2025 BlueCross/BlueShield Healthcare Benefit Plan Medical Options

For Full-Time Salaried, Reduced Salaried, and Full-Time Hourly Employees of Union Pacific Corporation and Affiliates

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

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GUIDE TO MANAGEMENT BENEFITS

This booklet contains important information about how your health and welfare benefit plan works. It includes information about who is covered, the kinds of benefits provided, limitations or restrictions you should know about, and how to claim benefits. These benefits are covered by provisions of 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. A description of ERISA provisions is found in the ERISA section beginning on page 247 of the 2025 Employee Flexible Benefits Guide.

INTRODUCTION

This document contains the terms of and summarizes the BlueCross/BlueShield (BCBS) Healthcare Benefit Plan Medical Options (the "Plan") effective January 1, 2025. It includes information about who is covered, the kinds of benefits provided, limitations, or restrictions you should know about, and how to claim your benefits. The BCBS Healthcare Benefit Plan Medical Options are offered as part of the Union Pacific Corporation Group Health Plan. The Union Pacific Corporation Group Health Plan is one of the benefit plans offered under the 2025 Union Pacific Employee Flexible Benefits Program (the "Flexible Benefits Program"). Details about the Flexible Benefits Program can be found in the 2025 Employee Flexible Benefits Guide ("2025 Flex Guide" or "Flex Guide").

The Plan is 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. ERISA requires that you receive an easily understood description of your benefits called a summary plan description. The information about the Plan described in this document, together with the information in the Union Pacific Corporation 2025 Flex Guide and in the documents furnished by the various health maintenance organizations in which you may be eligible to enroll, constitute the summary plan description under ERISA.

This document, together with the 2025 Flex Guide and the documents furnished by the various health maintenance organizations in which you may be eligible to enroll, along with the insurance contract under which life, accidental death & dismemberment, vision and long term disability benefits are provided, 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.

While Union Pacific Corporation intends to continue the plan indefinitely, it reserves the right to terminate or amend any or all of the benefit plans described in this document and the Flex Guide for any reason. If Union Pacific Corporation, through its senior human resources officer, or such officer with similar authority, terminates or amends a welfare benefit plan, benefits under the plan for Employees would cease or change. Union Pacific may also increase the required Employee contributions at any time. Similarly, a participating employer can take such actions with respect to its Employees. Every effort will be made to provide plan participants with reasonable notice of any such change.

Note that the terms "you" and "your" throughout this document refer to the Employee and all eligible Dependents covered under the Plan, except where otherwise indicated.

The "Glossary" section, beginning on page 95, is an important reference tool to help you understand how the Plan works by providing definitions of terms used throughout this document. Also, you will find definitions of other terms in the various sections of this document and the 2025 Flex Guide.

As used in this document, the word "Year" refers to the Calendar Year, which is the 12-month period beginning January 1 and ending December 31. All Annual Benefit Maximums and Deductibles accumulate during the Calendar Year. The term "Overall Maximum" as used in this document refers to the period of time you or your eligible Dependents participate in this Plan.

ELIGIBILITY

You are eligible to participate in a Blue Cross/BlueShield Healthcare Benefit Plan Medical Option if you are an Employee and reside in a ZIP code area designated as a BCBS Network.

For purposes of the BCBS Healthcare Benefit Plan Medical Options, the following definitions apply:

- "Employee" means:
  - An active, full-time salaried, reduced salaried, or full-time hourly person employed by Union Pacific Corporation or Union Pacific Railroad Company and whose terms and conditions of employment are NOT subject to collective bargaining (other than any person classified as a co-op or intern); or
  - Any other classification of employees specified by any other Union Pacific affiliate that becomes a participating employer in the Flexible Benefits Program.

Furthermore, the term "Employee" shall not include a person who is classified by Union Pacific Corporation, Union Pacific Railroad, or any other Union Pacific affiliate that becomes a participating Employer in the Flexible Benefits Program (individually, Flexible Benefits Program Employer") as an independent contractor or a person who is not

treated by a Flexible Benefits Program Employer as an Employee for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding. If an individual is engaged in an independent contractor or similar capacity and is subsequently classified by a Flexible Benefits Program Employer, a governmental body or the judiciary as an Employee, such person, for purposes of the Flexibles Benefit Program, shall be deemed to be an Employee from the actual (and not effective) date of such classification by a Flexible Benefits Program Employer or the date as of which such classification by the governmental body or judiciary is final and not appealable. Additionally, the term "Employee" excludes any person who, as to the United States, is a non-resident alien with no U.S. source income from a Flexible Benefits Program Employer.

- A "Dependent" means the Employee's "Spouse" or a "Child".

The Plan reserves the right to require documentation with respect to any individual who elects to enroll in coverage, verifying that such individual satisfies the Plan's definition of Dependent and such other information necessary to administer the plan, including but not limited to social security numbers.

- A "Spouse" means the individual with whom the Employee has entered into a valid marriage in accordance with the law of the jurisdiction in which the marriage between the Employee and such individual is entered into, regardless of whether such marriage is recognized in the jurisdiction in which the Employee is domiciled. Such individual ceases to be the Employee's Spouse on the date a decree of divorce, legal separation or annulment between the Employee and such individual 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 Employee 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.

- "Child" is defined as one of the following:
  1. An individual (son, stepson, daughter, or stepdaughter) who is directly related to the Employee by blood, adoption (or placement for adoption), or marriage, or who is a foster child placed with the Employee 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 Employee's home and the Employee 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 Employee is required to enroll in coverage pursuant to a Qualified Medical Child Support Order (QMCSO).
  4. A Disabled Child.

- A "Disabled Child" means any unmarried Child described in paragraph 1 or 2 in 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 Employee 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 Employee must submit proof to the Plan Administrator, when requested, that the Child meets these conditions at the time the Child attains the age of 26 and throughout the period in which coverage is provided.

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

- A "Qualified Medical Child Support Order" or "QMCSO" is any judgment, order, or decree issued by a court of competent jurisdiction that provides child support pursuant to a state domestic relations law or pursuant to an

administrative proceeding authorized by state statute as described in section 1908 of the Social Security Act which provides for health benefit coverage of an alternate recipient. A QMCSO cannot require a Plan to provide any type or form of benefit or option not already provided under the Plan. The QMCSO must specify the name and address of the Employee and each alternate recipient, describe the coverage to be provided, identify the period for which the coverage is to be provided, and specify the Plan to which the QMCSO applies. If you are required to enroll an alternate recipient pursuant to a QMCSO, your election under the Flexible Benefits Program may be changed to provide coverage for such alternate recipient. Additional information, including a copy of the guidelines for preparing and administering QMCSOs, may be obtained by submitting a ticket to Union Pacific Employee Benefits via the instructions provided in the Benefit Contacts section on page 110.

An individual enrolled in one of the BCBS Medical Options is referred to as a "Covered Person."

Healthcare Coverage Level Definitions:
The following definitions apply for purposes of the Medical Care Program.

"Employee Only" coverage means coverage offered to the Employee, but not to any Dependent of the Employee.
"Employee + Spouse" coverage means coverage offered to the Employee and the Employee's Spouse, but not the Employee's Child(ren).
"Employee + Child(ren)" coverage means coverage offered only to the Employee and the Employee's Child(ren), but not the Employee's Spouse.
"Employee + Family" coverage means coverage offered to the Employee, the Employee's Spouse and the Employee's Child(ren).
"Employee + Dependent(s) Coverage" means any of the following:

- Employee + Spouse coverage;
- Employee + Child(ren) coverage; or
- Employee + Family coverage.

Employee + Spouse coverage, Employee + Child(ren) coverage and Employee + Family coverage are collectively referred to as the "Employee + Dependent(s) Coverages".

HEALTHCARE COVERAGE LEVEL ELECTIONS

The following healthcare coverage elections are available to Employee married to another Employee (as such term is defined in either this 2025 Blue Cross/BlueShield Healthcare Benefit Plan Medical Option Guide or the Part-Time Benefits Guide):

1. You and your Employee Spouse each elect Employee Only coverage under the same or different medical, dental and/or vision program options; or
2. You or your Employee Spouse elects Employee + Spouse or Employee + Family medical, dental and/or vision coverage (covering the other as a Dependent) and the other waives the medical, dental and/or vision coverage for which the other elected Employee + Spouse or Employee + Family coverage; or
3. You or your Employee Spouse elects Employee Only medical, dental and/or vision coverage and the other elects Employee + Child(ren) coverage under the same or different medical, dental and/or vision coverage;
4. You or your Employee Spouse Employee Only medical, dental and/or vision coverage and the other waives such coverage; or
5. Both you and your Employee Spouse waive medical, dental and/or vision coverage.

NOTE: If you are the Dependent of another Employee, and such Employee has elected coverage under the Medical, Dental Care and/or Vision Care Program(s) coverage covering you as a Dependent, then you must waive the Medical, Dental and/or Vision coverage for which you are already covered as a Dependent.

Waiving Medical Coverage:
An Employee may waive medical coverage. To waive medical coverage, an Employee must affirmatively elect to do so. However, once you affirmatively waive medical coverage, your waiver election will remain in effect unless you change your election either as a result of a Life Event or during an annual Open Enrollment period for a subsequent Calendar Year.

Who Pays for Your Benefits: You and your Employer share the cost of providing benefits for you and your Dependents.

ENROLLMENT AND WHEN COVERAGE BEGINS

Newly Eligible During the Calendar Year:

If you are hired, or first become eligible during the Calendar Year, you have 30 days from the date you become an eligible Employee to make your benefit elections and 45 days from the date you become an eligible Employee to provide any requested documentation regarding the individuals you elect to enroll in medical, dental and/or vision coverage. If requested documentation is not received within the 45 days, coverage will be cancelled retroactively to the first day of eligibility for the individual to which the documentation request applied, and any submitted claims will be denied and premiums refunded, if applicable.

If you do not make an affirmative election (including an election to waive coverage) during this 30-day period, you will be defaulted to Core Benefits from the date you became an eligible Employee. Core Benefits are described in the Flexible Benefits Overview on page 6 of the 2025 Flex Guide. If you receive the default enrollment (Core Benefits), your Dependents, if any, will not receive benefits for the remainder of the Calendar Year unless you are permitted to enroll your Dependents as a result of a "Life Event" as described on pages 30-67 in the 2025 Flex Guide and the benefit plan permits enrollment of your Dependents as a result of such Life Event.

Your Flexible Benefits Program elections (or default coverage (Core Benefits)) become effective on the date you become an eligible Employee. Any before-tax contributions will begin as soon as administratively practicable following your election(s). This includes your contribution to the Dependent Care FSA, which will be prorated over the remaining months in the Calendar Year.

Open Enrollment:

During the fall of each Calendar Year, you will be given the opportunity to enroll for the subsequent Calendar Year. Your enrollment must be completed during the open enrollment period and elections made during open enrollment are effective January 1st of the following Calendar Year provided that any requested documentation regarding the individuals you elect to enroll in coverage is provided within 45 days following the end of the open enrollment period. If you fail to timely provide any required documentation regarding the addition of a Dependent, coverage for such Dependent will not be added for the following Calendar Year. If you do not make an affirmative election (including an election to waive coverage), you will be defaulted to the same coverages in the new Calendar Year as you are receiving in the current Calendar Year, with these exceptions:

- **For the 2025 Calendar Year, you must make an affirmative election (including an election to waive coverage) for medical, dental and vision coverage, regardless of whether you are enrolled in or waived coverage at the end of 2024. If you do not make an affirmative election for the 2025 Calendar Year, you will be defaulted to Core level (i.e., Employee Only) medical, dental and vision coverage. Core Benefits are described in the Flexible Benefits Overview on page 6 of the 2025 Flex Guide.**
- Your Dependent Care FSA contribution election will terminate on December 31st and cannot be renewed without your affirmative election during open enrollment each Calendar Year.

Life Events:

Except for your Employee HSA Contribution election (which is described in the 2025 Flex Guide), once you have enrolled, your elections remain in effect until the end of the Calendar Year and you cannot change your elections until the next Open Enrollment period unless you experience a Life Event and the benefit program in which you enrolled through the Flexible Benefits Program permits such a change. For a description of the permitted election changes you may make based upon a Life Event, see the 2025 Flex Guide pages 30-67.

Changes in elections resulting from a Life Event must be on account of and correspond with the Life Event outlined on pages 30-67 in the 2025 Flex Guide. In addition, your election change must be made within 30 days of the event date (unless the election change is the result of a Special Enrollment Right related to Medicaid or SCHIP, as described below). It is your responsibility to notify Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110, to update your Plan benefits as needed. You must provide notification for a birth, adoption, marriage, or divorce or to add or drop a Dependent or a Domestic Partner through the UP Employees website SAP-"My Benefits", or by calling Union Pacific Employee Benefits. Changes after 30 days can only be made during the next annual Open Enrollment period for coverage effective January 1st of the following year.

The Plan Administrator requires written documentation of a Life Event change. You generally have 45 days following the date of the Life Event to provide such written documentation. The documentation that must be provided with respect to the applicable Life Event is indicated in the 2025 Flex Guide on pages 30-67. In the event you do not provide the required documentation by this deadline, effective with the first month following the month in which the deadline expired, your coverage (and any salary reduction or salary deduction amount) that were changed as a result of the Life Event will automatically revert back to the coverage (and salary reduction or salary deduction amount) that were in effect prior to the Life Event change. Also, it may be necessary for the Plan Administrator to change your election to prevent the Flexible Benefits Program from violating certain rules set forth in the Internal Revenue Code. You will be advised if the Plan Administrator determines that any change in your election is necessary.

Changes in coverage elections resulting from a birth, adoption, or placement for adoption of a Dependent Child will be effective on the event date, and changes to your medical election as a result of a transfer from a Craft Professional position to a Management position will be effective on the date of the Management position. Changes in your medical election as a result of all other Life Events described in the Flex Guide will be effective on the first day of the month following the event date (for example, if the event occurred on January 15th, benefits will take effect on February 1st). Any required salary reductions, salary deductions, or waiver of medical payments will begin as soon as administratively practicable following receipt of your completed elections. Remember, an election change cannot be made unless the election change is on account of and corresponds with the Life Event and Union Pacific Employee Benefits is notified of the change within 30 days of the event.

Generally, each Dependent (i.e., Spouse and/or Child(ren)) you wish to enroll in any coverage offered under the Flexible Benefits Program first must be registered as your Dependent through the SAP-"My Benefits" portal. However, because enrollment for Life and AD&D coverage is performed through a separate website maintained by MetLife, you may enroll your **"Spouse" or "Child" (as those terms are defined for purposes of the Life and Accidental Death and Dismemberment Insurance Plan), even if those individuals are not registered through the SAP-"My Benefits" portal.**

Note: If you gain a Child through birth or adoption, the Covered Health Services incurred by the Child during the first 31 days of life will be covered by the Plan, regardless of whether you make an affirmative election to enroll the Child in a medical coverage option. If you do not provide notification and supporting documentation to Union Pacific Employee Benefits as described in the "Life Events & Permissible Benefit Changes" table on page 35 of the 2025 Flex Guide, the Child's coverage will be cancelled effective the 32nd day.

Important Dependent Information:

- When you enroll your Dependents in the Flexible Benefits Program, you are affirming that you have reviewed the Flexible Benefits Program's eligibility terms and that each listed individual meets the applicable definition of a "Dependent." You are also affirming that you will advise Employee Benefits about any change in circumstances that affects your Dependent's eligibility for coverage.
- Coverage for you and your Dependents is available only through the date coverage is provided under the terms of the Plan. See "When Coverage Ends" beginning on page 16.
- In the event of fraud or intentional misrepresentation of material fact regarding a Dependent's eligibility for coverage, coverage for such Dependent may be rescinded, and claims paid for Dependents who are found to be ineligible for coverage may be the responsibility of the Employee. Deductibles and Annual out-of- pocket expenses or other plan limitations may also be recalculated and may cause further expense to the Employee. Further, unless a Life Event permits you to change your enrollment election, if you enroll in an Employee + Dependent(s) Coverage level and an individual listed as your Dependent is not eligible, you will continue to be charged at the rate for the enrolled coverage level even if one or more of your dependents is no longer eligible for coverage.
- The Plan reserves the right to require documentation with respect to any individual you elect to enroll in coverage, including but not limited to evidence of the "Life Event", if applicable; evidence that such individual satisfies the Flexible Benefits Program's definition of a Dependent, and such individual's social security number.

