growth hormone therapy. • Health services and supplies that do not meet the definition of a Covered Service. • Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends. • Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. • Health services provided by an Out-of-Network Provider for which the Annual Deductible and/or Coinsurance are waived. • Health services and supplies received due to Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) for which the individual is charged or a felony for which the individual is charged; • Health services and supplies which are illegal in the jurisdiction in which the Health Services are received • Private Duty Nursing. • Non-prescribed disposable medical supplies; • Non-surgical treatment of obesity, including morbid obesity; • Orthognathic Surgery, jaw alignment, and treatment for the Temporo Mandibular Joint, except what is described in the "Covered Services" section beginning on page 20 of this document. • Orthoptic therapy services for the treatment of convergence insufficiency or any other purpose. • Orthotic appliances that straighten or re-shape a body part, except as described under Durable Medical Equipment. Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. • Outpatient rehabilitation services, spinal treatment, or supplies including (but not limited to) Spinal Manipulations by a chiropractor or other Doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. • Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Plan when: o Related to judicial or administrative proceedings or orders; o Conducted for purposes of medical research; or o Required to obtain or maintain a license of any type. • Psycho-Surgery. • Respite care. • Rest cures. • Services or supplies received before you become covered under this Plan. • Speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a congenital anomaly, or if such therapy is considered "habilitative services." Habilitative services are healthcare services that help a Covered Person keep, learn or improve skills and functioning for daily living.

HEALTH MANAGEMENT PROGRAMS

In addition to the items discussed in the previous section, specific programs are offered to help you manage your health, including Preventive Care, Dario, Maven Fertility & Family Building and Transplant Management. These programs are described in more detail in the following pages.

Preventative Care Benefits:

The Plan supports you and your Dependents in keeping healthy by offering preventive healthcare benefits. Benefits are payable for Covered Services for preventive healthcare benefits you receive while you are covered under this Plan if certain conditions are met.

If you use a Preferred Provider, preventive services described below are payable at 100% of covered expenses. No preventive healthcare benefit is available from an Out-of-Network Provider, unless there are no participating providers available. In that case, it is your responsibility to call Quantum Health to find an alternative Doctor and, if you have made prior arrangements with Quantum Health to use an alternative Doctor, preventive healthcare benefits are payable at 100% of the Maximum Benefit Amount.

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

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

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force ("USPSTF") with respect to the individual involved, except for the USPSTF recommendations regarding breast cancer screening, mammography, and prevention issued in or around November, 2009 continue to apply.
2. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration.
3. With respect to women, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration and not included in USPSTF recommendations described above.
4. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

In addition to the Preventive Services required by the PPACA as described above, the Medical Care Program also covers at 100% certain other services and items that are considered preventive care, including those prescribed to treat certain chronic conditions. A complete list of preventive care services and items may be found at www.upquantumhealth.com. You may obtain a copy of this list free of charge by contacting Quantum Health at (855) 649-3855. You should contact Quantum Health if you have questions regarding whether a specific service or item is considered preventive care.

Benefits for the Preventive Services outlined above will be paid at 100% in accordance with the Schedule of Benefits on page 12.

Dario:

Dario offers diabetes, hypertension, and weight management programs to you and your Dependents. Participation requires satisfaction of specific clinical criteria established for each program is met. A screening questionnaire is used during the online enrollment process to determine program eligibility. Each Dario program includes:

- Dario's easy-to-use mobile app for tools, tips, and tracking your progress
- A smart device that syncs with the app, shipped right to your door
- One-on-one coaching for motivation and support
- Personalized guidance on food, exercise, managing stress, and more.

Call Dario at (833) 708-3061 to get started.

Maven:
Maven offers a virtual platform that provides specialized navigation, education, resources and support in areas such as preconception, fertility preservation, IUI, IVF, adoption, surrogacy, menopause, midlife health and related mental health. To get started, visit the Maven website www.mavenclinic.com or download the Maven Clinic app. For questions about Maven, email support@mavenclinic.com.

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

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

For all BCBS Medical Options: If you are enrolled in a BCBS Medical Option and a Qualified Procedure (listed below) is performed at an In-Network facility, the Covered Services provided in connection with the transplant procedure are covered at 80%, after Deductible. In addition, certain travel and accommodation expenses are covered as described below.

Qualified Procedures:
- Heart transplants;
- Lung transplants;
- Heart/Lung transplants;
- Liver transplants;
- Kidney transplants;
- Pancreas transplants;
- Kidney/Pancreas transplants;
- Liver/Kidney transplants.
- Intestinal transplants.
- Liver/Intestinal transplants.
- Bone Marrow/Stem Cell transplants;
- Cornea, when performed in a Hospital setting.

Donor costs that are directly related to organ removal are Covered Services for which benefits are payable through the organ recipient's coverage under the Plan.

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a Covered Service.

Transplants Not Performed at a Blue Distinction Center*:* A transplant procedure is not required to be performed at a BCBS Blue Distinction Center for coverage to apply. If a transplantprocedure is Medically Necessary but not performed at a BCBS Blue Distinction Center, eligible expenses will be covered as would any other expense covered under the Plan, subject to In-Network and Out-of-Network Deductibles and Coinsurance.

CONTACTING QUANTUM HEALTH FOR ASSISTANCE

Quantum Health's Care Coordinators can be reached at (855) 649-3855. Care Coordinators are available from 7:30 a.m.to 9:00 p.m. CT, Monday through Friday (excluding holidays).

UPQUANTUMHEALTH.COM – QUANTUM HEALTH'S MEMBER WEBSITE

The Quantum Health member website, www.upquantumhealth.com, is your online gateway to a broad range of tools and services.

To register:
- Go to www.upquantumhealth.com

- Click the "Register" button.
- Enter the information requested.
- Once registered, an email confirmation will be sent to you to verify your account before you log-in for the first time.

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

- Confirm eligibility, specific benefits, Deductible, Coinsurance.
- Review claims status and claims history.
- Compare fees for common services.
- View exact replicas of your Explanation of Benefits at any time.
- Find an In-Network Doctor or Hospital.
- Estimate Health Care Costs for treatments you are considering.
- Print a temporary Medical ID Card or order a replacement Medical ID Card.

MEDICAL CLAIMS & APPEALS

Internal Claim and Appeal Process:

This section provides information about how and when to file a BCBS Medical Option claim for benefits, describes the 4 types of medical claims, and establishes that Quantum Health has the discretionary authority to decide your claim or your appeal of a denied claim.

Union Pacific has delegated to Quantum Health discretionary decision-making authority with respect to certain types of BCBS Medical Option claims and appeals, as set forth below. This means that with respect to the type of claim or appeal for which Quantum Health has decision-making authority, Quantum Health has the exclusive and discretionary authority to make factual findings, interpret and administer the provisions of the Plan. Any findings, interpretation, or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. The decisions of Quantum Health are conclusive and binding, except to the extent a decision is eligible for review under the external review process described below.

Please note that the decisions of Quantum Health are based on whether or not the services are Medically Necessary, whether or not benefits are available under the Plan for the proposed treatment or procedure, and whether or not the services are provided in the appropriate setting.

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

NOTE: In each section describing the process for deciding the particular type of claim or appeal, the entity with discretionary decision-making authority to decide such claim or appeal (Quantum Health) is identified as the "Claims Administrator." However, regardless of Quantum Health having the authority and responsibility to decide your claim or appeal, all Plan benefits are paid through Highmark BCBS.

Your Explanation of Benefits Statement:

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

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

In those instances where you are not required to submit a claim because, for example, the In-Network Provider will submit the bill as a claim for payment under its contract with Highmark BCBS, you will receive an EOB only when you are

required to pay amounts other than your required Copayment. If you do not have access to a computer or prefer to continue receiving printed EOBs, please notify Quantum Health by calling the number on the back of your ID card.

If you receive services from an In-Network Provider, you will not have to file a claim. The In-Network Provider is responsible for filing claims. Highmark BCBS pays the In-Network Provider directly. However, you are responsible for paying Coinsurance and/or Deductible amounts to an In-Network Provider when a bill is received from the provider. If an In- Network Provider bills the Covered Person for any Covered Services in excess of the Medical Deductible or Medical Coinsurance Amount, contact Quantum Health.

If you receive services from an Out-of-Network Provider, you may be required to file the claim yourself. Claim forms can be obtained by contacting Quantum Health at (855) 649-3855 or going to Quantum Health at www.upquantumhealth.com.

Right to and Payment of Benefits:

Benefits and rights under this Plan are available only to Covered Persons. Except as required by law, a Covered Person may not assign, in whole or in part, any benefit or right under the Plan to any person, including but not limited to, a Doctor or other provider, nor are any such benefits and rights subject to garnishment or attachment. However, the Plan will honor a Covered Person's written authorization to allow direct payment to a Doctor or other provider, so as to permit all or a portion of a payment due for Covered Health Services owed to the Doctor or other provider to be paid directly to the Doctor or provider. An authorization of direct payment is for the convenience of the Covered Person, and shall not be recognized by the Plan as assigning to the Doctor or other provider the Covered Person's rights to any benefit under the Plan.

You have the right to designate an authorized representative to submit a request for Pre-Service Claim reimbursement or a Post-Service Claim on your behalf. The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. You or your representative shall notify the Claims Administrator in writing of the designation. Nothing in the above paragraph is intended to prohibit a Covered Person from designating another person (including, in the case of an Urgent Care claim or appeal, a health care professional with knowledge of the Covered Person's medical condition) to serve as the Covered Person's authorized representative with respect to any claim or appeal filed in accordance with Plan procedures.

Non-English Services:

Depending on the county in which you reside, the Claims Administrator may be able to provide you, upon request, with benefit determinations and other notices required to be provided under this internal claim and appeal process in a non-English language. Telephonic oral language services may also be available. Such non-English services shall be made available by the Claims Administrator in accordance with applicable federal requirements for culturally and linguistically appropriate communications.

Post-Service Claims:

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

Quantum Health is the Claims Administrator of all Post-Service claims and requested internal appeals of denied Post-Service claims.

Filing a Post-Service claim is simple. Just take the following steps:

Know Your benefits. Review this information to see if the services you received are eligible under the Plan. Get an Itemized Bill. Itemized bills must include:

- The name and address of the service provider;
- The patient's full name;
- The date of service or supply;
- A description of the service or supply;
- The amount charged;
- The diagnosis or nature of Illness;
- For Durable Medical Equipment, the Doctor's certification;
- For private duty nursing, the Nurse's license number, charge per day and shift worked, and signature of provider prescribing the service.

