2025 United Health Care Retiree Medical Guide

Medical Benefits Available to Union Pacific Retirees
and their Dependents effective January 1, 2025

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

SUMMARY PLAN DESCRIPTION

This booklet describes a covered person's rights and obligations under an employee welfare benefit plan established by Union Pacific Corporation, provided that the covered person is a participant of the Plan. It includes information about who is covered, the kinds of benefits provided, limitations or restrictions you should know about, and how to claim benefits. All of the details of this Plan are not provided. Union Pacific Corporation reserves the right to change or discontinue this Plan at any time for any reason. Similarly, a participating employer can take such actions with respect to its Retirees.

The benefits described herein are covered by provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA) – a federal law that governs the operation of employee benefit plans. It is important to understand some of the provisions of this law since they could affect you. This booklet is a covered person's Summary Plan Description for purposes of ERISA. A description of ERISA provisions is found in the ERISA section at the end of this booklet on page 87. This Summary Plan Description does not create a contract of employment.

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Table of Contents

INTRODUCTION....5
PLAN PARTICIPATION....5
Eligibility for Benefits at Retirement (Retirement Prior To January 1, 1992)....5
Eligibility for Benefits at Retirement (Retirement On or After January 1, 1992)....5
Eligibility for Benefits at Retirement (Former Southern Pacific Retirees Retiring Before January 1, 1998)....6
How Eligibility for Medicare Affects Retiree Medical Program Coverage....6
Retiree Coverage Election....6
Special Enrollment Periods....6
Coverage If You Relocate....8
Dependents:....9
RETIREE MEDICAL PROGRAM COVERAGE....10
UHC HDHP PPO PROGRAM....11
Components:....11
Preferred Provider:....11
Mental Health and Substance-Related and Addictive Disorders Treatment....13
Pharmacy Benefits....13
Vision Care Discount Program....13
Plan Features....13
SCHEDULE OF BENEFITS....16
CARE COORDINATION PROCESS....17
Designated Coordinating Physician....18
Prior Authorization of Certain Procedures....18
Utilization Review....19
Concurrent Review....19
Case Management....19
Chronic Condition Management....20
GENERAL PROVISIONS FOR CARE COORDINATION....20
COVERED HEALTH SERVICES....22
ADDITIONAL EXCLUSIONS....45
HEALTH MANAGEMENT PROGRAMS....50
Preventive Care Benefits....50
Cancer Resource Services....51
Dario....51
Maven Fertility & Family Building....51
Transplant Management Program:....51
QUANTUM HEALTH....52
MEDICAL CLAIMS....52
Post-Service Claims....53
Pre-Service Claims....53
Urgent Care Claims....53
Concurrent Care Claims....53
MEDICAL CLAIM QUESTIONS AND APPEAL PROCESS....57
COORDINATION OF BENEFITS....59
UHC HDHP PPO PROGRAM: PHARMACY BENEFITS....61
Member Identification (ID) Card – In-Network Pharmacy:....61
Limitation on Selection of Pharmacies:....61
Concurrent Drug Utilization Review:....61
Additional Information About Your Prescriptions:....61
What's Covered:....61
Benefits for Outpatient Prescription Drug Products:....62
Prior Authorization:....62
Quantity Level Limits (QLL)/Quantity per Duration (QD):....62
Notification Requirements:....63

Progression Rx/Step Therapy: 63
Specialty Pharmacy Services: 63
SmartFill Programs: 64
Mandatory Mail Order Program: 64
Pharmacy Benefit Payment Information 65
Three-Tier Pharmacy Coinsurance: 68
Preventive Pharmacy Benefits: 68
Coverage Policies and Guidelines: 68
NOTE: 68
Benefit Information: 69
What's Not Covered – Exclusions: 72
How to File Pharmacy Claims: 73
Right to and Payment of Benefits: 73
Claim and Appeal Process: 73
Pharmacy Claim Questions and Appeals: 74
Pharmacy Benefit Defined Terms: 76
UHC HDHP PPO PROGRAM: VISION CARE DISCOUNT PROGRAM 79
What's Covered? 79
Limitations/Exclusions: 79
How To Access the Access Discount Plan: 80
How to File Vision Claims: 80
Member Grievance Procedure: 80
WHEN COVERAGE ENDS 80
CONTINUATION OF COVERAGE UNDER COBRA 81
What is COBRA Continuation Coverage? 82
When is COBRA Coverage Available? 82
How is COBRA Coverage Provided? 82
Premium for COBRA Continuation Coverage 83
Termination of Continuation Coverage 83
RETIREE MEDICAL PROGRAM - THIRD PARTY LIABILITY/SUBROGATION 84
MEDICAID 86
REFUND FOR OVERPAYMENT OF BENEFITS 86
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) 87
IMPORTANT PLAN INFORMATION 90
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) 91
GLOSSARY 93
BENEFIT CONTACTS 99

INTRODUCTION

This 2025 UnitedHealthcare (UHC) Retiree Medical Guide (the "Guide") describes the healthcare benefits available to certain Union Pacific retirees and their Dependents through the Union Pacific Retiree Medical Program ("Plan" or "Retiree Medical Program") and reflects the Retiree Medical Program provisions in effect January 1, 2025 for those residing in a UHC Choice Plus Network.

Technically, the Retiree Medical Program is part of the Union Pacific Corporation Group Health Plan (the "Group Health Plan"), but Retiree Medical Program benefits are offered only to Union Pacific retirees (and their Dependents) who satisfy the Retiree Medical Program's eligibility requirements. Consequently, the Retiree Medical Program is intended to be a 'retiree only' plan described in section 732(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and section 9831(a) of the Internal Revenue Code of 1986, as amended (the "Code") as a plan that, as of January 1, 2025, has less than 2 participants who are current employees. Included are eligibility information, available benefits, limitations and restrictions you should be aware of, and information regarding how to claim your benefits.

It is important to note that the benefits provided are covered by provisions of ERISA, a federal law which governs the operation of employee benefit plans. ERISA requires that you receive an easily understood description of your benefits (a "Summary Plan Description"). The Summary Plan Description for the Retiree Medical Program consists of this document, together with the 2025 BlueCross/BlueShield Retiree Medical Guide and the documents pertaining to the medical programs offered to certain retirees of Alton & Southern Railroad (whose benefit rights under the Plan are described in those documents).

This document, together with the 2025 BlueCross/BlueShield Retiree Medical Guide and the documents pertaining to the medical programs provided to certain retirees of Alton & Southern Railroad, also serve as the official plan document and will help you understand your benefits, as well as your rights under the Plan and ERISA. For more information concerning your ERISA rights, see the ERISA section of this document.

Union Pacific Corporation ("Company") reserves the right to terminate or amend the Plan for any reason. If the Company, acting through its senior human resources officer or such officer with similar authority, terminates or amends the Plan, benefits under the Plan for retirees will cease or change. The Company may also increase the required retiree contributions at any time. Similarly, a participating employer can take such actions with respect to its retirees. Reasonable efforts will be made to provide Plan participants with notice of any such change.

Note that the terms "you" and "your" throughout this Guide refer to the retiree and all Dependents covered under the Plan, except where otherwise indicated. The "Glossary" section on page 93 is an important reference tool designed to help you understand how the Plan works. Also, you will find definitions of other terms in the various sections of this Guide.

PLAN PARTICIPATION

Eligibility for Benefits at Retirement (Retirement Prior To January 1, 1992)

If you retired prior to January 1, 1992, and either were not eligible to continue participation in the Plan after retirement or were eligible but declined such participation, you may not elect to participate now (the exception being for those events as described in the "Special Enrollment Periods" section shown below).

Eligibility for Benefits at Retirement (Retirement On or After January 1, 1992)

You are eligible to participate in the Retiree Medical Program if you satisfy ALL of the following requirements:

- Your original hire date with: (i) Union Pacific Corporation; or (ii) any Union Pacific Corporation affiliate that was a participating Employer in the Flexible Benefits Program on December 31, 2003, was before January 1, 2004;
- You terminate employment with Union Pacific and participate in the Union Pacific Corporation Flexible Benefits Program immediately before you terminate employment;
- You do not elect COBRA continuation coverage with respect to your active employee medical coverage under the Group Health Plan (or your surviving Spouse did not elect COBRA coverage, if such active employee medical coverage terminated because of your death); and
- Upon termination of employment, you are at least age 65, or at least age 55 with 10 years of vesting service.

For this purpose, vesting service is calculated by applying the rules for "Vesting Service" under the Pension Plan for Salaried Employees of Union Pacific Corporation and Affiliates ("UPC Pension Plan"), regardless of whether you were ever a participant in the UPC Pension Plan.

Union Pacific will determine whether you satisfy these requirements based on its employment records and may, in its sole discretion, make reasonable assumptions regarding such records as may be necessary or appropriate in order to make such determination.

Eligibility for Benefits at Retirement (Former Southern Pacific Retirees Retiring Before January 1, 1998)
If you retired prior to January 1, 1998 from Southern Pacific and were eligible and elected retiree medical coverage, you are eligible to participate in the Retiree Medical Program. If you retired prior to January 1, 1998 and either were not eligible to continue participation in the Plan after retirement or were eligible but declined such participation, you may not elect to participate now (the exception being for those events as described in the "Special Enrollment Periods" section shown below).

How Eligibility for Medicare Affects Retiree Medical Program Coverage
Medicare Part A and Part B are considered the primary coverages for retirees, Spouses and Dependent Children age 65 and above, or for such persons under age 65 who have qualified for Medicare because of disability. Each such person is "Medicare eligible." If you satisfy all the above-described Retiree Medical Program requirements, the Retiree Medical Program is available to you, your Spouse and/or Dependent Children as defined in this document on page 10, provided that each person you wish to enroll in Retiree Medical Program coverage– including yourself – is not Medicare eligible at the time of enrollment. If you are Medicare eligible when you terminate employment with Union Pacific (or subsequently become Medicare eligible) but you otherwise meet the requirements for Retiree Medical Program coverage, your enrolled non-Medicare eligible Spouse and/or Dependent Children, if any, remain eligible for Retiree Medical Program coverage until such person becomes Medicare eligible or loses coverage for some other reason. (See "When Coverage Ends" on page 80.)

Your surviving Spouse is eligible to enroll in the Retiree Medical Program if the above requirements are satisfied after substituting the terms 'die' and 'when you die' for 'terminate employment' and 'upon termination of employment', respectively, where they appear in the above requirements, and subject to the same exclusion if your surviving Spouse is Medicare eligible.

Retiree Coverage Election
If you are eligible to elect Retiree Medical Program coverage at the time you retire from Union Pacific, your election to begin such coverage for you and/or your Dependent(s) must be made within 30 days following your last day of active employee medical coverage or you will waive your right to this coverage and will not be allowed to enter the Plan at a later date, except as described in the section entitled "Special Enrollment Periods" shown below.

Special Enrollment Periods
Regardless of whether you retired before or after January 1, 1992, if you were eligible to elect Retiree Medical Program coverage and waived your right to do so, you may later enroll yourself in Retiree Medical Program coverage offered to non-Medicare eligible retirees (See "Retiree Medical Program Coverage" page 10) if the conditions described in either A. or B. are met:

A. Loss of Eligibility for Other Coverage.
    1. You were covered under a group health plan or health insurance coverage at the time coverage under this Plan was previously offered to you;
    2. Your group health plan or health insurance coverage was terminated as a result of loss of eligibility for such coverage (including legal separation, divorce, annulment, death, termination of employment, eligibility for Medicare, or reduction in the number of hours of employment), or the employer's contributions were terminated, or your coverage under COBRA was exhausted (unless such coverage was COBRA continuation coverage you elected under the Group Health Plan following your termination of employment), or you lost eligibility for coverage due to a relocation;
    3. You are not Medicare eligible prior to the date your Retiree Medical Program coverage would be effective (See, "Effective Date of Coverage for Special Enrollment" below); and
    4. You request enrollment of yourself in this Plan not later than 30 days after the date of loss of coverage, or the employer's contributions were terminated, or exhaustion of COBRA coverage or lost eligibility

due to your relocation.

B. No Longer Enrolled as a Dependent under Active Employee Coverage.
   1. You were enrolled in Union Pacific active management employee medical coverage under the Group Health Plan as a Dependent of your Spouse (as such terms are defined in the Group Health Plan) at the time coverage under this Plan was previously offered to you;
   2. Your Spouse had an annual open enrollment election right with respect to the Group Health Plan and elected not to enroll you in medical coverage under the Group Health Plan as his/her Dependent for the Calendar Year for which the open enrollment election was made;
   3. You are not Medicare eligible prior to the date your Retiree Medical Program coverage would be effective (See, "Effective Date of Coverage for Special Enrollment" below); and
   4. You request enrollment of yourself in this Plan not later than 30 days after the date you are no longer enrolled in Union Pacific active management employee medical coverage under the Group Health Plan as a Dependent of your Spouse.

If you enroll pursuant to this special enrollment right, you may also enroll your non-Medicare eligible Dependent(s) in Retiree Medical Program coverage at the same time you enroll in such coverage.

NOTE: If this special enrollment right would apply to you, but you are not eligible to enroll in Retiree Medical Program coverage solely due to your being Medicare eligible, you nevertheless may enroll your non-Medicare eligible Dependent(s) in Retiree Medical Program coverage if conditions (1) & (2) under either A or B above are met. In that case, you must request enrollment for your eligible Dependent(s) not later than 30 days after the date your non-Retiree Medical Program coverage was lost.

In addition, your surviving Spouse may later enroll in Retiree Medical Program coverage offered to non-Medicare eligible retirees (See "Retiree Medical Program Coverage" page 10) if all of the following conditions are met:

1. You retired on or after January 1, 1999 and were eligible to elect Retiree Medical Program coverage for yourself and/or your Spouse, but either waived your right to do so or elected Retiree Only coverage;
2. Your surviving Spouse was covered under a group health plan or health insurance coverage at the time coverage under this Plan was previously offered to you;
3. Your surviving Spouse's coverage was terminated as a result of loss of eligibility for the coverage (including death, termination of employment, eligibility for Medicare, or reduction in the number of hours of employment), or the employer's contributions were terminated, or coverage under COBRA was exhausted (unless such coverage was COBRA continuation coverage your surviving Spouse elected under the Group Health Plan following your death);
4. Your surviving Spouse is not Medicare eligible prior to the date his or her Retiree Medical Program coverage would be effective (See, "Effective Date of Coverage for Special Enrollment" below); and
5. Your surviving Spouse requests enrollment in this Plan not later than 30 days after the date of loss of coverage, or the employer's contributions were terminated, or exhaustion of COBRA coverage.