Notice of HIPAA Enrollment Rights:

The passage of the Health Insurance Portability and Accountability Act of 1996, or HIPAA, provides special enrollment rights to participate in group health plans (see "Life Event & Permissible Benefit Changes" section on pages 30-67 in the 2025 Flex Guide for more information). If you are declining enrollment for yourself or your Dependents in a Medical Care Program option because of other health insurance or group health plan coverage, you may, in the future, be eligible to enroll yourself or your Dependents in a Medical Care Program option if you or your Dependents lose eligibility for that other

coverage (or if the employer stops contributing towards your or your Dependents' other coverage), provided that you request enrollment within 30 days after you or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Solely for the purposes of these HIPAA enrollment rights, "Dependent" also includes individuals who are eligible for coverage under an HMO option or the Domestic Partner Non-HDHP PPO medical option because of a relationship to the Employee).

Notice of Special Enrollment Rights Related to Medicaid or SCHIP Coverage:
If you or your Dependent:

- Is covered under a Medicaid plan under Title XIX of the Social Security Act, or under a state child health insurance plan ("SCHIP") under Title XXI of such Act, and your coverage under the Medicaid or SCHIP plan is terminated as a result of loss of eligibility for such coverage; or
- Become eligible for Medicaid or SCHIP plan assistance with respect to coverage under a Medical Care Program option,

then you and your Dependent may enroll in a Medical Care Program option, provided you request enrollment within 60 days after the date the applicable event occurs (i.e., the termination of the Medicaid or SCHIP Plan coverage, or determination of eligibility for Medicaid or SCHIP plan assistance). If you request enrollment in a Medical Care Program option within such period, your medical care coverage will be effective the first day of the month following the date you provide notification of the event.

To request special enrollment or obtain more information, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

Special Enrollment Rights Applicable to the Kaiser HMOs:
Employees eligible to enroll in a Kaiser HMO may have a special enrollment right upon the occurrence of a "qualifying event" as defined in section 603 of ERISA. See the documents furnished by the Kaiser HMO for more information.

Special Election for Employees and Spouses Age 65 and Over:
If you remain an Employee after reaching age 65, you or your Spouse may choose to remain covered under a Medical Program Option without reduction for Medicare benefits or designate Medicare as the primary payer of benefits. If you choose to remain covered under a Medical Program Option, the Medical Program Option will be the primary payer of benefits and Medicare will be secondary. If you choose Medicare as primary, coverage under the Medical Program Option will end for you; however, your Spouse may elect to continue coverage under a Medical Care Program Option. If you do not specifically choose between Medicare and the Medical Program Option, the Medical Program Option will be primary. If you are under age 65 and your Spouse is over age 65, he or she can make their own choice to choose Medicare or remain on your coverage under the Plan.

DOMESTIC PARTNER COVERAGE

If you reside in a residential ZIP code area designated as a BCBS Network area, you may enroll your Domestic Partner in the BCBS Non-HDHP PPO described in this document. For more information regarding medical coverage for your Domestic Partner, including the Schedule of Benefits for such coverage, see the "Medical Program-Domestic Partners" section of the 2025 Flex Guide on page 167.

If your Domestic Partner is enrolled in the BCBS Non-HDHP PPO, then, except as provided in the "Medical Program-Domestic Partners," section of the 2025 Flex Guide, all terms and conditions of the BCBS Non-HDHP PPO as described in this 2025 BCBS Healthcare Benefit Plan Medical Options Guide shall apply to such Domestic Partner as if the Domestic Partner were an Employee with BCBS Non-HDHP PPO Employee Only coverage.

CHANGES IN EMPLOYMENT STATUS

Termination or Transfer to an Ineligible Status:
With the exception of the STD/LTD Plan, benefit plan coverage and salary reduction contributions under the Flexible Benefits Program will cease at the end of the month in which you terminate employment or become ineligible to continue participation. Coverage and applicable salary deductions under the STD/LTD Plan cease upon your termination of employment or the date you otherwise become ineligible to participate in the plan. If you are rehired or return to eligible status within the same Calendar Year, you will be automatically re-enrolled in the same plan coverages at the same coverage levels as were in effect

on the date you ceased participation, except that if you terminate employment and are re-hired, your eligibility for STD/LTD Plan coverage is determined based on your most recent hire date. Before-tax salary reductions and any after-tax payroll deductions will begin as of the monthly pay cycle following the month you start participation.

Relocation or Transfer to a New Work Location:
(Applies only to the Medical Care Program Options)
If you have medical coverage at your current location and a relocation or transfer causes you to lose coverage under your current medical coverage option, you may enroll in coverage under any medical coverage option offered at the new location at the same coverage level currently elected (i.e., Employee Only or an Employee + Dependent(s) Coverage level. If the relocation or transfer causes you to become newly eligible for a medical coverage option not otherwise available at your former location (i.e. certain geographical locations may have access to an HMO), you may enroll in coverage under the newly available coverage option at the same coverage level currently elected (i.e., Employee Only or an Employee + Dependent(s) Coverage level.

You must change your address on the UP Employees website SAP-"My Profile", or notify Union Pacific Employee Benefits of your new address within 30 days following your move. If you are eligible to make an election and you fail to do so within 30 days following your move, your medical coverage will be as follows:

- If your current medical coverage option is available in your new location, you will receive the same medical coverage option as received at your prior location at the same coverage level currently elected (i.e., Employee Only or an Employee + Dependent(s) Coverage level) received at your previous location; or
- If your current medical coverage option is not available in your new location, you will be defaulted to the HDHP2 medical option at the same coverage level currently elected(i.e., Employee Only or an Employee + Dependent(s) Coverage level) received at your previous location. Your Network will depend upon the home address of your new residence; either UnitedHealthcare (UHC) or BCBS.
- If you previously waived coverage at the prior location, you will not receive coverage at the new location unless you experience another "Life Event" as described under "Life Events & Permissible Benefit Changes" on pages 30-67 in the 2025 Flex Guide that would allow you to enroll in coverage.

Your new medical election (or default coverage if you fail to make a new election) will be effective the first day of the month coinciding with or next following the date your address is updated on the UP Employees website as described above, so long as your completed election(s) are received within 30 days from the date you relocate or otherwise move because of a transfer and you provide any requested documentation regarding the individuals you elect to enroll in coverage within 45 days of making your elections. Any before-tax contributions or waiver of medical payments for your new election will begin as soon as administratively practicable following the date your completed elections are received.

If You Retire:
(Applies only to the Medical Program)
You are eligible to participate in Union Pacific's Retiree Medical Program if you satisfy **ALL** of the following conditions:

- 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 participate in the Union Pacific Corporation Flexible Benefits Program immediately before you terminate employment;
- You did not elect COBRA continuation coverage with respect to your active Employee medical coverage under the Union Pacific Corporation Group Health Plan (or your surviving Spouse did not elect COBRA coverage if your active 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. 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 the above-described 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.

If you satisfy all the above requirements, the Retiree Medical Program is available to you, your Spouse and/or Dependent Children as defined in this document on page 6, provided that each person you wish to enroll in Retiree Medical Program coverage – including you – is not Medicare eligible at the time of enrollment.

At the time you retire, you must elect and begin retiree medical coverage or you will permanently waive your rights to this coverage unless, at a later time, you qualify for special enrollment provisions. Further information about election procedures and coverage can be found in the Retiree Medical Guide, which is available at http://www.up.com/employee/retirees/benefits/healthcare/index.htm. You may also obtain a copy by submitting a ticket to Union Pacific Employee Benefits via the instructions provided in the Benefit Contacts section on page 110.

Your surviving Spouse is eligible to participate 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.

Leaves of Absence:
Unpaid Leave of Absence: If you go on an unpaid leave of absence, you will be treated as a terminated Employee (except if such leave is: (a) family and medical leave under the terms of a policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating Employer in the Flexible Benefits Program) that complies with the Family and Medical Leave Act, (b) leave under the Unpaid Sabbatical Program, (c) unpaid vacation, (d) leave under the terms of a policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating Employer in the Flexible Benefits Program) that complies with a family military leave law enacted by the state in which you reside, leave under the Uniformed Services Employment and Reemployment Rights Act of 1994), (f) unpaid leave Status Assessment, (g) unpaid leave Suspension, or (h) required unpaid leave of absence (RULA). This means that your benefit coverage terminates at the end of the calendar month in which the unpaid leave begins unless your unpaid leave falls within one of the categories identified above.

If you return from an unpaid leave within the same Calendar Year in which the leave began, you will be automatically reenrolled in the same coverages at the same levels as were in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you return from your unpaid leave of absence in a Calendar Year subsequent to the Calendar Year in which your unpaid leave began, you may re-enroll for benefits upon your return from unpaid leave. Your enrollment rights are covered in the "Life Events & Permissible Benefit Changes" section on pages 30-67 in the 2025 Flex Guide.

Unpaid Family and Medical Leave:
If you go on family and medical leave under the terms of a policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating employer in the Flexible Benefits Program) that complies with the terms of the Family and Medical Leave Act, Core life coverage, Core AD&D coverage, and your short-term disability coverage and your Core level long-term disability coverage under the STD/LTD Plan will continue at no cost to you. In addition, you will be permitted to continue medical, dental, vision, voluntary life and AD&D coverage, Buy-up level of long-term disability coverage and your domestic partner medical, dental and/or vision coverage on an after-tax basis. Employee Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid family and medical leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific. For the coverage(s) you elect to continue while on your unpaid leave, salary reduction and after-tax payroll deductions will continue in the same way they are taken for active Employees, to the extent your required Employee contributions can be taken from your pay earned in the month your leave begins and/or ends. For months of your unpaid leave in which such amounts cannot be taken from your pay, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Union Pacific for all other coverages. To arrange for making payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

If you discontinue your coverage during your Family Medical Leave and you return from your Family Medical Leave in the same Calendar Year in which the Family Medical Leave commenced, you will be automatically re-enrolled for benefits upon your return to work in the same coverages at the same levels as were in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you discontinue your coverage during your Family Medical Leave and you return from your Family Medical Leave in a Calendar Year subsequent to the Calendar Year in which the Family Medical Leave commenced, you may re-enroll for benefits upon your return to work. Your enrollment rights are covered in the "Life Events & Permissible Benefit Changes" section on page 47 of the Flex Guide.

Unpaid Family Military Leave:
If you go on an unpaid leave of absence under the terms of a policy adopted by Union Pacific Corporation (or a Union Pacific affiliate that is a participating employer in the Flexible Benefits Program) that complies with a family military leave law enacted by the state in which you reside, coverage under the Flexible Benefits Program, except Dependent Care FSA and HSA Contributions, will continue for the duration of such leave, as long as you continue your required Employee contributions for such coverage. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid family military leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific. Salary reduction and after-tax payroll deductions will continue in the same way they are taken for active Employees, to the extent your required Employee contributions can be taken from your pay earned in the month your leave begins and/or ends. For months of your unpaid leave in which such amounts cannot be taken from your pay, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Union Pacific for all other coverages. To arrange for making payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

If you return from such family military leave in the same Calendar Year in which the family military leave began, you will be automatically re-enrolled upon return to work at the same level as was in effect on the date you ceased participation. If you return to work in the Calendar Year subsequent to the Calendar Year in which the family military leave began, you may re-enroll upon return to work.

Unpaid Military Leave – 30 days or fewer:
*If you go on an unpaid leave due to military s*ervice for 30 consecutive days or fewer, coverage under Flexible Benefits Program, except Dependent Care FSA and HSA Contributions, will continue for the duration of the military leave as long as you continue your required Employee contributions for such coverage. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid military leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific. Salary reductions and after- tax payroll deductions will continue in the same way they are taken for active Employees, to the extent your required Employee contributions can be taken from your pay earned in the month your leave begins or ends. For months of your unpaid leave in which such amounts cannot be taken from your pay, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Union Pacific for all other coverage. To arrange for making payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

Unpaid Military Leave – More than 30 days:
Generally speaking, if you go on a leave of absence due to military service for more than 30 consecutive days and such leave does not qualify you for differential pay under the Union Pacific Military Leave Policy ("Military Leave Policy"), your benefits coverage will terminate at the end of the month in which your leave started. Your Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific. However, Core life, Core AD&D, your short-term disability coverage and your Core level long-term disability coverage under the STD/LTD Plan will continue at no cost to you and you will be permitted to continue your medical, dental, vision (including domestic partner medical, dental and/or vision coverage), voluntary life and AD&D, and/or Buy-up level long-term disability coverages on an after-tax basis. To do so, you must first provide a copy of your orders to Union Pacific Leave Management prior to starting your military leave, unless you are precluded by military necessity from doing so, or it is otherwise impossible or unreasonable to do so under the circumstances. Upon being notified of your military leave, Union Pacific will notify the Plan Administrator of your military leave and you will be offered the right to continue these coverages. You will have the right to elect to continue these coverages on behalf of you, your Spouse and Dependent Children, if any. You must make your election no more than 60 days after receiving the Plan Administrator's notice of the right to continue such coverages. Your right to continue medical, dental and vision coverages is temporary.

You may continue medical, dental and vision coverages until the earlier of:

1) 24 months following the date on which your leave began or
2) the date you fail to return to work or apply for re-employment within the time period prescribed by USERRA.

You will be charged 102% of the full premium cost for coverage. The 102% of full premium cost will be effective on the first day of the month following the start of your military leave. You will be notified by Pay Flex 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 for payment of the regularly scheduled premium.

Your coverage may be cut short if Union Pacific no longer provides group health coverage for any of its employees or the premium for your coverage is not paid within 30 days of the date due.

If you discontinue your coverage during military leave and you return from your military leave in the same Calendar Year in which your military leave commenced, you will be automatically re-enrolled for benefits upon your return to work in the same coverages at the same levels as were in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you discontinue your coverage during your military leave and you return from your military leave in a Calendar Year subsequent to the Calendar Year in which your military leave commenced, you may re-enroll for benefits upon your return to work. Your enrollment rights are covered in the "Life Events & Permissible Benefit Changes" section on page 51 of the Flex Guide.

Military Leave with Differential Pay:
If you go on a leave of absence due to military service for more than 30 consecutive days and such leave qualifies you for differential pay under the Military Leave Policy, you should refer to the "Benefit Coverage for Management Employees on Military Leave" section of the Military Leave Policy for rules governing your benefit options while on such leave of absence. A copy of the Military Leave Policy may be found on the Workforce Resources page via the UP Employees website www.up.com.

If your military leave qualifies for differential pay, you will be permitted to continue certain coverages by paying the same monthly Employee contribution amount for the coverage as an active Employee. If your Union Pacific differential pay for a month is insufficient to cover the benefit deductions, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Union Pacific for all other coverages. To arrange to make payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

Unpaid Sabbatical Leave:
If you go on an unpaid sabbatical leave under the Unpaid Sabbatical Program for Management Employees, you are allowed to continue your medical, dental, vision, voluntary life and AD&D, Buy-up level of long-term disability coverage, and domestic partner medical, dental, and/or vision coverage on an after-tax basis. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid sabbatical leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific, For the coverage(s) you elect to continue while on your unpaid leave, salary reduction and after-tax payroll deductions will continue in the same way they are taken for active Employees, to the extent your required Employee contributions can be taken from your pay earned in the month your leave begins and/or ends. For months of your unpaid leave in which such amounts cannot be taken from your pay, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Union Pacific for all other coverages. To arrange to make payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

With respect to the above coverages that are discontinued while on unpaid sabbatical leave (either at your election or automatically), if you return from such sabbatical in the same Calendar Year in which the sabbatical began, you will be automatically re-enrolled upon return to work in the same coverages and at the same levels as were in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you return to work in the Calendar Year subsequent to the Calendar Year in which the sabbatical began, you may re-enroll upon return to work.

Unpaid Status Assessment Leave:
If you are on a temporary unpaid status assessment leave for Management Employees, which is a leave of absence during which an assessment regarding your ability to return to a specific position or to work generally is occurring, you are allowed to continue your medical, dental, vision, voluntary life and AD&D, Buy-up level of long-term disability coverage, and domestic partner medical, dental and/or vision coverage on an after-tax basis. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid status assessment leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific, For the coverage(s) you elect to continue while on your unpaid leave, salary reduction and after-tax payroll deductions will continue in the same way they are taken for active

Employees, to the extent your required Employee contributions can be taken from your pay earned in the month your leave begins and/or ends. For months of your unpaid leave in which such amounts cannot be taken from your pay, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Union Pacific for all other coverages. To arrange to make payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

With respect to the above coverages that are discontinued while on unpaid sabbatical leave (either at your election or automatically), if you return from such status assessment leave in the same Calendar Year in which the status assessment leave began, you will be automatically re-enrolled upon return to work in the same coverage and at the same level as was in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you return to work in the Calendar Year subsequent to the Calendar Year in which the status assessment leave began, you may re-enroll upon return to work.

