



**2021
BlueCross/ BlueShield
Retiree Medical Guide**

Medical Benefits
Available to Union Pacific
Retirees and their
Dependents effective
January 1, 2021

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

SUMMARY PLAN DESCRIPTION **January 1, 2021**

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

The benefits described herein are covered by provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA) – a federal law that governs the operation of employee benefit plans. It is important to understand some of the provisions of this law since they could affect you. This booklet is a covered person's Summary Plan Description for purposes of ERISA. A description of ERISA provisions is found in the ERISA section at the end of this booklet beginning on page 163. This Summary Plan Description does not create a contract of employment.

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INTRODUCTION

This 2021 BlueCross/BlueShield (BCBS) Retiree Medical Guide (the “Guide”) describes the healthcare benefits available to certain Union Pacific retirees and their Dependents through the Union Pacific Retiree Medical Program (“Plan” or “Retiree Medical Program”), and reflects the Retiree Medical Program provisions in effect January 1, 2021 for those residing in a BlueCard Network area.

Technically, the Retiree Medical Program is part of the Union Pacific Corporation Group Health Plan (the “Group Health Plan”), but Retiree Medical Program benefits are offered only to Union Pacific retirees (and their Dependents) who satisfy the Retiree Medical Program’s eligibility requirements. Consequently, the Retiree Medical Program is intended to be a ‘retiree only’ plan described in section 732(a) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) and section 9831(a) of the Internal Revenue Code of 1986, as amended (the “Code”) as a plan that, as of January 1, 2021, has less than 2 participants who are current employees. Included are eligibility information, available benefits, limitations and restrictions you should be aware of, and information regarding how to claim your benefits.

It is important to note that the benefits provided are covered by provisions of ERISA, a federal law which governs the operation of employee benefit plans. ERISA requires that you receive an easily understood description of your benefits (a “Summary Plan Description”). The Summary Plan Description for the Retiree Medical Program consists of this document, together with the 2021 UHC Retiree Medical Guide, Retiree HRA Guide and the documents pertaining to the medical programs offered to certain retirees of Alton & Southern Railroad (whose benefit rights under the Plan are described in those documents).

This document, together with the 2021 UHC Retiree Medical Guide, Retiree HRA Guide and the documents pertaining to the medical programs provided to certain retirees of Alton & Southern Railroad, also serve as the official plan document and will help you understand your benefits, as well as your rights under the Plan and ERISA. For more information concerning your ERISA rights, see the ERISA section of this document.

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

Note that the terms “you” and “your” throughout this Guide refer to the retiree and all Dependents covered under the Plan, except where otherwise indicated. The “Glossary” section beginning on page 174 is an important reference tool designed to help you

understand how the Plan works. Also, you will find definitions of other terms in the various sections of this Guide.

PLAN PARTICIPATION

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

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

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

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

- Your original hire date with: (i) Union Pacific Corporation; or (ii) any Union Pacific Corporation affiliate that was a participating Employer in the Flexible Benefits Program on December 31, 2003, was before January 1, 2004;
- You terminate employment with Union Pacific and participate in the Union Pacific Corporation Flexible Benefits Program immediately before you terminate employment;
- You do not elect COBRA continuation coverage with respect to your active employee medical coverage under the Group Health Plan (or your surviving Spouse did not elect COBRA coverage, if such active employee medical coverage terminated because of your death); and
- Upon termination of employment you are at least age 65, or at least age 55 with 10 years of vesting service. For this purpose, vesting service is calculated by applying the rules for “Vesting Service” under the Pension Plan for Salaried Employees of Union Pacific Corporation and Affiliates (“UPC Pension Plan”), regardless of whether you were ever a participant in the UPC Pension Plan.

Union Pacific will determine whether you satisfy 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.

Medicare Part A and Part B are considered the primary coverage for retirees, Spouses and Dependents age 65 and above, or for such persons under age 65 who have qualified for Medicare because of disability. Each such person is “Medicare eligible.” If you satisfy all the above-described requirements, the Retiree Medical Program is available to you, your Spouse and/or Dependents as defined in this document on page 13, provided that each person you wish to enroll in Retiree Medical Program coverage on

or after January 1, 2020 – including yourself – is not Medicare eligible at the time of enrollment.

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

Eligibility for Benefits at Retirement (Former Southern Pacific Retirees Retiring Before January 1, 1998):

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

Retiree Coverage Election:

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

Important Medicare Part D Coverage Note:

A Medicare Eligible Participant’s (i.e., a Medicare eligible retiree or Dependent with Retiree HRA coverage) enrollment in a Medicare Part D plan on or after September 1, 2009 will not result in the termination of coverage under the Union Pacific Retiree Medical Program. Medicare Eligible Participants who enrolled in Medicare Part D coverage effective prior to September 1, 2009 were terminated from the Union Pacific Retiree Medical Program and coverage will not be reinstated.

Special Enrollment Periods:

Regardless of whether you retired before or after January 1, 1992, if you were eligible to elect Retiree Medical Program coverage and waived your right to do so, you may later enroll yourself in Retiree Medical Program coverage offered to non-Medicare eligible retirees (See “Retiree Medical Program Coverages” page 17) if the conditions described in either A. or B. are met:

- A. Loss of Eligibility for Other Coverage.
 - 1. You were covered under a group health plan or health insurance coverage at the time coverage under this Plan was previously offered to you;
 - 2. Your coverage was terminated as a result of loss of eligibility for the coverage (including legal separation, divorce, annulment, death,

termination of employment, eligibility for Medicare, or reduction in the number of hours of employment), or the employer's contributions were terminated, or your coverage under COBRA was exhausted (unless such coverage was COBRA continuation coverage you elected under the Group Health Plan following your termination of employment), or you lost eligibility for coverage due to a relocation;

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

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

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

In addition, your surviving Spouse may later enroll in Retiree Medical Program coverage offered to non-Medicare eligible retirees (See "Retiree Medical Program Coverages" page 17) if all of the following conditions are met:

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

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

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

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

Retiree Enrolled in Retiree Medical Program Coverage – Dependent Loses Coverage:

If you are enrolled in Retiree Medical Program coverage, you may later enroll an eligible Dependent in Retiree Medical Program coverage offered to non-Medicare eligible retirees (See "Retiree Medical Program Coverages" page 17) if all of the following conditions are met:

1. Your Dependent was covered under a group health plan or health insurance coverage at the time coverage under this Plan was previously offered to you; and
2. Your Dependent's coverage was terminated as a result of loss of eligibility for the coverage (including legal separation, divorce, death, termination of

employment, reduction in the number of hours of employment), or the employer's contributions towards such coverage were terminated, or your Dependent's coverage under COBRA was exhausted (unless such coverage was COBRA continuation coverage elected by or on behalf of your Dependent under the Group Health Plan following your termination of employment);

3. Your Dependent is not Medicare eligible prior to the date his or her coverage would be effective (See, "Effective Date of Coverage for Special Enrollment" below); and
4. You requested enrollment of your Dependent in this Plan not later than 30 days after the date of loss of coverage, exhaustion of COBRA, or the employer's contributions were terminated.

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

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

1. were enrolled in Retiree Medical Program coverage, but lost such coverage on or after January 1, 2020 as a result of either you becoming Medicare eligible or Union Pacific's termination of Retiree HRA coverage under the Plan, or
2. terminate employment with Union Pacific on or after January 1, 2020 and meet the Retiree Medical Program eligibility requirements found on page 8, but cannot enroll yourself in Retiree Medical Program coverage solely due to your being Medicare eligible.

Only Retiree Medical Program coverage offered to non-Medicare eligible retirees (See "Retiree Medical Program Coverages" page 17) is available for your Dependents.

Effective Date of Coverage for Special Enrollment: Enrollment in Retiree Medical Program coverage resulting from a birth, adoption, or placement for adoption of a Dependent Child will be effective as of the event date if notification is received within 30 days of the event. Enrollment in Retiree Medical Program coverage as a result of

any other event described in this “Special Enrollment Periods” section will be effective on the first day of the month following the event date, if notification is received within 30 days of the event.

To request special enrollment or obtain more information, contact Union Pacific Workforce Shared Services at (877) 275-8747.

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

Coverage If You Relocate:

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

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

- If you are not Medicare-eligible, you will be enrolled in either the UHC HDHP PPO or the BCBS HDHP PPO, depending upon your residential address ZIP code at your new location, at the same level of coverage (i.e., single or family) received at your old location.
- If you are Medicare-eligible and have Retiree HRA coverage, your Retiree HRA coverage is not affected by your relocation. Your Dependents who are not Medicare-eligible, if any, will be enrolled in the UHC HDHP PPO or the BCBS HDHP PPO, depending upon your residential address ZIP code. (**Note:** If you have a Medicare Supplemental or Medicare Part D prescription plan you should notify the carrier for those plan(s) directly of any address changes.)
- If you previously waived coverage at your old location, you will not receive coverage at your new location unless you experience another event described in the ‘Special Enrollment Period’ section that would allow you to enroll in coverage.

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

Dependents:

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

- A “Dependent” means the retiree’s Spouse, if not legally separated from the retiree, or the retiree’s Child.
- A “Spouse” is the person with whom the retiree has entered into a valid marriage in accordance with the law of the jurisdiction in which the marriage between the retiree and such person is entered into, regardless of whether such marriage is recognized in the jurisdiction in which the retiree is domiciled. For purposes of eligibility under the Retiree Medical Program, a person who is the retiree’s Spouse is no longer considered a Dependent on the date a decree of divorce, legal separation or annulment between the retiree and his or her Spouse is entered by a court.

A Spouse does not include an individual with whom the retiree has entered into a registered domestic partnership, civil union or other formal relationship recognized under state law that is not denominated as a marriage under the law of the state in which such relationship is established.