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

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

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

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

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

Benefit Determinations Involving Post-Service Claims:
Quantum Health will notify you in writing of its determination on your Post-Service Claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. However, this 30-day period of time may be extended one time by Quantum Health for an additional 15 days, provided that Quantum Health determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day Post-Service Claim determination period. If an extension of time is necessary because you failed to submit information necessary for Quantum Health to make a decision on your Post-Service Claim, the notice of extension that is sent to you will specifically describe the information that you must submit. In this event, you will have 45 days in which to submit the information before a decision is made on your Post-Service Claim.

If your claim is denied, see the "If Your Claim is Denied" section, below.

Non-Urgent Pre-Service Claims:

Pre-Service claims, also known as prior authorizations, pre-certifications or as prospective reviews, are those claims that require Prior Authorization prior to receiving medical care. Call Quantum Health Member Service at (855) 649-3855, as shown on the back of your ID card, to submit a Pre-Service Claim. Pre-Service Claims begin upon Quantum Health's receipt of your treatment information.

After receiving the request for care, Quantum Health:

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

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

Quantum Health is the Claims Administrator of all Pre-Service claims and all requested internal appeals of a denied Pre-Service claim.

Benefit Determinations Involving Non-Urgent Pre-Service Claims:
You will receive written notice of any decision on a request for Pre-Service Claim, whether the decision is adverse or not,

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

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

Concurrent Care Claims:

Concurrent care claims are those claims to extend an on-going course of treatment that was previously approved for a specific period of time or number of treatments. Concurrent reviews are used to assess the Medical Necessity and appropriateness of the length of stay and level of care.

Quantum Health is the Claims Administrator of all Concurrent Care claims and all requested internal appeals of a denied Concurrent Care claim.

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

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

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

Urgent Care Claims*:*

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

Quantum Health is the Claims Administrator of all Urgent Care claims and all requested internal appeals of a denied Urgent Care claim.

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

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

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

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

If Your Claim is Denied:

If your claim is denied, the Claims Administrator will send you a written notice of denial that will describe the Plan's internal and external review processes, including information regarding how to initiate an appeal. The notice will include information sufficient to identify the claim involved (including the date of service, the Provider, and the claim amount, if applicable). The notice will refer to the part of the Plan on which the denial is based and explain the reason for denial, including the denial code, if any, and its corresponding meaning, as well as a description of the Claims Administrator's standard, if any, that was used in denying your claim (e.g., if your claim was denied because the services were not Medically Necessary, Experimental or unproven, the denial notice will include an explanation of this determination.). If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your claim, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. In addition, the notice will include the following:

- a description of any additional material or information needed to perfect your claim and an explanation of why the material or information is important;
- a statement describing your right to receive, upon request, a copy of the diagnosis code and/or treatment code, and their corresponding meanings. If you request such code(s), the Claims Administrator will provide the code(s) (and its corresponding meaning) to you as soon as practicable following receipt of your request; and
- information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the healthcare reform law to assist you with the internal claims and appeals and external appeal process.

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

Except as described in the section, "Your Options if the Internal Claim and Appeal Process Is Not Followed" on page 52 you must first exhaust all appeals available to you under the BCBS Medical Care Program – both internal and external – before you have a right to bring a civil action under ERISA regarding your denied claim.

MEDICAL APPEALS PROCEDURES

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

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

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

At any time during the appeal process, you may contact Quantum Health at (855) 649-3855 to inquire about the filing or status of your appeal.

This appeal process will ordinarily apply to determinations as to your eligibility for coverage only if they are part of a claim for actual benefits, which includes an impatient precertification or any other request that you are required to make to obtain full benefits under the Plan (this does not include a predetermination of medical benefits which you may seek voluntarily). However, if your coverage is discontinued retroactively for reasons other than the failure to make your contributions on time, you may file an appeal that contests the retroactivity of the termination of coverage. Such an appeal should be filed with the Plan Administrator, not with Quantum Health.

Quantum Health Internal Review:

If you receive notification that a claim has been denied by the Claims Administrator, in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from the Claims Administrator of the adverse benefit determination.

Upon request to Quantum Health, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

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

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

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is Medically Necessary and appropriate or Experimental/Investigative, Quantum Health will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the claim that is the subject of your appeal and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the claim that is the subject of your appeal. Your appeal will be promptly investigated and Quantum Health will provide you with written notification of its decision within the following time frames:

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

In the event Quantum Health renders an adverse benefit determination on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse benefit determination and a reference to the part of the Plan on which the denial is based, and the procedure for appealing the decision.

In addition, in the case of an adverse benefit determination involving a Pre-Service Claim (including an Urgent Care claim), the denial notice will include information sufficient to identify the appeal involved (including the date of service, the Provider, and the appeal amount, if applicable), the denial code, if any, and its corresponding meaning, as well as a description of Quantum Health's standard, if any, that was used in denying your appeal (e.g., if your appeal was denied because the services were not Medically Necessary, Experimental or unproven, the denial notice will include an explanation of this determination.) If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. In addition, the notice will include the following:

- a statement describing your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal;

- a statement describing your right to receive, upon request, a copy of the diagnosis code and/or treatment code, and their corresponding meanings. If you request such code(s), Quantum Health will provide the code(s) (and its corresponding meaning) to you as soon as practicable following receipt of your request;
- information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the healthcare reform law to assist you with the internal claims and appeals and external appeal process; and
- a statement regarding your right, if eligible, to request an external review of Quantum Health's internal adverse benefit determination and, if external review is unavailable or also results in a denial of your claim, to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Your decision to proceed with a second level review of a Pre-Service Claim (other than an Urgent Care claim, which involves one level of review) is voluntary. In other words, you are not required to pursue the second level review of a Pre-Service Claim before pursuing a claim for benefits in court under § 502(a) of ERISA. Should you elect to pursue the second level review before filing a claim for benefits in court, your benefit program:

- Will not later assert in a court action under § 502(a) of ERISA that you failed to exhaust administrative remedies (i.e. that you failed to proceed with a second level review) prior to the filing of the lawsuit;
- Agrees that any statute of limitations applicable to the claim for benefits under §502(a) of ERISA will not commence (i.e. run) during the second level review; and
- Will not impose any additional fee or cost in connection with the second level review.

If you have further questions regarding second level reviews of Pre-Service Claims, you should contact Quantum Health at (855) 649-3855.

Second Level Review:

If you are dissatisfied with the decision following the initial review of your appeal (other than the review of an Urgent Care claim), you may request to have the decision reviewed by Quantum Health. Except as described in the section, "Your Options if the Internal Claim and Appeal Process Is Not Followed" on page 52, you **must** submit a second level appeal of your Post-Service Claim in order to preserve your rights to external review or to bring a civil action under ERISA concerning the Plan's denial of your claim. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 45 days from the date of an adverse benefit determination. Upon request to Quantum Health, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and shall have the right to submit or present additional evidence or testimony, which includes any written or oral statements, comments and/or remarks, documents, records, information, data or other material in support of your appeal.

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

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

In rendering a decision on a second level appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is Medically Necessary and appropriate or Experimental/Investigative, Quantum Health will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the matter under review and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the matter under review.

If, in response to your second level appeal Quantum Health intends to issue an adverse benefit decision on the basis of new or additional evidence first considered as part of your second level appeal, or on the basis of a new or different rationale than relied on before, Quantum Health will provide you, free of charge, with a description of such new evidence or rationale in

advance of its determination so that you may have a reasonable opportunity to respond before the final determination is made.

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

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

In the event Quantum Health renders an adverse benefit determination on your second level appeal, the denial notice will include information sufficient to identify the appeal involved (including the date of service, the Provider, and the appeal amount, if applicable). The notice will refer to the part of the Plan on which the denial is based and explain and discuss the reason for denial, including the denial code, if any, and its corresponding meaning, as well as a description of Quantum Health's standard, if any, that was used in denying your appeal (e.g., if your appeal was denied because the services were not Medically Necessary, Experimental or unproven, the denial notice will include an explanation of this determination.) If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. In addition, the notice will include the following:

- a statement describing your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal;
- a statement describing your right to receive, upon request, a copy of the diagnosis code and/or treatment code, and their corresponding meanings. If you request such code(s), Quantum Health will provide the code(s) (and its corresponding meaning) to you as soon as practicable following receipt of your request;
- information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the healthcare reform law to assist you with the internal claims and appeals and external appeal process; and
- a statement regarding your right, if eligible, to request an external review of Quantum Health's adverse benefit determination and, if external review is unavailable or also results in a denial of your claim, to bring a civil action under Section 502(a) of ERISA.

Your Options if the Internal Claim and Appeal Process Is Not Followed:

If you believe Quantum Health has failed to follow the internal review procedures described above and that failure denies you the opportunity to obtain a decision on the merits of your claim, you may take the following action, without having to exhaust the Plan's internal claim and appeal process:

- initiate an immediate external review of your claim or appeal using the external review process described below, if your claim is otherwise eligible for review under such external review process; or
- bring a civil action under Section 502(a) of ERISA, if your claim is not otherwise eligible for review under the external review process described below.

Before taking such action, however, you may request a written explanation of the failure from Quantum Health and Quantum Health will furnish such explanation within 10 days of your request. You may want to obtain such explanation because a request for immediate review can be rejected if it is determined that the failure was de minimis and unlikely to cause you prejudice or harm. Quantum Health's explanation may therefore help you to decide whether to proceed outside the internal review process. If an external reviewer or a court rejects your request for immediate review of your claim on the basis that the violation was de minimis, you have the right to resubmit and pursue the internal appeal of your claim. Quantum Health will notify you of this right within a reasonable time after the external reviewer or court rejects your claim for immediate review, but no later than 10 days following such rejection.

External Review

An external review program is offered in certain circumstances. If, after exhausting your internal appeals, you are not satisfied with Quantum Health's adverse benefit determination, you may be entitled to request an external review of Quantum Health's determination. You may also be entitled to an external review (or, to file a civil action under Section 502(a) of ERISA) if Quantum Health fails to follow the internal review procedures described above and that failure denies you the opportunity to obtain a decision on the merits of your claim. If you request such immediate external review and it is

rejected, you may be able to resubmit and pursue the internal appeal of your claim. (See "Your Options if the Internal Claim and Appeal Process Is Not Followed," above.) The external process is available at no charge to you.