Unpaid Suspension Leave:
If you are on an unpaid suspension leave, which is a period of time a management employee is off work for rule or policy violations, you are allowed to continue your medical, dental, vision, voluntary life and AD&D Buy-up level of long-term disability coverage, and domestic partner medical, dental and/or vision coverage on an after-tax basis. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid suspension leave and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific, For the coverage(s) you elect to continue while on your unpaid leave, salary reduction and after-tax payroll deductions will continue in the same way they are taken for active Employees, to the extent your required Employee contributions can be taken from your pay earned in the month your leave begins and/or ends. For months of your unpaid leave in which such amounts cannot be taken from your pay, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Union Pacific for all other coverages. To arrange to make payments, Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

If you return from such suspension leave in the same Calendar Year in which the suspension leave began, you will be automatically re-enrolled upon return to work in the same coverages and at the same levels as were in effect on the date you ceased participation, except that if you are re-enrolled in an HDHP medical option and wish to make Employee HSA Contributions, you must affirmatively elect to do so. If you return to work in the Calendar Year subsequent to the Calendar Year in which the suspension leave began, you may re-enroll upon return to work.

Unpaid Vacation Leave or Required Unpaid Leave of Absence ("RULA"):
If you go on unpaid vacation under the Unpaid Vacation Policy for Management Employees or a required unpaid leave of absence of short duration initiated by Union Pacific in response to changing business requirements ("RULA"), coverage under the Flexible Benefits Program, except Dependent Care FSA and HSA Contributions, will continue for the duration of such leave, as long as you continue your required Employee contributions for such coverage. Dependent Care FSA coverage terminates at the end of the month in which you begin an unpaid vacation leave or RULA and Employee HSA Contributions cannot be continued in any month without sufficient pay from Union Pacific. Salary reduction and after-tax payroll deductions will continue in the same way they are taken for active Employees, to the extent your required Employee contributions can be taken from your pay earned in the month your leave begins or ends. For months of your unpaid leave in which such amounts cannot be taken from your pay, your required Employee contribution(s) for the coverage(s) you elect to continue must be paid directly to MetLife (for Life and AD&D) and Union Pacific for all other coverages. To arrange to make payments, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

Absence Due to Disability: If you receive short-term disability benefits under the STD/LTD Plan, coverage under the Flexible Benefits Program will continue for the duration of the short-term disability. Salary reduction and after-tax payroll deductions will continue in the same way they are taken for active employees.

If you receive long-term disability benefits under the STD/LTD Short-Term and Long-Term Disability Plan, coverage under the Flexible Benefits Program will cease at the end of the month in which you begin receiving long- term disability benefits. However, you will be given the opportunity to continue certain benefits during your disability.

Continuation of coverage will require contributions made on an after-tax basis. See the "Short-Term & Long Term

Disability" section on page 217 of the 2025 Flex Guide for more details.

Death:
If you die while covered as an active Employee, healthcare coverage for your Dependents may continue under COBRA for up to 36 months. These rights are explained in detail beginning on page 20 under the "How is COBRA Coverage Provided?" section of this document.

If you die while an Employee:

- either after attaining age 65 or after attaining 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);
- 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; **and**
- you participated in the Union Pacific Corporation Flexible Benefits Program immediately before your death,

then your non-Medicare eligible covered surviving Spouse may elect retiree medical coverage. Alternatively, regardless of whether your covered surviving Spouse is Medicare eligible, he or she may elect COBRA continuation coverage. A covered surviving Spouse cannot elect both retiree medical coverage and COBRA coverage. If there is no surviving Spouse, covered Dependent Children may only elect COBRA continuation coverage.

Union Pacific will determine whether you satisfy the above-described 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.

Change in Your Hours of Work:
Change from full-time salaried, reduced salaried, or full-time hourly to part-time hourly status:
If you change from full-time salaried, reduced salaried, or full-time hourly to part-time hourly status, medical, dental, vision, disability and Domestic Partner medical, dental and vision coverages terminate and you become subject to the plan provisions for Part-Time Hourly Employees. If the Employee enrolls in an HDHP medical option under the Flexible Benefits Program provisions for Part-Time Hourly Employees, your then-current Employee HSA Contribution election, if any, will remain in effect unless changed by you. For purposes of Life and/or AD&D coverages, you may keep current elections at the same coverage and premium deduction level or waive coverage for the remainder of the Calendar Year. An individual changing to a part-time hourly status should refer to the *Part-Time Hourly Benefits Guide*, which provides the terms of the Flexible Benefits Program applicable to part-time hourly management employees.

See the "Core and Optional Benefits" section on page 6 of the 2025 Flex Guide for more details.

Change from part-time hourly to full-time salaried, reduced salaried, or full-time hourly status:
If you change from part-time hourly to full-time salaried, reduced salaried, or full-time hourly status, your health coverages terminate and you may newly enroll in medical, dental and/or vision coverages for yourself, your Spouse/Domestic Partner, and/ or your Dependent Children. If you enroll in an HDHP medical option, your then-current Employee HSA Contribution election, if any, will remain in effect unless changed by you. For purposes of Life and/or AD&D coverages, you may keep current elections at the same coverage level and premium deduction level or waive coverage for the remainder of the Calendar Year.

Upon completion of three months of continuous service, short-term disability ("STD") and Core long-term disability ("LTD") coverage will be provided under the STD/LTD Plan for the remainder of the Calendar Year in which you change from part-time hourly to full-time salaried, reduced salaried, or full-time hourly status. During Open Enrollment, you may elect Buy-Up LTD coverage for the next Calendar Year.

WHEN COVERAGE ENDS

Medical Care Program, Vision Care Program, and Dental Care Program:
Coverage under Medical Care Program (other than Domestic Partner Medical Benefits), Vision Care Benefits (other than Domestic Partner Vision Benefits), and/or Dental Care Program (other than Domestic Partner Dental Benefits) for you and/or your Dependents will, unless otherwise stated, end as of the last day of the month in which:

1. You terminate employment;
2. You cease to be an Employee;
3. You cease making any required contribution;
4. Your dependent no longer meets the definition of an eligible Dependent ("Dependent"); or
5. Any of these plans, programs, policies, options thereunder end; and/or, with respect to a program that is insured, the Group Contract providing such insurance ends.

Notwithstanding #4 above, medical, dental, and vision 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 a 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 Leave Management within 30 days of the commencement of the leave of absence.

It is the Employee's responsibility to provide notification within 30 days following 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. COBRA continuation rights and obligations are explained in the "Continuation of Coverage Under COBRA section on page 19.

Domestic Partner Medical Coverage:
Medical coverage for your Domestic Partner or registered Domestic Partner (and/or dependents of your registered Domestic Partner) will end as of the last day of the month in which:

1. You terminate employment;
2. You cease to be an Employee;
3. You cease making any required contribution;
4. Your Domestic Partner no longer meets the definition of a Domestic Partner as defined in the "Medical Care Program-Domestic Partners" section of this document on page 10;
5. Your registered Domestic Partner (and/or dependents of your registered Domestic Partner) is no longer eligible for coverage under the terms of the California HMO in which he/she is enrolled; or
6. The Flexible Benefits Program or the medical options under which Domestic Partner medical coverage is available ends.

Notwithstanding #5 above, medical coverage provided under a California HMO to a dependent of your registered Domestic Partner who is 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 is 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 physician of the individual which states that the individual is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. This certification must be provided to Union Pacific Employee Benefits within 30 days of the commencement of the leave of absence.

Domestic Partner Dental Coverage:
Dental coverage for your Domestic Partner will end as of the last day of the month in which:

- You terminate employment;
- You cease to be an Employee;
- You cease making any required contribution;
- Your Domestic Partner no longer meets the definition of a Domestic Partner; or
- The Flexible Benefits Program or the Domestic Partner dental benefit option thereunder ends.

Domestic Partner Vision Coverage:
Vision coverage for your Domestic Partner will end as of the last day of the month in which:

- You terminate employment;
- You cease to be an Employee;
- You cease making any required contribution;
- Your Domestic Partner no longer meets the definition of a Domestic Partner; or
- The Flexible Benefits Program or the Domestic Partner vision benefit option thereunder ends.

It is the Employee's responsibility to provide notification within 30 days of any event affecting the eligibility of a Domestic Partner, registered Domestic Partner or a dependent of a registered Domestic Partner.

A Domestic Partner, registered Domestic Partner or dependent of a registered Domestic Partner is not a "qualified beneficiary" and thus, is not eligible to elect COBRA continuation coverage. However, an Employee who elects to continue medical coverage under COBRA may also elect to continue Domestic Partner medical coverage for a Domestic Partner who (a) was covered under Domestic Partner coverage immediately before the date the Employee's medical coverage ended and (b) lost coverage as a result of the Employee's COBRA qualifying event. The Employee will be entitled to continue Domestic Partner coverage until the Employee's COBRA continuation coverage ends. The same rule applies with respect to an Employee who elects to continue Dental and/or Vision coverage under COBRA and wants to continue such Domestic Partner coverage.

If You are No Longer HSA Eligible:
If during the Calendar Year you are no longer enrolled in a Union Pacific HDHP option, your Employee HSA Contribution election will terminate at the end of the month in which your Union Pacific HDHP coverage terminates. Any Employee HSA contributions or Union Pacific HSA Contribution made after you are no longer enrolled in Union Pacific HDHP coverage will be included in your compensation and is subject to applicable income and employment taxes. Such amounts may also be subject to an additional 6% excise tax. You should contact Health Equity or your tax or legal advisor if you have questions regarding this excise tax.

In addition, the HSA Contribution Program is not a health plan and as a result, COBRA continuation coverage rights do not apply to it. This means that although you may have a COBRA right to continue group health plan coverage under a Union Pacific HDHP Option, you cannot make Employee HSA Contributions via payroll deduction and you will not receive the Union Pacific HSA Contribution when continuing group health plan coverage under COBRA.

Life and AD&D Program:

- Life Insurance and AD&D coverage will end on the last day of the calendar month in which your employment ends or you no longer meet the conditions of eligibility. However, a death benefit is payable if the death occurs within 31 days after ceasing to be a covered person while entitled to conversion of the insurance to an individual contract.
- Dependent Life and AD&D coverage will end at the end of the month in which your death occurs.
- All Dependent coverage will end at the end of the month that Dependent ceases to meet the definition of a Dependent. However, a death benefit is payable if the death occurs within 31 days after ceasing to be a covered person while entitled to conversion of the insurance to an individual contract.
- If a covered person does not make a payment that is required, that coverage will end on the last day of the period for

which a required payment was made.
- If the plan ends in whole or in part, your benefits that are affected will end.

Such termination of coverage will not affect a claim that is incurred before the coverage ended.

Short-Term and Long-Term Disability:
Information regarding when coverage ends for the Short-Term Disability and Long-Term Disability Plan (STD/LTD Plan") is provided in that section of the 2025 Flex Guide.

CONTINUATION OF COVERAGE UNDER COBRA

Introduction:

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage available under the Union Pacific Corporation Group Health Plan (for purposes of this section, the "Group Health Plan"). **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Group Health Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Group Health Plan and under federal law, you should contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

Of the benefits described in this document and the 2025 Flex Guide, COBRA continuation rights apply ONLY to the medical, dental, and vision Programs. COBRA continuation rights apply separately to each of these programs. COBRA continuation rights do not apply to the Life and AD&D, Dependent Care FSA, HSA, or Short-Term & Long-Term Disability Plans.

A Domestic Partner, registered Domestic Partner, or dependent of a registered Domestic Partner is not a "qualified beneficiary" and thus, is not eligible to elect COBRA continuation coverage. However, an Employee who elects to continue medical coverage under COBRA may also elect to continue Domestic Partner medical coverage for a Domestic Partner who was covered under Domestic Partner coverage immediately before the date the Employee's medical coverage ended as a result of the Employee's COBRA qualifying event. The Employee will be entitled to continue Domestic Partner coverage until the Employee's COBRA continuation coverage ends.

You may have other options available to you when you lose Group Health 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 Group Health 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 Group Health Plan is lost because of the qualifying event. Under the Group Health Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Group Health Plan because either one of the following qualifying events happens:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

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

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

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B (or both), or Part D);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Group Health 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 coverage of any retired Employee with Retiree Medical Program coverage under the Group Health Plan, the retired Employee will become a qualified beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plan.

When is COBRA Coverage Available?
The Group Health Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee's becoming entitled to Medicare benefits (under Part A or Part B (or both)), 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 or Part B (or both), you must notify Union Pacific Employee Benefits immediately by submitting a ticket to Union Pacific Employee Benefits via the instructions provided in the Benefit Contacts section on page 110

You Must Give Notice of Some Qualifying Events:
For the other qualifying events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days of the date on which coverage would end under the Group Health Plan because of the qualifying event. You must provide this notice by submitting a ticket to Union Pacific Employee Benefits via the instructions provided in the Benefit Contacts section on page 110. When providing this notice, you must provide your name, employee identification number (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 Employee, Spouse or Dependent Child, or any person representing any of these individuals can provide this notification. Notification by the Employee, 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 Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B (or both), or Part D), your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA continuation coverage lasts for

up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension beyond an 18-month period of continuation coverage: If you or anyone in your family covered under the Group Health Plan is determined by the Social Security Administration/Railroad Retirement Board to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months.
Notice must be made in writing and addressed as follows:

Inspira Financial Health, Inc.
Attn: Benefit Billing Dept
P.O. Box 953374
St. Louis, MO 63195.

The notice can also be faxed to (402) 231-4302. The notice must be provided before the end of the 18-month period of continuation coverage and no later than 60 days after the latest of the following dates: (1) the date of the Social Security Administration/Railroad Retirement Board determination of the disability; (2) the date on which the qualifying event occurs that gives rise to your right to elect COBRA; or (3) the date on which coverage is lost as a result of the qualifying event. The notice must contain your name, account or Social Security number, and include a copy of the Social Security Administration/Railroad Retirement Board determination. The Employee, Spouse Dependent Child, or any person representing any of these individuals can provide this notice. Notification by the Employee, Spouse, or Dependent Child (or their representative) will satisfy this notice requirement with respect to all individuals who may extend continuation coverage because of this disability determination. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. During the additional 11 months of continuation coverage, the premium for that coverage will be approximately 50% higher than it was during the preceding 18 months.

The affected individual receiving extended continuation coverage because of a disability determination must also notify the Plan Administrator within 30 days of any final determination by the Social Security Administration / Railroad Retirement Board that the individual is no longer disabled. Notice must be made in writing and addressed as follows: Inspira FinancialHealth, Inc., Attn: Benefit Billing Dept, P.O. Box 953374, St. Louis, MO 63195. The notice can also be faxed to (402) 231-4302. The notice must contain your name, account or Social Security number, and include a copy of the Social Security/Railroad Retirement determination. The Employee, Spouse, Dependent Child, or any person representing any of these individuals can provide this notice.

Notification by the Employee, Spouse, or Dependent Child (or their representative) will satisfy this notice requirement with respect to all individuals who may lose continuation coverage because of the determination that the individual is no longer disabled.

Second qualifying event extension beyond an 18-month period of continuation coverage: If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Group Health Plan. This extension may be available to the Spouse and any Dependent Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A or Part B (or both)), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Group Health Plan had the first qualifying event not occurred. If you experience an event that permits you to extend continuation coverage, you must provide the Plan Administrator with written notice of the event. The notice must be sent within 60 days from the date continuation coverage would end under the Group Health Plan because of such other event and must be addressed as follows: Inspira Financial Health, Inc., Attn: Benefit Billing Dept., P.O. Box 953374, St. Louis, MO 63195. The notice can also be faxed to (402) 231-4302. The

Employee, Spouse, Dependent Child, or any person representing any of these individuals can provide this notice. Notification by the Employee, Spouse, or Dependent Child (or their representative) will satisfy this notice requirement with respect to all individuals who may extend continuation coverage because of the event. The notice must contain your name, account or Social Security number, and a description of the event, along with the following documentation, depending on the event:

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

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

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

1. The Employer no longer provides group health coverage for any of its employees;
2. The premium for your continuation coverage is not paid within 30 days of the date due;
3. 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;
4. You become entitled to Medicare benefits; or
5. You have the special extended disability continuation coverage and are determined to be no longer disabled by the Social Security Administration or by the Railroad Retirement Board.