If your surviving Spouse enrolls pursuant to this special enrollment right, he or she also may enroll your non-Medicare eligible Child who meets the definition of a covered Dependent disregarding your death.

NOTE: If this special enrollment right would apply to your surviving Spouse, but he or she is not eligible to enroll in Retiree Medical Program coverage solely due to your Surviving Spouse being Medicare eligible, your surviving Spouse nevertheless may enroll your non-Medicare eligible Dependent(s) in Retiree Medical Program coverage if conditions 1-3 above regarding surviving Spouse enrollment are met. In that case, your surviving Spouse must request enrollment for your eligible Dependent(s) not later than 30 days after the date his or her non-Retiree Medical Program coverage was lost.

Addition of Dependents after Retirement: Generally speaking, except in the case when your surviving Spouse enrolls as described above and in the circumstances described below, only Dependents you enroll at the time you elect Retiree Medical Program coverage will receive coverage.

Retiree Enrolled in Retiree Medical Program Coverage – Dependent Loses Coverage: If you are enrolled in Retiree Medical Program coverage, you may later enroll an eligible Dependent in Retiree Medical Program coverage offered to non- Medicare eligible retirees (See "Retiree Medical Program Coverage" page 10) if all the following

conditions are met:

1. Your Dependent was covered under a group health plan or health insurance coverage at the time coverage under this Plan was previously offered to you; and
2. Your Dependent's coverage was terminated as a result of loss of eligibility for the coverage (including legal separation, divorce, death, termination of employment, reduction in the number of hours of employment), or the employer's contributions towards such coverage were terminated, or your Dependent's coverage under COBRA was exhausted (unless such coverage was COBRA continuation coverage elected by or on behalf of your Dependent under the Group Health Plan following your termination of employment);
3. Your Dependent is not Medicare eligible prior to the date his or her Retiree Medical Program coverage would be effective (See, "Effective Date of Coverage for Special Enrollment" below); and
4. You request enrollment of your Dependent in this Plan not later than 30 days after the date of loss of coverage, exhaustion of COBRA, or the employer's contributions were terminated.

Retiree Enrolled (or Eligible for, but Declined Enrollment) in Retiree Medical Program Coverage and Dependent Added Through Marriage, Birth, Adoption or Placement for Adoption: If you are enrolled in the Plan (or were eligible to enroll in the Plan at retirement from Union Pacific but failed to enroll during your enrollment period) and a person becomes a Dependent of yours through marriage, birth, adoption or placement for adoption, then you may enroll yourself, your spouse and your new Dependent, provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, and further provided that each person you request to enroll in the Plan (including yourself) is not Medicare eligible.

Retiree No Longer Enrolled (or Never Enrolled) in Retiree Medical Program Coverage Due to Medicare Eligibility: You may enroll your non-Medicare eligible Dependent who lost coverage or a new non-Medicare eligible Dependent acquired as a result of marriage, birth, adoption or placement for adoption – upon satisfaction of the above conditions and requirements for adding a Dependent who lost coverage or new Dependent, as applicable – if you either:

1. were enrolled in Retiree Medical Program coverage, but lost such coverage on or after January 1, 2020 as a result of either you becoming Medicare eligible or Union Pacific's termination of Retiree HRA coverage under the Plan, or
2. terminate employment with Union Pacific on or after January 1, 2020 and meet the Retiree Medical Program eligibility requirements found on page 5, but cannot enroll yourself in Retiree Medical Program coverage solely due to your being Medicare eligible.

Effective Date of Coverage for Special Enrollment

Enrollment in Retiree Medical Program coverage resulting from a birth, adoption, or placement for adoption of a Dependent Child will be effective as of the event date if notification is received within 30 days following the event. Enrollment in Retiree Medical Program coverage as a result of any other event described in this "Special Enrollment Periods" section will be effective on the first day of the month following the event date, if notification is received within 30 days following the event. To request special enrollment or obtain more information, contact Union Pacific Employee Benefits by submitting a ticket via https://www.uprr.com/hrm/hrsc-submit-inquiry/index.html#/benefits/create.

Claims paid for Dependents who are found to be ineligible for coverage will be the responsibility of the retiree. Family Deductibles and annual out-of- pocket or other Plan limitations will also be recalculated and may cause further expense to the retiree.

Coverage If You Relocate

If you have Plan coverage at your current location ZIP code, you will be enrolled in a new medical coverage program if you relocate and your current retiree medical coverage program is not available at your new location ZIP code.

You must notify Union Pacific Employee Benefits of your new address within 30 days following your relocation. If your current retiree medical coverage program is not available at your new location, your retiree medical coverage program will be as follows:

- You will be enrolled in either the UHC HDHP PPO or the BCBS HDHP PPO, depending upon your residential address ZIP code at your new location, at the same level of coverage (i.e., Retiree Only or

Family) received at your old location, provided that you and your Dependents you wish to enroll are not Medicare-eligible.

- If you previously waived coverage at your old location, you will not receive coverage at your new location unless you experience another event described in the 'Special Enrollment Period' section that would allow you to enroll in coverage.

Your new retiree medical coverage will be effective as soon as administratively practicable following your notification to Union Pacific Employee Benefits of your relocation to a new address. Also, the contributions attributable to your new coverage will begin as soon as administratively practicable following your notification.

Dependents:

For purposes of the UHC HDHP PPO, the following definitions apply. For all other Retiree Medical Program coverages, all terms are defined pursuant to the Plan documents that govern the specific coverage.

- A "Dependent" means the retiree's Spouse or the retiree's Child.
- A "Spouse" is the individual with whom the retiree has entered into a valid marriage in accordance with the law of the jurisdiction in which the marriage between the retiree and such individual is entered into, regardless of whether such marriage is recognized in the jurisdiction in which the retiree is domiciled. An individual who is the retiree's Spouse ceases to be the retiree's Spouse on the date a decree of divorce, legal separation or annulment between the retiree and his or her Spouse is entered by a court, regardless of whether the effective date of the decree under its terms or applicable state law is subsequent to the decree's entry date.
    - A Spouse does not include an individual with whom the retiree has entered into a registered domestic partnership, civil union or other formal relationship recognized under state law that is not denominated as a marriage under the law of the state in which such relationship is established.
- A "Child" is one of the following:
    1. An individual (son, stepson, daughter, or stepdaughter) who is directly related to the retiree by blood, adoption (or placement for adoption), or marriage, or who is a foster child placed with the retiree by an authorized placement agency or by judgment, order, or decree of any court of competent jurisdiction, and who is under age 26;
    2. An unmarried individual not described in 1, above, who satisfies both a) and b), below:
        a) Such individual is under age 26, and
        b) The individual's principal place of residence is the retiree's home and the retiree expects to claim the individual as a dependent on his/her federal income tax return for the Calendar Year. (For information regarding whether an individual may be claimed as your dependent, please see the instructions for IRS Form 1040 or consult your personal tax advisor.)
    3. An individual for whom the retiree is required to enroll in coverage pursuant to a Qualified Medical Child Support Order (QMCSO); or
        a) A "Qualified Medical Child Support Order" or "QMCSO" means any judgment, order, or decree issued by a court of competent jurisdiction that provides Child support pursuant to a state domestic relations law or pursuant to an administrative proceeding authorized by state statute as described in section 1908 of the Social Security Act which provides for health benefit coverage of an alternate recipient. A QMCSO cannot require the Plan to provide any type or form of benefit or option not already provided under the Plan. The QMCSO must specify the name and address of the retiree and each alternate recipient, describe the coverage to be provided, identify the period for which the coverage is to be provided, and specify the plan to which the QMCSO applies. If you are required to enroll an alternate recipient pursuant to a QMCSO, your election under the Retiree Medical Program may be changed to provide coverage for such alternate recipient. Additional information, including a copy of guidelines for preparing and administering QMCSOs, may be obtained by calling Union Pacific Employee Benefits at (877) 275-8747, Monday through Friday, 9:00 AM to 5:00 PM Central Time, excluding holidays.
    4. A Disabled Child
        a) A "Disabled Child" means an unmarried Child described in paragraph 1 or 2 of the definition of Child above (without regard to the Child's age but otherwise subject to all other applicable eligibility requirements) who is not self-supporting due to physical handicap, mental handicap, or learning disability. A Child who is not self-supporting must be mainly dependent on the retiree for care and support. Coverage is available for a

Disabled Child on or after attaining age 26 if the Child was a covered Dependent on the day before the Child's 26th birthday and only for the period during which the disability and coverage continue without interruption. The retiree must submit proof to the Plan Administrator, when requested, that the Child meets these conditions at the time the Child attains the age of 26 and throughout the period in which coverage is provided.

b) A "disability" of a "Disabled Child," means the Child's inability to perform normal activities of a person of like age or sex.

You are responsible for notifying Union Pacific Employee Benefits by submitting a ticket via https://www.uprr.com/hrm/hrsc-submit-inquiry/index.html#/benefits/create., within 30 days after an event that either allows an individual to be considered a Dependent (if you wish to enroll such Dependent in Retiree Medical Program coverage) or an event that disqualifies the individual from being considered a Dependent.

The Plan reserves the right to require documentation with respect to you and the individuals you elect to enroll in coverage, including but not limited to, social security numbers and evidence that such individuals satisfy the Plan's definition of Dependent.

Your Cost for Coverage:
Retiree Medical Program coverage offered to non-Medicare Eligible Participants (See "Retiree Medical Program Coverage" page 10) is contributory. This means that retirees must make contributions toward the cost of this coverage.

RETIREE MEDICAL PROGRAM COVERAGE

Retiree Medical Program coverage offered to retirees and Dependents is provided through a Preferred Provider Organization ("PPO"). The Plan includes 2 different PPOs. All coverage is self-insured by Union Pacific. This means that Union Pacific, not an insurance company, pays for Covered Health Services that are incurred and payable by the Plan. Union Pacific contracts with third parties to provide for administrative services, claims processing, network access, and related medical benefit support services for these self-insured medical arrangements. A brief overview of each coverage type is presented below.

PPO Program:
A Preferred Provider Organization (PPO) is a network of Providers who have agreed to charge discounted rates for medical services in exchange for increased business opportunity. If you are covered by a PPO, you are given incentives to use PPO Providers. These incentives are in the form of lower Deductibles (the portion of the medical expense paid by you before the Plan begins to pay for healthcare services), higher Plan Coinsurance (the portion of the medical expense paid by the Plan after the Deductible has been met), and lower Coinsurance Maximums. If you go outside the PPO Network for medical care, your expenses will be greater. The PPO networks used by the Retiree Medical Program are the UHC "Choice Plus" network and the BCBS BlueCard Network. The network available to you depends on your home address ZIP code.

PPO Providers also have agreed to accept contracted rates for Covered Health Services. Charges for non-covered services are your responsibility. PPO Providers also file claims for you. The claims processor typically pays the Provider directly and sends you a notice of payment that identifies what amount has been paid and what amount is your responsibility. This notice is often called an Explanation of Benefits (EOB). If you use a Provider outside of the PPO Network (also known as an Out-of-Network Provider), you will likely need to file the claim with your medical coverage program's claim administrator and the amount the Plan will pay for Covered Health Services will be based on the medical coverage program's Usual and Customary Charges for such services. The non-PPO Provider may bill you for the balance between his/her fee and the Usual and Customary Charges. This is known as "balance billing."

You can select the Doctors of your choice within the PPO Network. You do not need to select a Primary Care Physician (PCP) in order to receive benefits. Nonetheless, it is still recommended that you select and contact a Doctor prior to requiring medical services. Quantum Health will assist you in finding Hospitals, Doctors, and other providers that are In-Network. The UHC Choice Plus Preferred Provider Directory is available through the Quantum Health website at www.upquantumhealth.com or by calling Quantum Health at (855) 649-3855 for assistance.

Both the PPO offered by UHC and the PPO offered by BlueCross/Blue Shield are High Deductible Health Plans. A High Deductible Health Plan (HDHP) is a PPO designed to meet the requirements of a "high deductible health plan"

as defined in Internal Revenue Code section 223. As the name implies, an HDHP typically has a higher deductible than a PPO that is not designed to meet these requirements. In this document, the UHC PPO and BlueCross/Blue Shield PPO are referred to as the "UHC HDHP PPO" and "BCBS HDHP PPO", respectively. A person enrolled in a PPO is a "Covered Person."

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

- UHC HDHP PPO
- BCBS HDHP PPO

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

The UHC HDHP PPO is described in this 2025 UHC Retiree Medical Guide. The BCBS HDHP PPO is described in the 2025 BlueCross/BlueShield Retiree Medical Guide.

Discretionary Authority of Plan Administrator and Other Fiduciaries:
In carrying out their respective responsibilities under a medical coverage program and the Plan, the Plan Administrator and other plan fiduciaries and the third party claims administrators of the UHC HDHP PPO and BCBS HDHP PPO shall have discretionary authority to make factual findings, interpret and administer the terms of the medical coverage program, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the medical coverage program and the Plan. 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.

UHC HDHP PPO PROGRAM

Components:
The UHC HDHP PPO Program consists of four 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 UMR, a subsidiary of UnitedHealthcare (UHC), to administer claims and medical management services. In order to carry out their specific responsibilities under the UHC HDHP PPO Program, Quantum Health and UMR have been granted discretionary authority to make factual findings and interpret the terms of the UHC HDHP PPO Program, and to determine entitlement to Plan benefits in accordance with the terms of the Plan.
2. **Mental Health and Substance-Related and Addictive Disorders Treatment Benefits:** These benefits are self-insured by Union Pacific and are administered by Quantum Health and UMR. In order to carry out their specific responsibilities under the UHC HDHP PPO Program, Quantum Health and UMR have been granted discretionary authority to make factual findings and interpret the terms of Mental Health and Substance-Related and Addictive Disorders Treatment benefits and to determine entitlement to Plan benefits in accordance with the terms of the Plan.
3. **Pharmacy Benefits**: These benefits are self-insured by Union Pacific and are administered by OptumRx. In order to carry out its specific responsibilities under the UHC HDHP PPO Program, 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.
4. **Vision Care Discount Program:** The discount program enables you to pay discounted rates for exams, frames, and lenses at participating Providers. Union Pacific has contracted with EyeMed Vision Care to administer the vision discount program. EyeMed has discretionary authority to determine facts, interpret the terms of the vision discount program, and determine entitlement to program benefits in accordance with the terms of the program.