- A “Child” is one of the following:
 1. An individual (son, stepson, daughter, or stepdaughter) who is directly related to the retiree by blood, adoption (or placement for adoption), or marriage, or who is a foster child placed with the retiree by an authorized placement agency or by judgment, order, or decree of any court of competent jurisdiction, and who is under age 26;
 2. An unmarried individual not described in 1, above, who satisfies both a) and b), below:
 - a) Such individual is under age 26, and
 - b) The individual’s principal place of residence is the retiree’s home and the retiree expects to claim the individual as a dependent on his/her federal income tax return for the Calendar Year. (For information regarding whether an individual may be claimed as your dependent, please see the instructions for IRS Form 1040 or consult your personal tax advisor.);
 3. An individual for whom the retiree is required to enroll the individual pursuant to a Qualified Medical Child Support Order (QMCSO); or
 4. A Disabled Child.
- A “Disabled Child” means an unmarried Child described in paragraph 1 or 2 of the definition of Child above (without regard to the Child’s age but otherwise subject to all other applicable eligibility requirements) who is not self-supporting due to physical handicap, mental handicap, or mental retardation. A Child who is not self-supporting must be mainly dependent on the retiree for care and support. Coverage is available for a Disabled Child on or after attaining age 26 if the Child was a covered Dependent on the day before the Child’s 26th birthday and only for the period during which the disability and coverage continue without interruption. The retiree must submit proof to the Plan Administrator, when requested, that the Child meets these conditions at the time the Child attains the age of 26 and throughout the period in which coverage is provided.

- 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” means any judgment, order, or decree issued by a court of competent jurisdiction that provides Child support pursuant to a state domestic relations law or pursuant to an administrative proceeding authorized by state statute as described in section 1908 of the Social Security Act which provides for health benefit coverage of an alternate recipient. A QMCSO cannot require the Plan to provide any type or form of benefit or option not already provided under the Plan. The QMCSO must specify the name and address of the retiree and each alternate recipient, describe the coverage to be provided, identify the period for which the coverage is to be provided, and specify the plan to which the QMCSO applies. If you are required to enroll an alternate recipient pursuant to a QMCSO, your election under the Retiree Medical Program may be changed to provide coverage for such alternate recipient. Additional information, including a copy of guidelines for preparing and administering QMCSOs, may be obtained by calling Union Pacific Workforce Shared Services (toll free at (877) 275-8747, Monday through Friday from 9:00 a.m. to 5:00 p.m. Central Time, excluding holidays).

You are responsible for notifying Union Pacific Workforce Shared Services at (877) 275-8747, within 30 days after an event that either allows an individual to be considered a Dependent (if you wish to enroll such Dependent in Retiree Medical Program coverage) or an event that disqualifies the individual from being considered a Dependent.

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

Your Cost for Coverage:

Retiree Medical Program coverage offered to non-Medicare Eligible Participants (See “Retiree Medical Program Coverages” page 17) is contributory. This means that retirees must make contributions toward the cost of coverage.

MEDICAL COVERAGE PROGRAM TYPES: AN OVERVIEW

The medical coverage program offered to retirees and Dependents is provided in two different ways, depending upon a person’s location and eligibility for Medicare. Whomever you elect to cover under the medical coverage program is considered a “Covered Person” for purposes of this Medical Care Program section of this document.

All coverage is self-insured by Union Pacific. This means that Union Pacific, not an insurance company, pays for Covered Services that are incurred and payable by the Plan. Union Pacific contracts with third parties to provide for administrative services,

claims processing, network access, and related medical benefit support services for these self-insured medical arrangements. A brief overview of each coverage type is presented below.

PPO Program:

A Preferred Provider Organization (PPO) is a network of providers who have agreed to charge discounted rates for medical services in exchange for increased business opportunity. If you are covered by a PPO program, you are given incentives to use PPO Providers. These incentives are in the form of lower Deductibles (the portion of the medical expense paid by you before the Plan begins to pay for healthcare services), higher Plan Coinsurance (the portion of the medical expense paid by the Plan after the Deductible has been met), and lower Coinsurance Maximums. If you go outside the PPO Network for medical care, your expenses will be greater.

The PPO networks used by the Retiree Medical Program are the BlueCard network and the UHC “Choice Plus” network. The network available to you depends on your home address ZIP code.

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

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

Both the PPO offered by BCBS and the PPO offered by UHC are High Deductible Health Plans. A High Deductible Health Plan (HDHP) is a PPO designed to meet the requirements of a “high deductible health plan” as defined in Internal Revenue Code section 223. As the name implies, an HDHP typically has a higher deductible than a PPO that is not designed to meet these requirements.

Retiree HRA Program:

A Retiree HRA is an account that you may use to reimburse yourself for certain medical, dental, and vision expenses that are otherwise not reimbursed or reimbursable from any other source. This includes premiums paid for Medicare coverage for you and your Medicare eligible covered Dependents, including Medicare Part B premiums. If you do not use all of your Retiree HRA balance during the Calendar Year, any balance remaining is carried over and can be used to reimburse eligible expenses in a later Calendar Year, provided the Retiree HRA coverage remains in effect. The Retiree HRA gives you considerable flexibility to manage your out-of-pocket medical, dental, and vision expenses.

Retiree HRA Closure: The Retiree HRA was closed to new entrants effective December 31, 2019. This means Retiree HRA coverage is available after December 31, 2019 only to those retirees with a Retiree HRA in existence on December 31, 2019 as a result of either the retiree or one or more of the retiree's covered Dependents being Medicare eligible on or before that date. Retiree HRA coverage will remain in effect after December 31, 2019 only for the period in which the retiree or surviving Spouse remains continuously enrolled in the Plan without interruption, but no later than December 31, 2023. (See "When Retiree HRA Coverage Ends and Retiree HRA Continuation of Coverage" on page 131).

RETIREE MEDICAL PROGRAM COVERAGES

Retirees and their Dependents who are not Medicare eligible may enroll in either:

- BCBS HDHP PPO
- UHC HDHP PPO

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

The BCBS HDHP PPO is described in this 2021 BCBS Retiree Medical Guide. The UHC HDHP PPO is described in the 2021 UHC Retiree Medical Guide.

Retiree Medical Program coverage consisting of a Retiree HRA is available during 2021 only to those retirees who had a Retiree HRA in existence on December 31, 2019 as a result of either the retiree or one or more of the retiree's covered Dependents being Medicare eligible on or before that date. You, your Spouse or other Dependent who is Medicare eligible and enrolled in Retiree HRA coverage is a "Medicare Eligible Participant." Retiree HRA coverage is administered by ViaBenefits and described in this 2021 BCBS Retiree Medical Guide beginning on page 129.

Discretionary Authority of Plan Administrator and Other Fiduciaries:

In carrying out their respective responsibilities under the medical coverage program and the Plan, the Plan Administrator and other plan fiduciaries and the third party claims administrator of the BCBS HDHP PPO, the UHC HDHP PPO, and the Retiree HRA shall have discretionary authority to determine facts, interpret the terms of the medical coverage program, and to determine eligibility for and entitlement to plan benefits in accordance with the terms of the medical coverage program and the Plan.

Any finding, interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the finding, interpretation or determination was arbitrary and capricious.

BCBS HDHP PPO PROGRAM FOR RETIREES AND DEPENDENTS WHO ARE NOT MEDICARE ELIGIBLE

Components:

The BCBS HDHP PPO Program consists of four components, and each component has its own network of Preferred Providers:

1. **Medical Benefits:** These benefits are self-insured by Union Pacific. Union Pacific has contracted with Quantum Health and BCBS to administer claims and medical management services. In order to carry out their specific responsibilities under the BCBS HDHP PPO Program, Quantum Health and BCBS have been granted discretionary authority to make factual findings and interpret the terms of the BCBS HDHP PPO Program, 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 the BCBS HDHP PPO Program, Quantum Health and BCBS have been granted discretionary authority to make factual findings and interpret the terms of Mental Healthcare and Substance Use Disorder Treatment benefits and to determine entitlement to Plan benefits in accordance with the terms of the Plan.
3. **Pharmacy Benefits:** These benefits are self-insured by Union Pacific and are administered by OptumRx. In 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.
4. **Vision Care Benefits:** These benefits enable you to pay discounted rates for exams, frames, and lenses at participating Providers. Union Pacific has contracted with EyeMed Vision Care to administer the vision care benefits. EyeMed has discretionary authority to determine facts, interpret the terms of

the vision care benefits and determine entitlement to Plan benefits in accordance with the terms of the Plan.

Preferred Provider:

The BCBS HDHP PPO Program offers health benefits through a Preferred Provider Organization (PPO) network. BlueCross/BlueShield of Nebraska is the contract administrator for these benefits. BCBS of Nebraska, as well as 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.

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 a 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 Covered 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 MyQHealth at www.UPMyQHealth.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 Doctor 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 27.

The BCBS HDHP PPO allows 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 MyQHealth at www.UPMyQHealth.com.

SPECIAL PROVISIONS THAT APPLY TO PREFERRED PROVIDER NETWORKS

Out-of-Network expenses may be covered at the In-Network level. Even in the BCBS PPO Network area, occasionally a provider in a particular specialty is not readily available. To accommodate these cases, whenever a network provider is not available within a 30-mile radius of a retiree’s residence, the retiree may use an Out-of-Network provider and still obtain the network level of benefits (i.e., lower Deductibles and higher Plan Coinsurance, if applicable). Since the Out-of-Network Provider does not have a contract with BCBS, Plan benefits payable will be based on the Maximum Benefit Amount. If an eligible Dependent does not reside with the retiree, his/her residence is deemed to be the same as the retiree’s residence. **To qualify for coverage of Out-of-Network expenses at the In-Network benefit level, the participant must contact Quantum Health at (877) 649-3855 BEFORE services are rendered** to verify that the Out-of-Network Provider qualifies for coverage at the network level and to facilitate the appropriate payment of applicable claim(s).