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

In no event will COBRA continuation coverage last beyond three years from the date coverage was lost under the Group Health 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 Group Health 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 Group Health Plan and COBRA continuation coverage, you may contact:

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

If you are currently receiving COBRA continuation coverage and have questions about such coverage, please contact the Group Health Plans' COBRA Administrator:

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

HIPAA Special Enrollment Rights:
The passage of the Health Insurance Portability and Accountability Act of 1996, or HIPAA, provides special enrollment rights to participate in group health plans (see the "Life Event & Permissible Benefit Changes" section on pages 30-67 of the 2025 Flex Guide for more information).

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

Inspira Financial Health, Inc.
Attn: Benefit Billing Department
P.O. Box 953374
St. Louis, MO 63195-3374

If you have any questions about your current COBRA or USERRA continuation coverage, please contact Inspira Financial COBRA Services at (800) 359-3921. If you have additional benefits questions, contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110. If you have changed marital status or you or your Spouse have changed addresses while receiving continuation of benefits under COBRA or USERRA, you should notify Inspira Financial COBRA Services.

MEDICAL OPTION TYPES: AN OVERVIEW

The Plan offers Employees and Dependents the following types of medical program options:

- Preferred Provider Organizations ("PPOs") that are Non-High Deductible Health Plans ("HDHPs") underthe Internal Revenue Code; and
- PPOs that are HDHPs under the Internal Revenue Code

Note – only the Non-HDHP PPO medical option is available to: 1) Medicare-eligible Employees receiving long-term disability benefits under the STD/LTD Plan ("Medicare LTD Employees"); and 2) Domestic Partners of Employees.

All of these options are self-insured by Union Pacific. This means that Union Pacific, not an insurance company, pays for Covered Services that are incurred, subject to applicable Plan limits. Union Pacific contracts with third parties to provide for administrative services, claims processing, network access, and related medical benefit support services for its medical options. A brief overview of each plan type is presented below.

Preferred Provider Organization (PPO):
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. PPO medical options provide participants an incentive to use Preferred Providers (also known as Network Providers) by offering higher benefit levels whenever a Preferred Provider is used. 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), lower Coinsurance (the portion of the medical expense paid by you 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 amount of Deductibles and Coinsurance, as applicable, is described in the materials for each PPO option. The term Preferred Provider may also be referred to as a Network Provider or a Provider that is In-Network. Similarly, the term Non-Preferred Provider may also be referred to as a Non- Network Provider or a Provider that is Out-of-Network.

PPO members typically pay a monthly premium through a before-tax deduction under the Flexible Benefits Program. PPO Coverage for Medicare LTD Employees, Domestic Partners, and Employees withPPO coverage while on an unpaid leave of absence is paid on an after-tax basis. In addition, the member typically pays for Covered Services until a Deductible has been met. After the Deductible has been met, the member pays a percentage of costs (Coinsurance) until a Coinsurance Maximum has been met. Consult the documents of the particular PPO option for specific coverage and limitations. PPO providers have agreed to accept contracted payments for Covered Services as payments in full, except for any Deductible and Coinsurance amounts. 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 amounts have been paid and the amounts for which you are responsible. This notice is often called an Explanation of Benefits (EOB). If you use a provider that is Out-of-Network, you will likely need to file the claim with your medical option's claim administrator.

You can select the Doctors of your choice that are In-Network, and you do not need to select a Primary Care Physician (PCP) in order to receive benefits. However, 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 BlueCard 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.

High Deductible Health Plan (HDHP):

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. An individual covered by a HDHP may be eligible to contribute to a Health Savings Account (HSA).

MEDICAL COVERAGES: YOUR OPTIONS

Unless you are a Medicare LTD Employee, if you reside in a ZIP code area designated as a BCBS Network area, you will have the following medical options (administered by Quantum Health and Highmark BCBS) available to you:

- BCBS HDHP1

- BCBS HDHP2
- BCBS Non-HDHP PPO

If you are Medicare LTD Employee and reside in a ZIP code designated as a BCBS Network area, you will have the BCBS Non-HDHP PPO (administered by Quantum Health and BCBS) available to you.

The BCBS HDHP PPO options and the BCBS Non-HDHP PPO option are collectively referred to as the "BCBS Medical Options."

The BCBS Medical Options are offered based upon the residential ZIP code. All Employees have either the UHC Medical Options (within the UHC "Choice Plus" Network) or the BCBS Medical Options (within the BlueCard Network) available to them, but not both. The UHC Medical Options are described in the 2025 Flex Guide and the BCBS Medical Options are described in this document. You may also waive coverage. For more details, see the "UHC Medical Options: Components and Network Information" section on page 74 of 2025 Flex Guide.

In addition, in certain geographical locations you may be able to enroll in a Kaiser HMO. You may also waive coverage.

BCBS Medical Options:
The BCBS Medical Options are Preferred Provider Organization (PPO) arrangements, self-insured by Union Pacific. Union Pacific has contracted with Quantum Health and BCBS to administer the PPO Network and to administer claims and medical management services for medical benefits and mental healthcare benefits and substance use disorder treatment benefits. In order to carry out their specific responsibilities under the BCBS Medical Options, Quantum Health and BCBS have been granted discretionary authority to interpret terms of the BCBS Medical Options and to determine entitlement to plan benefits in accordance with the terms of these options. Generally, BCBS Medical Options benefits are offered through the BlueCard Network. In addition to medical benefits, BCBS Medical Options include mental healthcare and substance use disorder treatment benefits. To access the BCBS BlueCard Preferred Provider Directory list of Hospitals, Doctors, and other providers affiliated with the BlueCard Network, you may view online through the Quantum Health website at www.upquantumhealth.com or by calling Quantum Health at (855) 649-3855 for assistance. The BCBS Medical Options also include pharmacy benefits, which are administered separately from the BlueCard Network by OptumRx. The BCBS Medical Options are described in this document.

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

1. ***Medical Benefits*:** These benefits are self-insured by Union Pacific. Union Pacific has contracted with Quantum Health and Highmark BCBS to administer the BlueCard Network and to administer claims and medical management services. In order to carry out their specific responsibilities under BCBS Medical Options, Quantum Health and Highmark BCBS have been granted discretionary authority to make factual findings and interpret terms of the medical benefits portion of the Plan and to determine entitlement to Plan benefits in accordance with the terms of the Plan.
2. ***Mental Healthcare and Substance Use Disorder Treatment Benefits:*** These benefits are self-insured by Union Pacific and are administered by Quantum Health and BCBS. In order to carry out their specific responsibilities under BCBS Medical Options, Quantum Health and Highmark BCBS have been granted discretionary authority to interpret the terms of Mental Healthcare and Substance Use Disorder Treatment benefits portion of the Plan and to determine entitlement to Plan benefits in accordance with the terms of the Plan.
3. ***Pharmacy Benefits:*** These benefits are self-insured by Union Pacific and are administered by OptumRx. In this capacity, OptumRx has been granted discretionary authority to make factual findings and interpret the terms of the pharmacy benefits portion of the Plan and to determine entitlement to Plan benefits in accordance with the terms of the Plan. Although OptumRx administers the pharmacy benefits, Quantum Health serves as the primary point of contact for you and your covered Dependents to answer questions and provide information about your pharmacy benefits. For more information about pharmacy benefits, refer to the "Pharmacy Program" section on page 73 of this document.

PREFERRED PROVIDER NETWORK

The BCBS Medical Options offer health benefits through a PPO Network. Highmark BCBS is the contract administrator for these benefits. BCBS, including BCBS plans in other states, has contracted with a PPO network of Hospitals, Doctors and

other Healthcare Providers, each in their own geographical area. All BCBS plans participate in a national program called the BlueCard Program. Each plan has a network of providers who specifically have agreed to participate as a member of the BlueCard Program provider network. The providers in the BlueCard Program network will be referred to collectively in this document as "Preferred Providers."

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

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

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

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

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

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

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

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

The final choice of Healthcare Providers is yours. However, if you receive services from a Healthcare Provider included in the BCBS BlueCard Network, the Plan's Coinsurance may be increased, which may decrease the amount you must pay. The benefits are outlined in the Schedule of Benefits beginning on page 33.

The BCBS Medical Options allow the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in the BCBS BlueCard Network and who is available to accept you or your covered Dependent(s). For Children, you may designate a pediatrician as the primary care Provider. For information on how to select a primary care Provider, and for a list of the primary care Preferred Providers, contact Quantum Health at (855) 649-3855 or at Quantum Health at www.upquantumhealth.com.

You do not need prior authorization from a BCBS Medical Option in which you are enrolled or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the BCBS BlueCard Network who specializes obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Preferred Providers who specialize in obstetrics or gynecology, contact Quantum Health at (855) 649-3855 or access Quantum Health at www.upquantumhealth.com.

BLUECARD PROGRAM (NATIONAL)

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

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

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

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

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

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

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

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

PLAN FEATURES

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

Note: All Employees (other than Medicare LTD Employees) will have either the UHC Medical Options or the BCBS Medical Options (depending upon their residential ZIP code) available to them, but not both. If you are Medicare eligible and receiving benefits under the STD/LTD Plan, you will have either the UHC Non-HDHP PPO or the BCBS Non-HDHP PPO, depending on your residential ZIP code.

COST SHARING FEATURES OF THE BCBS MEDICAL OPTIONS

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

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

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

Deductible:
The Deductible is the amount you pay each year before expenses are paid by the Plan. Under each BCBS HDHP Option, there is a single Deductible for medical expenses (including mental healthcare and Substance Use Disorder Treatment) and pharmacy expenses. Under the BCBS Non-HDHP PPO, there is only a Deductible for medical expenses (including mental healthcare and Substance Use Disorder Treatment). The BCBS Non-HDHP PPO pays a portion of all expenses for Prescription Drug Products, which are those Prescription Drug Products on the Prescription Drug List. (See the "Pharmacy Program Definitions" on page 103 for the definition of "Prescription Drug Product" and Prescription Drug List").

If you are enrolled at an Employee + Dependent(s) Coverage level, each Covered Person must satisfy the Employee +

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

- The amounts you pay for contracted rates with a Preferred Provider for Covered Services (page 41) are applied against the Deductible. In situations in which you receive Covered Services from Non-Preferred Provider and the Balance Billing protections described on page 31 apply, your Deductible will be based on the amount the Plan would pay a Preferred Provider for the Covered Service. Otherwise, if a Non-Preferred Provider is used to receive Covered Services, only the amount you pay up to the Maximum Benefit Amount for Covered Services are applied against the Deductible.
- If you are enrolled in a BCBS HDHP Option, the amount paid at an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Deductible. If you obtain a Prescription Drug Product from an Out-of-Network Retail Pharmacy, only the amount you pay up to the Predominant Reimbursement Rate for a Prescription Drug Product on the Prescription Drug List are applied against the HDHP Deductible. Medications not listed on the Pharmacy Drug List are excluded from coverage.
- Amounts paid for over-the-counter drugs and dental or vision care Copayments do not count toward your Deductible.
- Each BCBS Medical Option has a higher Deductible to meet if Non-Preferred Providers are used and the Balance Billing protections do not apply to the Covered Service received. Any eligible expenses incurred will apply to either or both the In-Network and Out-of-Network Deductible amounts.

Specific Deductible features of each BCBS Medical Option are presented in the Schedule of Benefits, beginning on page 33.

Craft Professional Employee Transfers: If you transfer from a Union Pacific Craft Professional position to a Management position during a Calendar Year and elect coverage under any of the BCBS Medical Options, the amounts counted during the same Calendar Year against your Deductible under the Railroad Employees National Health and Welfare Plan may be credited toward your Deductible under the newly elected Management medical plan option. To initiate this process, you must contact Union Pacific Employee Benefits by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110.

Coinsurance Amount:

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

- The medical Coinsurance is a percentage of the contracted rate if a Preferred Provider is used. In situations in which you receive Covered Services from a Non-Preferred Provider and the Balance Billing protections described on page 31 apply, your medical Coinsurance will be based on the amount the Plan would pay a Preferred Provider for the Covered Health Service. Otherwise, if a Non-Preferred Provider is used, a lower percentage of the Maximum Benefit Amount for Covered Services applies. Medical Coinsurance payments are capped by the Annual HDHP Coinsurance Maximum.
- The pharmacy Coinsurance level depends on the Plan's Prescription Drug List. The member pays a small flat dollar amount for Tier-1 (typically Generic drugs), a percentage for Tier-2 (typically Preferred Brand-Name drugs), and a higher percentage for Tier-3 (typically Non-Preferred Brand Name drugs). The lesser of actual costs or a minimum pharmacy Coinsurance amount applies and for each Tier-2 and Tier-3 prescription or refill, a maximum pharmacy Coinsurance applies. In addition, the pharmacy Coinsurance is a portion of the Prescription Drug Cost if the prescription is dispensed by an In-Network Pharmacy. If an Out-of-Network Retail Pharmacy is used, the pharmacy Coinsurance is a portion of the Prescription Drug Product's Predominant Reimbursement Rate. Pharmacy Coinsurance Payments are capped by the Annual HDHP Coinsurance Maximum.

BCBS Non-HDHP PPO: After the Deductible is met, the BCBS Non-HDHP PPO pays a specified percentage of the Covered Services for the rest of the Calendar Year and you pay the remaining percentage. The medical Coinsurance is a percentage of the contracted rate if a Preferred Provider is used. In situations in which you receive Covered Services from a Non-Preferred Provider and the Balance Billing protections described on page 31 apply, your medical Coinsurance will be based on the amount the Plan would pay a Preferred Provider for the Covered Service. Otherwise, if a Non-Preferred Provider is used, a lower percentage of the Maximum Benefit Amount for Covered Services applies.
Medical Coinsurance payments are capped by the Annual Coinsurance Maximum.

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

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

Specific medical Coinsurance features of each BCBS Medical Option are presented in the Schedule of Benefits, beginning on page 33.

Specific pharmacy Coinsurance levels, minimum and maximum costs, and Annual out-of-pocket limit features are presented in the Schedule of Benefits beginning on page 33.

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

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

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

Specific Coinsurance Maximum features of each BCBS Medical Option are presented in the Schedule of Benefits, beginning on page 33.

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

Use of Preferred Providers:
The Plan offers a broad network of providers and provides the highest level of benefits when Covered Persons utilize Preferred Providers. These networks will be indicated on your Plan identification card. Specific benefit levels are shown in the Schedule of Benefits beginning on page 33.

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

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

If an eligible Dependent does not reside with the Employee, his/her residence is deemed to be the same as the Employee's residence. **To qualify for coverage of Out-of-Network expenses at the In-Network benefit level, the participant must contact Quantum Health at (855) 649-3855 BEFORE services are rendered** to verify that the Non- Preferred Provider Doctor/specialist qualifies for coverage at the network level and to facilitate the appropriate payment of applicable claim(s).

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

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

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

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

You are never required to give up your protections from balance billing. You also aren't required to get care

Out-of- Network. You can choose a provider or facility in the BCBS PPO Network.

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

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

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

Overall Maximum Benefit:
Except as otherwise indicated in the "Covered Services" section beginning on page 41, there is no overall maximum benefit for essential Covered Services.

Note: Additional limitations that apply to specific benefits are described throughout this document.