There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

You have four months from the date you receive notice of a final Quantum Health adverse benefit determination to file a request for an external review with Quantum Health. Note that for Pre-Service Claims, the four month period begins to run from the date you received Quantum Health's first-level adverse benefit determination. To be eligible for external review, the decision of Quantum Health must have involved (i) a claim that was denied involving medical judgment, including, application of Quantum Health's requirements as to Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a Covered Service or a determination that the treatment is Experimental or Investigational; or (ii) a determination made by the Plan Administrator to rescind your coverage.

In the case of a denied claim, the request for external review may be filed by either you or a Health Care Provider with your written consent in the format required by or acceptable to Quantum Health. The request for external review should include any reasons, material justification and all reasonably necessary supporting information as part of the external review filing. Appeal denial letters will include information about how to request an external review.

Preliminary Review:

Quantum Health will conduct a preliminary review of your external review request within five business days following the date on which Quantum Health receives the request. Quantum Health's preliminary review will determine whether:

- You were covered by your plan at all relevant times;
- The adverse benefit determination relates to your failure to meet your plan's eligibility requirements;
- You exhausted the above-described appeal process; and
- You submitted all required information or forms necessary for processing the external review.

Quantum Health will notify you of the results of its preliminary review within one business day following its completion of the review. This will include our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Quantum Health's notification will describe the information or materials needed to make the request complete. You will then have the balance of the four month filing period or, if later, 48 hours from receipt of the notice, to perfect your request for external review; whichever is later.

In the event that the external review request is complete but not eligible for external review, notification by Quantum Health will include the reasons why the request is ineligible for external review and contact information that you may use to receive additional information and assistance.

Standard External Review-Referral to an Independent Review Organization (IRO):

Quantum Health will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, Quantum Health will provide the IRO with documents and information it considered when making its final adverse benefit determination. The IRO may reverse Quantum Health's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day time frame.

The IRO will timely notify you in writing of your eligibility for the external review and will provide you with at least 10 business days following receipt of the notice to provide additional information. The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim de novo. In other words, the IRO will not be bound by any decisions or conclusions reached during the above described appeal process.

The assigned IRO must provide written notice of its final external review decision within 45 days after the IRO received the request for the external review. The IRO will deliver its notice of final external review decision to you and Quantum Health.

The IRO's notice will inform you of:

- The date it received the assignment to conduct the review and the date of its decision;

- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either you or your plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Quantum Health's receipt of the IRO's notice of a final external review decision from the IRO that reverses Quantum Health's prior final internal adverse benefit determination.

Expedited External Review (Applies to Urgent Care Claims Only):

You are entitled to the same procedural rights to an external review as described above on an expedited basis:

- If the final adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- Following a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency services, but you have not been discharged from the facility rendering the Emergency services.

In the above circumstances, Quantum Health will immediately conduct a preliminary review and will immediately notify you of our reasons regarding the ineligibility of your request, if applicable, and will further provide you with contact information for the Employee Benefits Security Administration. If your request is not complete, Quantum Health's notification will describe the information or materials needed to make the request complete. You will then have 48 hours from receipt of the notice, to perfect your request for external review.

Expedited External Review-Referral to an Independent Review Organization (IRO):

Quantum Health will, randomly or by rotation, select an IRO to perform an external review of your claim if your request is found acceptable after preliminary review. The IRO will be accredited by a nationally-recognized accrediting organization. Thereafter, Quantum Health will immediately provide the IRO with documents and information it considered when making its final adverse benefit determination via the most expeditious method (e.g., electronic, facsimile, etc.)

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Quantum Health. The IRO will provide notice of the external review decision for an expedited external review as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. Notice of the IRO's determination does not need to be provided in writing initially, but written notice confirming the determination must be provided to you and Quantum Health within 48 hours after the date of the initial verbal notice.

Regardless of whether the external review is a standard external review or expedited external review, if the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

COORDINATION OF BENEFITS

Coordination of benefits applies when a covered Employee, a Domestic Partner or a covered Dependent has health coverage under the BCBS Medical Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary. The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision works:

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

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

Right to Exchange Information:

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

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

GLOSSARY – BCBS MEDICAL CARE PROGRAM DEFINITIONS

(See also "Pharmacy Program Definitions" beginning on page 82).

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

Accident: An unforeseen and unavoidable event resulting in an Injury, which is not due to any fault of the Covered Person.

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

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

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

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

Annual Benefit Maximum: Specific Covered Services are limited to a maximum amount within each Annual period. Limitations may take several forms, such as, number of visits or sessions, number of days, etc. The Annual Benefit Maximum is specified within the section "Covered Services" for each type of Covered Service to which a maximum pertains.

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

The Birthing Center must provide:

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

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

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

Coinsurance is the percentage of the covered expenses for which benefits are payable under the BCBS Medical Options after application of the Deductible and before reaching the Coinsurance Maximum.

Coinsurance Maximum is the maximum amount of annual Coinsurance payments you pay every Calendar Year. If you use both In-Network benefits and Outside Network benefits, two separate Coinsurance Maximums apply. Once you reach the Coinsurance Maximum, benefits for those Covered Services that apply to the Coinsurance Maximum are payable at 100% of eligible expenses during the rest of the Calendar Year.

Coinsurance for some Covered Services will never apply to the Coinsurance Maximum, and those benefits will never be payable at 100% even when the Coinsurance Maximum is reached.

The following costs will never apply to the Coinsurance Maximum:

- Any charges for non-Covered Services.
- Amounts paid toward your medical Deductible.
- Copayments or Coinsurance for Covered Services available by an optional rider.
- Any Coinsurance payments for Covered Services that do not apply to the Coinsurance Maximum.
- The amount of any reduced benefits if you do not obtain prior authorization.
- Charges which exceed eligible expenses.

Copayment or Copay is the patient's part of the bill paid at the time of service. Copays are usually flat fees for a particular service, such as for a Doctor's visit.

Covered Service(s): Services and supplies that are covered under the Plan which are determined to be Medically Necessary and satisfy other terms and conditions of the Plan.

Custodial Care: The level of care that consists primarily of assisting with the activities of daily living such as bathing, continence, dressing, transferring and eating. The purpose of such care is to maintain and support the existing level of care and preserve health from further decline. Custodial Care is care given to a patient who:

1. is mentally or physically disabled; and
2. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home, and
3. is not under active and specific medical, surgical or psychiatric treatment, ordered by a Doctor which will reduce the disability to the extent necessary to allow the patient to function outside such environment or without such assistance within a reasonable time, not to exceed one year in any event.

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

Deductible: The cost of covered medical services (and pharmacy expenses) you are responsible for paying before healthcare benefits (and/or pharmacy benefits) are payable for all or some healthcare services and pharmacy expenses. No prescription drug Deductible applies under the Non-HDHP PPO Option. For more information regarding the Pharmacy benefit Deductible, see "Pharmacy Benefit Payment Information", beginning on page 68.

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

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

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

- placing your health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- causing serious impairment to bodily functions; and/or
- causing serious dysfunction of any bodily organ or part;
- and for which care is sought as soon as possible after the medical condition becomes evident to you.

Employer: Union Pacific Corporation, its subsidiaries, and affiliates electing to participate in the Union Pacific Flexible

Benefits Program.

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

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

Decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with a nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices.
To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit.

Technology that does not merit this status is usually considered "Experimental/Investigative" and is not generally covered. However, it may be re-evaluated in the future.

Situations may occur when you elect to pursue Experimental/Investigative treatment. If you have a concern that a service you will receive may be Experimental/Investigative, you or the Hospital and/or professional provider may contact Quantum Health to determine coverage.

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

Diagnostic criteria for adults and adolescents:

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

Diagnostic criteria for children:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):

    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - A strong preference for cross-gender roles in make-believe play or fantasy play.
    - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
    - A strong preference for playmates of the other gender.
    - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
    - A strong dislike of ones' sexual anatomy.
    - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

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

Healthcare Provider: A Doctor, Practitioner, Nurse, Hospital or Specialized Treatment Facility as those terms are specifically defined in this Definitions section.

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

Hospice Facility(ies): A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive and other related care for a Covered Person diagnosed as terminally ill with a medical prognosis that life expectancy is 6 months or less. The facility must have an interdisciplinary medical team consisting of at least one Doctor, one registered Nurse, one social worker, one volunteer and a volunteer program.

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

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

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

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

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

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

Maximum Benefit Amount: A maximum amount determined by BCBS or a BlueCard Program On-site Plan to be reasonable for Covered Services. The Maximum Benefit Amount will be the amount agreed upon between BCBS and BluePreferred and Preferred Providers of the Covered Service, or the maximum amount agreed upon by the On-site and it

contracting providers. If the provider does not participate with BCBS then the Maximum Benefit Amount may be a negotiated amount. In the event the negotiations with a Non-Preferred Provider are unsuccessful, then the Maximum Benefit Amount will be based on pricing determined by a national database or at the out-of-network rate under the No Surprises Act.

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

Medically Necessary (Medical Necessity): Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and not primarily for the convenience of the patient, Physician, or other Health Care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

Highmark BCBS reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is Medically Necessary and appropriate. No benefits will be provided unless Highmark BCBS determines that the service, supply or covered medication is Medically Necessary and appropriate.

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

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

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

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

Morbid Obesity: A diagnosed condition in which the body weight exceeds the normal weight by either 100 pounds or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed. The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes or heart disease.

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

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

Orthotic Appliance is a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person’s Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

Other Plans are any of the following types of plans which provide health benefits or services for medical care or treatment: group medical or dental plans, government plans, or no fault coverage.

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

Partial Hospitalization/Day Treatment: The provision of medical, nursing, counseling or therapeutic mental health care services or substance abuse services on a planned and regularly scheduled basis in a facility provider designed for a patient or client who would benefit from more intensive services than are generally offered through Outpatient treatment but who does not require Inpatient care.

Plan Administrator: The Plan Administrator is the Senior Vice President & Chief HR Officer, Union Pacific Railroad Company. The Plan Administrator administers the Plan and makes decisions about how Plan provisions apply in specific cases not otherwise assigned to Quantum Health, Highmark BCBS or OptumRx, as applicable.