Services performed by Out-of-Network radiologists, anesthesiologists, pathologists, CRNAs or laboratories: If a member is referred by an In-Network Doctor to an Out-of-Network radiologist, anesthesiologist, pathologist, CRNA or laboratory or receives Inpatient care or Outpatient Surgery care from an In-Network Hospital or In-Network Ambulatory Surgical Facility, but services are performed by Out-of-Network radiologists, anesthesiologists, pathologists, CRNAs or laboratories, services will be considered In-Network for the purpose of determining Plan benefits. If the radiologists, anesthesiologists, pathologists, CRNAs or laboratories are not members of the BCBS PPO Network, In-Network benefits will be based on billed charges.

You do not need prior authorization from a BCBS HDHP PPO in which you are enrolled or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the 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 MyQHealth at www.UPMyQHealth.com.

Under certain circumstances, you will be required to notify Quantum Health in order to avoid having your benefits reduced. See “Covered Services” on page 36 for additional information.

BlueCard Program (National):

BCBS plans across the country participate in the BlueCard Program. This program enables the plan servicing the geographic area where healthcare services are provided to receive and apply their contracted rate for Covered Services.

When you obtain healthcare services through the BlueCard Program, the amount you pay for Covered Services is usually calculated on the lower of:

- The billed charges for your Covered Services, or
- The contracted amount that the local BCBS (Host Blue) passes onto BlueCross/BCBS of Nebraska.

Often, this contracted amount will consist of a simple discount which reflects the actual price paid by the Host Blue. The contracted amount may also be billed charges reduced to reflect an average expected savings with your Healthcare Provider or with a specified group of providers.

The contracted amount may also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered the final price.

BCBS of Nebraska will calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care. BCBS of Nebraska will process your claim, issue the applicable benefit payment, and create your Explanation of Benefit documents.

An Important Reminder: If more than one Doctor is involved in your care, it is important for you to check the preferred status of each provider. This is especially important when you are receiving services from multiple providers while hospitalized. If you wish to stay within the Preferred Provider Network, make sure your attending Doctor knows this. Ask that you be informed, before the service is performed, if he or she is referring you to a provider outside the Preferred Provider Network.

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 MyQHealth at www.UPMyQHealth.com to obtain information on Preferred Providers.

Pharmacy Benefits: Pharmacy benefits are governed by whether you use In-Network Pharmacies (see section “Pharmacy Benefits” on page 93).

Vision Care Benefits: Vision care benefits are governed by whether you use participating vision care Providers (see section “Vision Care Benefits” on page 119).

Plan Features:

This section describes the following features of the BCBS HDHP PPO Program: premium contribution, Deductibles, Coinsurance amount, PPO Provider charges, Maximum Benefit Amount for charges by Non-PPO Providers, and the Maximum Lifetime Benefit limit.

Note: Retirees and Dependents who are not Medicare eligible will have either the BCBS HDHP PPO Program or the UHC HDHP PPO Program available to them, depending on your residential address ZIP code, but not both.

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

Premium Contribution: You pay a portion of the cost of your medical coverage program in the form of a premium contribution, an after-tax deduction from your monthly pension check or you pay directly to Union Pacific. The amount of the premium contribution depends on your coverage level (Retiree Only or Family). If you are enrolled in the Retiree HRA and have one or more non-Medicare eligible Dependents enrolled in the BCBS HDHP PPO, then your BCBS HDHP PPO premium

contribution will be the amount charged for Retiree Only coverage. The services of an actuary and/or underwriter are used to determine premiums for the BCBS HDHP PPO Program.

Deductible: The Deductible is the amount you pay each year before expenses are paid by the Plan. Under the BCBS HDHP PPO Program, there is a single Deductible for medical, including mental healthcare and Substance Use Disorder treatment and pharmacy expenses (“HDHP Deductible”).

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

- For the BCBS HDHP PPO Program, the amounts you pay for contracted rates with a Preferred Provider for Covered Services are applied against the HDHP Deductible. 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 is applied against the HDHP Deductible.
- The amount paid at an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List (See the Pharmacy Benefits Defined Terms Section on page 116 for the definition of these terms) is applied against the HDHP Deductible. If you obtain a Prescription Drug Product from an Out-of-Network Retail Pharmacy, only the amount you pay up to the Predominant Reimbursement Rate for a Prescription Drug Product on the Prescription Drug List is applied against the HDHP Deductible. Medications not listed on the Prescription Drug List are excluded from coverage.
- Amounts paid for over-the-counter drugs and vision care Copayments do not count toward your HDHP Deductible.
- The BCBS HDHP PPO Program has a higher HDHP Deductible to meet if Non-Preferred Providers are used. Any eligible expenses incurred will apply to either or both the In-Network and Out-of-Network HDHP Deductible amounts.

Specific Deductible features are presented in the Schedule of Benefits, starting on page 27.

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

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

After the HDHP Deductible is met, the Plan pays a specified portion of the Covered Services and Prescription Drug Products on the Prescription Drug List and you pay the remaining portion, up to the Coinsurance Maximum.

- The medical Coinsurance is a percentage of the fee-for-service contracted rate if a Preferred Provider is used. If a Non-Preferred Provider is used, a lower percentage of Maximum Benefit Amount for Covered Services applies. Your medical Coinsurance payments are capped by the Annual HDHP Coinsurance Maximum.
- The pharmacy Coinsurance level depends on the Plan's Prescription Drug List. The member pays a flat dollar amount for Tier-1 (typically Generic drugs), a percentage for Tier-2 (typically Preferred brand-name drugs), and a higher percentage for Tier-3 (typically Non-Preferred brand name drugs). There is a per prescription pharmacy Coinsurance payment equal to the lesser of actual costs or a minimum pharmacy Coinsurance amount. In addition, the pharmacy Coinsurance is a portion of the Prescription Drug Cost if the prescription is dispensed by an In-Network Pharmacy. If an Out-of-Network Pharmacy is used, the pharmacy Coinsurance is a portion of the Prescription Drug Product's Predominant Reimbursement Rate. Per prescription pharmacy Coinsurance payments are capped to lessen the burden of high cost drugs. Your pharmacy Coinsurance payments are capped by the Annual HDHP Coinsurance Maximum.

Specific medical Coinsurance features are presented in the Schedule of Benefits, starting on page 27.

Specific pharmacy Coinsurance levels, and per prescription minimum and maximum pharmacy Coinsurance amounts are presented in the Schedule of Benefits, starting on page 27.

Coinsurance Maximum: The Coinsurance Maximum is the amount you pay each year before the BCBS HDHP PPO Program pays 100% of the fee-for-service contracted Preferred Provider rate or the Maximum Benefit Amount for Covered Services and 100% of the Prescription Drug Cost or Predominant Reimbursement Rate for Prescription Drug Products ("Coinsurance Maximum" or "HDHP Coinsurance Maximum"), for the remainder of the Calendar Year.

Under the BCBS HDHP PPO, there is a single Coinsurance Maximum for medical, including mental health and Substance use Disorder treatment, and pharmacy expenses.

- Expenses above the Maximum Benefit Amount for Covered Services and the Predominant Reimbursement Rate for Prescription Drug Products do not count toward a Coinsurance Maximum.

- Expenses you pay to satisfy a Deductible do not count toward a Coinsurance Maximum.
- Any benefit reduction for not obtaining Prior Authorization from Quantum Health as described in the “Prior Authorization Requirements” section on page 30 does not count toward the Coinsurance Maximum.
- Any expense incurred for any health service that is not a Covered Service does not count toward the Coinsurance Maximum.

In a family, each covered individual must either satisfy the individual Coinsurance Maximum or a combination of covered family members must satisfy the family Coinsurance Maximum. The Annual Coinsurance Maximum for a family is capped regardless of family size. The individual Coinsurance Maximum will be satisfied for all covered family members of the family for the remainder of the Calendar Year once two or more members of your family incur expenses which together equal the family Coinsurance Maximum. Specific Coinsurance Maximum features are presented in the Schedule of Benefits, starting on page 27.

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

Out-of-network Emergency Care will be considered as having been provided by an In-Network Provider. If the Covered Person receives initial, short-term (48 hours or less) Outpatient care by an Out-of-Network Physician or other Out-of-Network Provider for an Emergency Medical Condition and/or accidental Injury, benefits for those Covered Services will be subject to the In-Network Deductible, Coinsurance, and/or Copayment. Benefits for Inpatient Services will continue to be paid at the In-network level, as long as the Services are for an Emergency Medical Condition. In addition, any Covered Services provided by an Out-of-Network urgent care Physician and/or other Out-of-Network professional Provider will be paid at the In-Network level when the corresponding facility charges are paid subject to the In-Network benefit amount.

Eligible expenses for non-Emergency services received from Out-of-Network providers are determined by BCBS at the billed rate up to the Maximum Benefit Amount. If the provider is not an In-Network provider, the Plan will only consider the fees up to a Maximum Benefit Amount. The Out-of-Network provider may bill you for the balance between his/her fee and the amount determined by BCBS to be the Maximum Benefit Amount. This practice is known as “Balance Billing.” Amounts charged above Maximum Benefit Amount are not “covered” expenses and do not count toward the Deductible or Coinsurance Maximum.

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

- Receive contracted rates, often at a substantial discount,
- Avoid “Balance Billing,” and
- Eliminate claim forms.

Maximum Benefit Amount: The Maximum Benefit Amount is a maximum amount determined by BCBS to be reasonable. The Maximum Benefit Amount will be the amount agreed upon between BCBS and Preferred Providers for the Covered Service. If no amount has been established for a Covered Service, BCBS may consider the charges submitted by providers for like procedures, a relative value scale that compares the complexity of services provided, or any other factors deemed necessary.