PLAN BENEFITS OFFERED

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

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

2025 SCHEDULE OF BENEFITS						
HEALTHCARE						
	BCBS HDHP1		**BCBS HDHP2**		**BCBS Non-HDHP PPO**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible						
Employee Only	$3,300	$6,600	$4,800	$9,600	$750	$1,500
Employee + Dependent(s) Coverage						
- Per Person	$3,300	$6,600	$4,800	$9,600	$750	$1,500
- Annual Maximum	$6,600	$13,200	$9,600	$19,200	$1,500	$3,000
HSA+* MAXIMUM COMPANY CONTRIBUTIONS						
Employee Only	$900		$900		N/A	
Employee + Spouse	$1,800		$1,800		N/A	
Employee + Child(ren)	$1,800		$1,800		N/A	
Employee + Family	$2,700		$2,700		N/A	
Medical Coinsurance After Deductible						
Plan Pays	85%	65%	85%	65%	85%	65%
Employee Pays	15%	35%	15%	35%	15%	35%
Coinsurance Maximum (Annual Limit after Deductible)						
Employee Only	$2,000	$4,000	$1,500	$3,000	$2,750	$5,500
Employee + Dependent(s) Coverage						
- Per Person	$2,000	$4,000	$1,500	$3,000	$2,750	$5,500
- Annual Maximum	$4,000	$8,000	$3,000	$6,000	$5,500	$11,000
Preventive Care (As outlined under "Health Management Programs" and "Preventive Pharmacy Benefits")	Paid at 100%	No benefits are paid for an Out-of-Network Provider	Paid at 100%	No benefits are paid for an Out-of-Network Provider	Paid at 100%	No benefits are paid for an Out-of-Network Provider
Maximum Lifetime Benefit	Unlimited, except as otherwise indicated in the "Covered Services" section beginning on page 41.					

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

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

OUT-OF-POCKET MAXIMUM						
Annual Deductible and Coinsurance Maximum	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Employee Only	$5,300	$10,600	$6,300	$12,600	$3,500	$7,000
Employee + Dependents(s) Coverage						
- Per Person	$5,300	$10,600	$6,300	$12,600	$3,500	$7,000
- Annual Maximum	$10,600	$21,200	$12,600	$25,200	$7,000	$14,000

CARE COORDINATION PROCESS

Introduction

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

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

Process of Care Requirements

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

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

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

Designated Coordinating Physician

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

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

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

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

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

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

- ***Prior Authorization of Certain Procedures***

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

The following services require Prior Authorization, provided it is not an Emergency*:
- Inpatient and Skilled Nursing Facility Admissions
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy and radiation therapy)
- Genetic Testing
- Home Health Care
- Hospice Care
- DME – all rentals and any purchase over $1500
- Organ, Tissue and Bone Marrow Transplants
- Dialysis
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Abuse

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

***Penalties for Not Obtaining Prior Authorization*:**

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL PROVISIONS FOR CARE COORDINATION

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

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

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

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

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

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

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

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

Care Coordinators: 1-855-649-3855

MEDICAL AND MENTAL HEALTHCARE COVERED SERVICES

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

This Plan does not claim to cover all medical expenses that you may incur. To be covered by the Plan, the Claims Administrator must determine that the services and supplies are Medically Necessary, and given for the diagnosis or treatment of an accidental Injury or Illness. (See, "Medical Claims & Appeals" beginning on page 62, which explains the types of claims for which either Quantum Health or Highmark BCBS serves as the "Claims Administrator.") These requirements apply whether or not you receive services or supplies from Preferred or Non-Preferred Providers.

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

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

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

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

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

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

Custodial Care:
The Plan does not provide benefits for services and supplies that are furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a Healthcare Provider. An Alternate Facility may also provide Mental Healthcare or Substance Use Disorder Services on an Outpatient basis or Inpatient basis (for example a Residential Treatment Facility).

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

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Doctor and approved by the Mental Healthcare/Substance Use Disorder Administrator;
- a nurse is available 24/7
- 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 by a licensed physician;
    - counseling; and
    - referral and orientation to specialized community resources.

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

***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.

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

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

Newborns' and Mothers' Health Protection Act of 1996:
In accordance with the Newborns' and Mothers' Health Protection Act (NMHPA), enacted on September 26, 1996, group health plans and health insurance issuers 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 vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours after vaginal delivery or 96 hours after a cesarean section. In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the Plan or insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act of 1998:
The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. If you or your Dependent receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, coverage will be provided for:

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

in a manner determined in consultation with the attending Physician and the patient. Such coverage is subject to Annual Deductibles, Coinsurance provisions and other provisions that are applicable to other benefits of the Plan.

COVERED SERVICES

Benefits paid for the Covered Services shown in the chart below depend on the BCBS Medical Option in which you are enrolled and the In-Network status of the provider. What you pay and what the Plan pays is described in more detail in the "Schedule of Benefits" beginning on page 33.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Acupuncture	Acupuncture services provided in an office setting by a provider who is practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body: Doctor of Medicine, Doctor of Osteopathy, Chiropractor, or Acupuncturist. Limited to 20 visits per year.	Acupuncture services by a non- qualified provider or in excess of 20 visits per year.
Allergy Care	Testing in a Doctor's office and treatment (including injection administered by a Nurse).	
Ambulance Services	**Emergency Only:** Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. **Non-Emergency:** Local transportation by professional ambulance, other than air ambulance, to and from a medical facility. Longer distance transportation by ambulance or air ambulance, to the nearest medical facility qualified to give the required treatment where Medically Necessary. **Air Ambulance:** 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.	Air ambulance benefits in excess of a $25,000 maximum per occurrence will not be paid.
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 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 rental or purchase cost of one breast pump in conjunction with childbirth.	Benefits are only available if obtained by a DME provider with an accompanying prescription from your Doctor.
Breast Reconstruction	Breast reconstruction required as a result of a mastectomy. **Special Notice Regarding Mastectomies:** If you or your Dependent receives a mastectomy, the covered benefits for the patient also include coverage for: a) all stages of reconstruction of the breast on which the mastectomy has been performed, b) Surgery and reconstruction of the other breast to produce a symmetrical appearance, c) prostheses including mastectomy bras and lymphedema stockings for the arm, d) treatment of physical complications in all stages of mastectomy, including lymphedemas, e) replacement of an existing breast implant if the initial breast implant followed mastectomy, and f) other services required by the Women's Health and Cancer Rights Act of 1998, including breast treatment of complications. Benefits payable will be determined in a manner in consultation with the attending Doctor and patient. Such coverage is subject to Annual Deductibles, Coinsurance, and other provisions that are applicable to other benefits of the BCBS Medical Options.	Breast Reconstruction, other than in conjunction with a mastectomy, that does not meet the criteria established through the Prior Authorization process.
Breast Reduction	Breast reduction Surgery is a Covered Service with documentation of the following functional impairments: 1) Shoulder grooving or excoriation resulting from the brassiere shoulder straps, due to the weight of the breasts; AND 2) Documentation from medical records of medical services related to complaints of the shoulder, neck or back pain attributable to macromastia. In addition, the Surgery must be determined not to be cosmetic 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 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 Services	The following cosmetic procedures are covered, provided Notification is received and the procedure has been determined to be reconstructive rather than cosmetic:	Cosmetic 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. Accident/Injury must have occurred while coverage is in effect. Dental treatment is covered only if needed because of accidental Injury to natural teeth. Services must be: • Provided by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). • As a result of damage that is severe enough that the initial contact with the Doctor or dentist occurred within 72 hours of the Accident. Benefits are available only for treatment of sound, natural teeth. The dentist must certify that the Injury to the tooth was a virgin or unrestored tooth; has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally during chewing and speech. Services for final treatment to repair the damage must be completed within 12 months of the Accident.	Dental services that are not a result of an Accident. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of teeth.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Diabetic Supplies	Diabetic supplies including syringes, test strips, lancets and Omnipod 5 devices/supplies are covered under the Pharmacy Program. Insulin pump (excluding Omnipod 5) and Glucose Monitors are covered under Durable Medical Equipment.	
Dialysis	See Therapeutics - Outpatient	
Disposable Medical Supplies	Must be prescribed by Doctor, including ostomy supplies.	Non-prescribed supplies.
Durable Medical Equipment	Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Doctor for Outpatient use; • Used for medical purposes • Not consumable or disposable; and • 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 orthopedic device and is not covered under the DME benefit, except for cranial banding. Dental braces are also excluded from coverage. Air conditioners, humidifiers, dehumidifiers, air purifiers, and filters are not covered. All rentals or purchases of any DME expense over $1,500 is subject to the Prior Authorization requirements.
Emergency Health Services (i.e. Emergency Room)	A true emergency is paid at the In-Network level regardless of the network status of the facility that provides the emergency health services. A true emergency is defined as a serious medical condition or symptom resulting from Injury, sickness or mental Illness which arises suddenly, and in the judgment of a reasonable person requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health. Notification should be provided to a Quantum Health Coordinator within 24 hours of the first business day after receiving Emergency care and a subsequent and corresponding Hospital admittance.	
Enteral Nutrition	Defined as the delivery of nutrients in liquid form directly into the stomach, duodenum, or jejunum and used when the patient's condition precludes oral intake. Enteral nutrition is covered when it is the sole source of nutrition or when a certain nutritional formula treats inborn error of metabolism.	
Family Planning	See Reproductive Services.	

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Gender Dysphoria	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.
Hearing Aids and Related Services	Diagnostic testing, audiometric examination and the purchase/fitting/adjustments of hearing aid devices, when prescribed by a professional provider. **Limits:** Hearing aids – one (1) pair every three (3) Calendar Years Dollar Limit - $5,000 every three (3) Calendar Years	
Home Healthcare	Services received from a Home Healthcare Agency that are both ordered by a Doctor and provided by or supervised by a registered Nurse in your home. Benefits are available only when the Home Healthcare Agency services are provided on a part-time, intermittent schedule and when skilled home healthcare is required. Skilled home healthcare is skilled nursing, skilled teaching, and skilled rehabilitation services when the care: 1) Is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient; 2) Is ordered by the Doctor; 3) Is not delivered for the purpose of assisting with the activities of daily living; 4) Requires clinical training in order to be delivered safely and effectively; and 5) Is not Custodial Care. The Claims Administrator will decide if skilled home healthcare is required by reviewing both the skilled nature of the service and the need for Doctor-directed medical management. Limited to any combination of 40 In-Network and Out-of-Network visits per Calendar Year.	Custodial Care or care for the purpose of assisting with the activities of daily living, including (but not limited to) dressing, feeding, bathing, or transferring from a bed to a chair, are not covered. A service will not be determined to be "skilled" simply because there is not an available caregiver.

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

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Hospital – Inpatient Stay	Benefits available for services and supplies (including room and board) received during the Inpatient stay in a semi-private room (two or more beds). Private rooms are covered up to the highest semi-private room rate for that facility, except that the extra costs of a private room can be covered: 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; 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 Services chart, below.	
Laboratory Services	Laboratory tests for diagnosis or treatment are covered expenses.	
Maternity Care	See Reproductive Services.	
Medical Supplies	Surgical supplies (such as bandages and dressings). Supplies provided during Surgery or a diagnostic procedure is included in the overall cost for that Surgery or diagnostic procedure. Blood or blood derivatives only if not donated or replaced. Ostomy supplies.	
Mental Healthcare Benefits	Mental Healthcare Services include those received on an Inpatient or Intermediate Care basis in a Hospital or Alternate Facility, and those received on an Outpatient basis in a provider's office or at an Alternate Facility. Benefits for Mental Healthcare Services include: • Mental health evaluations and assessment; • Diagnosis; • Treatment planning; • Referral services; • Medication management; • Inpatient services; • Partial Hospitalization/Day Treatment; • Intensive Outpatient treatment; • Services at a Residential Treatment Facility; • Individual, family and group therapeutic services; • Crisis intervention; • Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses; and • 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: 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; 3) When a private room must be used to keep the patient isolated because of the patient's diagnosis. You are encouraged to contact Quantum Health for referrals to providers and coordination of care. Mental Healthcare services and supplies are subject to Deductibles and Coinsurance as presented in the **Schedule of Benefits on page 33**.	• 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 or tall ship programs or 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 disorders; and • Attention-deficit hyperactivity disorder

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Neurobiological Disorders - Mental Healthcare Services for Autism Spectrum Disorders	The Plan pays for 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 Service for which benefits are available under the applicable medical Covered 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 • psychotherapy, consultation and training session for parents and paraprofessional and resource support to family; and • crisis intervention. You are encouraged to contact Quantum Health for referrals to providers and coordination of care. Neurobiological Disorders – Mental Healthcare Services for Autism Spectrum Disorder services and supplies are subject to Deductibles and Coinsurance as presented in the **Schedule of Benefits on page 33.**	• 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 disorders; and • Attention-deficit hyperactivity disorder
Nutritional Counseling	Covered Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • 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.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Obesity Surgery	See Surgery.	
Organ/Tissue Transplants	Services and supplies for organ or tissue transplants are covered subject to the following limitations. **Donor Charges for Organ/Tissue Transplants:** Donor charges are considered covered expenses ONLY if the recipient is a Covered Person under the 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 Service unless the search is made in connection with a transplant procedure arranged by a designated transplant facility. (See **Transplant Management Program page 61** for additional covered benefits for certain qualified transplant procedures).	
Orthognathic Surgery	See Surgery.	
Outpatient Therapy	Short-term Outpatient rehabilitation services (including habilitation 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. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. The therapy must be ordered and monitored by a Doctor as part of a Medically Necessary course of treatment for a bodily Injury or disease. The therapy must be provided in accordance with a written treatment plan approved by a Doctor. Benefits for speech therapy are available only when the speech impediment or speech dysfunction results from Injury, stroke, a congenital anomaly or if such therapy is considered "habilitative services." Habilitative services are healthcare services that help a Covered Person keep, learn or improve skills and functioning for daily living. Additional visits beyond the 30 visit limit may be available if Medically Necessary.	The 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.
Physician Services	Medical care and treatment by a Doctor including Hospital, office and home visits, and Emergency room services. Covered 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 Services		
Type of Service	**What's Covered**	**What's Not Covered**
Physical Therapy	See Outpatient Therapy.	
Prescribed Drugs and Medicines	Prescribed drugs and medicines for Inpatient services are covered under the medical plan provisions.	
Preventive Care	See Preventive Care under "Health Management Programs" on page 60.	
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 • 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 Therapy	See Cardiac and Pulmonary Rehabilitation Therapy.	
RAPL (Radiology, Anesthesiology, Pathology and Lab)	Services performed by radiologists, anesthesiologists, pathologists, and laboratory.	
Reconstructive Surgery	See Surgery.	
Reproductive Services	**Abortion Services:** Termination of pregnancy; surgically or non-surgically or drug induced Services for the care and treatment of spontaneous abortions (miscarriage). Must meet current federal and state guidelines.	
Reproductive Services Reproductive Services	**Family Planning:** Norplant, diaphragms, IUDs and Depo-Provera are covered under the medical plan provisions. When Reproductive Services are billed as a preventive care service, these services will be paid as described under Preventive Care.	Oral contraceptives are not covered under this medical program but are covered under the Pharmacy Program.
	Fertility: Covered Assisted Reproductive Technology (ART) Treatment services for Covered Members are listed below, including confinement in a Hospital or specialized facility in connection with treatments. • Intrauterine insemination (IUI) • In vitro fertilization (IVF), • Artificial insemination (AI), • The use of donor ovum and donor sperm related costs, including collection and preparation, • Embryo transfer, • Gamete intrafallopian transfer (GIFT), • Zygote intrafallopian transfer (ZIFT), • Tubal ovum transfer (TOT), • Surgery, and • Injectable-drug-therapy administered within the Doctors office. • Expenses for embryo cryopreservation and short-term temporary storage are covered for IVF, AI, GIFT and ZIFT. • Male factor infertility related services, excluding reversal of sterilization.	Injectable drug therapy that is self-administered is not covered under this medical program but is covered under the Pharmacy Program. (See "Pharmacy") Freezing or storage of embryo, eggs, or semen (including, but not limited to, oocyte cryopreservation) beyond one year is not covered by the Medical Care Program. The Medical Care Program will not pay for any fertility services provided to an individual who is not a Covered Person. Reversal of sterilization.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Reproductive Services (cont.)	**Maternity Care:** Benefits for pregnancy will be paid at the same level as benefits for any other condition, sickness or Injury, unless the services are considered to be preventive services, which are payable at 100% of In-Network covered expenses. This includes all maternity- related medical services for prenatal care, postnatal care, delivery, and any related complications.	
	The 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 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: a) Be for convalescent care; b) 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 c) Be for the same or related conditions as the Hospital stay.	
Sleep Disorders	See Surgery for sleep apnea surgery. See Laboratory Services for sleep studies.	
Speech Therapy	See Outpatient Therapy.	
Sterilization	See Reproductive Services.	