Plan Sponsor: Union Pacific Corporation.

Plan Year: The 12-month fiscal period for BCBS Health Plan members beginning January 1st and ending December 31st.

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

Pre-Service & Post-Service Claims: Pre-Service Claims are those claims that require prior authorization prior to receiving medical care. Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received.

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

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

Preferred Provider Organization (PPO): A program that does not require the selection of a primary care Physician, but is based on a provider network made up of Physicians, Hospitals and other health care facilities. Using this provider network helps assure that you receive maximum coverage for eligible services.

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

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

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

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

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

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

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

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

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

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

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

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

Sickness is a physical illness, disease or pregnancy. The term Sickness as used in the Flex Guide includes mental illness and substance abuse disorder, regardless of the cause or origin of the mental illness or substance use disorder.

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

Specialized Treatment Facility(ies): A Specialized Treatment Facility, as the term relates to this Plan, includes Birthing Centers, Ambulatory Surgical Facilities, Hospice Facilities, Skilled Nursing Facilities, Mental/Nervous Treatment Facilities, Psychiatric Day Treatment Facilities, Substance Abuse Treatment Facilities, Partial Hospitalization/Day Treatment Facility, Rehabilitation Facilities, and Residential Treatment Facilities, as those terms are specifically listed in Covered Health Expenses.

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

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

Transitional Living - Mental Healthcare/Substance Use Disorders services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

BCBS MEDICAL OPTIONS – PHARMACY BENEFITS

OVERVIEW

The BCBS Medical Options include an In-Network Retail Pharmacy, In-Network Mail Order Pharmacy Service, Specialty Pharmacy Service, and Out-of-Network Retail Pharmacy feature. The In-Network Retail Pharmacy, In- Network Mail Order Pharmacy Service, Specialty Pharmacy Service and Out-of-Network Retail Pharmacy features apply to covered outpatient prescription drugs.

Whomever you elect to cover under a BCBS Medical Option is considered a "Covered Person" for purposes of the Pharmacy Program. You can find the meaning of other capitalized terms found in this Section in the "Pharmacy Program Definitions" on page 82 and the "Glossary" Section on page 56 of this 2026 BCBS Attachment.

The Pharmacy benefits under the BCBS Medical Options are provided by OptumRx.

Member Identification (ID) Card - In-Network Pharmacy:
You must either present your Member ID card at the time you obtain your Prescription Drug Product at an In-Network Pharmacy or you must provide the In-Network Pharmacy with identifying information that can be verified by OptumRx. The Union Pacific group number for OptumRx is 01963146. You can access your Member ID card through the Quantum Health website or app. Quantum Health provides care coordination services for the BCBS Medical Options, including prescription drug benefits.

If you do not present your Member ID Card or provide verifiable information at an In-Network Pharmacy, you will be required to pay the amount charged by the pharmacy for the Prescription Drug Product at the pharmacy. You may seek reimbursement as described in the "How to File Pharmacy Claims" section on page 76. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility at the time the Prescription Drug Product was dispensed. The amount of the reimbursement will be based on the Prescription Drug Cost, less any HDHP Deductible (if enrolled in a BCBS HDHP Option) or Pharmacy Coinsurance Payment that applies.

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

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

Additional Information About Your Prescriptions:
Employees can find helpful resources for prescription drugs, such as cost and the usage of a drug, drug interactions and side effects, clinical programs (e.g., supply limits and Prior Authorization requirements), pharmacy locations, cost saving options, and Specialty Pharmacies by visiting the Quantum Health website. To access this site, log onto your account at www.upquantumhealth.com. You may also call Quantum Health at (855) 649-3855 for assistance.

WHAT'S COVERED

The Plan pays benefits for outpatient Prescription Drug Products given to a Covered Person according to the provisions described below (see "Discretionary Mail Order Program," "Mandatory Mail Order Program," "Specialty Pharmacy Services," and "Pharmacy Benefit Payment Information" sections). Refer to "What's Not Covered - Exclusions" on page 74 for exclusions. Prescribed drugs and medicines for inpatient services are covered as medical expenses under the BCBS Medical Option provisions. The BCBS Medical Option provisions also apply to outpatient prescription drugs that are administered in a Doctor's office or other licensed outpatient setting, unless the drugs are specifically excluded from the BCBS Medical Options under "Additional Exclusions" on page 38. These drugs and medicines eligible for payment under the BCBS Medical Options' provisions then are not payable under the Pharmacy provisions. Likewise, the drugs and medicines eligible under the Pharmacy provisions then are not payable under the BCBS Medical Option provisions.

Benefits for Outpatient Prescription Drug Products:

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

- Prescribed to treat a Covered Service (see "Covered Services" table beginning on page 20) or to prevent conception;
- The prescription is not experimental, investigational, or unproven; and
- Determined by OptumRx to be Medically Necessary.

Supply Limits:

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

You may learn whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing online at www.upquantumhealth.com or by calling Quantum Health at (855) 649-3855 and choosing the pharmacy prompt.

PRIOR AUTHORIZATION:

OptumRx uses a series of reviews when processing certain prescriptions known collectively as "prior authorization."

Benefits may not be available for the Prescription Drug Product after OptumRx reviews the documentation provided if OptumRx determines that the Prescription Drug Product is not prescribed to treat a Covered Health Service or it is experimental, investigational, or unproven. You may appeal this determination as described in the "Pharmacy Claim Questions and Appeals" section on page 77.

If you are using an In-Network Retail Pharmacy, your pharmacist will be notified that your Doctor must get approval for the prescription to be covered by calling OptumRx at (877) 559-2955. If you are using the OptumRx Mail Order Pharmacy Service, the pharmacist will call your Doctor to start the approval process. For prescriptions, your Doctor will be asked to provide information to determine if the prescription meets the coverage conditions of your pharmacy benefit. The information your Doctor provides will be reviewed, and coverage will be approved or denied. Letters will be sent to you and your Doctor to explain any denial decision and provide instructions on how to appeal if denied coverage.

If you use an Out-of-Network Retail Pharmacy, prior authorization still applies and will be reviewed at the time that you submit a claim for reimbursement; otherwise you or your Doctor can check beforehand by calling OptumRx at (877) 559-2955 to ensure that the medications prescribed are in conformance with their prior authorization. Only approved claims will be reimbursed. Employees will also receive a statement outlining the authorization procedures.

Quantity Level Limits (QLL) /Quantity per Duration (QD):

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

If your prescription exceeds the limit and you are using an In-Network Retail Pharmacy or the OptumRx Mail Order Pharmacy Service, your Doctor or pharmacist will be notified of the quantity covered under a single prescription, which is

generally, for up to 31 days (Retail) or up to 90 days (Mail Order). You will have the option to:

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

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

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

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

To learn more about medication patient safety programs and prior authorizations through your pharmacy benefit, call Quantum Health at (855) 649-3855 for assistance.

Notification Requirements:
In-Network Pharmacy Notification: When Prescription Drug Products are dispensed at an In-Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying OptumRx.

Out-of-Network Retail Pharmacy Notification: When Prescription Drug Products are dispensed at an Out-of-Network Retail Pharmacy, you or your Doctor must notify OptumRx, as required.

Regardless of the pharmacy's network status (i.e., In-Network or Out-of-Network), if OptumRx is not notified before the Prescription Drug Product is dispensed, you can ask OptumRx to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from OptumRx as described in the "How to File Pharmacy Claims" section, page 76. When you submit a claim on this basis, the amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from an In-Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from an Out-of-Network Retail Pharmacy), less any remaining HDHP Deductible (if enrolled in a BCBS HDHP Option) and/or your required Pharmacy Coinsurance Payment, if any. The OptumRx contracted pharmacy reimbursement rates (the OptumRx Prescription Drug Cost) will not be available to you at an Out-of-Network Retail Pharmacy.

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

Progression Rx/Step Therapy:
High cost Prescription Drug Products belonging in certain therapeutic classes are subject to step therapy requirements. This means that, in order to receive benefits for such Prescription Drug Product, you will be required to try a lower cost Prescription Drug Product in the same therapeutic class first. You may learn whether a particular Prescription Drug Product is subject to step therapy requirements by visiting Quantum Health at www.upquantumhealth.com or by calling Quantum Health at (855) 649- 3855.

SPECIALTY PHARMACY SERVICES

Certain pharmacy prescriptions are made using special compounds, which are not ordinarily kept in stock and may require advance notice to fill. OptumRx has established a group of Specialty Pharmacies with clinical expertise in dispensing specialty drugs that must be filled through an OptumRx Specialty Pharmacy. Except as described below under the section titled "SmartFill Programs," prescriptions obtained through the Specialty Pharmacy are dispensed in 30-day quantities and delivered directly to your home.

Specific drugs that must be dispensed through a Specialty Pharmacy can be found at Quantum Health at www.upquantumhealth.com. If you have a new prescription for a Prescription Drug Product that must be filled by a

Specialty Pharmacy, you must contact the Specialty Pharmacy to process the prescription. If you present a specialty prescription to a retail pharmacy, the retail pharmacy will receive a message from OptumRx that includes a Specialty Pharmacy's phone number.

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

- You will have access to a Specialty Pharmacy pharmacist who has been trained in dispensing of your drug and is available 24 hours a day, seven days a week, to answer your questions.
- Your prescription will be delivered directly to your home.
- Refills will be coordinated between the Specialty Pharmacy and your Doctor, delivered directly to your home every 30 days.

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

Benefits for the Specialty Pharmacy drugs are payable, following the "Schedule of Benefits" on page 72 entitled "Prescription Drugs from Retail or Specialty Pharmacy."

SmartFill Programs:
If you begin taking a medication for one of the categories listed below and show that you have stayed on track for 6 consecutive fills, you may opt in to fill a larger, 90-day supply. If you are already taking a medication for one of the categories listed, you will automatically be eligible for a 90-day supply.

- Inflammatory conditions
- Transplant
- Multiple sclerosis

If you are taking oncology drugs, it may take a few tries to find a specialty medication and dose that works for you. Newly written prescriptions for oncology drugs will allow a 15-day supply per fill. Once you have 6 fills showing on your coverage, you will be able to get a 30-day supply.

If you have questions, contact the Specialty Pharmacy referral line through Quantum Health at (855) 649-3855. You will be provided contact information for the specific Specialty Pharmacy that specializes in the drug you use. Quantum Health will work with you to establish your contact with the Specialty Pharmacy.