Preferred Provider:
The UHC HDHP PPO Program is offered through UHC's "Choice Plus" PPO Network. The UHC PPO Network

refers to the network of providers maintained by UHC for medical services and supplies and made available to the UHC HDHP PPO. The pharmacy benefit is administered separately from the UHC PPO Network. United Behavioral Health (UBH) maintains its own network of Mental Health and Substance-Related and Addictive Disorders Treatment providers. A Preferred Provider is also referred to as a Network Provider or an In-Network Provider. Similarly, a Non-Preferred Provider is also referred to as a Non-Network Provider or an Out-of-Network Provider.
The UHC HDHP PPO allows for the designation of a Primary Care Physician. You have the right to designate any primary care physician who participates in either the UHC PPO Network or UBH Preferred Provider Program and who is available to accept you or your covered Dependent(s). For Children, you may designate a pediatrician as the primary care Provider. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, contact Quantum Health at (855) 649-3855 or view online through the Quantum Health website at www.upquantumhealth.com.

You do not need Prior Authorization from the UHC HDHP PPO 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 UHC PPO 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 participating health care professionals who specialize in obstetrics or gynecology, contact Quantum Health at (855) 649-3855 or view online through the Quantum Health website at www.upquantumhealth.com.

It is the retiree'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. If the provider's status has changed and is no longer in the UHC PPO Network or UBH Preferred Provider Program, out-of-network criteria will apply.

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

To the extent an item or service is otherwise a Covered Health 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.

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

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

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

Special Provisions That Apply To Preferred Provider Networks

- **Out-of-Network expenses may be covered at the In-Network level:** Even in the UHC PPO Network area,

occasionally a provider in a particular specialty is not readily available. To accommodate these cases, whenever an In-Network Provider is not available within a 30-mile radius of a retiree's residence, the retiree may use an Out-of-Network Provider and still obtain the In-Network level of benefits (i.e., lower Deductibles and higher Plan Coinsurance, if applicable). However, since the Out-of- Network Provider does not have a contract with UHC, Plan benefits will be based on Usual and Customary Charges and balance billing may occur.

- If a covered Dependent does not reside with the retiree, his/her residence is deemed to be the same as the retiree'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 Out-of-Network Doctor/specialist qualifies for coverage at the In- Network level and to facilitate the appropriate payment of applicable claim(s).**
- **Services performed by Out-of-Network radiologists, anesthesiologists, pathologists, CRNAs or laboratories:** If a member is referred by an In- Network Doctor to an Out-of-Network radiologist, anesthesiologist, pathologist, CRNA or laboratory or receives Inpatient care or outpatient surgery care from an In-Network Hospital or In- Network Ambulatory Surgical Center, but services are performed by Out-of-Network radiologists, anesthesiologists, pathologists, CRNAs or laboratories, these services will be considered In-Network for the purpose of determining Medical Care Program benefits. If the radiologists, anesthesiologists, pathologists, CRNAs or laboratories are not members of the UHC PPO Network, In-Network benefits will be based on billed charges to avoid balance billing.
- Under certain circumstances, you will be required to notify Quantum Health in order to avoid having your benefits reduced. See "Covered Health Services" on page 22 for additional information.

How to Determine if a Provider is in the UHC PPO Network? Go to Quantum Health at www.upquantumhealth.com to view the Preferred Provider Directory or call Quantum Health at (855) 649-3855 to request a printed copy.

Mental Health and Substance-Related and Addictive Disorders Treatment: Your use of In-Network or Out-of-Network Mental Health and Substance-Related and Addictive Disorders Treatment providers determines the benefits available to you. Under certain circumstances, you will be required to notify Quantum Health in order to avoid having your benefits reduced. (See section "Prior Authorization of Certain Procedures" on page 18 for additional information). The Claims Administrator – either Quantum Health or UMR – determines whether and to what extent benefits will be paid for Inpatient and alternate care Mental Health and Substance-Related and Addictive Disorders Treatment services and supplies. (See, "Medical Claim Questions and Appeals Process" beginning on page 57, which explains the types of claims for which either Quantum Health or UMR serves as the "Claims Administrator.") You may call Quantum Health at (855) 649-3855 for a confidential referral to an appropriate clinician or to insure proper Prior Authorization of your behavioral healthcare.

Pharmacy Benefits: Pharmacy benefits are governed by whether you use In- Network Pharmacies (see section "UHC HDHP PPO Program: Pharmacy Benefits" on page 61).

Vision Care Discount Program: The vision care discount program is governed by whether you use participating vision care Providers (see section "UHC HDHP PPO Program: Vision Care Discount Program" on page 79).

Plan Features

This section describes the following features of the UHC HDHP PPO Program: premium contribution, Deductibles, Coinsurance amount, PPO Provider charges, Usual and Customary limit for charges by non-PPO Providers, and the maximum lifetime benefit limit.

Cost Sharing: "Cost sharing" is a term that refers to the ways in which the Plan and the retiree each pays for a portion of the cost of medical care coverage. Cost of medical coverage is shared through a combination of premium contributions and subsidies, as well as through pay-as-you-go Deductibles and/or Coinsurance.

Premium Contribution: You pay a portion of the cost of your medical coverage program in the form of a premium contribution, an after-tax deduction from your monthly pension check or you pay directly to Union Pacific. The amount of the premium contribution depends on your coverage level (Retiree Only or Family). If you are not enrolled in the Retiree Medical Program but have one or more non-Medicare eligible Dependents enrolled in the UHC HDHP PPO, then your UHC HDHP PPO premium contribution will be the amount charged for Retiree Only coverage. The

services of an actuary and/or underwriter are used to determine premiums for the UHC HDHP PPO Program.

Deductible: The Deductible is the amount you pay each year before expenses are paid by the Plan. Under the UHC HDHP PPO Program, there is a single Deductible for medical, including Mental Health and Substance-Related and Addictive Disorders Treatment and pharmacy expenses ("HDHP Deductible").

In a family, each covered individual must either satisfy the individual Deductible or a combination of covered family members must satisfy the family Deductible. The annual Deductible for a family is capped regardless of family size. The individual Deductible will be satisfied for all Covered Persons of the family for the remainder of the Calendar Year once two or more members of your family incur expenses which together equal the family Deductible.

- For the UHC HDHP PPO Program, the amounts you pay for contracted rates with a Preferred Provider for Covered Health Services are applied against the HDHP Deductible. If a Non-Preferred Provider is used to receive Covered Health Services, only the amounts you pay for Usual and Customary Charges for Covered Health Services are applied against the HDHP Deductible.
- The amount paid at an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List (See the "Pharmacy Benefit Defined Terms" on page 76 for the definition of these terms) is 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 is applied against the HDHP Deductible. Medications not listed on the Prescription Drug List are excluded from coverage.
- Amounts paid for over-the-counter drugs and vision care Copayments do not count toward your HDHP Deductible.
- The UHC HDHP PPO Program has a higher HDHP Deductible to meet if Non-Preferred Providers are used. Any eligible expenses incurred will apply to either or both the In-Network and Out-of-Network HDHP Deductible amounts.

Specific Deductible features are presented in the Schedule of Benefits on page 16.

Retire on a Date Other than January 1st: If you were enrolled in a Medical Care Program Option (other than an HMO) under the Group Health Plan immediately before you retired, and you retire on a date other than January 1st of a Calendar Year and enroll in the UHC HDHP PPO, the amount already paid toward active employee Deductibles in the year in which you retire will be counted toward the Retiree Medical Program Deductible in the same Calendar Year.

Coinsurance Amount: Coinsurance is the percentage of the Covered Health Services for which benefits are payable under the UHC HDHP PPO Program after application of the HDHP Deductible and before you reach the Coinsurance Maximum.

After the HDHP Deductible is met, the Plan pays a specified portion of the Covered Health Services and Prescription Drug Products on the Prescription Drug List 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. If a Non-Preferred Provider is used, a lower percentage of the Usual and Customary Charges for Covered Health Services applies. Your 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 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).
- There is a per prescription pharmacy Coinsurance payment equal to the lesser of actual costs or a minimum pharmacy Coinsurance amount. 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 Pharmacy is used, the pharmacy Coinsurance is a percentage of the Prescription Drug Product's Predominant Reimbursement Rate. Per prescription pharmacy Coinsurance payments are capped to lessen the burden of high cost drugs. Your pharmacy Coinsurance payments are capped by the annual HDHP Coinsurance Maximum.

Specific medical Coinsurance features, pharmacy Coinsurance levels, and per prescription minimum and maximum pharmacy Coinsurance amounts are presented in the Schedule of Benefits on page 16.

Coinsurance Maximum: The Coinsurance Maximum is the amount you pay each year before the UHC HDHP PPO Program pays 100% of the contracted Preferred Provider rate or the Usual and Customary Charges for Covered Health Services and 100% of the Prescription Drug Cost or Predominant Reimbursement Rate for Prescription Drug Products ("Coinsurance Maximum" or "HDHP Coinsurance Maximum"), for the remainder of the Calendar Year. Under the UHC HDHP PPO Program, there is a single Coinsurance Maximum for medical, including Mental and Substance-Related and Addictive Disorders Treatment, and pharmacy expenses.

- Expenses above Usual and Customary Charges for Covered Health Services and the Predominant Reimbursement Rate for Prescription Drug Products do not count toward a Coinsurance Maximum.
- Expenses you pay to satisfy a Deductible do not count toward a Coinsurance Maximum.
- Any benefit reduction for not obtaining Prior Authorization from Quantum Health as described in the "Prior Authorization of Certain Procedures" section on page 18 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.

In a family, each covered individual must either satisfy the individual Coinsurance Maximum or a combination of covered family members must satisfy the family Coinsurance Maximum. The annual Coinsurance Maximum for a family is capped regardless of family size. The individual Coinsurance Maximum will be satisfied for all covered family members of the family for the remainder of the Calendar Year once two or more members of your family incur expenses which together equal to the family Coinsurance Maximum. Specific Coinsurance Maximum features are presented in the Schedule of Benefits on page 16.

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 an In-Network 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 an In-Network Provider is used. You will not be responsible for the difference between the amount your In-Network Provider bills and the contracted rates.

When Covered Health Services are received from Out-of-Network Providers as a result of an Emergency or as otherwise arranged through Quantum Health, eligible expenses are the amounts billed by the provider, unless UMR negotiates lower rates. Charges for non-Emergency services received from Out-of-Network Providers not arranged through Quantum Health are limited to the Usual and Customary amounts as determined by UMR.

Eligible expenses for non-Emergency services received from Out-of-Network Providers not arranged through Quantum Health are determined by UMR at the billed rate up to a Usual and Customary amount. The Out-of-Network Provider may bill you for the balance between his/her fee and the amount determined by UMR to be Usual and Customary. This practice is known as "balance billing." Amounts charged above Usual and Customary limits are not "covered" expenses and do not count toward the Deductible or Coinsurance Maximum.

To save money and time, you should use an In-Network Provider whenever possible to:

- Receive contracted rates, often at a substantial discount,
- Avoid "balance billing," and
- Eliminate claim forms.

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.

Maximum Lifetime Benefit: The Maximum Lifetime Benefit for Covered Health Services, including Mental Health and Substance-Related and Addictive Disorders Treatment services, for retirees and their Dependents is $2,000,000 per person beginning with expenses paid by the Plan once you have retired (i.e., expenses paid while covered as an active employee are not included). Amounts for outpatient pharmacy benefits paid by the Plan are not counted towards the Maximum Lifetime Benefit for Covered Health Services.

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

SCHEDULE OF BENEFITS

Benefits are payable under the UHC HDHP PPO Program for Covered Health Services and supplies performed or prescribed by a Doctor, which are deemed Medically Necessary as determined by the Claims Administrator for medical services and medical supplies, Mental Health and Substance-Related and Addictive Disorders Treatment services or supplies and/or OptumRx for prescription drugs. Such services and supplies must be provided while coverage is in effect.

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

SCHEDULE OF BENEFITS UHC HDHP PPO		
Plan Feature	**In-Network**	**Out-of-Network**
Medical Care, Mental Health & Substance-Related & Addictive Disorder Treatment		
Annual HDHP Deductible ▪ Individual ▪ Family: 2+ Persons	$3,300 $6,600	$6,600 $13,200
Medical Coinsurance after HDHP Deductible ▪ Plan pays ▪ You pay	85% 15%	65% 35%
HDHP Coinsurance Maximum (Annual Limit after HDHP Deductible) ▪ Individual ▪ Family: 2+ Persons	$2,000 $4,000	$4,000 $8,000
Preventive Care (As outlined under "Health Management Programs," page 50 and "Preventive Pharmacy Benefits", page 68)	Paid at 100%	No benefits are paid for an Out-of-Network Provider
Maximum Lifetime Benefit (Combined)	$2,000,000 Per Person	

Pharmacy Program: Retail	
Annual Deductible	Combined Medical and Pharmacy Deductible See "Annual HDHP Deductible"
Pharmacy Coinsurance You pay: Tier 1 – Generic Tier 2 – Preferred Tier 3 – Non-Preferred	Up to 31-day Supply* After the Deductible $10 Copay 30% 40%
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	After the Deductible N/A $30/$90 $60/$150

Pharmacy Program: Mail Order		
Annual Deductible	Combined Medical and Pharmacy Deductible See "Annual HDHP Deductible"	
Pharmacy Coinsurance You pay: Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	Up to 90-day Supply After the Deductible $25 Copay 25% 40%	
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	After the Deductible N/A $75/$225 $150/$375	
Pharmacy Coinsurance Maximum	Combined Medical and Pharmacy Coinsurance Maximum See "HDHP Coinsurance Maximum"	
*Certain generic drugs may be purchased at a Retail Pharmacy for a 90-day supply. **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 ▪ Individual ▪ Family: 2+ Persons	$5,300 $10,600	$10,600 $21,200

CARE COORDINATION PROCESS

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 an In-Network 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," an In-Network 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.

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 proceduresreceive 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 $1,500
- Organ, Tissue and Bone Marrow Transplants
- Dialysis
- Partial Hospitalization and Intensive Outpatient for Mental Health and Substance-Related and Addictive Disorders Treatment

***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.

All Prior Authorization requests are reviewed by Quantum Health, unless the request requires Clinical Review of services provided by an In-Network Provider. All In- Network Provider Clinical Review services are conducted by UMR Care Management which is part of your overall Care Coordinators team. Care Coordinators will assist Covered Persons in understanding what services require Prior Authorization and to facilitate contact with the UMR Care Management team to initiate and complete the process.

"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.

Penalties for Not Obtaining Prior Authorization:
A non-Prior Authorization penalty is the amount you must pay if Prior Authorization is not obtained for a 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 UMR 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 Clinical Review functions are the sole responsibility of UMR Care Management. The case manager will assist providers and Covered Persons with ensuring that this is coordinated and timely.