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Substance Use Disorder Treatment	Substance Use Disorder Services include those received on an Inpatient or Intermediate Care 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 Use Disorder Services include: • Substance use disorder 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; • individual, family and group therapeutic services and; • crisis intervention. Quantum Health 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; 3) When a private room must be used to keep the patient isolated because of the patient's diagnosis. You are encouraged to contact Quantum Health for referrals to providers and coordination of care. • Substance Use Disorder Treatment services and supplies are subject to Deductibles and Coinsurance as presented in the Schedule of Benefits on page 33.	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 disorders; and • Attention-deficit hyperactivity disorder
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.	

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (cont.)	**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. • 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.	Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure.
	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: a) All stages of reconstruction of the breast on which the mastectomy has been performed; b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; c) prostheses including mastectomy bras and lymphedema stockings for the arm; d) treatment of physical complications in all stages of mastectomy, including lymphedemas, e) replacement of an existing breast implant if the initial breast implant followed mastectomy, and f) other services required by the Women's Health and Cancer Rights Act of 1998, including breast treatment of complications, Such coverage is subject to Annual Deductibles, Coinsurance, and other provisions applicable to the other benefits of the BCBS Medical Options.	
	Assistant Surgeon Services: Covered expenses for assistant surgeon services are limited to one-fifth (20%) of the amount of covered expenses for the surgeon's charge for the Surgery. An assistant surgeon must be a Doctor.	
	Second Surgical Opinion Program: This voluntary program applies when a Doctor recommends that you or a covered Dependent undergo any elective or non-emergency surgical procedure. You may voluntarily obtain a Second Surgical Opinion for any non-emergency surgical procedure. The purpose of the Second Surgical Opinion is advisory only. It is the patient's decision whether or not to undergo the Surgery. Benefits for the Second Surgical Opinion are subject to the cost sharing features of the 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 following are not covered by the Second Surgical Opinion Program: • An opinion on a surgical procedure that would not be covered under the BCBS Medical Options. • Any charges in connection with a surgical procedure, if they are payable under other provisions of the BCBS Medical Options. • 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.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility)	**Second Surgical Opinion Program:** The Doctor who gives the second opinion must: a) Be qualified to render an opinion on the specific surgical procedure in question, and b) Examine you in person.	
	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:
	  • Inability to incise solid foods; or choking on incompletely masticated solid foods; or
	  • Damage to soft tissue during mastication; or
	  • Speech impediment determined to be due to the jaw deformity; or
	  • Malnutrition and weight loss due to inadequate intake secondary to the jaw deformity.
	•
		Orthognathic Surgery is not covered for the following symptoms:
		• Myofacial, neck, head and shoulder pain.
		• Irritation of head/neck muscles.
		• Popping/clicking of Temporo Mandibular Joint(s).
		• Potetential for development or exacerbation of Temporo Mandibular Joint dysfunction.
		• Teeth grinding.
		• Treatment of malocclusion.

Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility)	**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.

Covered Services		
Type of Service	**What's Covered**	**What's Not Covered**
Therapeutics Outpatient	Covered 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 • MR-guided focused ultrasound Benefits include the charges for the facility, related supplies and equipment, and Physician services for anesthesiologists, pathologists and radiologists. Covered 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 • There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.	
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 if the patient is not in the Hospital. When a Child is the patient, two persons may accompany the Child. • Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the provider's facility. • Taxi fares/standard Uber and Lyft rider (not including limos or car services). • Economy or coach airfare only • Parking • Trains • Boats • Bus • Tolls	• Alcoholic beverages • Groceries • Meals • Over-the-counter dressings or medical supplies • Personal or cleaning supplies • Phone calls, newspapers, movie rentals • Utilities and furniture rental, when billed separate from the rent payment • Deposits
Transplants	See Organ/Tissue Transplants.	

ADDITIONAL EXCLUSIONS

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

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

The services, treatments, items, or supplies listed in this section are not Covered Services, except as may be specifically provided for in the "Covered Services" section beginning on page 41 of this document. Note also the exclusions stated in the "Covered Services" section under the column headed "What's Not Covered."

Additional Exclusions	
Type of Service	**What's Not Covered**
Alternative Treatments	• Acupressure. • Aromatherapy. • Hypnotism. • Massage therapy. • Rolfing. • Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
Comfort or Convenience	• Television. • Telephone. • Beauty/barber service. • Guest service. • Supplies, equipment, and similar incidental services and supplies for personal comfort (i.e., air conditioners, air purifiers and filters, batteries and battery charges, dehumidifiers, humidifiers). • Devices and computers to assist in communication and speech. • Home remodeling to accommodate a health need, such as (but not limited to) ramps and swimming pools.
Cosmetic Services	• All cosmetic services, except those described under "Covered Services" on page 43 of this document.
Dental under the Medical Plans	• Dental care, except as described under "Covered Services" on page 43 of this document. • Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums (i.e., extraction, restoration and replacement of teeth, medical or surgical treatments of dental conditions, services to improve dental clinical outcomes). • Dental implants. • Dental braces. • Dental x-rays, supplies and appliances, and all associated expenses, including Hospitalizations and anesthesia. The only exceptions to this are for transplant preparation, initiation of immunosuppressives or the direct treatment of acute traumatic Injury, cancer, or cleft palate; in which case, the treatment and required anesthesia to perform the treatment are Covered Services. • Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
Drugs under the Medical Plans	• Prescription drug products for Outpatient use that are filled by a Prescription Order or Refill. • Self-injectable medications. • Non-injectable medications provided in a Doctor's office, except as required in an Emergency. • Over-the-counter drugs and treatments. • Coordination of Benefits as a secondary payment for Prescription Drugs purchased through a non-Union Pacific Health Plan.
Experimental, Investigational, or Unproven Services	• Experimental, Investigational, or unproven services are excluded. The fact that an Experimental, Investigational, or unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental, Investigational, or unproven in the treatment of that particular

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

Additional Exclusions	
Type of Service	**What's Not Covered**
Nutrition	• Megavitamin and nutrition based therapy. • Except as described under "Covered Services" on page 44 enteral feedings and other nutritional and electrolyte supplements (including infant formula and donor breast milk – infant formula available over the counter is always excluded), dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat/cholesterol), oral vitamins, and oral minerals except when the sole source of nutrition. **Note:** Limited nutritional counseling services are covered as described under "Covered Services" on page 48.
Physical Appearance	• Cosmetic procedures including, but not limited to: o Pharmacological regimens, nutritional procedures, or treatments. o Scar or tattoo removal or revision procedures (such as salabrasion, chemoSurgery, and other such skin abrasion procedures). o Skin abrasion procedures performed as a treatment for acne. • Physical conditioning program (such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation). • Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. • Wigs regardless of the reason for the hair loss, except for loss of hair resulting from treatment of a malignancy, hair loss due to alopecia or similar conditions, or permanent loss of hair from an accidental Injury.
Providers	• Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Doctor or other provider. Services which are self-directed to a freestanding or Hospital-based diagnostic facility. Services (excluding mammography testing) ordered by a Doctor or other provider who is an Employee or representative of a free-standing or Hospital-based diagnostic facility, when that Doctor or other provider: o Has not been actively involved in your medical care prior to ordering the service, or o Is not actively involved in your medical care after the service is received. • Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent, or Child. This includes any service the provider may perform on himself or herself. • Services performed by a provider with your same legal residence. • Services of a provider or facility beyond the scope of their medical license.
Services provided under Another Plan	• Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes (but is not limited to) coverage required by Workers' Compensation, no-fault auto insurance, or similar legislation. If coverage under Workers' Compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any Injury, sickness, or mental Illness that would have been covered under Worker's Compensation or similar legislation had that coverage been elected. (Note: Medical services, that are Covered Services, provided to treat an on-duty Injury, where the company is not at fault and no FELA claim will be filed, will be allowed to be paid by the Plan.) • Health services for treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you. • Health services while on active military duty.
Transplants	• Health services for organ and tissue transplants, except those described under the "Transplant Management Program" on page 61. • Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (donor costs for removal are not a Covered Service under the Plan). • Health services for transplants involving mechanical or animal organs. • Any solid organ transplant that is performed as a treatment for cancer. • Any multiple organ transplants not listed as a Covered Service.
Vision	• Purchase cost of eyeglasses or contact lenses. (See the "Vision Care Program" section on page 159 of the 2025 Flex Guide for a description of the vision plan. • Fitting charge for eyeglasses or contact lenses. • Surgery that is intended to allow you to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, radial keratotomy, laser, and other refractive eye Surgery.

Additional Exclusions	
Type of Service	**What's Not Covered**
All Other Exclusions	• Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing. • Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply, or equipment. • Any charges for services, supplies, or equipment advertised by the provider as free. • Any charges by a provider sanctioned under a federal program for reason of fraud, abuse, or medical competency. • Any charges prohibited by federal anti-kickback or self-referral statutes. • Any charges by a resident in a teaching Hospital where a faculty Doctor did not supervise services. • Any additional charges submitted after payment has been made and your account balance is zero. • Any Outpatient facility charge in excess of payable amounts under Medicare. • Appliances for snoring. • Breast reduction Surgery, except as described under "Covered Services" on page 42. • Charges in excess of eligible expenses or in excess of any specified limitation. • Custodial Care or care for the purpose of assisting with the activities of daily living, including (but not limited to) dressing, feeding, bathing, or transferring from a bed to a chair. • Domiciliary care. • Growth hormone therapy. • Health services and supplies that do not meet the definition of a Covered Service. • Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends. • Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. • Health services provided by an Out-of-Network Provider for which the Annual Deductible and/or Coinsurance are waived. • Health services and supplies received due to Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) for which the individual is charged or a felony for which the individual is charged; • Health services and supplies which are illegal in the jurisdiction in which the Health Services are received • Private Duty Nursing. • Non-prescribed disposable medical supplies; • Non-surgical treatment of obesity, including morbid obesity; • Orthognathic Surgery, jaw alignment, and treatment for the Temporo Mandibular Joint, except what is described in the "Covered Services" section on page 54 of this document. • Orthoptic therapy services for the treatment of convergence insufficiency or any other purpose. • Orthotic appliances that straighten or re-shape a body part, except as described under Durable Medical Equipment. Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. • Outpatient rehabilitation services, spinal treatment, or supplies including (but not limited to) Spinal Manipulations by a chiropractor or other Doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. • Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments that are otherwise covered under the Plan when: o Related to judicial or administrative proceedings or orders; o Conducted for purposes of medical research; or o Required to obtain or maintain a license of any type. • Psycho-Surgery. • Respite care. • Rest cures. • Services or supplies received before you become covered under this Plan. • Speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a congenital anomaly, or if such therapy is considered "habilitative services." Habilitative services are healthcare services that help a Covered Person keep, learn or improve skills and functioning for daily living.

HEALTH MANAGEMENT PROGRAMS

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

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

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

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

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

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

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

Benefits for the Preventive Services outlined above will be paid at 100% in accordance with the Schedule of Benefits on page 33.

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

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

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

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

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

For all BCBS Medical Options: If you are enrolled in a BCBS Medical Option and a Qualified Procedure (listed below) is performed at an In-Network facility, the Covered Services provided in connection with the transplant procedure are covered at 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/Stem Cell transplants;
- Cornea, when performed in a Hospital setting.

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

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

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

CONTACTING QUANTUM HEALTH FOR ASSISTANCE

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

UPQUANTUMHEALTH.COM – QUANTUM HEALTH'S MEMBER WEBSITE

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

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

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

- Confirm eligibility, specific benefits, Deductible, Coinsurance.
- Review claims status and claims history.
- Compare fees for common 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 & APPEALS

Internal Claim and Process:
This section provides information about how and when to file a BCBS Medical Option claim for benefits, describes the 4 types of medical claims, and establishes which entity (either Quantum Health or Highmark BCBS) has the discretionary authority to decide your claim or your appeal of a denied claim.

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

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

Decisions will be made in accordance with the terms of the Plan (including without limitation its provisions limiting benefits to services and supplies that are Medically Necessary), and any applicable internal practices or guidelines that are maintained by Quantum Health or Highmark BCBS. Quantum Health or Highmark BCBS 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 Highmark BCBS, 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 through Highmark BCBS.

Your Explanation of Benefits Statement:
When you submit a claim, you will receive an Explanation of Benefits (EOB) statement that lists:
- the provider's actual charge;
- the allowable amount as determined by Highmark BCBS;
- the Copayment, Deductible and Coinsurance amounts, if any, that you are required to pay;
- total benefits payable; and
- the total amount you owe.

In those instances where you are not required to submit a claim because, for example, the In-Network Provider will submit the bill as a claim for payment under its contract with Highmark BCBS, you will receive an EOB only when you are required to pay amounts other than your required Copayment. If you do not have access to a computer or prefer to continue receiving printed EOBs, please notify Quantum Health by calling the number on the back of your ID card.

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

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

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

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

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

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

Highmark BCBS is the Claims Administrator of all Post-Service claims.

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

Filing a Post-Service claim is simple. Just take the following steps:
Know Your benefits. Review this information to see if the services you received are eligible under the Plan. Get an Itemized Bill. Itemized bills must include:

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

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

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

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

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

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

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

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

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

After receiving the request for care, Quantum Health:

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

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

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

Benefit Determinations Involving Non-Urgent Pre-Service Claims:

You will receive written notice of any decision on a request for Pre-Service Claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Quantum Health receives your claim. However, this 15-day period of time may be extended one time by Quantum Health for an additional 15 days, provided that Quantum Health determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 15-day Pre-Service Claim determination period. If an extension of time is necessary because you failed to submit information necessary for Quantum Health to make a decision on your Pre-Service Claim, the notice of extension that is sent to you will specifically

describe the information that you must submit. In this event, you will have at least 45 days in which to submit the information before a decision is made on your Pre-Service Claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Except as described in the section, "Your Options if the Internal Claim and Appeal Process Is Not Followed" on page 90 you must first exhaust all appeals available to you under the BCBS Medical Care Program – both internal and external – before you have a right to bring a civil action under ERISA regarding your denied claim.

MEDICAL APPEALS PROCEDURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

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

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

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

Second Level Review:
If you are dissatisfied with the decision following the initial review of your appeal (other than the review of an Urgent Care claim), you may request to have the decision reviewed by Quantum Health. Except as described in the section, "Your Options if the Internal Claim and Appeal Process Is Not Followed" on page 90, you **must** submit a second level appeal of your Post-Service Claim in order to preserve your rights to external review or to bring a civil action under ERISA concerning the Plan's denial of your claim. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 45 days from the date of an adverse benefit determination.

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

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

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

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

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

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

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

- When the appeal involves a Post-Service Claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal.

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

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

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

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

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

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

There are two types of external reviews available:

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

You have four months from the date you receive notice of a final Quantum Health adverse benefit determination to file a request for an external review with Quantum Health. Note that for Pre-Service Claims, the four month period begins to

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

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

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

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

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

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

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

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

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

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

The IRO's notice will inform you of:

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

assistance or ombudsman established under Section 2793 of the Public Health Service Act.

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

Expedited External Review (Applies to Urgent Care Claims Only):
You are entitled to the same procedural rights to an external review as described above on an expedited basis:

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

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

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

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

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

COORDINATION OF BENEFITS

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

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

Here is how the coordination of benefits provision works:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your plan.
- When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first.

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

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

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

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

OVERVIEW

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

Whomever you elect to cover under a BCBS Medical Option is considered a "Covered Person" for purposes of the Pharmacy Program section of this document. You can find the meaning of other capitalized terms found in this Section in the "Pharmacy Program Definitions" on page 102 and in the "Medical Care Program Definitions" Section on page 95 of this document.

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

Member Identification (ID) Card – In-Network Pharmacy:

You must either present your Member OptumRx 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 ID card through the Quantum Health website or app. Quantum Health provides care coordination services for the UHC Medical Options, including prescription drug benefits.

If you do not present your Member OptumRx ID Card or provide verifiable information at an In-Network Pharmacy, you will be required to pay the amount charged by the pharmacy for the Prescription Drug Product at the pharmacy. You may seek reimbursement as described in the "How to File Pharmacy Claims" section on page 86. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility at the time the Prescription Drug Product was dispensed. The amount of the reimbursement will be based on the Prescription Drug Cost, less any HDHP Deductible (if enrolled in a BCBS HDHP Option) or Pharmacy Coinsurance Payment that applies.

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

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

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

WHAT'S COVERED

The Plan pays benefits for Outpatient Prescription Drug Products given to a Covered Person according to the provisions described below (see "Discretionary Mail Order Program", "Mandatory Mail Order Program," "Specialty Pharmacy Services,"

and “Pharmacy Benefit Payment Information” sections). Refer to “What's Not Covered - Exclusions” on page 84 for exclusions.