MANDATORY MAIL ORDER PROGRAM
The Mandatory Mail Order (MMO) Program is a program that requires you to use the Mail Order Pharmacy to obtain certain maintenance medications. Maintenance medications are Prescription Drug Products, which are designed to be prescribed as an ongoing therapy. Many maintenance medications can be purchased more conveniently, at a lesser cost to you and the Plan, through the Mail Order Pharmacy. You will be contacted by OptumRx if your medication is required to be filled through the OptumRx Mandatory Mail Order Program.

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

For prescriptions being filled for the first time through the Mail Order Pharmacy, you or your Doctor must complete a Mail Order Form. This form can be found at Quantum Health at www.upquantumhealth.com.

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

OptumRx
P.O. Box 2975
Mission, KS 66201
Fax Number: (800) 491-7997

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

Opting Out of Mandatory Mail Order
The MMO program is designed to provide maintenance medications to you at the lowest cost for both you and the Plan. However, because of continually changing market conditions, there are some instances when purchasing through MMO may not be your lowest cost option. If you are able to obtain the medication at a Retail Pharmacy at a lower cost than the Mail Order Pharmacy cost, you can opt out of the Mandatory Mail Order Program with respect to that medication by calling Quantum Health at (855) 649-3855. You may then continue to use that Retail Pharmacy to purchase your maintenance medication and the medication will be covered under the Pharmacy Program.

If you have questions, contact the Mail Order Pharmacy through Quantum Health at (855) 649 3855.

DISCRETIONARY MAIL ORDER PROGRAM

A Mail Order Pharmacy Service option is available for your convenience. If you are enrolled in a BCBS HDHP Option and you have not yet met your HDHP Deductible, you will pay 100% of the Prescription Drug Cost for the Prescription Drug Product. If you are enrolled in the BCBS Non-HDHP PPO, or a BCBS HDHP Option and have met your HDHP Deductible, you must pay for the Prescription Drug Product according to the three-tier Coinsurance structure shown in the table for "Prescription Drugs From Mail Order Pharmacy" table on page 74. Payment is made for up to a 90-day supply for each prescription filled by the Mail Order Pharmacy Service. The original prescription must be written for a 90-day supply, plus refills.

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

- You or your Doctor must complete a Mail Order Form. This form can be found on the Quantum Health site at www.upquantumhealth.com. The form can be faxed by you or your Doctor, or you can mail it to:

  OptumRx
  P.O. Box 2975
  Mission, KS 66201
  Fax Number: (800) 491-7997

The prescription should be written for a 90-day supply, plus refills.

- You can contact the Mail Order Pharmacy to find out the cost of the prescription by calling Quantum Health at (855) 649-3855.
- Your payment options for the Mail Order Pharmacy Service are:
  - Payment by credit card or debit card;
  - Payment by check with your order;
  - Payment by ACH transfer or "Tele-check" handled over the telephone (Note: there are no additional fees for this service); or
  - You can submit an order and be billed for the cost of a 90-day prescription up to $100.
- If your Doctor has prescribed a 90-day medication with refills, after the initial prescription is submitted, you can request a refill over the phone or at Quantum Health at www.upquantumhealth.com.
- When your prescription expires, you will need to request a new prescription from your Doctor. Your prescription may be for up to 12 months. Then a 90-day supply will be delivered directly to your home.

For additional information about your pharmacy benefits, call Quantum Health at (855) 649-3855 or visit Quantum Health at www.upquantumhealth.com.

PHARMACY BENEFIT PAYMENT INFORMATION

Deductible:
For the BCBS HDHP Options: You are responsible for paying the cost of covered pharmacy and covered medical services until the HDHP Deductible is met, before pharmacy benefits are payable under the Plan. (For more information on the HDHP Deductible, see the "Schedule of Benefits" section on page 12 of this 2026 BCBS Attachment.) The In-Network HDHP Deductibles, including family limits, are listed in the following table.

- The amounts you pay for contracted rates with an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Deductible. If an Out-of-Network Retail Pharmacy is used, only the amounts you pay up to the Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List are applied against the HDHP In-Network Deductible.
- The amounts you pay for contracted rates with a Preferred Provider for Covered Medical Services are also applied against the HDHP Deductible. If a Non-Preferred Provider is used to receive Covered Medical Services, only the Usual and Customary Charges for Covered Medical Services are applied against the HDHP Deductible.

HDHP DEDUCTIBLE	
In-Network	
HDHP1	• Employee Only Coverage: $3,400 per Calendar Year. • Employee + Dependent(s) Coverage: $3,400 per Covered Person per Calendar Year, not to exceed $6,800 for all Covered Persons in a family.
HDHP2	• Employee Only Coverage: $4,900 per Calendar Year. • Employee + Dependent(s) Coverage: $4,900 per Covered Person per Calendar Year, not to exceed $9,800 for all Covered Persons in a family.

If you are enrolled in a BCBS HDHP Option, after the HDHP Deductible is met, you are responsible for paying the applicable Pharmacy Coinsurance Payment as described below.

For the BCBS Non-HDHP PPO Option: No prescription drug Deductible applies. Cost sharing through the Pharmacy Coinsurance Payment, described below, begins with the first prescription.

Pharmacy Coinsurance Payment:
The Pharmacy Coinsurance Payment that you will be required to pay depends on (1) the BCBS Medical Option you are covered by, (2) the type of pharmacy that fills the prescription (i.e., Retail Pharmacy, Specialty Pharmacy, Mail Order Pharmacy, or Out-of-Network Retail Pharmacy), and (3) the Tier that the prescription falls in.

For the BCBS HDHP1 and BCBS HDHP2: After the HDHP Deductible is met, you are responsible for paying the applicable Pharmacy Coinsurance Payment, up to the HDHP Coinsurance Maximum (described in the following Payment Information Schedule), when Prescription Drug Products on the OptumRx Prescription Drug List are obtained from a Retail, Mail Order, or Specialty Pharmacy. The amount you pay for the HDHP Deductible or any non-covered drug product will not be included in calculating the HDHP Coinsurance Maximum. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and the OptumRx contracted rates (the OptumRx Prescription Drug Cost) will not be available to you.

- After the HDHP Deductible is met, the amounts you pay for contracted rates with an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Coinsurance Maximum. If an Out-of-Network Retail Pharmacy is used, only the amounts you pay up to the Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Coinsurance Maximum.
- After the HDHP Deductible is met, the amounts you pay for contracted rates with a Preferred Provider for Covered Medical Services are also applied against the HDHP Coinsurance Maximum. If a Non-Preferred Provider is used to receive Covered Medical Services, only the Usual and Customary Charges for Covered Medical Services are applied

against the HDHP Coinsurance Maximum.

For the BCBS Non-HDHP PPO: You are responsible for paying the applicable Pharmacy Coinsurance Payment, up to the Coinsurance Maximum (described in the following Payment Information Schedule), when Prescription Drug Products on the OptumRx Prescription Drug List are obtained from a Retail, Mail Order, or Specialty Pharmacy. No prescription drug Deductibles apply. Cost sharing through pharmacy Coinsurance begins with the first prescription. The amount you pay for any non-covered drug product will not be included in calculating the Coinsurance Maximum. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product, and the OptumRx contracted rates (the OptumRx Prescription Drug Cost) will not be available to you.

- The amounts you pay for contracted rates with an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the Coinsurance Maximum. If an Out-of-Network Retail Pharmacy is used, only the amounts you pay up to the Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List are applied against the Coinsurance Maximum.
- The amounts you pay for Covered Medical Services are applied against the same Coinsurance Maximum.

PAYMENT INFORMATION SCHEDULE		
Payment Term	**Description**	**Amounts**
Pharmacy Coinsurance Payment (applies to all BCBS Medical Options)	Pharmacy Coinsurance Payments for a Prescription Drug Product at an In-Network Pharmacy are a portion of the Prescription Drug Cost. Pharmacy Coinsurance Payments for a Prescription Drug Product at an Out-of-Network Retail Pharmacy are a portion of the Predominant Reimbursement Rate. Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned a Prescription Drug Product. **NOTE**: The tier status of a Prescription Drug Product can change periodically, generally on January 1st and July 1st, based on the Pharmacy and Therapeutics Committee's periodic tier decisions. When that occurs, your Coinsurance payment may change. If there is a tier change which increases your Coinsurance percentage payment for a medication you have previously filed with OptumRx you will be notified by OptumRx either by letter or by sending information to the pharmacy when the prescription is being processed. In addition you can go to Quantum Health at www.upquantumhealth.com, or call Quantum Health at (855) 649-3855, for the most up-to-date tier status.	For Prescription Drug Products at an In- Network Pharmacy, you are responsible for paying the lower of: • The applicable Pharmacy Coinsurance Payment; or • The Prescription Drug Cost for that Prescription Drug Product. See the Pharmacy Coinsurance Payment description in the table beginning on page 68.

PAYMENT INFORMATION SCHEDULE		
Payment Term	**Description**	**Amounts**
Coinsurance Maximum (applies to all BCBS Medical Options)	The Coinsurance Maximum is the maximum amount you are required to pay for Covered Medical Services and/or Covered Prescription Drug Products on the OptumRx Prescription Drug List in a single Calendar Year. Once you reach the Coinsurance Maximum, you will not be required to pay Coinsurance payments for covered Prescription Drug Products on the OptumRx Prescription Drug List for the remainder of the Calendar Year. Note: For prescriptions purchased at an Out-of- Network Retail Pharmacy, any charges above the Predominant Reimbursement Rate are not considered by the Plan as benefit payments and do not count toward your Coinsurance Maximum.	**In-Network:** HDHP1: combined medical and prescription Coinsurance Maximum of $2,000 per Covered Person per Calendar Year, not to exceed $4,000 for all Covered Persons in a family. HDHP2: combined medical and prescription Coinsurance Maximum of $1,500 per Covered Person per Calendar Year, not to exceed $3,000 for all Covered Persons in a family. Non-HDHP PPO: combined medical and prescription Coinsurance Maximum of $2,750 per Covered Person per Calendar Year, not to exceed $5,500 for all Covered Persons in a family. **Out-of-Network:** Note – Prescription Drug Products provided by an Out-of-Network Retail Pharmacy will apply towards the In-Network Coinsurance Maximum.