If the case manager, Covered Person, his or her provider and UMR all agree on alternative care that can reasonably be expected to achieve the desired results without sacrificing the quality of care provided, UMR may alter or waive the normal provisions of this Plan to cover such alternative care, at the benefit level determined by UMR.
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; or
- The alternative plan of care is not achieving the desired results or isno 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, UMR 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 including the services provided by UMR Care Management is not a guarantee of payment and is not intended as authorization for services to be provided. All specific Plan exclusions and limitations will be applied at the time the claim is processed. Eligibility and benefit summary information is based upon the information currently available to UMR and is subject to change without notice.

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 Benefit 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.

Medical and Mental Health Covered Health Services
This section generally describes the Covered Health Services and limits that may apply to the benefits provided by the Retiree Medical Program which are administered by Quantum Health and UMR. 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 Claim Questions and Appeal Process" beginning on page 57, which explains the types of claims for which either Quantum Health or UMR serves as the "Claims Administrator.") These requirements apply to the Retiree Medical Program and whether or not you receive services or supplies from participating or non- participating providers.

NOTE: You and your Doctor decide which services and supplies are provided, but this Plan only pays for Covered Health Services which are deemed Medically Necessary as defined in the Glossary and determined by the Claims Administrator.

COVERED HEALTH SERVICES

Benefits paid for the Covered Health Services shown below depend on the network status of the provider. What you pay and what the Plan pays is described in the "Schedule of Benefits" section starting on page 16.

Covered Health 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 Health 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 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.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
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.	
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: 1) all stages of reconstruction of the breast on which the mastectomy has been performed, 2) surgery and reconstruction of the other breast to produce a symmetrical appearance, 3) prostheses including mastectomy bras and lymphedema stockings for the arm, 4) treatment of physical complications in all stages of mastectomy, including lymphedemas, 5) replacement of an existing breast implant if the initial breast implant followed mastectomy, and	Breast Reconstruction, other than in conjunction with a mastectomy, that does not meet the criteria established through the Prior Authorization process.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Breast Reconstruction (Cont.)	6) 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 Plan.	
Breast Reduction	Breast reduction surgery is a Covered Service with documentation of the following functional impairments: • Shoulder grooving or excoriation resulting from the brassiere shoulder straps, due to the weight of the breasts; AND • 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.
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 Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
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 Plan 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 Treatment Services	The following Cosmetic Treatment procedures are covered, provided the procedure has been determined to be reconstructive rather than Cosmetic Treatment: • Correction of a congenital anomaly. • Repair, following accidental Injury or Sickness. • Reconstructive Surgery (See Surgery)	Cosmetic Treatment services that do not meet the criteria listed will not be 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	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.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Dental Services (Cont.)	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.	
Diabetic Supplies	Diabetic supplies including syringes, test strips, lancets and Omnipod 5 devices/supplies are covered under the Pharmacy Program. Insulin pumps (excluding Omnipod 5) and Glucose Monitors are covered under DME.	
Dialysis	See Therapeutics - Outpatient	
Disposable Medical Supplies	Must be prescribed by Doctor, including ostomy supplies.	Non-prescribed supplies.
Doctor Services	Medical care and treatment by a Doctor including Hospital, office and home visits, 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.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
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 Plan 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 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. Notification should be provided to a Quantum Health Care Coordinator within 24 hours of the first business day after receiving Emergency care and a subsequent and corresponding Hospital admittance.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Enteral Nutrition	Defined as the delivery of nutrients in liquid form directly into the stomach, duodenum, or jejunum and used when the patient's condition precludes oral intake. Enteral nutrition is covered when it is the sole source of nutrition or when a certain nutritional formula treats inborn error of metabolism.	
Family Planning	See Reproductive Services.	
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 medical necessity criteria.	Contact Quantum Health at (855) 649-3855 for details on what services may be covered and related medical necessity criteria.
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 health 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 health agency services are provided on a part-time, intermittent schedule and when skilled home healthcare is required. Skilled home healthcare is skilled nursing, skilled teaching, and skilled rehabilitation services when the care: 1) Is 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;	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 Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Home Healthcare (Cont.)	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.
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 Personal Health Support 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;	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 Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Hospice Care (Cont.)	• 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. • 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; • Up to 7 visits of respite care when part of an integrated hospice program; • Other services which your Doctor and 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.	
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: 1) When the Hospital is an all private room Hospital; 2) When the Hospital's semi-private rooms are filled and only a private room is available; or 3) When a private room must be used to keep the patient isolated because of the patient's diagnosis.	Charges over and above the highest semi- private room rate are not covered, except as noted in the adjacent covered benefits paragraph.
Inpatient Prescription Drugs	See Prescribed Drugs and Medicines within this Covered Health Services chart, below.	
Laboratory Services	Laboratory tests for diagnosis or treatment are covered expenses.	
Maternity Care	See Reproductive Services.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
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 Health Services	Mental Health 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 Health 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 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 Plan 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 and Addictive Disorders; and • Attention-deficit hyperactivity disorder

Covered Health 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 Health and Substance-Related and Addictive Disorders Treatment services and supplies are subject to Deductibles and Coinsurance as presented in the "Schedule of Benefits".	
Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders	The Plan 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.	• 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 Plan 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 and Addictive Disorders; and • Attention-deficit hyperactivity disorder

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders (Continued)	Covered Health 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. 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)). 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 (starting on page 16).	
Nutritional Counseling	Covered Health 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 Plan. This limit applies to non-preventive nutritional counseling services only.
Obesity Surgery	See Surgery.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
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 Plan. If the recipient is not a Covered Person, no benefits are payable for donor charges. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health 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 51).	
Orthognathic Surgery	See Surgery.	
Outpatient Therapy	Short-term outpatient rehabilitation services (including habilitative services) limited to 30 visits per year for the combination of: • Physical Therapy • Occupational therapy • Speech therapy Rehabilitation services must be provided by a licensed therapy provider, under the direction of a 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.	The Plan excludes any type of therapy, service, or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Vocational rehabilitation is not covered.

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Outpatient Therapy (Continued)	**Speech Therapy.** 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.	
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 50.	
Prosthetic Devices	Benefits are paid by the Plan 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.	
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.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Reproductive Services (Cont.)	**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 UHC HDHP PPO Program: Pharmacy Benefits on page 61)
	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 Member. Reversal of sterilization.
	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.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Reproductive Services (Cont.)	**Maternity Care (Cont.):** This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. The Plan will pay benefits for an Inpatient stay for the birth of a child of at least 48 hours for the mother and newborn child following a normal vaginal delivery and 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. For Inpatient care (for either the mother or child) which continues beyond the 48/96 hour limits, 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 Plan. 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 Plan; and 3. Be for the same or related conditions as the Hospital stay.	

Covered Health 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. 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: 1) When the Hospital is an all private room Hospital; 2) When the Hospital's semi-private rooms are filled and only a private room is available; or 3) When a private room must be used to keep the patient isolated because of the patient's diagnosis.	Wilderness therapy (including Outward bound wilderness camping, tall ship programs and other similar activities) is excluded under the Plan 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 and Addictive Disorders; and • Attention-deficit hyperactivity disorder

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Substance-Related and Addictive Disorders Treatment Services (Cont.)	You are encouraged to contact Quantum Health for referrals to providers and coordination of care. Substance-Related and Addictive Disorders Treatment services and supplies are subject to Deductibles and Coinsurance as presented in the "Schedule of Benefits" (page 16).	
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:	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (Cont.)	1. All stages of reconstruction of the breast on which the mastectomy has been performed; 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3. prostheses including mastectomy bras and lymphedema stockings for the arm; 4. treatment of physical complications in all stages of mastectomy, including lymphedemas; 5. replacement of an existing breast implant if the initial breast implant followed mastectomy, and 6. 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 Plan **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.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (Cont.)	Benefits for the Second Surgical Opinion are subject to the cost sharing features of the Plan, such as Deductible and Coinsurance. Benefits will be payable for a third opinion on the same basis as benefits for the second opinion. The Doctor who gives the second opinion must: 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 Plan; • Any charges in connection with a surgical procedure, if they are payable under other provisions of the Plan; 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.
	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.
	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 or	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. • Treatment of malocclusion

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (Cont.)		
	Gender Dysphoria Surgery: The Plan 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 medical necessity criteria.	Contact Quantum Health at (855) 649-3855 for details on what services may be covered and related medical necessity criteria.
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. Note - dialysis is subject to coordination with Medicare for End Stage Renal Disease.	

Covered Health Services		
Type of Service	**What's Covered**	**What's Not Covered**
Transplants	See Organ/Tissue Transplants.	
Travel & Lodging Reimbursement	If an In-Network provider for a Covered Health 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 Health 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. 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 UHC HDHP PPO Program does not cover any expenses incurred for services, treatments, items or supplies described in this section, even if either or both of the following are true:

- Such service, treatment, item or supply 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 Health Services, except as may be specifically provided for in the section on "Medical and Mental Health Covered Services" on page 21.

Additional Exclusions	
Type of Service	**What's Not Covered**
Alternative Treatments	• Acupressure, • Aromatherapy, • Hypnotism, • Massage therapy, and • Rolfing. • Other forms of alternative treatment as defined by the Office 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; and • Home remodeling to accommodate a health need, such as (but not limited to) ramps and swimming pools.
Cosmetic Treatment Services	All Cosmetic Treatment services, except those described in the "Covered Health Services" table, beginning on page 22.
Dental under the Medical Plans	• Dental care, except as described in the "Covered Health Services" table, beginning on page 22; • 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 Health Services; and • Treatment of congenitally missing malpositioned, or super numerary teeth, even if part of a congenital anomaly. • 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; and • Over-the-counter drugs and treatments. • Coordination of Benefits as a secondary payment for Prescription Drugs purchased through a non-Union Pacific Health Plan.

Additional Exclusions	
Type of Service	**What's Not Covered**
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; or • 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.) • 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 • determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition. 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.
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 Orthotic Appliances; • Shoes (standard or custom), lifts and wedges; • Shoe inserts; and • Arch supports.
International Coverage	• Health services provided in a foreign country unless required as Emergency health services.

Additional Exclusions	
Type of Service	**What's Not Covered**
Mental Health, Neurobiological Disorders, Autism Spectrum Disorder and Substance-Related and Addictive Disorders Treatment Services	• 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. • 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 (or tuition for such services). • Outside of the initial assessment, unspecified disorders for which the provider • is not obligated to provide clinical rational as defined in the current edition of • the Diagnostic and Statistical Manual of the American Psychiatric Association; and • Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl- Methadol), Cyclazocine, or their equivalents for drug addiction. • Transitional Living services.
Nutrition	Megavitamin and nutrition based therapy. Except as described in the "Covered Health Services" table, beginning on page 22 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 in the "Covered Health Services" table, beginning on page 22.
Physical Appearance	Cosmetic Treatment procedures including, but not limited to: • Pharmacological regimens, nutritional procedures, or treatments; • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures); • Skin abrasion procedures performed as a treatment for acne. • Physical conditioning program (such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation); • Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded; and • 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.

Additional Exclusions	
Type of Service	**What's Not Covered**
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 Health 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 51. • 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 "UHC HDHP PPO Program: Vision Care Discount Program" on page 79 for a description of the vision discount program.) • Fitting charge for eyeglasses or contact lenses. • Surgery that is intended to allow you to correct nearsightedness, farsightedness, presbyopia and astigmatism including, 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 in the "Covered Health Services" table, beginning on page 22; • 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 a non-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; • Inpatient Private Duty Nursing; • Non-prescribed disposable medical supplies; • Non-surgical treatment of obesity, including morbid obesity; • Orthognathic surgery and jaw alignment except what is described in the "Covered Health Services" table, beginning on page 22; • Orthoptic therapy services for the treatment of convergence insufficiency or any other purpose;

Additional Exclusions	
Type of Service	**What's Not Covered**
All Other Exclusions (Cont.)	• 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 Orthotic Appliances or any Orthotic Appliances 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; and/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; and • Speech therapy, except as required for treatment of a speech impediment or speech dysfunction that 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.

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 Family Building, Cancer Resource Services and Transplant Management. These programs are described in more detail in the following pages.

Preventive Care Benefits

The Plan supports you and your Dependents in keeping healthy by offering preventive healthcare benefits. Benefits are payable for Covered Health 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 Usual and Customary Amount.

Preventive services are payable at 100% of covered expenses as described below if the services are routine and consistent with the preventive care guidelines of UMR 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 16.

Cancer Resource Services
Quantum Health will arrange for access to certain In-Network Providers participating in the Cancer Resource Services (CRS) Program offered under the Plan for the provision of oncology services at a Designated Facility. Oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to oncology.

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. 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 Fertility & Family Building
Maven offers a virtual platform that provides specialized fertility and family building related navigation, education, resources and support in areas such as preconception, fertility preservation, IUI, IVF, adoption, surrogacy 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:
Access to a network of transplant centers is provided through UMR's Transplant Management Program. The Plan has specific guidelines regarding benefits for transplant services. Contact Quantum Health at (855) 649-3855 about these guidelines.

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.)

If a Qualified Procedure (listed below) is performed at an In-Network facility, the Covered Health Services provided in connection with the transplant procedure are covered at 85%, 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 (either from you or from a compatible donor) and Peripheral Stem Cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service – please see below.
- Cornea, when performed in a hospital setting.

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

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

Transplants Not Performed at a Designated Transplant Facility: A transplant procedure is not required to be performed at a UMR Designated Transplant Facility for coverage to apply. If a transplant procedure is Medically Necessary but not performed at a UMR Designated Transplant Facility, 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.

QUANTUM HEALTH

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). 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 provider 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

This section provides information about how and when to file a UHC HDHP PPO claim for benefits, describes the 4 types of medical claims, and establishes which entity (either Quantum Health or UMR) has the discretionary authority to decide your claim or your appeal of a denied claim.

Union Pacific has delegated to Quantum Health or UMR discretionary decision- making authority with respect to certain types of Plan claims and appeals, as set forth below. This means that with respect to the type of claim or appeal for which Quantum Health or UMR has decision-making authority, Quantum Health or UMR, as applicable, has the exclusive and discretionary authority to make factual findings, interpret and administer the provisions of the Plan, and determine benefits payable under the Plan. 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 Quantum Health or UMR are conclusive and binding.

Please note that the decisions of Quantum Health or UMR are based only on whether or not the services are Medically

Necessary and benefits are available under the Plan for the proposed treatment, procedure, service or supply.