Maximum Lifetime Benefit: The Maximum Lifetime Benefit for Covered Services, including Mental Healthcare/Substance Use Disorder Services, for retirees and their Dependents is \$2,000,000 per person beginning with expenses paid by the Plan once you have retired (i.e., expenses paid while covered as an active employee are not included). Amounts for Outpatient pharmacy benefits paid by the Plan are not counted towards the Maximum Lifetime Benefit for Covered Services.

<p>Note: Additional limitations that apply to specific benefits are described throughout this document.</p>
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Plan Benefits Offered – Schedule of Benefits:

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

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

SCHEDULE OF BENEFITS BCBS HDHP PPO		
Plan Feature	In-Network	Out-of-Network
Medical Care, Mental Health and Substance Use Disorder Treatment		
Annual HDHP Deductible <ul style="list-style-type: none"> • Individual • Family: 2+ Persons 	\$3,000 \$6,000	\$6,000 \$12,000
Medical Coinsurance after HDHP Deductible <ul style="list-style-type: none"> • Plan pays • You pay 	85% 15%	65% 35%
HDHP Coinsurance Maximum (Annual Limit after HDHP Deductible) <ul style="list-style-type: none"> • Individual • Family: 2+ Persons 	\$2,000 \$4,000	\$4,000 \$8,000
Preventive Care (As outlined under “Health Management Programs,” page 78 and “Preventive Pharmacy Benefits” page 105.)	Paid at 100%	No benefits are paid for an Out-of-Network Provider
Maximum Lifetime Benefit (Combined)	\$2,000,000 Per Person	

Pharmacy Program		
Retail		
Annual Deductible	Combined Medical and Pharmacy Deductible See “Deductible”	
Pharmacy Coinsurance You pay: Tier 1 – Generic Tier 2 – Preferred Tier 3 – Non-Preferred	Up to 31-day Supply* After the Deductible \$10 Copay 30% 40%	
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	After the Deductible N/A \$30/\$90 \$60/\$150	
Mail Order		
Annual Deductible	Combined Medical and Pharmacy Deductible See “Deductible”	
Pharmacy Coinsurance You pay: Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	Up to 90-day Supply After the Deductible \$25 Copay 25% 40%	
Pharmacy Coinsurance Minimums/Maximums per Script** Tier 1 - Generic Tier 2 - Preferred Tier 3 - Non-Preferred	After the Deductible N/A \$75/\$225 \$150/\$375	
Pharmacy Coinsurance Maximum	Combined Medical and Pharmacy Coinsurance Maximum See “Coinsurance Maximum”	
* Certain generic drugs may be purchased at a Retail Pharmacy for a 90-day supply. ** If the actual cost of the drug is less than the stated minimum, the member will pay the actual drug cost.		
OUT-OF-POCKET MAXIMUM		
Annual Deductible and Coinsurance Maximum		
• Individual	\$5,000	\$10,000
• Family: 2+ Persons	\$10,000	\$20,000

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 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 MyQHealth 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 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 Service.

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

This section generally describes the Covered Services, and limits that may apply to the benefits provided under the Retiree Medical Program which are administered by Quantum Health and 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 81, which explains the types of claims for which either Quantum Health or BCBS serves as the “Claims Administrator.”) These requirements apply to the Retiree Medical Program whether or not you receive services or supplies from Preferred Providers or Non-Preferred Providers.

Important: You and your Doctor decide which services and supplies are provided, but this Plan only pays for Covered Services which are deemed Medically Necessary as defined below and 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.

Covered Services

Benefits paid for the Covered Services shown below depend on the 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 27.

BCBS HDHP PPO 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).	

<p>Ambulance Services</p>	<p>Emergency Only: Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.</p> <p>Non-Emergency: Local transportation by professional ambulance, other than air ambulance, to and from a medical facility. Longer distance transportation by regularly scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment. Air ambulance transport is covered in the following circumstances: Patient requires transport to a Hospital or from one Hospital to another because the first Hospital does not have the required services and/or facilities to treat the patient, and ground ambulance transportation is not Medically Necessary because of the distance involved, or because the patient has an unstable condition requiring medical supervision and rapid transport.</p>	<p>Air ambulance benefits in excess of a \$25,000 maximum per occurrence will not be paid.</p>
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BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Anesthesia	<p>Anesthesia and related services given in connection with a covered surgical procedure.</p> <p>Dental anesthesia fees and related facility fees at outpatient hospital, inpatient hospital or ambulatory surgical center for the following:</p> <ul style="list-style-type: none">• 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.	Charges for services relating to prescription hearing aids or basic hearing evaluations.

Breast Pumps	<p>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 for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:</p> <ul style="list-style-type: none"> • Which pump is the most cost effective; • Whether the pump should be purchased or rented; • Duration of a rental; and • Timing of an acquisition. <p>Benefits are only available if breast pumps are obtained from a DME provider or Physician.</p>	
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BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Breast Reconstruction	<p>Breast reconstruction required as a result of a mastectomy.</p> <p>Special Notice Regarding Mastectomies: If you or your Dependent receives a mastectomy, the covered benefits for the patient also include coverage for:</p> <ul style="list-style-type: none"> 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, and d) Treatment of physical complications in all stages of mastectomy, including lymphedemas, e) replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy, and 	Breast Reconstruction, other than in conjunction with a mastectomy, that does not meet the criteria established through the notification process.
Breast Reconstruction (Continued)	<ul style="list-style-type: none"> f) other services required by the Women's Health and Cancer Rights Act of 1998, including breast treatment of complications, <p>Benefits payable will be determined in a manner determined 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 HDHP PPO.</p>	

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Breast Reduction	<p>Breast reduction Surgery is a Covered Service with documentation of the following functional impairments:</p> <ol style="list-style-type: none"> 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. <p>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).</p>	Breast reduction Surgery is NOT a Covered Service when performed to improve appearance or for the purpose of improving athletic performance.
Cardiac and Pulmonary Rehabilitation Services	<p>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 four months of the start of treatment. The primary intent is to improve the functional capacity of the heart 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.</p>	Membership to health clubs or equipment to use at home is 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.

BCBS HDHP PPO COVERED SERVICES		
Type of Service	What's Covered	What's Not Covered
Chiropractic Care/Spinal Manipulation	<p>Services of a spinal treatment specialist in the specialist's office for chiropractic and osteopathic manipulative therapy, including diagnosis and related treatment.</p> <p>Limited to 30 visits per Calendar Year.</p>	<p>Massage therapy is NOT covered.</p> <p>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.</p>
Clinical Trials	<p>Approved Clinical Trials for qualified individuals, as described in the PPACA Approved Clinical Trials:</p> <p>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:</p> <ul style="list-style-type: none"> • 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	<p>Covered if diagnosis of severe to profound bilateral sensorineural hearing loss and severely difficult speech discrimination, or post-lingual sensorineural deafness in an adult.</p>	

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Cosmetic Services	<p>The following cosmetic procedures are covered, provided notification is received and the procedure has been determined to be reconstructive rather than cosmetic:</p> <ul style="list-style-type: none"> • Correction of a congenital anomaly. • Repair, following accidental Injury. • Reconstructive Surgery (See Surgery, page 65). 	Cosmetic services that do not meet the criteria listed will not be covered.
Dental Services	<p>The following services and supplies are covered only if needed because of accidental Injury to natural teeth:</p> <ul style="list-style-type: none"> • Oral Surgery. • Full or partial dentures. • Fixed bridgework. • Prompt repair to natural teeth. • Crowns. • Required anesthesia to perform covered dental services. <p>Accident/Injury must have occurred while coverage is in effect.</p> <p>Dental treatment is covered only if needed because of accidental Injury to natural sound teeth. Services must be:</p> <ul style="list-style-type: none"> • Provided by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). 	<p>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.</p> <p>Dental Services that are submitted for payment consideration under the BCBS HDHP PPO are subject to the notification procedures for determination of meeting the criteria as a Covered Service.</p>

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Dental Services (Continued)	<ul style="list-style-type: none"> • As a result of damage severe enough that the initial contact with the Doctor or Dentist occurred within 72 hours of the Accident. <p>Benefits are available only for treatment of sound, natural teeth.</p> <p>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.</p> <p>Services for final treatment to repair the damage must be completed within 12 months of the Accident.</p>	
Diabetic Supplies	Diabetic supplies including syringes, test strips and lancets are covered under the Pharmacy Benefits, page 93. Insulin pump 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	<p>Durable Medical Equipment that meets each of the following criteria:</p> <ol style="list-style-type: none"> a. Ordered or provided by a Doctor for Outpatient use; b. Used for medical purposes; 	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.

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
<p>Durable Medical Equipment (Continued)</p>	<p>c. Not consumable or disposable; and</p> <p>d. Not of use to a person in the absence of a disease or disability.</p> <p>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:</p> <ul style="list-style-type: none"> • Equipment to assist mobility such as wheelchairs, 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. • 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. <p>The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.</p>	<p>Dental braces are also excluded from coverage. Air conditioners, humidifiers, dehumidifiers, air purifiers and filters are not covered. Tanning beds are not covered. Hearing aids, fittings and replacement hearing aids are not covered.</p> <p>All rentals or purchases of any DME expense over \$1,500 is subject to the Prior Authorization requirements.</p>

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
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.	
Gender Dysphoria	Non-surgical treatment: See Mental Healthcare Benefits on page 52. Laboratory testing to monitor the safety of continuous hormone therapy. Hormone replacement therapy covered under the Pharmacy Program. Surgical treatment: See Surgery, page 65.	Sperm preservation in advance of hormone treatment or gender surgery. Cryopreservation of fertilized embryos. Treatment received outside the United States.