Three-Tier Coinsurance: Your Pharmacy Coinsurance Payment under the BCBS HDHP Options once the HDHP Deductible has been met or under the BCBS Non-HDHP PPO depends on the tier to which the Prescription Drug Product is assigned. Prescription Drug Products are assigned to one of three tiers by OptumRx. Each tier is assigned a Pharmacy Coinsurance flat dollar Copay or percentage, with a minimum and maximum as shown in the next few pages. Tier 3 Prescription Drug Products have the highest Pharmacy Coinsurance Payment percentage and Tier 1 Prescription Drug Products have a flat dollar Copay. The tier assignments change periodically. Tiers indicate how much you will pay for a medication after you have satisfied any applicable Deductible. You can obtain information regarding which drugs fall into the different tiers by going to Quantum Health at www.upquantumhealth.com or by calling Quantum Health at (855) 649- 3855.

Sometimes your Doctor may prescribe a medication to be "dispensed as written" when a lower tier or lower cost brand or Generic alternative drug is available. As part of your Plan, the pharmacist may discuss with your Doctor whether an alternative drug might be appropriate for you. You and your Doctor make the final decision on your medication, and you can always choose to keep the original prescription at the higher Pharmacy Coinsurance Payment.

Preventive Pharmacy Benefits: Certain Prescription Drug Products categorized as preventive care benefits under the Patient Protection and Affordable Care Act (PPACA) are available to members at no charge and are not subject to deductible or coinsurance provisions of the Plan if such Prescription Drug Products are received from an In-Network Pharmacy. To learn whether a Prescription Drug Product is available to members at no charge, go to Quantum Health at www.upquantumhealth.com or call Quantum Health at (855) 649-3855 for the most up-to-date status.

Certain other Prescription Drug Products not categorized as preventive care under the PPACA, but considered preventive care for other purposes under federal law also are available to members at no charge and are not subject to deductible or coinsurance provisions of the Plan, if such Prescription Drug Products are received from an In-Network Pharmacy. The

list of these Prescription Drug Products can be found at www.upquantumhealth.com and is subject to OptumRx's periodic review and modification. Generally speaking, these Prescription Drug Products are prescribed to treat certain chronic conditions, or to prevent either the exacerbation of the chronic condition or the development of a secondary condition.

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

OptumRx may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur on January 1st and July 1st. These changes may occur without prior notice to you.

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

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

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please go to Quantum Health at www.upquantumhealth.com, or call Quantum Health at (855) 649-3855 for the most up- to-date tier status.

The following table describes Pharmacy Coinsurance Payments and benefits for participants enrolled in a BCBS Medical Option, i.e., a BCBS HDHP Option or the BCBS Non-HDHP PPO.

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits	**BCBS Medical Options Your Pharmacy Coinsurance Payment Amount**
In-Network Retail or Specialty Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by an In-Network Retail Pharmacy or a Specialty Pharmacy as written by the provider up to a consecutive 31-day supply (or a 30- day supply if provided by a Specialty Pharmacy) of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, based on supply limits or as described under the "SmartFill Programs" section of this guide. Certain generics may also be dispensed by an In-Network Retail Pharmacy up to a 90-day supply.	Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please go to Quantum Health at www.upquantumhealth.com or call Quantum Health at (855) 649-3855 to determine tier status. • $10 Copay for a Tier-1 Prescription Drug Product (or cost of drug, if less). • 30% of the Prescription Drug Cost for a Tier-2 Prescription Drug Product. • 40% of the Prescription Drug Cost for a Tier-3 Prescription Drug Product. Each In-Network Retail or Specialty Pharmacy Prescription Order or Refill for Tiers 2 and 3 above is subject to a per-prescription minimum Pharmacy Coinsurance Payment and a per prescription Pharmacy Coinsurance Maximum payment. Note – if your Specialty Pharmacy medication is filled under the "SmartFill Program": • 15-day supply cost = ½ a 30-day supply • 90-day supply cost = 3x a 30-day supply **COVERED AT NO COST** (Deductible and Coinsurance do not apply): • Prescription Drug Products that are preventive as described in the "Preventive Pharmacy Benefits" section on page 70. **NOT COVERED:** • Mandatory Mail Order (MMO) drugs filled at a Retail Pharmacy after the 2-fill transition period; or • Specialty Pharmacy drugs, including self-injectable infertility drugs, filled at a Retail Pharmacy.

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits	**BCBS Medical Options Your Pharmacy Coinsurance Payment Amount**
Out-of-Network Retail Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by an Out-of-Network Retail Pharmacy as written by the provider up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. If the Prescription Drug Product is dispensed by an Out-of-Network Retail Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with OptumRx. The Plan will not reimburse you for your HDHP Deductible, Pharmacy Coinsurance Payment, or the difference between the billed cost and the Predominant Reimbursement Rate for that Prescription Drug Product. In addition, the Plan will not reimburse you for any drug not on the Prescription Drug List. **In most cases, you will pay more if you obtain Prescription Drug Products from an Out-of-Network Pharmacy.**	Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please go to Quantum Health at www.upquantumhealth.com or call Quantum Health at (855) 649-3855 to determine tier status. • $10 Copay for a Tier-1 Prescription Drug Product (or cost of drug, if less). • 30% of the Predominant Reimbursement Rate for a Tier-2 Prescription Drug Product. • 40% of the Predominant Reimbursement Rate for a Tier-3 Prescription Drug Product. Each Out-of-Network Retail Pharmacy Prescription Order or Refill for Tiers 2 and 3 above is subject to a per-prescription minimum Pharmacy Coinsurance Payment and a per prescription Pharmacy Coinsurance Maximum payment. **NOT COVERED:** • Mandatory Mail Order (MMO) drugs filled at a Retail Pharmacy after the 2-fill transition period; or • Specialty Pharmacy drugs, including self- injectable infertility drugs, filled at a Retail Pharmacy.
Per Prescription Pharmacy Coinsurance Minimums and Maximums from a Retail Pharmacy and Specialty Pharmacy Each Tier 2 and 3 Prescription Order or Refill purchased from a Retail Pharmacy or Specialty Pharmacy is subject to the per prescription Pharmacy Coinsurance Minimum and Pharmacy Coinsurance Maximums described here, unless you have reached the Coinsurance Maximum.	**In-Network and Out-of-Network Retail** Tier 1 – NA Tier 2 - $30 Minimum*/$90 Maximum Tier 3 - $60 Minimum*/$150 Maximum *or cost of drug, if less **NOTE**: If your Specialty Pharmacy medication is filled under the "SmartFill Program": • 15-day Min/Max = ½ the amounts above • 90-day Min/Max = 3x the amounts above

PRESCRIPTION DRUGS FROM MAIL ORDER PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits	**BCBS Medical Options Your Pharmacy Coinsurance Payment Amount**
In-Network Mail Order Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy as written by the provider up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. **Out of Network Mail Order Pharmacy** Prescription Drug Products dispensed by an Out-of- Network Mail Order Pharmacy will not be covered by the Plan.	Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please go to Quantum Health at www.upquantumhealth.com or call Quantum Health at (855) 649-3855 to determine tier status. • $25 for a Tier-1 Prescription Drug Product (or cost of drug, if less). • 25% of the Prescription Drug Cost for a Tier-2 Prescription Drug Product. • 40% of the Prescription Drug Cost for a Tier-3 Prescription Drug Product. Each Mail Order Prescription Order or Refill for Tiers 2 and 3 above is subject to a per-prescription minimum Pharmacy Coinsurance Payment and a per-prescription Maximum Pharmacy Coinsurance Payment. COVERED AT NO COST (Deductible and Coinsurance do not apply): • Prescription Drug Products that are preventive as described in the "Preventive Pharmacy Benefits" section on page 70.
Per Prescription Coinsurance Minimums and Maximums from an In-Network Mail Order Pharmacy Each Tier 2 and 3 Prescription Order or Refill purchased through the Mail Order Pharmacy is subject to the per-prescription Pharmacy Coinsurance Minimum and Pharmacy Coinsurance Maximums described here, unless you have reached the Coinsurance Maximum.	**In-Network Mail Order Pharmacy** Tier 1 – NA Tier 2 - $75 Minimum*/$225 Maximum Tier 3 - $150 Minimum*/$375 Maximum *or cost of drug, if less

WHAT'S NOT COVERED – EXCLUSIONS

The following exclusions apply to the Pharmacy Program (Note: Some items excluded here may be covered under the Medical Care Program):

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

Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
- Prescription Drug Products that are subject to the Mandatory Mail Order Program when dispensed at a Retail Pharmacy following the two prescription transition period (unless you meet the conditions to opt-out of the MMO program with respect to a specific Prescription Drug Product and have elected to do so);
- Prescription Drug Products that are subject to the Specialty Pharmacy Program when dispensed at a Retail Pharmacy (i.e., not dispensed through a Specialty Pharmacy);
- Prescription Drug Products that are subject to the Progression Rx Step Therapy Program and for which you have not satisfied the program requirements to use a different Prescription Drug Product first;
- Prescription Drug Products for any condition, Injury, Sickness, or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws (e.g., Federal Employers' Liability Act or "FELA"), whether or not a claim for such benefits is made or payment or benefits are received. (Note: Prescription Drug Products prescribed to treat an on-duty injury, where the company is not at fault and no FELA claim will be filed, will be allowed to be paid by the Plan, subject to the terms, conditions and other exclusions of the Plan.);
- A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by OptumRx, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. These medications may be covered under the Medical Care Program. This exclusion does not apply to Depo-Provera and other injectable drugs used for contraception;
- Durable Medical Equipment, prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered (see "Prescription Drug Product" definition on page 84). Certain Durable Medical Equipment may be covered under the BCBS Medical Options;
- Coordination of benefits on Prescription Drug Products, including Prescription Drug Products on the BCBS/OptumRx Prescription Drug List;
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins, unless such general vitamins qualify to be covered as Preventive Care under PPACA;
- Unit dose packaging of Prescription Drug Products;
- Medications used for cosmetic purposes;
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be on the Prescription Drug List;
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken, or destroyed;
- Glucose monitors;
- Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill;
- Drugs available over the counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug.
- Prescription Drug Products that are comprised of components which are available in over-the-counter form or equivalent, unless such drugs available over the counter qualify to be covered as Preventive Care under PPACA;
- New Prescription Drug Products and/or new dosage forms that have not yet been reviewed by the Pharmacy and Therapeutics Committee until the date they are reviewed and assigned to a tier.
- Prescription Drug Products to the extent that benefits for such products are provided under any other plan to which the employer sponsors or contributes;
- Injectable drugs that must be administered by a licensed healthcare professional; which, if covered, would be paid under the Medical Plan provisions. This exclusion does not apply to certain insulin or self-administered injectables that are covered by the Plan and can be injected subcutaneously. The list of drugs which are considered "self-administered injectables" is determined by OptumRx. To verify if an injectable drug is considered a self-administered injectable, go to Quantum Health at www.upquantumhealth.com or call Quantum Health at (855) 649-3855;
- Prescribed devices or supplies of any type, including colostomy supplies or contraceptive devices and supplies (oral contraceptives on the OptumRx Prescription Drug List are covered under the Pharmacy Program);
- Progesterone suppositories;
- Over-the-counter drugs or products not approved by the U.S. Food and Drug Administration; and

- A Prescription Drug Product requested to be filled by the In-Network Mail Order Pharmacy for which an original Prescription Order or Refill is not submitted to the In-Network Mail Order Pharmacy. A Prescription Order or Refill provided to another pharmacy cannot be transferred to the In-Network Mail Order Pharmacy.