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 or UMR. Quantum Health or UMR 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 or UMR, as applicable) is identified as the "Claims Administrator." However, regardless of which entity has authority and responsibility to decide your claim or appeal, all Plan benefits are paid by Union Pacific through UMR.

Types of Claims and Claims Administrator:
Post-Service Claims
A Post-Service claim is a claim filed for payment of benefits after medical care has been received.

- UMR is the Claims Administrator of all Post-Service claims.
- UMR is also the Claims Administrator of a requested appeal of a denied Post-Service claim if the claim is for medical care provided by an In-Network Provider **and** the appeal requires Clinical Review.
- Quantum Health is the Claims Administrator of all other requested appeals of denied Post-Service claims.

Pre-Service Claims
A Pre-Service claim is a claim that requires Prior Authorization before receiving medical care, but is not an Urgent Care claim.

- UMR is the Claims Administrator of a Pre-Service claim if the claim is for medical care that will be provided by an In-Network Provider **and** the Pre-Service claim requires Clinical Review. UMR is also the Claims Administrator of a requested appeal of a denial of such Pre-Service claims.
- Quantum Health is the Claims Administrator of all other Pre-Service claims and the requested appeal of a denial of such Pre-Service claims.

Urgent Care Claims
An Urgent Care claim is a claim that requires Prior Authorization before 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. 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.

- UMR is the Claims Administrator of an Urgent Care claim if the claim is for medical care that will be provided by an In-Network Provider and the Urgent Care claim requires Clinical Review. UMR is also the Claims Administrator of a requested appeal of a denial of such Urgent Care claims.
- Quantum Health is the Claims Administrator of all other Urgent Care claims and the requested appeal of a denial of such Urgent Care claims.

Concurrent Care Claims
A Concurrent Care claim is a claim to extend an on-going course of treatment that was previously approved for a specific period of time or number of treatments.

- UMR is the Claims Administrator of a Concurrent Care claim if the claim is for medical care that will be provided by an In-Network Provider and the Concurrent Care claim requires Clinical Review. UMR is also the Claims Administrator of a requested appeal of a denial of such Concurrent Care claims.
- Quantum Health is the Claims Administrator of all other Concurrent Care claims and the requested appeal of a denial of such Concurrent Care claims.

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.

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 Plan procedures.

Neither UMR nor Quantum Health will reimburse third parties who have purchased or have been assigned benefits by Doctors or other providers.

Filing a Post-Service Claim for Benefits:
If Covered Health Services are received from an In-Network Provider, there is no need to file a claim. The In-Network Provider is responsible for filing claims. Generally, In-Network Providers submit claims within 90 days of the date of service.

UMR pays the In-Network Provider directly. You are responsible for paying Deductibles and/or Coinsurance when a bill is received from the Provider. If an In- Network Provider bills you for any Covered Health Service other than Deductibles and/or Coinsurance, contact Quantum Health, not UMR. Although it is not customary, In-Network Providers may request the Deductible payment at the time services are rendered.

When Covered Health Services are received from an Out-of-Network Provider, result from an Emergency, or result from a referral to an Out-of-Network Provider, the Covered Person is responsible for filing a claim. You must file the claim in a format that contains all of the information required as described below in the "Required Information" section. Claim forms can be obtained on the Workforce Resources page via the UP Employees website (www.up.com). The Union Pacific group number is 76-414072. The completed claim form, along with your medical documentation, should be submitted to:

UMR
PO Box 30541
Salt Lake City, UT 84130

A Post-Service claim for benefits must be submitted 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 file a Post- Service claim with UMR within one year of the date of service, benefits for that health service will be denied or reduced at the discretion of UMR. This time limit does not apply if you are legally incapacitated. If your Post-Service claim relates to an Inpatient stay, the date of service is the date your Inpatient stay ends.

Filing a Claim for Benefits - Pre-Service Claims and Urgent Claims:
If you have a Pre-Service claim or an Urgent Care claim, you or your Doctor can file your claim verbally by contacting Quantum Health at (855) 649-3855.

Filing a Claim for Benefits - Concurrent Claims:
If an on-going course of treatment was previously approved for a specific period of time or for a number of treatments and your request to extend the treatment is an Urgent Care claim, you or your Doctor must file your claim verbally by contacting Quantum Health at (855) 649-3855. If an on-going course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a non-urgent circumstance, you must file a claim form and submit it to:

Quantum Health
5240 Blazer Parkway
Dublin, OH 43017

When filing a claim for benefits, the following information is required:

Post-Service Claims:

1. The Covered Person's name and address;
2. The member and group number stated on your Medical ID Card; and
3. An itemized bill from the provider that includes the following:
   a) Patient diagnosis;
   b) Date(s) of service;
   c) Procedure code(s) and descriptions of service(s) rendered;
   d) Charge for each service rendered;
   e) Provider of service name, address and Tax Identification Number;
   f) The date the Injury or Sickness began; and
   g) A statement indicating either that the Covered Person is or is not enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Pre-Service Claims and Urgent Care Claims:

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

Through the Claims Administrator, a benefit determination will be made as set forth below. Benefits will be paid to you unless either of the following is true:

- The Provider notifies the Claims Administrator that your signature is on file, authorizing direct payments of benefits to that provider; or
- You make a written request for the Out-of-Network Provider to be paid directly at the time the claim is submitted.

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.

Benefit Determinations:

Post-Service Claims: Post-Service claims are those claims that are filed for payment of benefits after medical care has been received. If your Post-Service claim is denied, you will receive a written notice from the Claims Administrator within a reasonable period of time, but not later than 30 days of receipt of the claim as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension for not longer than 15 days, pending your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45- day period, your claim will be denied.

Pre-Service Claims: Pre-Service claims are those claims that require Prior Authorization before receiving medical care, but are not Urgent Care claims. If your claim was a Pre-Service claim and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days of receipt of the claim.

If you filed a Pre- Service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the Pre-Service claim was received. If additional information is needed to process the Pre-Service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received and may request a one-time extension for not longer than 15 days, pending your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied.

Urgent Claims: Urgent Care claims are those claims that require Prior Authorization before 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 these situations:

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

If you filed an Urgent Care claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination as soon as possible, but not later than 48 hours after the earlier of:

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

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

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

If an on-going course of treatment was previously approved for a specific period of time or number of treatments and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to the Post-Service claim or Pre-Service claim 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 the Claims Administrator has determined that such course of treatment will be reduced or terminated, the Claims Administrator 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.

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 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 Claim 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; and
- a statement describing your right to receive, upon request, a copy of the diagnosis code and/or treatment code, and their corresponding meaning. 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.

You must first exhaust all appeals available to you under the Plan before you have a right to bring a civil action under ERISA regarding your denied claim. See the section "Medical Claim Questions and Appeals," immediately below for information regarding your appeal rights.

MEDICAL CLAIM QUESTIONS AND APPEAL PROCESS

This section provides information to help you with the following:

- You have a question or concern about Covered Health Services or your benefits.
- You are notified that a claim has been denied because it has been determined that a treatment, procedure, service or supply is not eligible for benefits under the Plan and you wish to appeal such determination.

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 Prior Authorization or any other request that you are required to make to obtain full benefits under the Plan. 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 the Claims Administrator of your claim.

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

What To Do First:
If you disagree with the Claim Administrator's initial claim determination, you can appeal that decision. However, before doing so, you may – but are not required to – informally contact Quantum Health at (855) 649-3855 for assistance in resolving your issue. If the Quantum Health Care Coordinator cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. Remember, though, if you are not satisfied with a benefit determination as described in the section, "Medical Claim Questions and Appeal Process" beginning on page 57, you may appeal it as described below without first informally contacting Quantum Health. If you first informally contact Quantum Health and later wish to request a formal appeal in writing, you should contact Quantum Health and request an appeal.

How to Submit a Claim Decision for Appeal:
If you wish to file an appeal for any denied claim other than a denied Urgent Care claim, you must submit your appeal in writing to Quantum Health at the following address:

Quantum Health
5240 Blazer Parkway
Dublin, OH 43017

An appeal of an Urgent Care claim denial can be made via telephone (see "Appeals Determinations – Urgent Care Claims" below).

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

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

Although all appeals must be submitted directly to Quantum Health either in writing (or via telephone when appealing a denied Urgent Care claim), Quantum Health will forward your appeal to UMR for decision, if UMR is the Claims Administrator with authority and responsibility to decide an appeal of your denied claim. (See "Medical Claims" beginning on page 52 for an explanation of the claims and appeals for which UMR is the Claims Administrator.)

Appeal Process:
For all appeals, regardless of the type of claim denied (i.e., Post-Service, Pre- Service or Urgent Care) you must submit a request for review to Quantum Health within 180 days after you receive the claim denial notice from the Claims Administrator. If a Pre-Service claim or Post-Service claim is denied, there are two levels of appeal available. If an Urgent Care claim is denied, there is only one level of appeal.

Any review on appeal (first level, second level, or Urgent Care claim appeal) willnot give deference to the previous claim denials. A qualified individual who was not involved in the decision being appealed, nor a subordinate of the individual who decided the initial claim, will be appointed to decide the appeal. The review will take into account all documents and other information you submit relating to your appeal, regardless of whether such documents or information were submitted or considered in previous claim decisions. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not involved in the prior determination, nor a subordinate of a healthcare professional involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent medical claim information.

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 for benefits, including the identification of the medical experts consulted regarding your appeal.

Appeal Determinations – Pre-Service and Post-Service Claims:
For Pre-Service and Post-Service claim appeals, you will be provided written or electronic notification of a decision on your appeal as follows:

- For appeals of Pre-Service claims, the first level appeal will be conducted and Quantum Health will notify you of the Claim Administrator's decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for appeal of a denied claim. The second level appeal, if requested, will be conducted and Quantum Health will notify you of the Claim Administrator's decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for review of the first level appeal decision. If your second level appeal is denied, such denial is the Plan's Final Adverse Benefit Determination, and you then have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").
- For appeals of Post-Service claims, the first level appeal will be conducted and Quantum Health will notify you of the Claim Administrator's decision within a reasonable period of time, but not later than 30 days from receipt of a request for appeal of a denied claim. The second level appeal, if requested, will be conducted and Quantum Health will notify you of the Claim Administrator's decision within a reasonable period of time, but not later than 30 days from receipt of a request for review of the first level appeal decision. If your second level appeal is denied, such denial is the Plan's Final Adverse Benefit Determination, and you then have the right to bring a civil action under Section 502(a) of ERISA.

The denial notice of a first level appeal will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the services were not Medically Necessary, experimental or unproven, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal, and will describe the second level appeal procedures.

If you are not satisfied with the first level appeal decision, you must submit a second level appeal in order to preserve your rights to bring a civil action under ERISA concerning the Plan's denial of your claim. Your second level appeal request must be submitted to Quantum Health within 60 days from receipt of the first level appeal decision and must specify each and every reason why you believe your claim should be approved. The denial notice from your first level appeal will indicate what information you need to include when making a second level appeal. You may include with your second level appeal information that was not submitted as part of your original claim or first level appeal.

If your second level appeal is denied (i.e., there is a Final Adverse Benefit Determination), 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 the Claim Administrator'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; and
- a statement regarding your right to bring a civil action under Section 502(a) of ERISA.

Appeal Determinations - Urgent Care Claims:
An appeal of a denied Urgent Care claim does not need to be submitted in writing. You or your Doctor should call Quantum Health at (855) 649-3855 as soon as possible. Your Urgent Care claim appeal must specify each and every reason why you believe your claim should be approved. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition. The decision of the Claims Administrator on your Urgent Care claim appeal is the Plan's Final Adverse Benefit Determination.

If your Urgent Care claim appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the services were not Medically Necessary, experimental or unproven, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal. The denial notice will include a statement regarding your right to bring a civil action under Section 502(a) of ERISA.

Appeal Determinations - Concurrent Care Claims:
An appeal of a denied Concurrent Care claim will be decided according to the Urgent Care claim appeal, Pre-Service claim appeal, or Post-Service claim appeal procedures described above, whichever applies.

COORDINATION OF BENEFITS

Coordination of benefits applies when a covered retiree or a covered Dependent has health coverage under the UHC HDHP PPO Program and one or more Other Plans. One of the plans involved will pay the benefits first: that plan is Primary. The other of the plans involved will pay benefits next: that plan is Secondary.

The rules shown in this provision determine which plan is Primary and which plan is Secondary. Whenever there is more than one plan, the maximum benefit paid is determined by each plan's coordination of benefit rules, but no more than Allowable Expenses charged for that Calendar Year, in any event. When the UHC HDHP PPO Program is determined to be the Secondary Plan, the total amount of benefits paid in a Calendar Year cannot be more than the Paid Expenses had the Union Pacific Plan been the Primary Plan.

Example of Coordination of Benefits:

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

Allowable Expense……$100
Other Plan Benefit at 75%.....$75
Coinsurance: UHC HDHP PPO Program Benefit paid at 85%.....$10
($85 less amount paid by Other Plan)
Total Paid Benefit from Both Plans……$85
Retiree's Out of Pocket Expense……$15

How Coordination Works: When the UHC HDHP PPO Program is Primary, it pays its benefits as if the Secondary Plan(s) did not exist. When the UHC HDHP PPO Program is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than the amount the UHC HDHP PPO Program would have paid if it were the Primary Plan. Any reductions in benefits will be applied equally to each benefit that would have been paid under the UHC HDHP PPO Program.

Which Plan Pays First:

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

- For you, your plan will pay its benefits first.
- For your Spouse or Dependent Child(ren)if he/she is covered as an employee under another plan, that plan would pay benefits first.
- For your Spouse or Dependent Child(ren), if he/she is a student of a post- secondary educational institution and covered under another plan through that educational institution, that plan would pay benefits first.
- If your Dependent Children are covered under plans of both you and your Spouse, the UHC HDHP PPO Program would pay its benefits first if your birthday falls earlier in the Calendar Year than your Spouse's birthday. If your Spouse's birthday is earlier in the Calendar Year, your Spouse's plan would pay benefits first. This is called the "Birthday Rule." The year of birth is ignored. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period oftime.
- If the other plan has a different rule to determine which plans pays benefits first, the Claims Administrator will use that plan's rule in determining which plan pays benefits first.
- For a Dependent Child with separated or divorced parents, benefits willbe determined in the following order:
    - The plan of the parent with custody;
    - The plan of the Spouse of the parent with custody;
    - Finally, the plan of the parent without custody. However, if a legal decree states that one parent is responsible for healthcare expenses, that parent's plan would pay benefits first.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the healthcare expenses of the Child, the plans covering the Child shall follow the order of benefit determination rules that apply to Dependents of parents who are not separated or divorced.
- When a retiree is covered as an active Employee under another plan, the other plan would pay benefits first for the retiree and any Dependents covered. However, if the other plan does not use this rule, it will not apply.
- If none of these rules determines the order of benefits, the plan which has covered a person longer would pay its benefits first

Impact of Government Plans Other than Medicare on Benefits:

Benefits will not be payable to the extent that they are available to you under any government plan, program, or coverage, other than Medicare. This is true whether or not you have enrolled for all government plans for which you are eligible.