Prescribed drugs and medicines for Inpatient services are covered as medical expenses under the BCBS Medical Option provisions. The BCBS Medical Option provisions also apply to Outpatient prescription drugs that are administered in a Doctor’s office or other licensed Outpatient setting, unless the drugs are specifically excluded from the BCBS Medical Options under “Additional Exclusions” on page 56. These drugs and medicines eligible for payment under the BCBS Medical Options’ provisions then are not payable under the Pharmacy provisions. Likewise, the drugs and medicines eligible under the Pharmacy provisions then are not payable under the 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 Service (see page 41) or to prevent conception;
- The prescription is not Experimental, Investigational, or unproven; and
- Determined by OptumRx to be Medically Necessary.

Supply Limits:

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

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

Prior Authorization:
OptumRx uses a series of reviews when processing certain prescriptions known collectively as “prior authorization.”

Benefits may not be available for the Prescription Drug Product after OptumRx reviews the documentation provided if OptumRx determines that the Prescription Drug Product is not prescribed to treat a Covered Health Service or it is experimental, investigational, or unproven. You may appeal this determination as described in the “Pharmacy Claim Questions and Appeals” section on page 87.

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

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

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

If your prescription exceeds the limit and you are using an In-Network Retail Pharmacy or the OptumRx Mail Order Pharmacy Service, your Doctor or pharmacist will be notified of the quantity covered under a single prescription; which is generally, for Retail for up to 31 days or for mail order up to 90 days. 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 theprescription.
- 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.

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 86.

When you submit a claim on this basis, the amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from an In-Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from an Out-of-Network Retail Pharmacy), less any remaining HDHP Deductible (if enrolled in a BCBS HDHP Option) and/or your required Pharmacy Coinsurance Payment, if any. The OptumRx contracted pharmacy reimbursement rates (the OptumRx Prescription Drug Cost) will not be available to you at an Out-of-Network Retail Pharmacy.

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

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

SPECIALTY PHARMACY SERVICES

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

www.upquantumhealth.com. If you have a new prescription for a Prescription Drug Product that must be filled by a Specialty Pharmacy, you must contact the Specialty Pharmacy to process the prescription. If you present a specialty prescription to a retail pharmacy, the retail pharmacy will receive a message from OptumRx that includes a Specialty Pharmacy's phone number.

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

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

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

Benefits for the Specialty Pharmacy drugs are payable, following the "Schedule of Benefits" on page 33 entitled "Prescription Drugs from Retail or Specialty Pharmacy."

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

- Inflammatory conditions
- Transplant
- Multiple sclerosis

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

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

MANDATORY MAIL ORDER PROGRAM

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

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

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

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

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

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

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

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

DISCRETIONARY MAIL ORDER PROGRAM

A Mail Order Pharmacy Service option is available for your convenience. If you are enrolled in a BCBS HDHP Option and you have not yet met your HDHP Deductible, you will pay 100% of the Prescription Drug Cost for the Prescription Drug Product. Refer to "Pharmacy Benefit Payment Information - Deductible" below. If you are enrolled in the Non- HDHP BCBS PPO, or a BCBS HDHP Option and have met your HDHP Deductible, you must pay for the Prescription Drug Product according to the three-tier Coinsurance structure shown in the table for "Prescription Drugs from Mail Order Pharmacy" on page 79. 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:

For the BCBS HDHP Options: You are responsible for paying the cost of covered pharmacy and covered medical services until the HDHP Deductible is met, before pharmacy benefits are payable under the Plan. (For more information on the HDHP Deductible, see the "Schedule of Benefits" on page 33). The In-Network HDHP Deductibles, including family limits, are listed in the following table.

- The amounts you pay for contracted rates with an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Deductible. If an Out-of-Network Retail Pharmacy is used, only the amounts you pay up to the Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Deductible. Prescription Drug Products provided by an Out-of-Network Retail Pharmacy will apply towards the In-Network deductible.
- The amounts you pay for contracted rates with a Preferred Provider for Covered Services are also applied against the HDHP Deductible. If a Non-Preferred Provider is used to receive Covered Services, only the Maximum Benefit Amount for Covered Services is applied against the HDHP Deductible.

HDHP DEDUCTIBLE	
In-Network	
BCBS HDHP1	Employee Only Coverage: $3,300 per Calendar Year. Employee + Dependent(s) Coverage: $3,300 per Covered Person per Calendar Year, not to exceed $6,600 for all Covered Persons in a family.
BCBS HDHP2	Employee Only Coverage: $4,800 per Calendar Year. Employee + Dependent(s) Coverage: $4,800 per Covered Person per Calendar Year, not to exceed $9,600 for all Covered Persons in a family.

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

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

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

For the BCBS HDHP1 and BCBS HDHP2 Options: After the HDHP Deductible is met, you are responsible for paying the applicable Pharmacy Coinsurance Payment, up to the HDHP Coinsurance Maximum (described in the following Payment Information Schedule), when Prescription Drug Products on the OptumRx Prescription Drug List are obtained from a Retail Pharmacy, Mail Order Pharmacy 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.

- 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.
- The amounts you pay for contracted rates with a Preferred Provider for Covered Services are also applied against the HDHP Coinsurance Maximum. If a Non-Preferred Provider is used to receive Covered Services, only the Maximum Benefit Amount for Covered Services is applied against the HDHP Coinsurance Maximum.

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

contracted rates (the OptumRx Prescription Drug Cost) will not be available to you.

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

PAYMENT INFORMATION SCHEDULE		
Payment Term	**Description**	**Amounts**
Pharmacy Coinsurance Payment (applies to all BCBS Medical Options)	Pharmacy Coinsurance Payments for a Prescription Drug Product at an In-Network Pharmacy are a portion of the Prescription Drug Cost. Pharmacy Coinsurance Payments for a Prescription Drug Product at an Out-of-Network Retail Pharmacy are a portion of the Predominant Reimbursement Rate. Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned a Prescription Drug Product. **NOTE:** The tier status of a Prescription Drug Product can change periodically, generally on January 1st and July 1st, based on the Pharmacy and Therapeutics Committee's periodic tiering decisions. When that occurs, your Pharmacy Coinsurance Payment may change. If there is a tier change which increases your Pharmacy 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 a Retail In-Network Pharmacy, you are responsible for paying the lower of: • The applicable Pharmacy Coinsurance Payment; or • The Prescription Drug Cost for that Prescription Drug Product. See the Pharmacy Coinsurance Payment description in the table on page 82.

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

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

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

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

Certain other Prescription Drug Products not categorized as preventive care under the PPACA, but considered preventive care for other purposes under federal law also are available to members at no charge and are not subject to deductible or coinsurance provisions of the Plan, if such Prescription Drug Products are received from an In-Network Pharmacy The list of these Prescription Drug Products can be found at www.upquantumhealth.com and is subject to OptumRx's periodic review and modification. Generally speaking, these Prescription Drug Products are prescribed to treat certain chronic conditions, or to prevent either the exacerbation of the chronic condition or the development of a secondary condition.

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

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

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

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

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

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

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits	**BCBS Medical Options Your Pharmacy Coinsurance Payment Amount**
In-Network Retail or Specialty Pharmacy Benefits are provided for Outpatient Prescription Drug Products dispensed by an In-Network Retail Pharmacy or a Specialty Pharmacy as written by the provider up to a consecutive 31-day supply (or a 30-day supply if provided by a Specialty Pharmacy) of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, based on supply limits or as described under the "SmartFill Programs" section of this guide. Certain Generics may also be dispensed by an In-Network Retail Pharmacy up to a 90-day supply.	Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please go to Quantum Health at www.upquantumhealth.com or call Quantum Health at (855) 649-3855 to determine tier status. • $10 for a Tier-1 Prescription Drug Product (or cost of drug, if less). • 30% of the Prescription Drug Cost for a Tier-2 Prescription Drug Product. • 40% of the Prescription Drug Cost for a Tier-3 Prescription Drug Product. Each In-Network Retail or Specialty Pharmacy Prescription Order or Refill for Tiers 2 and 3 above is subject to a per- prescription minimum Pharmacy Coinsurance Payment and a per prescription Pharmacy Coinsurance Maximum payment. Note – if your Specialty Pharmacy medication is filled under the "SmartFill Program": • 15-day supply cost = ½ a 30-day supply • 90-day supply cost = 3x a 30-day supply COVERED AT NO COST (Deductible and Coinsurance do not apply): • Prescription Drug Products that are preventive as described under the "Preventive Pharmacy Benefits" section on page 80. NOT COVERED: • Mandatory Mail Order (MMO) drugs filled at a Retail Pharmacy after the 2-fill transition period; or • Specialty Pharmacy drugs, including self-injectable infertility drugs, filled at a Retail Pharmacy.

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

PRESCRIPTION DRUGS FROM MAIL ORDER PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits	**BCBS Medical Options Your Pharmacy Coinsurance Payment Amount**
In-Network Mail Order Pharmacy Benefits are provided for Outpatient Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy as written by the provider up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. **Out of Network Mail Order Pharmacy** Prescription Drug Products dispensed by an Out-of-Network Mail Order Pharmacy will not be covered by the Plan	Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, or Tier-3. Please go to Quantum Health at www.upquantumhealth.com or call Quantum Health at (855) 649-3855 to determine tier status. • $25 for a Tier-1 Prescription Drug Product (or cost of drug, ifless). • 25% of the Prescription Drug Cost for a Tier-2 Prescription Drug Product. • 40% of the Prescription Drug Cost for a Tier-3 Prescription Drug Product. Each Mail Order Prescription Order or Refill for Tiers 2 and 3 above is subject to a per prescription minimum Pharmacy Coinsurance Payment and a per prescription Maximum Pharmacy Coinsurance Payment. COVERED AT NO COST (Deductible and Coinsurance do not apply): • Prescription Drug Products that are preventive as described under the "Preventive Pharmacy Benefits" section on page 80.
Per Prescription Coinsurance Minimums and Maximums from an In-Network Mail Order Pharmacy Each Tier 2 and 3 Prescription Order or Refill purchased through the Mail Order Pharmacy is subject to the per prescription Pharmacy Coinsurance Minimum and Pharmacy Coinsurance Maximums described here, unless you have reached the Coinsurance Maximum.	**In-Network Mail Order Pharmacy** Tier 1 – NA Tier 2 - $75 Minimum*/$225 Maximum Tier 3 - $150 Minimum*/$375 Maximum *or cost of drug, if less

WHAT'S NOT COVERED - EXCLUSIONS

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

- Any product dispensed for the purpose of appetite suppression and other weight loss products.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) exceeding the supply limit.
- Prescription Drug Products that are prescribed, dispensed, or intended for use while you are an Inpatient (e.g., patient at a Hospital, Skilled Nursing Facility, etc.).
- Medications used for Experimental indications and/or dosage regimens determined by OptumRx to be Experimental, Investigational, or unproven.
- Prescription Drug Products which OptumRx has determined are not Medically Necessary.
- Prescription Drug Products for which the prescription is more than one year old.
- Prescription Drug Products furnished by the local, state, or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state, or federal government (e.g., Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products that are subject to the Mandatory Mail Order Program when dispensed at a Retail Pharmacy following the two prescription transition period (unless you meet the conditions to opt-out of the MMO program with respect to a specific Prescription Drug Product and have elected to do so).

- Prescription Drug Products that are subject to the Specialty Pharmacy Program when dispensed at a Retail Pharmacy (i.e., not dispensed through a Specialty Pharmacy).
- Prescription Drug Products that are subject to the Progression Rx Step Therapy Program and for which you have not satisfied the program requirements to use a different Prescription Drug Product first.
- Prescription Drug Products for any condition, Injury, sickness, or mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws (e.g., Federal Employers' Liability Act or "FELA"), whether or not a claim for such benefits is made or payment or benefits are received. (Note, Prescription Drug Products prescribed to treat an on-duty Injury, where the company is not at fault and no FELA claim will be filed, will be allowed to be paid by the Plan, subject to the terms, conditions and other exclusions of the Plan.)
- A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by OptumRx, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an Outpatient setting. These medications may be covered under the Medical Care Program. This exclusion does not apply to Depo-Provera and other injectable drugs used for contraception;
- Durable Medical Equipment, prescribed and non-prescribed Outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered (see "Prescription Drug List" definition on page 103. Certain Durable Medical Equipment may be covered under the BCBS Medical Options.
- Coordination of benefits on Prescription Drug Products, including prescriptions 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 purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be on the Prescription Drug List.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken, or destroyed.
- Glucose monitors.
- Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
- Drugs available over the counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the- counter drug. Prescription Drug.
- Products that are comprised of components which are available in over- the- counter form or equivalent, unless such drugs available over the counter qualify to be covered as Preventive Care under PPACA.
- New Prescription Drug Products and/or new dosage forms that have not yet been reviewed by the Pharmacy and Therapeutics Committee until the date they are reviewed and assigned to a tier.
- Prescription Drug Products to the extent that benefits for such products are provided under this Plan or under any other plan to which the Employer sponsors or contributes.
- Injectable drugs that must be administered by a licensed healthcare professional; which, if covered, would be paid under the Medical Plan provisions. This exclusion does not apply to certain insulin or self- administered injectables that are covered by the Plan and can be injected subcutaneously. The list of drugs which are considered "self-administered injectables" is determined by OptumRx. To verify if an injectable drug is considered a self-administered injectable, go to Quantum Health at www.upquantumhealth.com or call Quantum Health at (855) 649-3855.
- Prescribed devices or supplies of any type, including colostomy supplies or contraceptive devices and supplies. (Oral contraceptives on the OptumRx Prescription Drug List are covered under the Pharmacy Program).
- Progesterone suppositories.
- Over-the-counter drugs or products not approved by the U.S. Food and Drug Administration.
- A Prescription Drug Product requested to be filled by the In-Network Mail Order Pharmacy for which an original Prescription Order or Refill is not submitted to the In-Network Mail Order Pharmacy. A Prescription Order or Refill provided to another pharmacy cannot be transferred to the In-Network Mail Order Pharmacy.

HOW TO FILE PHARMACY CLAIMS

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

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

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

Also, nothing in the above paragraph is intended to prohibit a Covered Person from designating another person (including, in the case of an Urgent Care claim or appeal, a health care professional with knowledge of the Covered Person's medical condition) to serve as the Covered Person's authorized representative with respect to any claim or appeal filed in accordance with Pharmacy Program procedures.

OptumRx will not reimburse third parties who have purchased or have been assigned benefits by a Doctor, pharmacist or other provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

Except as described in the section, "Your Options if the Internal Claim and Appeal Process Is Not Followed" on page 90, you must first exhaust all appeals available to you under the Plan – both internal and external – before you have a right to bring a civil action under ERISA regarding your denied claim. See the section, "Pharmacy Claim Questions and Appeals," immediately below for information regarding your appeal rights.

PHARMACY CLAIM QUESTIONS AND APPEALS

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

This appeal process will ordinarily apply to determinations as to your eligibility for Pharmacy Program coverage only if they are part of a claim for actual benefits. However, if your coverage is discontinued retroactively for reasons other than the failure to make your contributions on time, you may file an appeal that contests the retroactivity of the termination of coverage. Such an appeal should be filed with the Plan Administrator, not with UHC/OptumRx.

How to Submit a Non-Urgent Care Claim Decision for Internal Review:
To initiate a request for an internal review of a non-Urgent Care claim denial, you or your Doctor must provide in writing, your name, member ID, Doctor's name and phone number, the Prescription Drug Product for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. This information must be mailed to:
OptumRx Attn: Appeals Request
OptumRx c\o Appeals Coordinator CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

Internal Appeal Determinations – Non-Urgent Care Claims:
OptumRx will review your first level appeal, and a decision regarding your appeal will be sent to you within a reasonable period of time, but not later than 30 days of receipt of your written request. If your appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the Prescription Drug Product has not been approved for that use, 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 decision, a second level appeal. You must submit a second level appeal in order to preserve your rights to external review or to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") concerning the Plan's denial of your claim. To initiate a second level appeal, you or your Doctor must provide in writing, your name, member ID, Doctor's name and phone number, the Prescription Drug Product for which benefit coverage has been denied, a statement of each and every reason why you believe your claim should be approved, and any additional information that may be relevant to your second level appeal. This information must be mailed to:

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

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

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

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

date of service, the Provider, and the appeal amount, if applicable). The notice will refer to the part of the Plan on which the denial is based and explain and discuss the reason for denial, including the denial code, if any, and its corresponding meaning, as well as a description of OptumRx's standard, if any, that was used in denying your appeal (e.g., if your appeal was denied because the Prescription Drug Product has not been approved for that use, or is Experimental 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. The notice will include the following:

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

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

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

Your appeal of an Urgent Care claim must identify each and every reason why you believe your claim should be approved. Appeals of Urgent Care claims are reviewed by OptumRx. In the case of an urgent appeal for coverage involving Urgent Care, you will be notified of the benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours of receipt of the claim. The decision of OptumRx of an Urgent Care appeal is the Plan's Final Internal Adverse Benefit Determination.