HOW TO FILE PHARMACY CLAIMS

For all claims and appeals for Pharmacy Program benefits provided under the BCBS Medical Options, Union Pacific has delegated to OptumRx the exclusive and discretionary right to make factual findings, interpret and administer the provisions of the Plan, and determine benefits payable under the Pharmacy Program. Any finding, interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the finding, interpretation or determination was arbitrary and capricious. The decisions of OptumRx are conclusive and binding, except to the extent a decision is eligible for review under the external review process described in the "External Review Program" section below.

Non-English Services:
Depending on the county in which you reside, OptumRx may be able to provide you, upon request, with benefit determinations and other notices required to be provided under this internal claim and appeal process in a non- English language. Telephonic oral language services may also be available. Such non-English services shall be made available by OptumRx in accordance with IRS rules for culturally and linguistically appropriate communications.

Right to and Payment of Benefits:
Benefits and rights under the Pharmacy Program are available only to Covered Persons. Except as required by law, a Covered Person may not assign, in whole or in part, any benefit or right under the Pharmacy Program to any person, including but not limited to, a Doctor, pharmacist or other provider, nor are any such benefits and rights subject to garnishment or attachment. However, the Pharmacy Program will honor a Covered Person's written authorization to allow direct payment to a Doctor, pharmacist or other provider, so as to permit all or a portion of a payment due for a Prescription Drug Product owed to the Doctor, pharmacist or other provider to be paid directly to the Doctor, pharmacist or other provider. An authorization of direct payment is for the convenience of the Covered Person and shall not be recognized by the Pharmacy Program as assigning to the Doctor, pharmacist or other provider the Covered Person's rights to any benefit under the Pharmacy Program.

Also, nothing in the above paragraph is intended to prohibit a Covered Person from designating another person (including, in the case of an Urgent Care claim or appeal, a health care professional with knowledge of the Covered Person's medical condition) to serve as the Covered Person's authorized representative with respect to any claim or appeal filed in accordance with Pharmacy Program procedures. OptumRx will not reimburse third parties who have purchased or have been assigned benefits by a Doctor, pharmacist or other provider.

Internal Claim and Appeal Process:
Unless your claim is for Urgent Care (defined below), your claim must be submitted to OptumRx within 12 Calendar Months of the date you fill the Prescription Order or Refill.

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

If you obtain prescription drugs from an Out-of-Network Retail Pharmacy, you will need to pay the entire cost of each prescription at the time it is filled. You or your pharmacist must then file a claim to receive benefits under the Pharmacy Program.

OptumRx will review your claim. The reimbursement claim form includes instructions on how to complete and where to send the form. To obtain a claim form, go to Quantum Health at www.upquantumhealth.com or call Quantum Health at (855) 649- 3855. You will usually be reimbursed for a covered Prescription Drug Product within 30 days after receipt of your approved claim form. The completed claim form, along with the prescription receipt, must be sent to:

OptumRx
P.O. Box 29450
Hot Springs, AR 71903

If you have a claim for Urgent Care, OptumRx will review your claim as an Urgent Care claim. You, your Doctor, or your pharmacist must submit your Urgent Care claim by calling OptumRx at (877) 559-2955.

An Urgent Care claim is a claim for care in which the application of the time periods for making non-urgent care determinations:

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

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

In the case of a claim for coverage involving Urgent Care, you will be notified of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours of receipt of the claim. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified as soon as possible, but not later than 24 hours after receipt of your claim. In this case you will be notified of the information necessary to complete the claim and you will have 48 hours to provide the information. You will then be notified of the decision as soon as possible, but not later than 48 hours after the earlier of: OptumRx's receipt of the information or the end of the 48 hour period given to provide the information.

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

If your claim is denied, OptumRx will send you a written denial notice that will describe the Plan's internal and external review processes, including information regarding how to initiate an appeal. The notice will include information sufficient to identify the claim involved (including the date of service, the Provider, and the claim amount, if applicable). The notice will refer to the part of the Plan on which the denial is based and explain the reason for denial, including the denial code, if any, and its corresponding meaning, as well as a description of Optum Rx's standard, if any, that was used in denying your claim (e.g., if your claim was denied because the Prescription Drug Product has not been approved for that use, or is experimental, investigational or unproven, the denial notice will include an explanation of this determination). If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your claim, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. In addition, the notice will include the following:

- a description of any additional material or information needed to perfect your claim and an explanation of why such material or information is necessary;
- a statement describing your right to receive, upon request, a copy of the diagnosis code and/or treatment code, and their corresponding meanings. If you request such code(s), OptumRx will provide the code(s) (and its corresponding meaning) to you as soon as practicable following receipt of your request; and
- information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the healthcare reform law to assist you with the internal claims and appeals and external appeal process.

NOTE: Except as described in the section, "Your Options if the Internal Claim and Appeal Process Is Not Followed" on page 80, you must first exhaust all appeals available to you under the Plan – both internal and external – before you have a right to bring a civil action under ERISA regarding your denied claim. See the section, "Pharmacy Claim Questions and Appeals," immediately below for information regarding your appeal rights.

PHARMACY CLAIM QUESTIONS AND APPEALS

In the event you receive an adverse determination following a request for coverage of a claim, you have the right to appeal the adverse benefit determination to OptumRx in writing within 180 days of receipt of notice of the initial coverage decision. This process is known as an "internal appeal" or "internal review." If a non-Urgent Care claim is denied, there are two levels of internal appeal to OptumRx. If an Urgent Care claim is denied, there is only one level of internal appeal.

This appeal process will ordinarily apply to determinations as to your eligibility for Pharmacy Program coverage only if they are part of a claim for actual benefits. However, if your coverage is discontinued retroactively for reasons other than the

failure to make your contributions on time, you may file an appeal that contests the retroactivity of the termination of coverage. Such an appeal should be filed with the Plan Administrator, not with OptumRx.

How to Submit a Non-Urgent Care Claim Decision for Internal Review:
To initiate a request for an internal review of a non-Urgent Care claim denial, you or your Doctor must provide in writing, your name, member ID, Doctor's name and phone number, the Prescription Drug Product for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. This information must be mailed to:

OptumRx
c\o Appeals Coordinator
CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

Internal Appeal Determinations – Non-Urgent Care Claims:
OptumRx will review your first level appeal, and a decision regarding your appeal will be sent to you within a reasonable period of time, but not later than 30 days of receipt of your written request. If your appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the Prescription Drug Product has not been approved for that use, or because it is experimental, investigational or unproven, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and at no charge, the information used to review your request for coverage and will describe the second level appeal procedures.

If you are not satisfied with the coverage decision made on the first level appeal, you may make a written request for a second level appeal. Your written request must be made within 90 days of your receipt of notice of the first level appeal decision. You must submit a second level appeal in order to preserve your rights to external review or to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") concerning the Plan's denial of your claim.

To initiate a second level appeal, you or your Doctor must provide in writing, your name, member ID, Doctor's name and phone number, the Prescription Drug Product for which benefit coverage has been denied, a statement of each and every reason why you believe your claim should be approved, and any additional information that may be relevant to your second level appeal. This information must be mailed to:

OptumRx
c\o Appeals Coordinator
CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

Your second level appeal will be reviewed by OptumRx. OptumRx will notify you and your Doctor in writing within a reasonable period of time, but not later than 30 days of receipt of your written request for appeal. The decision of OptumRx made on your second level appeal is the Plan's Final Internal Adverse Benefit Determination. Such decision is conclusive and binding, unless it is eligible and submitted for review under the external review process described in the "External Review Program" section below.

If in response to your second level appeal OptumRx intends to issue a Final Internal Adverse Benefit Determination on the basis of new or additional evidence first considered as part of your second level appeal, or on the basis of a new or different rationale than relied on before, OptumRx will provide you, free of charge, with a description of such new evidence or rationale in advance of its determination so that you may have a reasonable opportunity to respond before the final determination is made.

If your second level appeal is denied (i.e., there is a Final Internal Adverse Benefit Determination), the denial notice will describe the Plan's external review process (if it is available with respect to your appeal) including information regarding how to initiate such an appeal. The notice will include information sufficient to identify the appeal involved (including the date of service, the Provider, and the appeal amount, if applicable). The notice will refer to the part of the Plan on which

the denial is based and explain and discuss the reason for denial, including the denial code, if any, and its corresponding meaning, as well as a description of OptumRx's standard, if any, that was used in denying your appeal (e.g., if your appeal was denied because the Prescription Drug Product has not been approved for that use, or is experimental, investigational or unproven, the denial notice will include an explanation of this determination). If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. In addition, the notice will include the following:

- a statement describing your right to receive, upon request and at no charge, the information relevant to your claim and appeal;
- a statement describing your right to receive, upon request, a copy of the diagnosis code and/or treatment code, and their corresponding meanings. If you request such code(s), OptumRx will provide the code(s) (and its corresponding meaning) to you as soon as practicable following receipt of your request;
- information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the healthcare reform law to assist you with the internal claims and appeals and external appeal process; and
- a statement regarding your right, if eligible, to request an external review of OptumRx's Final Internal Adverse Benefit Determination and, if external review is unavailable or also results in a denial of your claim, to bring a civil action under Section 502(a) of ERISA.