This will not apply if the law mandates that benefits under this Plan be paid first, or if the government plan was not in effect on the date that your benefits became effective under this Plan.

Right to Exchange Information:
To enforce the Coordination of Benefits provision, Quantum Health and UMR have the right to give or receive information on your benefits and expenses without your consent. Any claim you submit must have the information that is needed to apply the Coordination of Benefits provision (i.e., proof of other coverage).

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

UHC HDHP PPO PROGRAM: PHARMACY BENEFITS

The UHC HDHP PPO Program includes an In-Network Retail Pharmacy, In- Network Mail Order Pharmacy Service, Specialty Pharmacy Service, and an 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 the UHC HDHP PPO Program is considered a "Covered Person" for purposes of the Pharmacy Program section of this document. You can find the meaning of other capitalized terms found in this Section in the "Pharmacy Benefit Defined Terms" on page 76 and "Glossary" sections on page 93 of this document.

The Pharmacy benefits under the UHC HDHP PPO Program 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 UHC HDHP PPO Program, 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. 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 Deductible 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 medications are taken at the same time. At the time the prescription is dispensed, an alert of a potential problem is sent electronically to the pharmacy. Once notified of a potential problem, the pharmacist may call the prescribing 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:
Retirees 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 “Mandatory Mail Order Program,” “Discretionary Mail Order Program,” “Specialty Pharmacy Services” and “Pharmacy Benefit Payment Information” sections). Refer to “What's Not Covered - Exclusions” below for exclusions.

Prescribed drugs and medicines for Inpatient services are covered as medical expenses under the UHC HDHP PPO Program provisions. The UHC HDHP PPO Program provisions also apply to outpatient prescription drugs that are administered in a Doctor’s office or other licensed outpatient setting, unless the drugs are excluded from the UHC HDHP PPO Program under “Additional Exclusions” on page 45. These drugs and medicines eligible for payment under the medical program 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 Medical 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 Health Service (see page 22), or to prevent conception;
- The prescription is not experimental, investigational, or unproven; and
- Determined by OptumRx to be Medically Necessary.

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 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 an Experimental, Investigational, or unproven. You may appeal this determination as described in the “Pharmacy Claim Questions and Appeals” section on page 74.

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 or you or your Doctor can check beforehand by calling (877) 559-2955 to ensure that the medications prescribed are in conformance with their prior authorization.
Only approved claims will be reimbursed. Retirees will also receive a statement outlining the authorization procedures.

Quantity Level Limits (QLL)/Quantity per Duration (QD):
The QLL program defines the maximum quantity of medication that can be covered for one prescription. The QD program defines the maximum quantity of medication that can be covered in a one-month period. The QLL and QD programs have been developed based upon 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. Generally, this limit is for up to 31 days for Retail or up to 90 days for 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 73.

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 your remaining Deductible 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 a 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 UHC 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 entitled "Prescription Drugs from Retail or Specialty Pharmacy" on page 69.

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. Effective January 1, 2022, 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 been receiving a 30-day supply regularly for a prescription written prior to January 1, 2022, then you will continue to receive 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 of 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 the UHC HDHP PPO, you may fill your prescription 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, your 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.

A Mail Order Pharmacy Service option is available for your convenience. You must pay 100% of the Prescription Drug Cost for the Prescription Drug Product until you meet the HDHP Deductible. Refer to "Pharmacy Benefit Payment Information" on page 65. After you have met your HDHP Deductible, you must pay for the Prescription Drug Product according to the three-tier Coinsurance structure shown in the Benefit Information table for Mail Order Prescription Drug Products. Payment is made for up to a 90-day supply for each prescription filled by the Mail Order Pharmacy Service. The original prescription must be written for a 90-day supply, plus refills.

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

- You 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 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: You are responsible for paying the cost of covered pharmacy and Covered Health 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" on page 16.) The In-Network HDHP Deductible, including family limits,

is 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 Health Services are also applied against the HDHP Deductible. If a Non-Preferred Provider is used to receive Covered Health Services, only the Usual and Customary Charges for Covered Health Services are applied against the HDHP Deductible.

HDHP DEDUCTIBLE	
In-Network	$3,300 per covered person per Calendar Year, not to exceed $6,600 for all Covered Persons in a family.

After the HDHP Deductible is met, you are responsible for paying the applicable Pharmacy Coinsurance Payment, described below.

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

After the HDHP Deductible is met, you are responsible for paying the applicable Pharmacy Coinsurance Payment, up to the HDHP Coinsurance Maximum (described in the following Payment Information Schedule), when Prescription Drug Products that are on the 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 Health Services are also applied against the HDHP Coinsurance Maximum. If a Non-Preferred Provider is used to receive Covered Health Services, only the Usual and Customary Charges for Covered Health Services are applied against the HDHP Coinsurance Maximum.

PAYMENT INFORMATION SCHEDULE		
Payment Term	**Description**	**Amounts**
Pharmacy Coinsurance Payment	Pharmacy Coinsurance Payments for a Prescription Drug Product on the Prescription Drug List at an In-Network Pharmacy are a portion of the Prescription Drug Cost. Pharmacy Coinsurance Payments for a Prescription Drug Product on the Prescription Drug List 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.
Payment Term	**Description**	**Amounts**
HDHP Coinsurance Maximum	After meeting the HDHP Deductible, the HDHP Coinsurance Maximum is the maximum amount you are required to pay for Covered Health Services and/or Prescription Drug Products on the OptumRx Prescription Drug List in a single Calendar Year. Once you reach the HDHP Coinsurance Maximum, you will not be required to pay Pharmacy Coinsurance Payments for covered Prescription Drug Products on the 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 HDHP Coinsurance Maximum.	**In-Network:** 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. **NOTE:** Prescription Drug Products provided by an Out-of-Network Retail Pharmacy will apply towards the In-Network Coinsurance Maximum.

Three-Tier Pharmacy Coinsurance: Your Pharmacy Coinsurance Payment under the UHC HDHP PPO Program once the HDHP Deductible has been met 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 the HDHP 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 should 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 and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety and/or relative efficacy of the Prescription Drug Product, 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 or 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 and economic 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.**

Benefit Information: The following tables describe Pharmacy Coinsurance Payments and benefits for retirees and Dependents.

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits	**Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)**
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. • **$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 **Minimums/Maximums** Tier 1 – N/A 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 **COVERED AT NO COST** (Deductible and Coinsurance do not apply): • Prescription Drug Products that are preventive care as described in the "Preventive Pharmacy Benefits" section on page 68. **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	**Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)**
Out-of-Network Retail Pharmacy: Benefits are provided for outpatient Prescription Drug Products on the Prescription Drug List 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 on the Prescription Drug List 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 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 Retail 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. **Minimums/Maximums** Tier 1 – N/A Tier 2 - $30 Minimum*/$90 Maximum Tier 3 - $60 Minimum*/$150 Maximum *or cost of drug, if less **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 MAIL ORDER PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits	**Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)**
In-Network Mail Order Pharmacy: Benefits are provided for outpatient Prescription Drug Products on the Prescription Drug List 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. **Minimums/Maximums** Tier 1 – N/A Tier 2 - $75 Minimum*/$225 Maximum Tier 3 - $150 Minimum*/$375 Maximum *or cost of drug, if less **COVERED AT NO COST** (Deductible and Coinsurance do not apply): • Prescription Drug Products that are preventive care as described in the "Preventive Pharmacy Benefits" section on page 68.

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

- 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 78). Certain Durable Medical Equipment may be covered under the UHC HDHP PPO Program.
- Coordination of benefits on Prescription Drug Products, including Prescription Drug Products on the 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 Treatment 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 comprised of components that 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 your employer sponsors or contributes.
- Injectable Prescription Drug Products that must be administered by a licensed healthcare professional; which, if covered, would be paid under the retiree medical program 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.
- 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 UHC HDHP PPO, 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.

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.

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 Order or Refill 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 24950
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 where 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 denial notice, which will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your claim, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. If your claim was denied because the Prescription Drug Product has not been approved for that use or is experimental, investigational or unproven, the denial notice will include an explanation of this determination. The notice will describe any additional material or information needed to perfect your claim and an explanation of why such material or information is necessary. It also will provide the claim appeal procedures.

You must first exhaust all appeals available to you under the Plan before you have a right to bring a civil action under ERISA regarding your denied pharmacy 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 Benefit 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. If a non-Urgent Care claim is denied, there are two levels of appeal to OptumRx. If an Urgent Care claim is denied, there is only one level of appeal.

Appeal of Non-Urgent Pharmacy Claims:
To initiate a request for an appeal 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

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 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. 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 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 final and binding.

If your second level appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the prescription drug has not been approved for that use, or 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 second level appeal. You have the right to bring a civil action under Section 502(a) of ERISA if your second level appeal is denied.

Appeal of Urgent Care Pharmacy Claims:
You have the right to request an urgent appeal of an Adverse Benefit 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 or 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 final and binding.

If your Urgent Care appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the Prescription Drug Product has not been approved for that use, or 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. You have the right to bring a civil action under Section 502(a) of ERISA if your Urgent Care appeal is denied.

Pharmacy Appeals 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. You will have the right to submit documents and other information relating to your claim. Your second level appeal or Urgent Care appeal must specify each and every reason why you believe your claim should be approved. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim, nor a subordinate of the person who denied your claim. 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. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Pharmacy Benefit Defined Terms:
Annual HDHP Deductible: See definition in the "Plan Features" section beginning on page 13.

Annual HDHP Coinsurance Maximum: See definition in the "Plan Features" section beginning on page 13.

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 a "brand name" by the manufacturer, pharmacy or your Doctor may not be classified as brand name by the Plan.

Generic: A Prescription Drug Product (1) that is chemically equivalent to a Brand- name drug or (2) that 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 a "generic" by the manufacturer, pharmacy or your Doctor may not be classified as a 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 a 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; and
- 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.up.quantumhealth.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.

UHC HDHP PPO PROGRAM: VISION CARE DISCOUNT PROGRAM

As a participant in the UHC HDHP PPO Program, you and your eligible Dependents are eligible to receive discounted vision care services through the Access Discount Plan administered by EyeMed Vision Care.

What's Covered?

The Access Discount Plan enables you to pay discounted rates for exams, frames, and lenses at participating EyeMed Vision Care Providers. The cost to you is shown as follows:

Vision Care Services	Member Cost
Exam	$5 off retail price
Contact Lens Fit and Follow-Up	$10 off retail price
Complete Pair of Glasses Purchase	Frame, lenses, and lens options must be purchased in the same transaction to receive full discount.
Standard Non-Glass Lenses	
Single Vision	$50
Bifocal	$70
Trifocal	$105
Frames	35% off retail price
Lens Options:	
UV Treatment	$15
Tint (Solid or Gradient)	$15
Scratch Coating-Standard Plastic	$15
Polycarbonate-Standard	$40
Anti-Reflective Coating-Standard	$45
Other Add-Ons and Services	20% off retail price
Contact Lens Materials: (Discount applied to materials only)	
Contacts-Disposable	0% off retail price
Contacts-Conventional	15% off retail price
Laser Vision Correction*	15% off retail price or 5% off promotional price
Lasik or PRK	
Frequency:	
Examination	Unlimited
Frame	Unlimited
Lenses	Unlimited
Contact Lenses	Unlimited

*LASIK or PRK discounts are offered through the U.S. Laser Network, owned and operated by LCA Vision. Call (800) 988-4221 for details.

Member will receive a 20% discount on those items purchased at participating Providers that are not specifically covered by this discount design. The 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Providers' professional services or contact lenses. Retail prices may vary by location. In the state of Texas, EyeMed Vision Care, LLC is the Discount Health Operator offering Union Pacific vision discounts. This discount design is offered with the EyeMed Network panel of Providers.

Limitations/Exclusions:

- Complete pairs of glasses (frame, lens and lens options) must be purchased in the same transaction to receive full discount.
- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.

- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- Services provided as a result of any Worker's Compensation law.
- Discount is not available on frames where the manufacturer prohibits a discount.

How To Access the Access Discount Plan:

- **Locate an eye doctor** – the EyeMed Network has thousands of independent eye doctors and popular retailers. Visit eyemed.com or call (800) 521-3605 to find a provider near you.
- **Schedule an appointment** – schedule an appointment straight from eyemed.com, call ahead or stop by one of the many eye doctors that offer walk-in appointments. Most offer evening and weekend hours to fit any schedule.
- **Use your discount** – when you arrive, let the eye doctor know you have an EyeMed discount through Union Pacific. The discount # is 9235524. and
- **Member services** – visit www.eyemed.com or call (866) 559-5252.

EyeMed Vision Care is solely responsible for the selection, credentialing, and monitoring of Providers in its Network. All Providers selected by EyeMed Vision Care are independent contractors. Union Pacific and its participating subsidiaries do not guarantee the quality of care provided by these Providers.

How to File Vision Claims:
No claim forms are needed for vision care benefits. However, you may contact EyeMed Vision Care if you have questions regarding your vision care benefits.

Member Grievance Procedure: If a member is dissatisfied with the services provided by an EyeMed Provider, the member should either write to EyeMed at the address indicated above or call the EyeMed Member Services toll free telephone number at (866) 939-3633. The EyeMed Member Services representative will log the telephone call and attempt to reach a resolution to the issues raised by the member. If a resolution is not able to be reached during the telephone call, the EyeMed Member Services representative will document all of the issues or questions raised. EyeMed will use its best efforts to contact the member within 4 business days with an acknowledgement to the issues or questions raised, and will resolve the issue within 30 calendar days. If the member is not satisfied with the resolution, they may appeal the grievance by using the appeal procedures set forth above.

For more information on member rights and how to obtain further review under the Employee Retirement Income Security Act of 1974 (ERISA) as amended, please refer to the ERISA section of this document on page 87. For all claims and appeals for vision care benefits under the UHC HDHP PPO Program, Union Pacific has delegated to EyeMed Vision Care the exclusive and discretionary right to make factual findings, interpret and administer the provisions of the Plan, and determine benefits payable under the Vision Care 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 EyeMed Vision Care are conclusive and binding.