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, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and at no charge, the information used to review your appeal.

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

Pharmacy Internal 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. The person who will perform the internal review of your appeal denial will not be the same person as the person who made the initial decision to deny your claim nor a subordinate of the person who denied your claim. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. If the initial denial is based in whole or in part on a medical judgment, OptumRx will consult with a healthcare professional with appropriate training and experience in the relevant medical field. This healthcare professional

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

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

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

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

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

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

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

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

There are two types of external reviews available:

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

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

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

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

Standard External Review: A standard external review is comprised of all of the following:

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

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

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

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

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

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO additional information for the IRO's consideration when conducting the external review. Your information must be submitted within 10 business days after you receive the IRO's notice. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days. Generally speaking, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in making its decision:

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by OptumRx. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45

days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and OptumRx, which will include the clinical basis for the determination and any other information as required by applicable law.

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

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

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

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

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

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

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

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

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

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

OTHER DISCLOSURES

Discretionary Authority of Plan Administrator and Other Fiduciaries:

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other plan fiduciaries including Quantum Health, BCBS and OptumRx, shall have discretionary authority to determine facts, interpret and administer the terms of the BCBS Medical Options and to determine eligibility for and entitlement to BCBS Medical Option benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

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 and then recover its payments from out of the funds the Covered Person receives through any award from or settlement with the third party, the third party's insurer, or any other source (e.g., uninsured/underinsured motorist coverage). By filing a claim for benefits under the Plan, the Covered Person (or that person's legal representative) is agreeing to promptly pay back to the Plan out of any such funds recovered from the third party, the third party's insurer, or any other source (for example, funds recovered in a lawsuit, a settlement, an arbitration or a payment from the third party's insurance company, or uninsured/underinsured motorist coverage) the claims paid by the Plan.

Subrogation: To the extent that a Covered Person is entitled to receive any recovery from a third party who caused or contributed to a sickness or Injury as a result of an intentional act or negligence, the third party's insurer, or any other source (for example, funds recovered in a lawsuit, a settlement, an arbitration, payment from the third party's insurance company, or uninsured/underinsured motorist coverage), the Plan has a right to funds obtained as a result of that recovery to the extent of the claims the Plan has paid. This right comes first (prior to any claim by any other party against the recovery) even if the Covered Person has not been compensated for all of his/her injuries and even if the recovery is described as being for other than medical expenses (for example, pain and suffering or emotional distress). This right is not dependent upon the third party admitting responsibility, and is not dependent upon the execution of an agreement by the Covered Person (or that person's legal representative) to the right of recovery. The Plan shall automatically have a lien against the proceeds of any such recovery to the extent of the claims it has paid.

"Subrogation" refers to the Plan's right to seek payment and/or reimbursement from a person or organization responsible, or potentially responsible, for the Plan's payment of health care expenses you incurred in connection with an Injury. The Plan also has the right to seek payment and/or reimbursement from you if you receive a payment, settlement, judgment or award from a person, organization or insurance company in connection with an Injury caused or alleged to be caused by the person or organization. The Plan has this right regardless of whether:

- liability is admitted by any potentially responsible person or organization;
- the payment, settlement, judgment or award you received identifies medical benefits provided by the Plan; or
- the payment, settlement, judgment or award is otherwise designated as "pain and suffering" or "non- economic damages" only.

The Plan shall have a first priority lien on the proceeds of any payment, settlement or award you receive in connection with an Injury caused by a person or organization. The lien shall be in the amount of benefits paid on your behalf regardless of whether you are made-whole for your loss or because you have incurred attorney fees or costs. The Plan will provide eligible benefits when needed, but you may be asked to show, execute and/or deliver documents, or take other necessary actions to support the Plan in any subrogation efforts. Neither you nor any of your Dependents shall do anything to prejudice the right given to the Plan by this Subrogation section without the Plan's consent. Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your Dependents, or when enforcing this provision is prohibited by an applicable state or federal law.

By filing a claim under the Plan, you are accepting the terms of this subrogation provision. If you pursue a recovery from a responsible third party, you must immediately give written notice to Highmark BCBS (for medical, mental healthcare/substance use disorder or prescription drug benefits). You must do nothing to prejudice a right of recovery, such as accept a settlement that is less than the reasonable value of the claim. The Plan is not responsible for any share of attorney fees incurred in pursuing or obtaining any recovery or settlement.

If a Covered Person does not seek recovery from a third party, the Plan may proceed in the name of the Covered Person against the third party.

MEDICAID

Benefits paid on behalf of a covered Employee or Dependent will be made in accordance with any assignment of rights made by or on behalf of such Employee or Dependent that is required under a state's Medicaid law. The Plan will not take into account an Employee's or Dependent's eligibility 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 an Employee 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 Employee or Dependent to such payment for benefits.

REFUND FOR OVERPAYMENT OF BENEFITS

Highmark BCBS and OptumRx has the right to a refund of any Medical, Mental Healthcare/ Substance Use Disorder or Prescription Benefit they paid to you if you or your Dependents or Domestic Partner did not pay for those expenses or if you or your Dependents or Domestic Partner were reimbursed for any of those expenses by a source other than Highmark BCBS or OptumRx. The refund is the difference between the amount of benefits actually paid and the amount that should have been paid. 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, Highmark BCBS 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 issued to your Employer by the amount of the refund.

MEDICAL CARE PROGRAM DEFINITIONS

(See also "Pharmacy Program Definitions" beginning on page 102).

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

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

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

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

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

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

The Birthing Center must provide:

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

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

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

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

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

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

The following costs will never apply to the Coinsurance Maximum:

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

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

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

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

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

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

Deductible: The cost of covered medical services (and pharmacy expenses) you are responsible for paying before healthcare benefits (and/or pharmacy benefits) are payable for all or some healthcare services and pharmacy expenses. No prescription drug Deductible applies under the Non-HDHP PPO Option. For more information regarding the Pharmacy benefit Deductible, see "Pharmacy Benefit Payment Information", beginning on page 78.

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

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

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

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

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

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

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

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

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

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

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

Diagnostic criteria for adults and adolescents:

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

Diagnostic criteria for children:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).

- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
- A strong dislike of ones' sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

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

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

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

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

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

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

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

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

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

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

Maximum Benefit Amount: A maximum amount determined by BCBS or a BlueCard Program On-site Plan to be reasonable for Covered Services. The Maximum Benefit Amount will be the amount agreed upon between BCBS and BluePreferred and Preferred Providers of the Covered Service, or the maximum amount agreed upon by the On-site and it contracting providers. If the provider does not participate with BCBS then the Maximum Benefit Amount may be a negotiated amount. In the event the negotiations with a Non-Preferred Provider are unsuccessful, then the Maximum

Benefit Amount will be based on pricing determined by a national database or at the out-of-network rate under the No Surprises Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan Sponsor: Union Pacific Corporation.

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

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

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

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

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

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

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

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

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

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

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

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

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

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Doctor and approved by the

Mental Healthcare/Substance Use Disorder Administrator;

- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full- time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured environment:
- room and board;
- evaluation and diagnosis;
- counseling; and
- referral and orientation to specialized community resources.

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

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

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

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

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

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

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

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

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

PHARMACY PROGRAM DEFINITIONS

(See also Medical Care Program Definitions in the Glossary section beginning on page 95.)

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

Coinsurance Maximum: The maximum amount you are required to pay for Covered Medical Services and/or Covered Prescription Drug Products on the OptumRx Prescription Drug List in a single Calendar Year. For more information, see "Pharmacy Benefit Payment Information", beginning on page 78.

Deductible: The cost of covered pharmacy (and covered medical services) you are responsible for paying before pharmacy benefits (and/or medical benefits) are payable under the Plan. No prescription drug Deductible applies under the Non-HDHP PPO Option. For more information, see "Pharmacy Benefit Payment Information", beginning on page 78.

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

In-Network Pharmacy: A pharmacy that has:

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

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

Medically Necessary: Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, 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 use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your Doctor or other Health Care Provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms/

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. 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.

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.upquantumhealth.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 ofnutrition).

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.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability & Accountability Act of 1996 (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 BCBS Medical Options described in this document and offered as part of the Union Pacific Corporation Group Health Plan (the "Group Health Plan"). 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: The Group Health Plan's HMOs and the insurance carrier for the Vision Care Program under the Group Health Plan are responsible for complying with HIPAA's privacy rules with respect to the Protected Health Information they create, maintain, or receive. These benefit programs are fully insured. The HMOs and the Vision Care Program insurance carrier are identified in the "Important Plan Information" and the "Benefit Contact" sections, beginning on pages 251 and 257 respectively, of the 2025 Flex Guide. Enrollees in an HMO or the Vision Care Program under the Group Health Plan should see the Privacy Notice provided by the HMO or the Vision Care Program insurer for more information about their obligations and your rights under the HIPAA privacy rules.

For benefits that are self-insured by Union Pacific, the Group Health Plan is responsible for complying with HIPAA's privacy rules with respect to the Protected Health Information that the Group Health Plan creates, maintains, or receives. The self-insured benefits under the Group Health Plan offered to Employees and their Dependents consist of the Dental Care Program, the UHC Medical Options and the BCBS Medical Options and the Pharmacy Program.

Availability of Notice of Privacy Practices: The Group Health Plan, with respect to the 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:

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

If you wish to receive the Notice of Privacy Practices adopted for the Vision Care Program under the Group Health Plan, contact the insurance carrier of that benefit. Enrollees in an HMO must contact the HMO to request a copy of the HMO's Notice of Privacy Practices.

Except as otherwise provided, the remainder of this HIPAA section applies only to the self-insured benefits under the Group Health Plan. For the remainder of this HIPAA section, the Group Health Plan is referred to as the "Plan."

Permitted and Required Uses and Disclosure of Protected Health Information:

The Plan may disclose Protected Health Information to Union Pacific only if one of the following applies:

1. The 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 Plan discloses information to Union Pacific that is, for purposes of HIPAA's privacy rule, enrollment or disenrollment information;
3. The 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 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 Plan receives a signed certification from Union Pacific that the 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 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 Plan in accordance with the Plan document.

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

a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.
b. Ensure that any agents to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to Union Pacific with respect to Protected Health Information.
c. 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.
d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
e. Make available to a Plan participant who requests access, the Plan participant's Protected Health Information in accordance with the HIPAA regulations.
f. Make available to a 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.
g. Make available to a 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.
h. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA regulations.
i. If feasible, return or destroy all Protected Health Information received from the 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.
j. Ensure that the adequate separation between the Plan and Union Pacific required in the HIPAA regulations is satisfied.

Adequate Separation between 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 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 Plan administrative functions that Union Pacific performs for the 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 Plan's Privacy Office:

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

Definitions:
For purposes of this HIPAA 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 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 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:

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

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

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Introduction: The Plan is covered by provisions of 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 to 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 the Plan described in this document, together with the information in the 2025 Flex Guide and the information on the various HMOs in which you are eligible to enroll, constitute the Summary Plan Description under ERISA for the Union Pacific Corporation Group Health Plan.

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

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

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

Plan Administrator: The Plan Administrator of the Plan is the Senior Vice President & Chief HR Officer, Union Pacific Railroad Company. The Plan Administrator administers the plans 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
Telephone: (402) 544-5000

The 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 by submitting a ticket via the instructions provided in the Benefit Contacts section on page 110, with any questions.

Your ERISA Rights:
As a participant in the Union Pacific benefits program, you are entitled to 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 plans, including insurance contracts and a copy of the latest annual reports (Form 5500 Series) filed by the plans 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 plans, 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 an applicable 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 plan and any other documents governing the plan on the rules regarding your COBRA continuation coverage rights.

Maternity and Newborn Infant Coverage:
For those medical program options that provide maternity or newborn infant coverage, those programs 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:
For those medical program options that cover mastectomies, 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 Doctor 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 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 plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or 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 it should happen that 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
Telephone: (402) 544-5000

Future of the Plan:
While Union Pacific intends to continue the Plan indefinitely, it reserves the right to terminate or amend the Plan for any reason. If the Company terminates or amends the Plan, benefits under the Plan would cease or change. The Company may also increase the required Employee contributions at any time. Similarly, a participating employer can take such actions with respect to its Employees. 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 determine facts, to interpret the terms of the Plan, and to determine entitlements to benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect unless it can be shown that the interpretation 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: For important Plan information, including employer identification number, contract information, and Plan number and Plan Year for the Plan, see the "Important Plan Information" section of the 2025 Flex Guide.

Technically, the Plan is known as a welfare plan.

Benefit Contacts

Quantum Health – for UHC and BCBS Medical Options (including OptumRx pharmacy benefits) available Monday-Friday, 7:30 a.m. to 9:00 p.m. CST

- Care Coordinator/Customer Service…….. (855) 649-3855
- Website Quantum Health……. www.upquantumhealth.com
  - Request Medical ID cards, answer claim/billing/benefit questions, find in-network providers, manage a health condition, save money on out-of-pocket costs, understand how to get the most out of your benefits

Union Pacific Employee Benefits

To submit a ticket:

- Employees with access to the UP network can submit a ticket by navigating to the Workforce Resources webpage and clicking "Create a ticket for Workforce Resources"
  - https://home.www.uprr.com/emp/it/oss/secure/tckt/tckt_dtl.cfm?action=add&sys_id=WR
- Employees without access to the UP network can submit a ticket by navigating to UP.com and selecting Employees > Retirees and Families Site > Benefits > Healthcare > Submit Healthcare Benefits Questions
  - https://www.uprr.com/hrm/hrsc-submit-inquiry/index.html#/benefits/create

Union Pacific Workforce Resources — 9:00 a.m. to 5:00 p.m. (CT)

Toll-Free ..... (877) 275-8747
UP Network 8-544-4000
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
- Educational Assistance
- Dependent Care Flexible Spending Account
- Pension
- Service Awards/Retirement Awards

Health Savings Account (HSA) Contributions (HealthEquity)

- Website……https://my.healthequity.com/ClientLogin.aspx
  - FAQs, HSA calculator, check account balance/transaction information
- Customer Service .....(877) 750-1445

Health Maintenance Organization (HMO)

- Kaiser Colorado..... (800) 632-9700
- Kaiser Northwest..... (800) 813-2000
- Kaiser Northern California ..... (800) 464-4000
- Kaiser Southern California ..... (800) 464-4000

Vision Care (EyeMed)

- Website/Provider Directory.....www.eyemed.com
- Member Services..... (866) 723-0513
  - Questions or help locating a participating provider: Contract #9891003 (Active population); #9891011 (COBRA); #1029447 (Domestic Partner)

Dental Care Benefits (Metropolitan Life)

- Website/Provider Directory.....www.metlife.com/dental
- Member Services..... (888) 777-6806 option 1
  - Locate a participating provider, questions about dental benefits or claims, Group #37625

Dependent Care Flexible Spending Account (Inspira Financial)

- Website……..…www.inspirafinancial.com
  - Set up direct deposit, access account balance/information, submit claims online
- Customer Service ..... (844) 729-3539
- Fax number for submitting claims..... (402) 231-4310

Life Insurance (Metropolitan Life)

- Website..... www.metlife.com/mybenefits
  - Enroll in benefits, update dependents and beneficiaries
- Member Services..... (866) 659-1377

Short and Long-Term Disability, claims beginning on or after 1/1/2008 (Metropolitan Life)

- Website..... www.metlife.com/mybenefits
  - Submit claims online, check claim status
- Customer Service ..... (888) 777-6806 option 2

Fertility and Family Building (Maven)

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

Weight, Diabetes, and Health Management (Dario)

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

Family First

- Member Services……877-585-7090
  - Available 8am – 8pm ET