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Hearing Care	Hearing screenings as part of a routine preventive office visit are covered under the Preventive Services Benefit.	Hearing aids, fittings and replacement hearing aids are not covered.
Home Healthcare	<p>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 health agency services are provided on a part-time, intermittent schedule and when skilled home healthcare is required.</p> <p>Skilled home healthcare is skilled nursing, skilled teaching, and skilled rehabilitation services when the care:</p> <ol style="list-style-type: none"> 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; 	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.

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
<p>Home Healthcare (Continued)</p>	<p>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.</p> <p>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.</p> <p>Limited to any combination of 40 In-Network and Out-of-Network visits per Calendar, Year.</p>	
<p>Hospice Care</p>	<p>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.</p> <p>The following Hospice Care Benefits are covered:</p> <ul style="list-style-type: none"> • 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 	<p>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.</p>

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Hospice Care (Continued) (Notification required)	<p>most common semi-private room rate for any day you are confined in a freestanding Hospice Facility. A Hospice Facility must offer a hospice program that is approved by the Claims Administrator and must either be a Hospital, a freestanding Hospice Facility that provides Inpatient care, or an organization that provides healthcare services in your home. The facility can provide these services using its own staff or by contracting with other organizations.</p> <ul style="list-style-type: none">• 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.	

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Hospice Care (Continued) (Notification required)	<ul style="list-style-type: none">• 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 determine to be Medically Necessary and which are provided through the hospice program, such as medical supplies, medicines, drugs, Doctor's services, and the rental or purchase of Durable Medical Equipment, whichever is less expensive	

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Hospital – Inpatient Stay	<p>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:</p> <ol style="list-style-type: none"> 1. When the Hospital is an all private room Hospital; 2. When the Hospital's semi-private rooms are filled and only a private room is available; or 3. When a private room must be used to keep the patient isolated because of the patient's diagnosis. 	Charges over and above the highest semi-private room rate are not covered, except as noted in the adjacent covered benefits paragraph.
Infertility	See Reproductive Services.	
Infertility – Assisted Reproductive Technology	See Reproductive Services.	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	What's Covered	What's Not Covered
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 are 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	<p>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:</p> <ul style="list-style-type: none"> • Mental healthcare evaluations and assessment; • Diagnosis; • Treatment planning; • Referral services; • Medication management; • Inpatient services; • Partial Hospitalization/Day Treatment; • Intensive Outpatient Treatment; • Services at a Residential Treatment Facility; • Individual, family and group therapeutic services; • Crisis intervention; and 	<ul style="list-style-type: none"> • Personality disorders • Behavior and impulse control disorders • "Z" codes (please call Quantum Health for further explanation) <p>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:</p> <ul style="list-style-type: none"> • Adjustment disorders • Mood disorders • Anxiety disorders • Conduct disorders • Impulse disorders • Social functioning disorders • Substance related disorders; and • Attention-deficit hyperactivity disorder

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
<p>Mental Healthcare Benefits (Continued)</p>	<ul style="list-style-type: none"> • Psychotherapy for Gender Dysphoria and associated comorbid psychiatric diagnoses; and • Eating Disorders <p>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:</p> <ol style="list-style-type: none"> 1. When the Hospital is an all private room Hospital When the Hospital's semi-private rooms are filled and only a private room is available; 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. <p>You are encouraged to contact Quantum Health for referrals to providers and coordination of care.</p> <p>Mental Healthcare services and supplies are subject to Deductibles and Coinsurance as presented in the Schedule of Benefits on page 27.</p>	

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
<p>Neurobiological Disorders – Mental Healthcare Services for Autism Spectrum Disorders</p>	<p>The Plan pays benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	<ul style="list-style-type: none"> • Personality disorders • Behavior and impulse control disorders • “Z” codes (please call Quantum Health for further explanation) <p>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:</p> <ul style="list-style-type: none"> • Adjustment disorders • Mood disorders • Anxiety disorders • Conduct disorders • Impulse disorders • Social functioning disorders • Substance related disorders; and • Attention-deficit hyperactivity disorder

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
<p>Neurobiological Disorders – Mental Healthcare Services for Autism Spectrum Disorders (Continued)</p>	<p>Benefits include:</p> <ul style="list-style-type: none"> • 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 <p>You are encouraged to contact Quantum Health for referrals to providers and coordination of care.</p> <p>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 27.</p>	

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
<p>Nutritional Counseling</p>	<p>Covered Services provided by a registered dietician in an individual session for Covered Person s with medical conditions that require a special diet. Some examples of such medical conditions include:</p> <ul style="list-style-type: none"> • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. <p>When nutritional counseling services are billed as a preventive care service, these services will be paid as described under Preventive Care.</p>	<p>Nutritional counseling for:</p> <ul style="list-style-type: none"> • Weight loss/obesity. • Conditions which have not been shown to be nutritionally related, including but not limited to chronic fatigue syndrome and hyperactivity. <p>Benefits are limited to three individual sessions during a Covered Person 's participation in the Plan.</p>
<p>Obesity Surgery</p>	<p>See Surgery on page 67.</p>	

<p>Organ/Tissue Transplants</p>	<p>Services and supplies for Medically Necessary organ or tissue transplants are covered subject to the following limitations.</p> <p>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.</p>	
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BCBS HDHP PPO COVERED SERVICES		
Type of Service	What's Covered	What's Not Covered
Organ/Tissue Transplants (Continued)	See the Transplant Management Program for additional covered benefits for certain qualified transplant procedures, page 79.	
Orthognathic Surgery	See Surgery.	
Outpatient Therapy	<p>Short-term Outpatient rehabilitation services (including habilitation services), limited to 30 visits per year for the combination of:</p> <ul style="list-style-type: none"> • Physical therapy. • Occupational therapy. • Speech therapy. <p>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.</p>	<p>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.</p>

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
<p>Outpatient Therapy (Continued)</p>	<p>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.</p> <p>Additional visits beyond the 30 visit limit may be available if Medically Necessary.</p>	
<p>Physician Services</p>	<p>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:</p> <ul style="list-style-type: none"> • 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. 	

BCBS HDHP PPO 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", page 78	
Prosthetic Devices	<p>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:</p> <ul style="list-style-type: none"> • Artificial limbs. • Artificial eyes. <p>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.</p>	
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	<p>Family Planning: Norplant, diaphragms, IUDs and Depo-Provera are covered under the medical plan provisions.</p> <p>When Reproductive Services are billed as a preventive care service, these services will be paid as described under Preventive Care.</p>	Oral contraceptives are not covered under this medical program, but are covered under the Pharmacy Program.

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Reproductive Services (Continued)	<p>Infertility - Assisted Reproductive Technology treatments, including (but not limited to) artificial insemination, GIFT, ZIFT, or in-vitro fertilization, are Covered Services. This includes confinement in a Hospital or specialized facility in connection with infertility treatments. Covered infertility treatment services include the following:</p> <ul style="list-style-type: none"> • In vitro fertilization. • Artificial insemination. • The use of donor ovum and donor sperm and related costs, including collection and preparation. • Embryo transfer. • Gamete intrafallopian transfer. • Zygote intrafallopian transfer. • Tubal ovum transfer. • Surgery. • Injectable drug therapy administered within the Doctor's office. 	<p>Injectable drug therapy that is self administered is not covered under this medical program but is covered under the Pharmacy Benefits on page 93.</p> <p>The Plan will not pay for the cost of donor sperm or egg or any related donor fees.</p>
	<p>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.</p>	

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Reproductive Services (Continued)	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.	
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	

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Skilled Nursing Facility/Inpatient Rehabilitation Facility (Continued) (Notification required)	the Plan. The stay must: <ol style="list-style-type: none"> a. Be for convalescent care; b. Start immediately after the end of a Hospital stay for which benefits are payable under the Plan; and c. Be for the same or related condition as the Hospital stay. 	
Speech Therapy	See Outpatient Therapy.	
Sterilization	See Reproductive Services.	
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: <ul style="list-style-type: none"> • 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.	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: <ul style="list-style-type: none"> • Adjustment disorders • Mood disorders • Anxiety disorders • Conduct disorders • Impulse disorders • Social functioning disorders • Substance related disorders; and • Attention-deficit hyperactivity disorder

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Substance Use Disorder Treatment (Continued)	<p>If an Inpatient Stay is required, it is a covered on a Semi-private Room basis; except:</p> <ol style="list-style-type: none">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. <p>You are encouraged to contact Quantum Health for referrals to providers and coordination of care. described in the program.</p> <p>Substance Use Disorder Treatment services and supplies are subject to Deductibles and Coinsurance as presented in the Schedule of Benefits on page 27.</p>	

BCBS HDHP PPO COVERED SERVICES		
Type of Service	What's Covered	What's Not Covered
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility)	Professional fees for surgical procedures and other medical care related to the surgical procedure received from a Doctor in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, Outpatient Surgery facility, Birthing Center, or via a Doctor house call. Benefits include the facility charge and the charge for required services, supplies and equipment.	
	<p>Reconstructive Surgery: Reconstructive Surgery to improve the function of a body part when the malfunction is the direct result of one of the following:</p> <ul style="list-style-type: none"> • 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. <p>Special Notice Regarding Mastectomies: If you or your Dependent receives a</p>	Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure.