WHEN COVERAGE ENDS

UHC HDHP PPO coverage provided to you and/or your covered Dependents under the Retiree Medical Program described in this document will end effective the earliest of the following events:

1. The last day of the month preceding the month You become Medicare eligible. (NOTE: Coverage of your enrolled non-Medicare eligible Dependents is not terminated because of the retiree's Medicare eligibility);
2. The last day of the month preceding the month your Dependent becomes Medicare eligible. (NOTE: Coverage of the enrolled retiree and other enrolled non-Medicare eligible Dependents is not terminated because of a Dependent's Medicare eligibility);
3. The last day of the month in which You stop making any required contribution;
4. The last day of the month in which You are rehired and become eligible for medical benefits as an active employee;
5. The last day of the month in which your Dependent no longer meets the definition of an eligible Dependent;
6. The last day of the month in which the Plan is terminated or amended in a manner that causes your coverage to end;

7. The last day of the month in which You die without a surviving Spouse covered by the Plan (unless your surviving Spouse has a right to later enroll in the Plan, as described in the Special Enrollment Periods section at the beginning of this document on page 6, and elects to do so); or
8. The last day of the month in which your surviving Spouse covered by the Plan dies.

Notwithstanding #5 above, UHC HDHP PPO medical coverage provided to a Dependent on a Medically Necessary Leave of Absence* will not terminate until the end of the month in which the earliest of the following events occurs:

- The date that is one year after the first day of the Medically Necessary Leave of Absence; or
- The date such individual is no longer an eligible Dependent for a reason other than being on a Medically Necessary Leave of Absence from a post-secondary educational institution.

*A Medically Necessary Leave of Absence must be from an accredited post-secondary educational institution that the individual had been attending full-time in accordance with the institution's policies immediately before the first day of the leave of absence. A Medically Necessary Leave of Absence is a leave of absence that:

- Commences while the individual is suffering from a serious illness or Injury;
- Is Medically Necessary;
- Results in the individual losing student status at the post-secondary educational institution the individual had been attending; and
- For which the Plan has received written certification by a treating Doctor of the individual which states that the individual is suffering from a serious illness or Injury and that the leave of absence (or other change of enrollment) is Medically Necessary. This certification must be provided to Union Pacific Employee Benefits within 30 days of the commencement of the leave of absence.

It is the retiree's responsibility to provide notification within 30 days of any other event affecting the eligibility of a covered Dependent, such as attainment of age 26, commencing or ceasing a Medically Necessary Leave of Absence, or any other reason that would cause the individual to fail to be a Dependent.

Continuation of Coverage:
Your covered Spouse and Children who are your covered Dependents immediately prior to your death will not cease to be eligible Dependents solely by reason of your death. Assuming the Plan is not terminated or amended in a manner that causes coverage to end, your surviving covered Spouse and other covered Dependents will be permitted to continue Retiree Medical Program coverage after your death so long as they continue to make the required contributions and meet the definition of a covered Dependent disregarding your death. A Child of a deceased retiree who meets the definition of a covered Dependent will continue to be eligible as a Dependent of a surviving covered Spouse. If, upon the death of the retiree, there is no surviving covered Spouse, the Child may have rights to continue UHC HDHP PPO coverage under the Retiree Medical Program for up to 36 months under COBRA.

If your Dependent(s) lose healthcare coverage due to loss of eligibility, your Dependent(s) may have rights to continue UHC HDHP PPO coverage under the Retiree Medical Program for up to 36 months under COBRA.

CONTINUATION OF COVERAGE UNDER COBRA

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family enrolled in the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact Union Pacific Employee Benefits at (877) 275-8747.

You may have other options available to you when you lose Plan coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace,

you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Generally, under the Plan qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- Your Spouse dies; or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The covered parent dies;
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Union Pacific Corporation and that bankruptcy results in the loss of Retiree Medical Program coverage of any retiree, the retiree will become a qualified beneficiary with respect to the bankruptcy. The retiree's Spouse, surviving Spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the retiree or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

When you, your Spouse or Dependent Children become entitled to Medicare Benefits (under Part A, Part B (or both), or Part D), you must notify Union Pacific Employee Benefits immediately by calling (877) 275-8747 or by submitting a ticket by navigating to www.UP.com and selecting Employees > Retires and Families site > Benefits > Healthcare > Submit Healthcare Benefits Questions.

You Must Give Notice of Other Qualifying Events:
For the other qualifying events (divorce or legal separation of the retiree and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days of the date on which coverage would end under the Plan because of the qualifying event. You must provide this notice by calling Union Pacific Employee Benefits at (877) 275-8747. When providing this notice, you must provide your name, employee ID or Social Security number, a description of the qualifying event, the date the qualifying event occurred, and the names of the individual(s) losing coverage as a result of the qualifying event. The retiree, Spouse or Dependent Child, or any person representing any of these individuals can provide this notification. Notification by the retiree, Spouse, or Dependent Child (or their representative) will satisfy this notification requirement with respect to all individuals who will lose coverage because of the qualifying event.

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. COBRA continuation coverage and the applicable notice period will commence with the date of loss of coverage as a result of the qualifying event. Each qualified beneficiary will have

an independent right to elect COBRA continuation coverage. A qualified beneficiary must make a COBRA election no more than 60 days after receiving the Plan Administrator's notice of the right to elect COBRA. Covered retirees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the retiree, your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is a proceeding in bankruptcy, COBRA continuation coverage for the retiree lasts for the retiree's lifetime and COBRA continuation coverage for the retiree's Spouse and Dependent Children may continue for 36 months after the retiree's death, if they survive the retiree. If the retiree is not living at the time of the proceeding in bankruptcy, but the retiree's surviving Spouse is covered by the Plan, COBRA continuation coverage lasts for the surviving Spouse's lifetime.

Premium for COBRA Continuation Coverage
You will be notified as to the amount of your required premium when you receive the notice of your right to continue coverage. The required premium is adjusted each Plan year to reflect actual and anticipated claims experience; thus, your required contribution may change during the continuation period. There is a grace period of 30 days from the premium due date for payment of the regularly scheduled premium. At the end of the continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under the Plan, if any.

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

- The employer no longer provides group health coverage to any of its retirees;
- The premium for your continuation coverage is not paid within 30 days of the due date;
- You become covered after the date you elect COBRA coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have; or
- You become entitled to Medicare benefits.

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions:
Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, visit the EBSA website at www.dol.gov/ebsa, or contact EBSA at (866) 444-3272. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes:
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:
For general information about the Plan and COBRA continuation coverage, you may contact Union Pacific Employee Benefits, 1400 Douglas Street, STOP 0320, Omaha, NE 68179-0320, or at (877) 275-8747.

COBRA Administration:
Union Pacific Corporation has retained Inspira Financial to provide certain COBRA services. In this capacity, Inspira Financial handles notifications, eligibility transmittals, record keeping, and billing services. If you are currently receiving COBRA continuation coverage or have questions about these services, please contact Inspira Financial at the following address:

Inspira Financial, Inc.
Attn: Benefit Billing
PO Box 953374
St. Louis, MO 63195-3374
Phone Number: (800) 359-3921

If you have any questions about your current COBRA coverage, please contact Inspira Financial at (800) 359-3921. If you have additional benefit questions, call Union Pacific Employee Benefits at (877) 275-8747. If you have changed marital status or you or your Dependents have changed addresses while receiving continuation of benefits under COBRA, you should notify Inspira Financial.

RETIREE MEDICAL PROGRAM - THIRD PARTY LIABILITY/SUBROGATION

Third Party Liability:
The Plan does not cover any expenses for which a third party is responsible as a result of having caused or contributed to a Sickness or Injury. The Plan may nonetheless pay the benefits that would otherwise be payable hereunder, subject to the Plan's rights described below. By filing a claim for benefits under the Plan, the covered person (or that person's legal representative) agrees to these terms.

Right of Subrogation, Reimbursement and Offset:
The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation or Federal Employers' Liability Act case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation Federal Employers' Liability Act coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising

out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree to cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
- Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
- Providing any relevant information requested by the Plan.
- Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or Injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.
- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common- fund doctrine" or "attorney's fund doctrine" will defeat this right.
- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.
- By participating in and accepting benefits from the Plan, You agree that:
    - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
    - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
    - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to Your own negligence.
- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent

of the Covered Expenses the Plan has paid for the Illness or Injury.

The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan Administrator has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.
- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You or Your Dependents; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

MEDICAID

Benefits paid on behalf of a covered retiree or Dependent will be made in accordance with any assignment of rights made by or on behalf of such retiree or Dependent that is required under a state's Medicaid law. The Plan will not take into account the eligibility of a retiree or Dependent for Medicaid for purposes of enrollment or paying benefits under the Plan. To the extent payment has been made under Medicaid for medical assistance to a retiree or Dependent covered by the Plan and the Plan has a legal liability to pay for such medical assistance, payment of benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to such retiree or Dependent to such payment for benefits.

REFUND FOR OVERPAYMENT OF BENEFITS

UMR, EyeMed Vision Care or OptumRx have the right to a refund of any Medical and Mental Health and Substance-Related and Addictive Disorders Treatment, Vision Care or Prescription Benefits, respectively they paid to you if you or your Dependents did not pay for those expenses or if you or your Dependents were reimbursed for any of those expenses by a source other than UMR, EyeMed Vision Care or OptumRx. The refund is the difference between the amount of benefits actually paid and the amount that should have been paid under the terms of the Plan. In addition,

the Plan has a right to a refund of any benefit amount paid in excess of the benefit amount you are entitled to receive under the terms of the Plan.
If you do not promptly refund the required amount, UMR, EyeMed Vision Care or OptumRx may, in addition to other rights they may have, reduce the amount of any future benefits payable under the Plan and under any group benefits plan they issued to your employer by the amount of the refund.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The Plan is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA), a federal law which governs the operation of employee benefit plans. It is important to understand some of the provisions of this law since they could affect you. This document helps you use your benefits and understand your rights under the Plan and ERISA.

Summary Plan Description:
ERISA requires that you receive easily understood descriptions of your benefits, called summary plan descriptions. The information about your benefits described in this document, together with the 2025 BlueCross/BlueShield Retiree Medical Guide and documents pertaining to the medical programs provided to certain retirees of Alton & Southern Railroad constitute the Summary Plan Description under ERISA.

Plan Sponsorship:
The Plan's coverage is sponsored by:

Union Pacific Corporation
1400 Douglas Street, Stop 0320
Omaha, NE 68179

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

Plan Administrator:
The official Plan Administrator of the Plan 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. To contact the Plan Administrator, forward your correspondence to:

Senior Vice President & Chief HR Officer, Union Pacific Railroad Company
1400 Douglas Street, Stop 350
Omaha, NE 68179
(402) 544-5000

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

Your ERISA Rights:
As a participant in the Plan, you have certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- Examine, without charge, in the Workforce Resources Department in Omaha or at your company headquarters if copies are kept there, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of the documents governing the operation of the Plan, including insurance contracts, copies of the latest annual reports (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:
You may continue health care coverage for yourself, your Spouse or Dependent Children if there is a loss of coverage under the Plan as a result of a qualifying event. You, your Spouse or your Dependent Children may have to pay for such coverage. Review the terms of the applicable retiree medical coverage option and any other documents governing the Plan on the rules regarding your COBRA continuation coverage rights.

Maternity and Newborn Infant Coverage:
The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Certain Mastectomy Coverage:
If you or your dependent receives a mastectomy, the covered benefits for the patient will also include coverage for:

- 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; and
- Treatment of physical complications in all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending physician and the patient. Such coverage is subject to annual Deductibles, Coinsurance and Copay provisions, and other provisions that are applicable to the other benefits of the Retiree Medical Program option.

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

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with a Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. However, before filing a lawsuit you must first exhaust all appeals required by the Plan. Please refer to each benefit section regarding claims and appeals.

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

Assistance with Your Questions:
If you have any questions about your Plan, you should contact the Workforce Resources Department. If you have any

questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration toll free at 866-444-3272 or by visiting EBSA's website at www.dol.gov/ebsa.

Claiming Your Benefits:
You generally must file a claim if you are eligible for a benefit from the Plan. Often, there are time limits for sending claim forms so be sure of the Plan's deadlines. You could lose benefits if you delay filing. You should refer to the claims and appeals sections regarding the filing of claims.

How You Can Appeal:
If your claim is denied, you have the right to appeal that decision. You may also submit in writing reasons why you think your claim should not be denied. Please refer to the claims and appeals sections regarding how you can appeal. Besides having the right to appeal, you or your authorized representative can examine any Plan documents (except legally privileged information) related to your claim.

Serving Legal Process:
If you or your beneficiary chooses to take legal action against the Plan over terms of the Plan, legal process should be served on:

Senior Vice President & Chief HR Officer, Union Pacific Railroad Company
1400 Douglas Street, Stop 350
Omaha, NE 68179
(402) 544-5000

Future of the Plan:
Union Pacific reserves the right to terminate or amend the Plan for any reason. If the Company acting through its senior human resources officer, or such officer with similar authority, terminates or amends the Plan, benefits under the Plan would cease or change. The Company may also increase the required retiree contributions at any time. Similarly, a participating employer can take such actions with respect to its retirees. Reasonable efforts will be made to provide Plan participants with notice of any such change.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries:
In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to make factual findings, interpret the terms of the Plan, and determine entitlements to benefits in accordance with the terms of the Plan. 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 Plan Administrator may designate other persons to carry out such of her responsibilities under the Plan for the operation and administration of the Plan as she deems advisable and delegate to the persons designated such of her powers as she deems necessary to carry out such responsibilities. Any designation and delegation shall be subject to such terms and conditions as the Plan Administrator deems necessary or proper. Any action or determination made or taken in carrying out responsibilities under the Plan by the persons so designated by the Plan Administrator shall have the same force and effect for all purposes as if such action or determination had been made or taken by the Plan Administrator.

IMPORTANT PLAN INFORMATION

The following chart lists the employer identification number, policy numbers and plan number for the Plan. It also lists the Plan year, the twelve-month period for which Union Pacific maintains financial records for the Plan. Technically, the Plan is known as a welfare benefit plan.

The Employer Identification Number (EIN) assigned by the IRS to Union Pacific Corporation as the Plan Sponsor is 13-2626465.