Internal Appeal of Urgent Care Claims:
You have the right to request an urgent appeal of an adverse determination if you request coverage of an Urgent Care claim for pharmacy benefits. Urgent Care appeal requests may be oral or written. You or your Doctor may call OptumRx at (888) 403-3398, fax to (877) 239- 4565 or write to:

OptumRx
c\o Appeals Coordinator
CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

Your appeal of an Urgent Care claim must identify each and every reason why you believe your claim should be approved. Appeals of Urgent Care claims are reviewed by OptumRx. In the case of an urgent appeal for coverage involving Urgent Care, you will be notified of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours of receipt of the claim. The decision of OptumRx of an Urgent Care appeal is the Plan's Final Internal Adverse Benefit Determination. Such decision is conclusive and binding, unless it is eligible and submitted for review under the external review process described in the "External Review Program" section below.

If your Urgent Care appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the Prescription Drug Product has not been approved for that use or because it is experimental, investigational or unproven, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and at no charge, the information used to review your appeal.

The denial notice will also describe the Plan's external review process, which, if you are eligible, includes an expedited process for Urgent Care claims. If you are not eligible for external review, or if your urgent claim appeal is denied on external review, you have the right to bring a civil action under Section 502(a) of ERISA.

Pharmacy Internal Appeal Process:
OptumRx will review all first level, second level, and Urgent Care appeals. Any review on appeal will not give deference to previous claim denials. The person who will perform the internal review of your appeal denial will not be the same person as the person who made the initial decision to deny your claim nor a subordinate of the person who denied your claim. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. If the initial denial is based in whole or in part on a medical judgment, OptumRx will consult with a

healthcare professional with appropriate training and experience in the relevant medical field. This healthcare professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination. If OptumRx obtained advice from medical or vocational experts with respect to your claim, these experts will be identified, regardless of whether OptumRx relied on their advice when deciding your claim.

In deciding whether to appeal a denial or to present additional evidence or testimony, you have the right to review your claim file. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim.

Your Options if the Internal Claim and Appeal Process Is Not Followed:
If you believe OptumRx has failed to follow the internal review procedures described above and that failure denies you the opportunity to obtain a decision on the merits of your claim, you may take the following action, without having to exhaust the Plan's internal claim and appeal process:

- initiate an immediate external review of your claim or appeal using the external review process described below, if your claim is otherwise eligible for review under such external review process; or
- bring a civil action under Section 502(a) of ERISA, if your claim is not otherwise eligible for review under the external review process described below.

Before taking such action, however, you may request a written explanation of the failure from OptumRx and OptumRx will furnish such explanation within 10 days of your request. You may want to obtain such explanation because a request for immediate review can be rejected if it is determined that the failure was de minimis and unlikely to cause you prejudice or harm. OptumRx's explanation may therefore help you to decide whether to proceed outside the internal review process. If an external reviewer or a court rejects your request for immediate review of your claim on the basis that the violation was de minimis, you have the right to resubmit and pursue the internal appeal of your claim. OptumRx will notify you of this right within a reasonable time after the external reviewer or court rejects your claim for immediate review, but no later than 10 days following such rejection.

External Review Program:
An external review program is offered in certain circumstances. If, you are not satisfied with the determination made by OptumRx after exhausting your internal appeals, you may be entitled to request an external review of OptumRx's determination. You may also be entitled to an external review (or, to file a civil action under Section 502(a) of ERISA) if OptumRx fails to follow the internal review procedures described above and that failure denies you the opportunity to obtain a decision on the merits of your claim. If you request such immediate external review and it is rejected, you may be able to resubmit and pursue the internal appeal of your claim. See "Your Options if the Internal Claim and Appeal Process Is Not Followed," above. The external review process is available at no charge to you.

You may request an external review of an adverse benefit determination based upon any of the following:

- the denial of your claim by reason of medical judgment (clinical reasons), including the application of the Plan's exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

You or your representative may request a standard external review by sending a written request to OptumRx at the address set out in its Final Internal Adverse Determination. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your Member ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received OptumRx's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance Member ID number;
- your designated representative's name and address, when applicable;

- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). OptumRx has entered into agreements with three or more IROs that have agreed to perform such reviews.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by OptumRx of the request;
- a referral of the request by OptumRx to the IRO; and
- a decision by the IRO.

Within 5 business days after receipt of the request, OptumRx will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the Prescription Drug Product at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that OptumRx may process the request.

Within one (1) business day of completing its preliminary review, OptumRx will issue a notification in writing to you. If your request for external review is complete, but not eligible for external review, the notification will include the reason(s) for its ineligibility and furnish contact information for the Employee Benefits Security Administration. If your request is not complete, the notification will describe the information or materials needed to make your request complete. You must furnish the missing information or materials before the end of the 4 month filing period or within 48 hours following your receipt of the notification, whichever is later. If the request is eligible for external review, OptumRx will assign an IRO to conduct such review. The IRO has no material affiliation or interest with OptumRx. OptumRx will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

OptumRx will furnish to the IRO documents and information relevant to your claim within five business days of the assignment. If there is information or evidence you or your Doctor wish to submit in support of the request that was not previously provided, you may include this information with the request for external review, and OptumRx will include it with the documents forwarded to the IRO.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO additional information for the IRO's consideration when conducting the external review. Your information must be submitted within ten business days following the date of receipt of the IRO's notice The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days. Generally speaking, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in making its decision:

- all relevant medical records;
- the attending health care professional's recommendations;
- reports from appropriate health care professionals and other documents submitted by OptumRx on behalf of the Plan, by you, or by your treating Provider;
- the terms of the Plan, including any applicable and lawful review criteria developed and used by the Plan;
- appropriate practice guidelines, based on evidence-based standards, which may include practice guidelines developed for Federal government, national or professional medical societies, boards and associations; and
- the opinion of the IRO's clinical reviewer(s) based on such available information or documents which such clinical reviewer deems appropriate.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by OptumRx. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and OptumRx, which will include the clinical basis for the determination and any other information as required by applicable law.

Upon receipt of a Final External Review Decision reversing OptumRx's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the Prescription Drug Product.

Expedited External Review:
An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination with respect to an Urgent Care claim for which you have filed a request for an internal appeal, and the adverse benefit determination involves a medical condition for which the time frame for completion of the internal appeal process described above for an Urgent Care claim would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a Final Internal Adverse Benefit Determination, if such determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service, procedure or product for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of a request for an expedited external review, OptumRx will determine whether you meet both of the following:

- you are or were covered under the Plan at the time the health care service or procedure at issue in the request was provided; and
- you have provided all the information and forms required so that OptumRx may process the request.

After OptumRx completes the review, OptumRx will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, OptumRx will assign an IRO in the same manner OptumRx utilizes to assign standard external reviews to IROs. OptumRx will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by OptumRx. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to OptumRx.

Regardless of whether the external review is a standard external review or expedited external review, if the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for the Prescription Drug Product in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the Prescription Drug Product.

You may contact Quantum Health at the toll-free number on your Member ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

PHARMACY PROGRAM DEFINITIONS

(See also Medical Benefit Definitions in the Glossary of the Medical Benefits section, beginning on page 56.)

Brand-Name*:* A Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a

specific drug manufacturer; or (2) that OptumRx identifies as a Brand-Name product, based on available data resources including, but not limited to, Medi-Span, that classify drugs as either brand or Generic based on a number of factors. You should know that all products identified as Brand Name by the manufacturer, pharmacy, or your Doctor may not be classified as Brand Name by the Plan.

Coinsurance Maximum: The maximum amount you are required to pay for Covered Medical Services and/or Covered Prescription Drug Products on the OptumRx Prescription Drug List in a single Calendar Year. For more information, see "Pharmacy Benefit Payment Information", beginning on page 68.

Deductible: The cost of covered pharmacy (and covered medical services) you are responsible for paying before pharmacy benefits (and/or medical benefits) are payable under the Plan. No prescription drug Deductible applies under the Non- HDHP PPO Option. For more information, see "Pharmacy Benefit Payment Information", beginning on page 68.

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

In-Network Pharmacy*:* A pharmacy that has:

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

An In-Network Pharmacy can be a Retail Pharmacy, Specialty Pharmacy, or Mail Order Pharmacy.

Medically Necessary: Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorders, condition, disease or its symptoms, that are all of the following as determined by OptumRx or its designee, within OptumRx's sole discretion. The services must be:

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

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. OptumRx reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within OptumRx's sole discretion. OptumRx develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services.

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

- The date it is assigned to a tier by the Prescription Drug List Management Committee.

- December 31st of the following Calendar Year.

Pharmacy Coinsurance Payment:
The portion of the Prescription Drug Cost or Predominant Reimbursement Rate you must pay for a Prescription Order or Refill of a Prescription Drug Product. You are responsible for paying the applicable Pharmacy Coinsurance Payment, up to the Coinsurance Maximum, when Prescription Drug Products on the OptumRx Prescription Drug List are obtained from a Retail Pharmacy, Mail Order Pharmacy or Specialty Pharmacy.

Pharmacy and Therapeutics Committee: The committee that OptumRx designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

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

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

Prescription Drug List: A list that identifies those Prescription Drug Products for which benefits are available under the Plan. This list is subject to periodic review and modification by OptumRx (generally on January 1st and July 1st). You may determine to which tier a particular Prescription Drug Product has been assigned at Quantum Health at www.MyQHealth.com or by calling Quantum Health at (855) 649-3855.

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

- Inhalers (with spacers);
- Insulin;
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood-testing strips - glucose;
  - Urine-testing strips - glucose;
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices.
  - Omnipod 5 and related supplies
- Neocate infant formula (if it is the sole source of nutrition).

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

OTHER IMPORTANT INFORMATION

Right To Continue Coverage Under COBRA

COBRA continuation coverage may be available to you when you would otherwise lose your coverage under a BCBS Medical Option. See the 2026 Flex Guide, "Continuation of Coverage Under COBRA" section beginning on page 24 for details regarding COBRA coverage.

Health Insurance Portability And Accountability Act Of 1996 (HIPAA)

HIPAA privacy rules apply to the BCBS Medical Options. See the 2026 Flex Guide, "HIPAA" section beginning on page 168 for information regarding HIPAA privacy practices and compliance.