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility)	<p>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:</p> <ul style="list-style-type: none"> 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; and 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. <p>Such coverage is subject to Annual Deductibles, Coinsurance and other provisions applicable to the other benefits of the BCBS HDHP PPO Program.</p>	
	<p>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.</p>	

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
<p>Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility)</p>	<p>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.</p> <p>Benefits will be payable for a third opinion on the same basis as benefits for the second opinion.</p> <p>The Doctor who gives the second opinion must:</p> <ol style="list-style-type: none"> a. Be qualified to render an opinion on the specific surgical procedure in question, and b. Examine you in person. 	<p>The following are not covered by the Second/Third Surgical Opinion Program:</p> <ul style="list-style-type: none"> • An opinion on a surgical procedure that would not be covered under the BCBS HDHP PPO. • Any charges in connection with a surgical procedure, if they are payable under other provisions of the BCBS HDHP PPO. • 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.
	<p>Obesity Surgery: Surgical treatment for severe/Morbid Obesity, as defined by NIH (National Institutes on Health) must meet the following:</p> <ul style="list-style-type: none"> • Severe Obesity: BMI of 35-40 with co-morbidities; or • Morbid Obesity: BMI of 40 or greater. <p>In addition, the patient's medical history must demonstrate that dietary attempts at weight control have been ineffective, and that</p>	<p>Non-surgical treatment of obesity, including Morbid Obesity, is not covered.</p> <p>Note: Abdominoplasty and panniculectomy are not covered, even when recommended as a result of approved obesity Surgery services.</p>

BCBS HDHP PPO COVERED SERVICES		
Type of Service	What's Covered	What's Not Covered
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility)	there is no specifically correctable cause for obesity (e.g. an endocrine disorder).	
	<p>Orthognathic Surgery is covered in the following situations:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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, jaw alignment and treatment for the Temporo Mandibular Joint as a treatment of obstructive sleep apnea. 	<p>Orthognathic Surgery is not covered for the following symptoms:</p> <ul style="list-style-type: none"> • Myofacial, neck, head and shoulder pain. • Irritation of head/neck muscles. • Popping/clicking of temporomandibular joint(s). • Potential for development or exacerbation of temporomandibular joint dysfunction. • Teeth grinding. • Treatment of malocclusion
	Gender Dysphoria Surgery: The Plan covers genital Surgery and Surgery to change secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty) and related services	<p>Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.</p> <p>Voice modification surgery.</p>

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility)	<p>When the following eligibility qualifications for Surgery are met:</p> <ul style="list-style-type: none"> • The treatment plan must conform to identifiable external sources including the <i>World Professional Association for Transgender Health (WPATH)</i> standards, and/or evidence-based professional society guidance; and • For irreversible surgical interventions, the Covered Person must be age 18 years or older; and • Prior to Surgery, the Covered Person must complete 12 months of successful continuous full time real life experience in the desired gender. <p>Important:</p> <ul style="list-style-type: none"> • Certain Covered Persons will be required to complete continuous hormone therapy prior to Surgery. In consultation with the Covered Person's Physician, this will be determined on a case-by-case basis through the prior authorization process. • Augmentation mammoplasty is allowed if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role. The Claims Administrator has specific guidelines regarding Benefits for treatment of 	Facial feminization surgery, including, but not limited to: facial bone reduction, face "lift," facial hair removal, and certain facial plastic procedures.

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
<p>Surgery (Services for Surgical Procedures, Surgeon, Anesthesiology and Facility) (All Inpatient hospitalization is subject to the notification requirements)</p>	<p>Gender Dysphoria (Gender Identity Disorder). Contact Quantum Health at (855) 649-3855 for information about these guidelines.</p>	
<p>Therapeutics- Outpatient</p>	<p>Covered Services includes therapeutic treatments received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:</p> <ul style="list-style-type: none"> • dialysis (both hemodialysis and peritoneal dialysis) • intravenous chemotherapy • intravenous infusion • radiation oncology • intensity modulated radiation therapy • MR-guided focused ultrasound <p>Benefits include the charges for the facility, related supplies and equipment, and Physician services for anesthesiologists, pathologists and radiologists.</p> <p>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:</p> <ul style="list-style-type: none"> • 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. 	

BCBS HDHP PPO COVERED SERVICES

Type of Service	What's Covered	What's Not Covered
Transplants	See Organ/Tissue Transplants.	

Additional Exclusions:

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

- Such service, treatment, item or supply is recommended or prescribed by a Doctor.
- It is the only available treatment for your condition.

The services, treatments, items, or supplies listed in this section are not Covered Services, except as may be specifically provided for in the section on “Medical and Mental Healthcare Services” on page 35. Note also the exclusions stated in the table beginning on page 71 under the column headed “What's Not Covered.”

Additional Exclusions

Type of Service	What's Not Covered
Alternative Treatments	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.

Additional Exclusions	
Type of Service	What's Not Covered
Cosmetic Services	<ul style="list-style-type: none"> • All cosmetic services except those described under "Covered Services" on page 43.
Dental	<ul style="list-style-type: none"> • Dental care, except as described under "Dental Services" on page 43. • 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 anesthesia required 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 Plan	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 condition.

Additional Exclusions	
Type of Service	What's Not Covered
Foot Care	<ul style="list-style-type: none"> • 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 subluxation of the foot. • Shoe orthotics. • Shoes (standard or custom), lifts and wedges. • Shoe inserts. • Arch supports.
Mental Healthcare/Substance Use Disorder	<ul style="list-style-type: none"> • Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i>. • 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 <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i>. • 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 <i>Individuals with Disabilities Education Act</i>. • 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 <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i>.

Additional Exclusions	
Type of Service	What's Not Covered
Mental Healthcare/Substance Use Disorder	<ul style="list-style-type: none"> • Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. • Transitional Living Services <p>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.</p>
Nutrition	<ul style="list-style-type: none"> • Megavitamin and nutrition based therapy. • Except as described under “Covered Services” on page 46 on 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 for specified diseases as described under “Covered Services” on page 56.
Physical Appearance	<ul style="list-style-type: none"> • Cosmetic procedures, including, but not to: <ul style="list-style-type: none"> ▪ Pharmacological regimens, nutritional procedures, or treatments. ▪ Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures). ▪ Skin abrasion procedures performed as a treatment for acne. • Physical conditioning program (such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation). • Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. • Wigs regardless of the reason for the hair loss, except for loss of hair resulting from treatment of a malignancy, hair loss due to alopecia or similar conditions or permanent loss of hair from an accidental Injury.

Additional Exclusions	
Type of Service	What's Not Covered
Providers	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ▪ Has not been actively involved in your medical care prior to ordering the service, or ▪ 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Health services for organ and tissue transplants, except those described under "Transplant Management Program" on page 79.

Additional Exclusions	
Type of Service	What's Not Covered
Transplants	<ul style="list-style-type: none"> • Health services for organ and tissue transplants, except those described under “Transplant Management Program”. • 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 payable for a transplant through the organ recipient’s benefits 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 transplant not listed as a Covered Service.
Travel	<ul style="list-style-type: none"> • Health services provided in a foreign country unless required as Emergency health services. • Travel or transportation expenses even though prescribed by a Doctor. Some travel expenses related to covered transplantation services may be reimbursed, as described in “Transplant Management Program” on page 79.
Vision and Hearing	<ul style="list-style-type: none"> • Purchase cost of eyeglasses, contact lenses, or hearing aids. (See “Vision Care Benefits” on page 119). • Fitting charge for hearing aids, 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.
All Other Exclusions	<ul style="list-style-type: none"> • 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.

All Other Exclusions	<ul style="list-style-type: none"> • 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 41. • 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, are not covered.. • 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 is waived. • Private Duty Nursing. • Non-prescribed disposable medical supplies. • Non-surgical treatment of obesity, including Morbid Obesity. • Orthognathic Surgery and jaw alignment, except what is described under “Covered Services” on page 68. • 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:
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All Other Exclusions	<ul style="list-style-type: none"> ▪ Related to judicial or administrative proceedings or orders. ▪ Conducted for purposes of medical research. ▪ Required to obtain or maintain a license of any type. • Psychosurgery. • 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, 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.
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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 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.

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.
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.
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.

Benefits for the Preventive Services outlined above will be paid at 100% in accordance with the Schedule of Benefits on page 27.

A complete list of preventive services may be found at www.UPMyQHealth.com. You may obtain a copy of this list free of charge by contacting Quantum Health at (855) 649-3855.

No preventive healthcare benefit is available from an Out-of-Network Provider, unless there are no Preferred Providers available. In that case, it is your responsibility to call Quantum Health to find an alternative Doctor. 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.

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.)

If 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.

The Plan covers Transplants included as a Qualified Procedure (listed below) when Medically Necessary.

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;
- Other transplant procedures when Quantum Health determines that it is Medically Necessary to perform the procedure at a designated transplant facility.

Medical Care and Treatment: Covered Services provided in connection with the transplant will be covered according to the Schedule of Benefits for the BCBS HDHP PPO. These services include:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- Hospital and Doctor fees.
- Transplant procedures.
- Follow-up care for a period up to one year after the transplant.
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient.
- 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.

Transportation and Lodging: Quantum Health will assist the patient and family with travel and lodging arrangements subject to the following requirements:

- Benefits will be available for transportation and lodging for the Covered Person and a traveling companion if the transportation and lodging are directly related to, or resulting from, a covered transplant procedure. This benefit is only available if the treating facility is 50 or more miles away (one way) from the Covered Person's home and the treating facility is a Preferred Provider. This transportation coverage may include transportation by an ambulance if that transportation meets the requirements of Quantum Health.
- These Transportation benefits of the patient are subject to Deductible or Coinsurance Amounts.
- The Covered Person is responsible to send a letter to Quantum Health to inform them that these expenses have been incurred. Applicable receipts must be provided along with written documentation confirming the name of the patient (and companion if applicable), the date/dates of travel, the facility where transplant services were received, treatment dates, and any other necessary information. Once provided with this information, Quantum Health will review the documentation to determine if charges are eligible for reimbursement. If benefits are available, payment will be issued directly to the Employee.

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).

UPMYOHEALTH.COM – QUANTUM HEALTH’S MEMBER WEBSITE

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

To register:

- Go to www.UPMyQHealth.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.
- 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

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

If you are Medicare eligible and have a Retiree HRA, information regarding how to file a claim under the “Retiree HRA” Section on page 129 of this document.