PLAN NAME	PLAN NO.	INSURANCE CARRIER, ADMINISTRATOR OR TRUSTEE	CONTRACT OR POLICY NO.	PLAN YEAR	CONTRIBUTION SOURCES
Union Pacific Corporation Group Health Plan Retiree Medical Program	502 Group Health Plan			12/31	Retirees & Employers
1. UHC HDHP PPO Program –					
(a) Medical & Mental Health/ Substance-Related and Addictive Disorders		UMR 115 W Wausau Ave Wausau, WI 54401 Quantum Health 5240 Blazer Parkway Dublin, OH 43017	76-414072		
(b) Pharmacy		OptumRx 11000 Optum Circle Eden Prairie, MN 55344	76-414072		
(c) Vision Care		EyeMed Vision Care LLC 4000 Luxottica Place Mason, OH 45040	9891003-Active 9891011-COBRA 1029447-Domestic Partner		
2. BCBS HDHP PPO Program –					Retirees & Employers
(a) Medical & Mental Health/ Substance Related and Addictive Disorders		BlueCross/ BlueShield Fifth Avenue Place, 120 Fifth Avenue Pittsburgh, PA 15222 Quantum Health 5240 Blazer Parkway Dublin, OH 43017			
(b) Pharmacy		OptumRx 11000 Optum Circle Eden Prairie, MN 55344	76-414072		
(c) Vision Care		EyeMed Vision Care LLC 4000 Luxottica Place Mason, OH 45040	9891003-Active 9891011-COBRA 1029447-Domestic Partner		

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability & Accountability Act (HIPAA) and regulations there under require health plans to protect the privacy of an individual's healthcare information. The HIPAA privacy rules and this section apply to the Union Pacific Corporation Group Health Plan (for purposes of this HIPAA section, the "Group Health Plan"), including the Retiree Medical Program, which is part of the Group Health Plan and described in this Guide. The privacy rules restrict the disclosure of Protected Health Information to Union Pacific Corporation and its affiliated companies ("Union Pacific"). Union Pacific may use or disclose Protected Health Information it receives from the Group Health Plan only as provided in this Health Insurance Portability and Accountability Act of 1996 section.

Entities Responsible for HIPAA Compliance:
For all Retiree Medical Program benefits provided to retirees, the Group Health Plan is responsible for complying with HIPAA's privacy rules with respect to the Protected Health Information the Group Health Plan creates, maintains, or receives.

Availability of Notice of Privacy Practices:
The Group Health Plan, with respect to benefits under the Group Health Plan that are self-insured by Union Pacific, has adopted a Notice of Privacy Practices ("Notice") which is available upon request to participants in the Group Health Plan. To request a copy of this Notice, contact:

Union Pacific Employee Benefits
1400 Douglas Street, Stop 0320
Omaha, NE 68179-0320
(877) 275-8747 or (402) 544-4000

Permitted and Required Uses and Disclosure of Protected Health Information: The Group Health Plan may disclose Protected Health Information to Union Pacific only if one of the following applies:

1. The Group Health Plan receives proper written authorization from the participant or the participant's representative. The authorization must specifically authorize the use or disclosure. A proper authorization form is required for uses by or disclosure to Union Pacific if the use or disclosure does not meet the condition described in Paragraphs 2, 3, or 4 below;
2. The Group Health Plan discloses information to Union Pacific that is, for purposes of HIPAA's privacy rule, enrollment or disenrollment information;
3. The Group Health Plan provides Union Pacific with Protected Health Information in the form of Summary Health Information for the purposes of obtaining premium bids, or determining whether to modify, amend or terminate the Group Health Plan provided, however, that such Protected Health Information used for 'underwriting purposes' (as defined in the HIPAA regulations) shall not include Protected Health Information that is 'genetic information' (as defined in the HIPAA regulations); or
4. The Group Health Plan receives a signed certification from Union Pacific that the Group Health Plan documents restrict the use and disclosure of the Protected Health Information as required by the HIPAA regulations on privacy and confidentiality, and Union Pacific agrees to comply with the restrictions, and the information has been requested to carry out administrative functions (i.e., payment or health care operations functions) which Union Pacific performs for the Group Health Plan, and the uses and disclosures of Protected Health Information by Union Pacific will be restricted to plan administration functions performed by Union Pacific on behalf of the Group Health Plan in accordance with the Group Health Plan document.

Conditions of Disclosure:
Union Pacific agrees that with respect to Protected Health Information disclosed to Union Pacific by the Group Health Plan, other than enrollment/disenrollment information, Summary Health Information, or disclosure pursuant to a valid HIPAA authorization, Union Pacific shall:

- Not use or further disclose the Protected Health Information other than as permitted or required by the Group Health Plan or as required by law.
- Ensure that any agents to whom it provides Protected Health Information received from the Group Health Plan, agree to the same restrictions and conditions that apply to Union Pacific with respect to Protected Health Information.
- Not use or disclose the Protected Health Information for employment- related actions and decisions or in connection with any other benefit or employee benefit plan, program or arrangement of Union Pacific.

- Report to the Group Health Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
- Make available to a Group Health Plan participant who requests access, the Group Health Plan participant's Protected Health Information in accordance with the HIPAA regulations.
- Make available to a Group Health Plan participant who requests an amendment, the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with the HIPAA regulations.
- Make available to a Group Health Plan participant, who requests an accounting of disclosures of the participant's Protected Health Information, the information required to provide an accounting of disclosures in accordance with the HIPAA regulations.
- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Group Health Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Group Health Plan with the HIPAA regulations.
- If feasible, return or destroy all Protected Health Information received from the Group Health Plan that Union Pacific still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Ensure that the adequate separation between the Group Health Plan and Union Pacific required in the HIPAA regulations is satisfied.

Adequate Separation between Group Health Plan and Plan Sponsor:
Union Pacific shall only allow access to Protected Health Information to employees whose duties include performing administrative functions on behalf of the Group Health Plan and are in the following categories:

- Senior Vice President & Chief HR Officer, Union Pacific Railroad Company
- Vice President Org. Development, Talent & Total Rewards, Union Pacific Railroad Company
- Union Pacific Employee Benefits Group
- Union Pacific Compensation Group
- Union Pacific Payroll Group
- Union Pacific Audit Group

These employees shall only have access to and use Protected Health Information to the extent necessary to perform the Group Health Plan administrative functions that Union Pacific performs for the Group Health Plan. In the event that any of these employees do not comply with the provisions of this paragraph, the employee shall be subject to disciplinary action by Union Pacific for non- compliance pursuant to Union Pacific's employee discipline and termination procedures.

Reports of Non-Compliance:
If you suspect an improper use or disclosure of Protected Health Information, you may report the occurrence to the Group Health Plan's Privacy Office:

Union Pacific Employee Benefits
Attn: HIPAA Privacy
1400 Douglas Street, Stop 0320
Omaha, NE 68179
(877) 275-8747 or (402) 544-4000

Definitions:
For purposes of this Health Insurance Portability and Accountability Act of 1996 section, the following terms shall have the meaning set forth below:

"Protected Health Information" means "individually identifiable health information" that is maintained or transmitted by the Group Health Plan. Protected Health Information does not include individually identifiable health information in employment records held by Union Pacific.

"Individually identifiable health information" is information, including demographic information, that is collected

from an individual and created or received by the Group Health Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare services to an individual; or the past, present, or future payment for the provision of healthcare services to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information includes information of persons who are living and persons who have been deceased for 50 years or less. The following components of an individual's information are considered Protected Health Information:

- Names;
- Street address, city, county, precinct, ZIP code;
- Dates directly related to a participant, including birth date, health facility admission and discharge date, and date of death;
- Telephone numbers, fax numbers, and electronic mail addresses;
- Social security numbers;
- Medical record numbers;
- Health plan beneficiary numbers;
- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web universal resource locators (URLs);
- Internet Protocol (IP) address numbers
- Biometric identifiers, including finger and voice prints;
- Full face photographic images and any comparable images; and
- Any other unique identifying number, characteristic, or code.

"Summary Health Information" means information that may be individually identifiable health information, and:

- Summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
- From which the applicable information described in the HIPAA regulations has been deleted, except that the geographic information need only be aggregated to the level of a five-digit ZIP code.

GLOSSARY

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

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

Birthing Center is a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services, and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

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

Cancer Resource Services (CRS) Program is a program made available under the Plan, through UMR, to Employees and Dependents. The Cancer Resource Services (CRS) Program provides information to Employees or their Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

Claims Administrator is Quantum Health and UMR, which provide certain administration services for the Plan.

Coinsurance is the portion of the covered expenses under the Plan paid by members after the deductible is met and before reaching the Coinsurance Maximum.

Coinsurance Maximum: See definition in the "Plan Features" section beginning on page 13.

Copayment or Copay is the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits on page 16, if applicable.

Cosmetic Treatment is medical or surgical procedure that is primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Health Services are those health services, including services, supplies or pharmaceutical products, which the Claims Administrator determines to be:

- Medically Necessary.
- Described as a Covered Health Service in this Guide.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under "Eligibility and Effective Date of Coverage" section in this Guide.
- Not otherwise excluded by the Plan in this Guide.

Deductible: See definition in the "Plan Features" section beginning on page 13.

Doctor/Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: a doctor of medicine (MD); doctor of medical dentistry, including an oral surgeon (DMD); doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the terms "Doctor" and "Physician" also include the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

NOTE: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology, TM or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Gender Dysphoria (Gender Identity Disorder) is a disorder characterized by the following diagnostic criteria:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- The disturbance is not concurrent with a physical intersex condition.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The transsexual identity has been present persistently for at least two years.
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

High Deductible Health Plan (HDHP) is a PPO designed to meet the requirements of a "high deductible health plan" as defined in Internal Revenue Code section 223. As the name implies, an HDHP typically has a higher Deductible than a PPO that is not designed to meet these requirements. An individual covered by a HDHP may be eligible to contribute to a Health Savings Account (HSA).

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes surgical centers and Birthing Centers licensed by the states in which they operate.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

In-Network is using a provider participating in one of the following networks:

- UnitedHealthcare's Preferred Provider Organization (PPO) network for medical services other than Mental Health and Substance-Related and Addictive Disorders Treatment and pharmacy services;
- United Behavioral Health's network of Mental Health and Substance- Related and Addictive Disorders Treatment providers; or
- OptumRx's network of participating pharmacies for retail or mail order pharmacy services.

When a Preferred Provider is used, benefits are paid according to In-Network provisions.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Intensive Outpatient Treatment is a structured outpatient Mental Health and Substance-Related and Addictive Disorders Treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Medical ID Card is the identification card issued to you by your healthcare plan and certifies your eligibility for benefits under the Medical Care Program. The Claims Administrator may issue ID cards in the Employee's name for use by both the Employee and his/her dependent(s).

Medically Necessary/Medical Necessity – for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance- related and addictive disorders, condition, or disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator'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, condition, disease or its symptoms;
- Not mainly for your convenience or that of your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or symptoms.

Clinical factors used when reviewing Medical Necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, site of care, relative safety or effectiveness of specialty drugs, and any applicable prior authorization requirements. The fact that a Doctor has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

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. The Claims Administrator 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 the Claims Administrator's sole discretion.

The Claims Administrator 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. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons upon request by calling Quantum Health at (855) 649-3855.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association.*

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

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

If there are multiple diagnoses, only the treatment for the sickness that is identified in the DSM is considered Mental Health and Substance-Related and Addictive Disorders Treatment.

Detoxification services given prior to, and independent of, a course of psychotherapy or substance abuse treatment are not considered Mental Health and Substance-Related Addictive Disorders Treatment.

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

Orthognathic Condition is a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

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.

Out-of-Network is using a provider who is not participating in the Preferred Providers networks provided by the plan to obtain medical services or supplies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

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 (other than Mental Health and Substance-Related and Addictive Disorders Treatment), UnitedHealthcare's Preferred Provider (PPO) Network.
- With respect to Mental Health and Substance-Related and Addictive Disorders Treatment, a United Behavioral Health contracted provider or otherwise authorized by United Behavioral Health.
- With respect to pharmacy services, a pharmacy that participates in the OptumRx network.

Preferred Provider Directory is a list of Doctors and Hospitals who are located in your area and with which the following organizations have contracted on behalf of the plan participants to be Preferred Providers and part of the Preferred Provider network: UnitedHealthcare, United Behavioral Health, and OptumRx. This list will be periodically updated.

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.

Private Duty Nursing (PDN) means continuous and skilled care by a registered nurse (RN) or licensed practical nurse (LPN) under the direction of a qualified practitioner for a medical condition that requires more than four continuous hours of skilled care that can be provided safely outside of an institution. It does not include care provided while confined at a Hospital, Extended Care Facility, or other Inpatient facility; care to help with Activities of Daily Living, including, but not limited to, dressing, feeding, bathing, or transferring from a bed to a chair; or Custodial Care.

Residential Treatment is treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. A Residential Treatment Facility 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 Health/Substance- Related and Addictive Disorders 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.

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 this 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 is a place that:

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

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorder 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.

Transplant Management Program is a program made available under the Plan to Employees and Dependents. The Transplant Management Program offers access to a network of transplant centers.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary – reimbursement for Covered Health Services received from providers, including Doctors or health care facilities, who are not part of the network are determined based on:

- 140 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.
    - A gap methodology may be utilized when CMS does not have rates published for certain procedural codes; or
    - 50% of the provider's billed charges when unable to obtain a rate published by CMS and/or a gap methodology does not apply.

BENEFIT CONTACTS

Quantum Health – for UHC HDHP PPO (including OptumRx pharmacy benefits)

- Care Coordinator/Customer Service..……(855) 649-3855
- Website – Quantum Health…….……...…..www.upquantumhealth.com

Union Pacific Employee Benefits — 9:00 a.m. to 5:00 p.m. (CT)

Toll-Free.....(877) 275-8747
Sumit a Ticket…….……. https://www.up.com/employee/retirees/
Fax Number.....(402) 233-2736
Email Address.....HRSC@up.com
Mailing Address.....1400 Douglas Street, Stop 0320, Omaha, NE 68179

- All General Management or Retirement Benefit Questions
- Medical/Dental/Vision
- Pension
- Service Awards/Retirement Awards

Dario (for retirees enrolled in the BCBS HDHP PPO Program)

- Website…….https://about.dariohealth.com/union-pacific
- Member Services……..……...……..(833) 708-3061

EyeMed Vision Care (for retirees enrolled in the BCBS HDHP PPO Program)

- Website/Provider Directory.....www.eyemed.com
- Member Services.....(866) 559-5252

Maven (for retirees enrolled in the BCBS HDHP PPO Program)

- Website……www.mavenclinic.com
- Email Address.……...support@mavenclinic.com

It is your right and responsibility to learn as much as you can about the wide variety of Union Pacific benefits and how you can make the most of all that is available to you. Please retain a copy for use throughout the year.