Union Pacific has delegated to Quantum Health or BCBSNE discretionary decision-making authority with respect to certain types of BCBS HDHP PPO claims and appeals, as set forth below. This means that with respect to the type of claim or appeal for which Quantum Health or BCBSNE has decision-making authority, Quantum Health or BCBSNE, as applicable, has the exclusive and discretionary authority to determine facts, interpret and administer the provisions of the Plan and determine benefits payable under the BSCS HDHP PPO. 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 Quantum Health or BCBSNE are conclusive and binding. 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 BCBSNE, 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 BCBSNE. Please note that the decisions of Quantum Health or BCBSNE are based whether or not the services are Medically Necessary, whether or not benefits are available under the Plan for the proposed treatment, service, supply 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 BCBSNE. Quantum Health or BCBSNE 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.

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 BCBSNE;
- 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 network provider will submit the bill as a claim for payment under its contract with BCBSNE, 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 at (855) 649-3855.

If you receive services from an In-Network provider, you will not have to file a claim. The network provider is responsible for filing claims. BCBSNE pays the network provider directly. However, you are responsible for paying Coinsurance and/or Deductible amounts to a network provider when a bill is received from the provider. If a network provider bills the Covered Person for any Covered Services in excess of the HDHP 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 MyQHealth at www.UPMyQHealth.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 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 or pursue a request for pre-service 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 to serve as the Covered Person's authorized representative with respect to any claim or appeal filed in accordance with Plan procedures.

BCBSNE will not reimburse third parties who have purchased or have been assigned benefits by Doctors or other providers.

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.

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 Form. Make sure all information is completed properly, and then sign and date the form. The Union Pacific group number is 13942. After you complete the above 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 BCBSNE within one year of the date of service, benefits for that health service will be denied or reduced at the discretion of BCBSNE. 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:

BCBSNE 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 BCBSNE for an additional 15 days, provided that BCBSNE 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 BCBSNE 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 at least 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 at (855) 649-3855, as shown on the back of your

ID card to submit a Pre-Service claim. Pre-Service claims begin upon Quantum Health's receipt of your treatment information.

After receiving the request for care, Quantum Health:

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

Inpatient Admission requests are reviewed by a 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 BCBSNE 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 Care 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 Care 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, you will receive written notice of the adverse determination. The 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 claim, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. If your claim was denied because the services were not Medically Necessary or Experimental/Investigative, the denial notice will include an explanation of this determination. The notice will describe any additional material or information needed to perfect your claim and an explanation of why the material or information is important, and provide the claim appeal procedures.

You must first exhaust all appeals available to you under the BCBS Retiree Medical Program before you have a right to bring a civil action under ERISA regarding your denied claim.

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

MEDICAL APPEALS PROCEDURE:

Your benefit program maintains an 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.

Initial 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 to the appeals address listed on the explanation of benefits (EOB) form or by contacting Customer Service at the number on the back of your ID card 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 any written comments, 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 comments, 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, a reference to the part of the Plan on which the denial is based, and the procedure for appealing the decision of a claim that is not an Urgent Care Claim. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the services were not Medically Necessary or Experimental/Investigative, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal and a statement regarding your right to pursue legal action in accordance with §502(a) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

The decision of Quantum Health on your appeal of your Urgent Care Claim is final and binding. The decision of Quantum Health on your appeal of your non-Urgent Care Pre-Service Claim is also final and binding, unless you decide to proceed with a second level review of such claim. 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 your non-Urgent Care Pre-Service Claim before pursuing a claim for benefits in court under § 502(a) of ERISA. Your decision of whether to proceed with a second level appeal will have no effect on your rights to any other benefits under the Plan. Should you elect to pursue the second level review before filing a claim for benefits in court, the Plan:

- 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 a second level review of your claim, you should contact Quantum Health at (855) 649-3855.

Your decision to proceed with a second level review of your Post-Service Claim is mandatory. In other words, you are required to pursue the second level review of your denied Post-Service Claim before pursuing a claim for benefits in court under § 502 of ERISA.

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. You must submit a second level appeal of your denied Post-Service Claim in order to preserve your right to bring a civil action under § 502(a) of 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) to the appeals address listed on the explanation of benefits (EOB) form or by contacting Quantum Health at (855) 649-3855 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 any written comments, 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 the Claims Administrator. 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.

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 notification shall include, among other items, the specific reason or reasons for the adverse benefit determination, a reference to the part of the Plan on which the denial is based and a statement regarding your right to pursue legal action in accordance with §502(a) of ERISA. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the services were not Medically Necessary or Experimental/Investigative, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal. The decision of Quantum Health on your second level appeal is final and binding.

TEMPORARY EXTENSION OF CLAIM AND APPEAL DEADLINES DUE TO COVID-19

The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak (“National Emergency Declaration”). The Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in the sections “Medical Claims & Appeals” and “Medical Appeals Procedures” – for you to submit or request any or all of the following:

- a claim for benefits; or
- an appeal (first level, second level or Urgent Care Claim appeal) of your denied claim.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your right to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in the sections “Medical

Claims & Appeals” and “Medical Appeals Procedures” - you may have additional time to do so. Please contact Quantum Health at (855) 649-3855 for more information.

COORDINATION OF BENEFITS:

Coordination of benefits applies when a covered retiree or a covered Dependent has health coverage under the BCBS HDHP PPO and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. The other of the plans involved will pay benefits next: that plan is Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

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.

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

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

Right to Exchange Information: To enforce the Coordination of Benefits provision, BlueCross/BlueShield 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.

BCBS HDHP PPO PROGRAM: PHARMACY BENEFITS

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

Whomever you elect to cover under the BCBS HDHP PPO Program is considered a “Covered Person” for purposes of the Pharmacy Program section of this document. You can find the meaning of other capitalized terms found in this Section in the “Pharmacy Benefits Defined Terms” on page 116 and “Glossary” sections on page 174 of this document.

<p>The Pharmacy benefits under the BCBS HDHP PPO Program are provided by OptumRx.</p>
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Member Identification (ID) Card - In-Network Pharmacy:

You must either present your Member OptumRx Rx Only 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 during regular business hours. The Union Pacific group number for OptumRx is 0196346. You can access your ID card through the MyQHealth 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 Rx Only ID card or provide verifiable information at an In-Network Pharmacy, you will be required to pay the amount charged by the pharmacy for the Prescription Drug Product at the pharmacy. You may seek reimbursement as described in the “How to File Pharmacy Claims” section. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility at the time the Prescription Drug Product was dispensed. The amount of the reimbursement will be based on the Prescription Drug Cost, less any Deductible or Pharmacy Coinsurance payment that applies.

Limitation on Selection of Pharmacies:

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

Concurrent Drug Utilization Review:

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

Additional Information About Your Prescriptions:

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

What’s Covered:

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

“Pharmacy Benefit Payment Information” sections). Refer to “What’s Not Covered - Exclusions” below, for exclusions.

Prescribed drugs and medicines for Inpatient services are covered as medical expenses under the BCBS HDHP PPO provisions. The BCBS HDHP PPO provisions also apply to Outpatient prescription drugs that are administered in a Doctor’s office or other licensed Outpatient setting, unless the drugs are excluded from the BCBS HDHP PPO under “Additional Exclusions” on page 71. These drugs and medicines eligible for payment under the medical program provisions then are not payable under the pharmacy provisions. Likewise, the drugs and medicines eligible under the pharmacy provisions then are not payable under the Medical provisions.

Benefits for Outpatient Prescription Drug Products:

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

- Prescribed to treat a Covered Service, see page 36; or to treat 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 determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing online at www.UPMyQHealth.com or by calling Quantum Health at (855) 649-3855 and choosing the pharmacy prompt.

Coverage Authorization: OptumRx uses a series of reviews when processing prescriptions known collectively as “coverage 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 Service, or it is Experimental, Investigational, or unproven. You may appeal this determination as described in the “Pharmacy Claim Questions and Appeals” on page 113.

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, coverage authorization still applies and will be reviewed at the time that you submit a claim for reimbursement or you or your Doctor check beforehand by calling OptumRx at (877) 559-2955 to ensure that the medications prescribed are in conformance with their coverage authorization. Only approved claims will be reimbursed. Retirees will also receive a statement outlining the authorization procedures.

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

If your prescription exceeds the limit and you are using an In-Network Retail Pharmacy or the OptumRx Mail Order Pharmacy Service, your Doctor or pharmacist will be notified of the quantity covered under a single prescription. Generally, this limit is for up to 31 days for Retail or up to 90 days for Mail Order. You will have the option to:

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

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

The QLL and QD limits are subject to change at OptumRx discretion. 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 coverage 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 on page 113.

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

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

Progression Rx/Step Therapy:

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 determine whether a particular Prescription Drug Product is subject to step therapy requirements by visiting MyQHealth at www.UPMyQHealth.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. UHC/OptumRx has established a group of Specialty Pharmacies with clinical expertise in dispensing specialty drugs that must be filled through a UHC/OptumRx Specialty Pharmacy.

Prescriptions obtained through a Specialty Pharmacy are dispensed in 30-day quantities and delivered directly to your home.

Specific drugs that must be dispensed through a Specialty Pharmacy can be found at MyQHealth at www.UPMyQHealth.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 may need to furnish payment information before the Specialty Pharmacy fills your prescription.

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

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

Benefits for the Specialty Pharmacy drugs are payable, following the Schedule of Benefits on page 106 entitled "Prescription Drugs from Retail or Specialty Pharmacy".

Note: A Prescription Order or Refill for a Prescription Drug Product identified as a "Specialty Drug" and required to be filled by a Specialty Pharmacy cannot be written for a 90-day supply and cannot be obtained through the Discretionary Mail Order Pharmacy Program. Specialty Pharmacy prescriptions are dispensed in 30-day quantities.

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

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

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

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

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

If you have a new Prescription Order or Refill for a Prescription Drug Product listed as a MMO maintenance medication that must be filled by the Mail Order Pharmacy, or if you have an existing Prescription Order or Refill for such a Prescription Drug Product at the time you become enrolled in the BCBS HDHP PPO, 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 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.

To contact the Mail Order Pharmacy for any questions call Quantum Health at (855) 649-3855.

Discretionary Mail Order Program:

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

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

- You or your Doctor must complete a Mail Order Form. This form can be found on the MyQHealth site at www.UPMyQHealth.com. The form can be faxed by 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 MyQHealth at www.UPMyQHealth.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 MyQHealth at www.UPMyQHealth.com.

Pharmacy Benefit Payment Information:

Deductible: You are responsible for paying the cost of covered pharmacy and Covered 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” see page 27.) The In-Network HDHP Deductible, including family limits, is listed in the following table.

- The amounts you pay for contracted rates with an In-Network Pharmacy for Prescription Drug Products on the Prescription Drug List are applied against the HDHP Deductible. If an Out-of-Network Retail Pharmacy is used, only the amounts you pay up to the Predominant Reimbursement Rate for Prescription Drug Products on the Prescription Drug List are applied against the HDHP 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	\$3,000 per Covered Person per Calendar Year, not to exceed \$6,000 for all Covered Persons in a family.

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

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

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

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

PAYMENT INFORMATION SCHEDULE

Payment Term	Description	Amounts
<p>Pharmacy Coinsurance Payment</p>	<p>Pharmacy Coinsurance Payments for a Prescription Drug Product on the Prescription Drug List at an In-Network Pharmacy are a portion of the Prescription Drug Cost.</p> <p>Pharmacy Coinsurance Payments for a Prescription Drug Product on the Prescription Drug List at an Out-of-Network Retail Pharmacy are a portion of the Predominant Reimbursement Rate.</p> <p>Your Pharmacy Coinsurance Payment is determined by the tier to which the Pharmacy and Therapeutics Committee has assigned a Prescription Drug Product.</p> <p>Note: The tier status of a Prescription Drug Product can change periodically, generally on January 1st and July 1st, based on the Pharmacy and Therapeutics Committee’s periodic tier decisions. When that occurs, your Pharmacy Coinsurance Payment may change. If there is a tier change which increases your Pharmacy Coinsurance Payment for a medication you have previously filled 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 MyQHealth at www.UPMyQHealth.com, or call Quantum Health at (855) 649-3855, for the most up-to-date tier status.</p>	<p>For Prescription Drug Products at an In Network Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none"> • The applicable Pharmacy Coinsurance Payment; or • The Prescription Drug Cost for that Prescription Drug Product. <p>See the Pharmacy Coinsurance description stated in the Benefit Information table on page 106 for amounts.</p>

PAYMENT INFORMATION SCHEDULE

Payment Term	Description	Amounts
HDHP Coinsurance Maximum	<p>After meeting the HDHP Deductible, the HDHP Coinsurance Maximum is the maximum amount you are required to pay for Covered Services and/or Prescription Drug Products on the OptumRx Prescription Drug List in a single Calendar Year.</p> <p>Once you reach the HDHP Coinsurance Maximum, you will not be required to pay Pharmacy Coinsurance Payments for covered Prescription Drug Products on the OptumRx Prescription Drug List for the remainder of the Calendar Year.</p> <p>Note: For prescriptions purchased at an Out-of-Network Retail Pharmacy, any Pharmacy, any charges above the Predominant Reimbursement Rate are not considered by the Plan as benefit payments and do not count toward your HDHP Coinsurance Maximum.</p>	<p>In-Network: Combined medical and prescription coinsurance maximum of \$2,000 per Covered Person per Calendar Year, not to exceed \$4,000 for all Covered Persons in a family.</p> <p>Note – Prescription Drug Products provided Out-of-Network Retail Pharmacy will apply towards the In-Network Coinsurance Maximum.</p>

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

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

Preventive Pharmacy Benefits: Certain Prescription Drug Products that are 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. Whether a Prescription Drug Product is available to members at no charge may be determined by going to MyQHealth at www.UPMyQHealth.com or by calling Quantum Health at (855) 649-3855 for the most up-to-date status.

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 a FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety and/or relative efficacy of the Prescription Drug Product, and whether or not supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates, and assessments on the cost effectiveness of the Prescription Drug Product.

OptumRx may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur on January 1st 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 and economic factors regarding covered persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is determined by the Covered Person and the prescribing Doctor.

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

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

Benefit Information:

The following tables describe Pharmacy Coinsurance payments and benefits for retirees and Dependents.

PRESCRIPTION DRUGS FROM RETAIL OR SPECIALTY PHARMACY	
In-Network and Out-of-Network Pharmacy Benefits and Supply Limits	Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)
<p>In-Network Retail or Specialty Pharmacy Benefits are provided for outpatient Prescription Drug Products on the Prescription Drug List dispensed by a Retail In-Network 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, or based on supply limits.</p> <p>Certain generics may also be dispensed by an In-Network Retail Pharmacy up to a 90-day supply.</p>	<p>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 MyQHealth at www.UPMyQHealth.com or call Quantum Health at (855) 649-3855 to determine tier status.</p> <ul style="list-style-type: none"> • \$10 Copay for a Tier-1 Prescription Drug Product (or cost of drug, if less). • 30% of the Prescription Drug Cost for a Tier-2 Prescription Drug Product. • 40% of the Prescription Drug Cost for a Tier-3 Prescription Drug Product. <p style="text-align: center;">Minimums/Maximums Tier 1 – N/A Tier 2 - \$30 Minimum*/\$90 Maximum Tier 3 - \$60 Minimum*/\$150 Maximum *or cost of drug, if less</p> <p>COVERED AT NO COST (Deductible and Coinsurance do not apply):</p> <ul style="list-style-type: none"> • Prescription Drug Products that are preventive care under the PPACA <p>NOT COVERED:</p> <ul style="list-style-type: none"> • 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 and Supply Limits	Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)
<p>Out-of-Network Retail Pharmacy Benefits are provided for outpatient Prescription Drug Products on the Prescription Drug List dispensed by an Out-of-Network Retail Pharmacy as written by the Provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer’s packaging size, or based on supply limits.</p> <p>If the Prescription Drug Product on the Prescription Drug List is dispensed by an Out-of-Network Retail Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with OptumRx. The Plan will not reimburse you for your Deductible, Pharmacy Coinsurance Payment or the difference between the billed cost and the Predominant Reimbursement Rate for that Prescription Drug Product. In addition, the Plan will not reimburse you for any drug not on the Prescription Drug List.</p> <p>In most cases, you will pay more if you obtain Prescription Drug Products from an Out-of-Network Retail Pharmacy.</p>	<p>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 MyQHealth at www.UPMyQHealth.com or call Quantum Health at (855) 649-3855 to determine tier status.</p> <ul style="list-style-type: none"> • \$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. <p style="text-align: center;">Minimums/Maximums Tier 1 – N/A Tier 2 - \$30 Minimum */\$90 Maximum Tier 3 - \$60 Minimum */\$150 Maximum * or cost of drug, if less</p> <p>NOT COVERED:</p> <ul style="list-style-type: none"> • 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 and Supply Limits	Your Pharmacy Coinsurance Payment Amount (after satisfaction of the HDHP Deductible)
<p>In-Network Mail Order Pharmacy Benefits are provided for outpatient Prescription Drug Products on the Prescription Drug List dispensed by an In-Network Mail Order Pharmacy as written by the Provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.</p> <p>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.</p>	<p>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 MyQHealth at www.UPMyQHealth.com or call Quantum Health at (855) 649-3855 to determine tier status.</p> <ul style="list-style-type: none"> • \$25 Copay for a Tier-1 Prescription Drug Product (or cost of drug, if less). • 25% of the Prescription Drug Cost for a Tier-2 Prescription Drug Product. • 40% of the Prescription Drug Cost for a Tier-3 Prescription Drug Product. <p style="text-align: center;">Minimums/Maximums</p> <p style="text-align: center;">Tier 1 – N/A</p> <p style="text-align: center;">Tier 2 - \$75 Minimum*/\$225 Maximum</p> <p style="text-align: center;">Tier 3 - \$150 Minimum*/\$375 Maximum *or cost of drug, if less</p> <p>COVERED AT NO COST (Deductible and Coinsurance do not apply):</p> <ul style="list-style-type: none"> • Prescription Drug Products that are preventive care under the PPACA

What's Not Covered - Exclusions:

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

- 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 or Pharmaceutical 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.)
- Any product dispensed for the purpose of appetite suppression and other weight loss products.
- 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 Coverage Program. This exclusion does not apply to Depo-Provera and other injectable drugs used for contraception.

- Durable Medical Equipment, prescribed and non-prescribed Outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered (see “Prescription Drug Product” on page 118). Certain Durable Medical Equipment may be covered under the BCBS HDHP PPO Program.
- 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 comprised of components that are available in over-the-counter form or equivalent, unless such drugs available over the counter qualify to be covered as Preventive Care under PPACA.
- New Prescription Drug Products and/or new dosage forms that have not yet been reviewed by the the Pharmacy and Therapeutics Committee until the date they are reviewed and assigned to a tier.
- Prescription Drug Products that are provided under any other plan to which your employer sponsors or contributes.
- Prescription Drug Products to the extent that benefits for such products are provided under this Plan or under any other plan to which your employer sponsors or contributes.
- Injectable Prescription Drug Products that must be administered by a licensed healthcare professional; which, if covered, would be paid under the retiree medical program provisions. (This exclusion does not apply to certain insulin or self-administered injectables that are covered by the Plan and can be injected subcutaneously. The list of drugs which are considered “self-administered injectables” is determined by OptumRx. To verify if an

injectable drug is considered a self-administered injectable, go to MyQHealth at www.UPMyQHealth.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.
- 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 HDHP PPO, Union Pacific has delegated to OptumRx the exclusive and discretionary authority to determine facts, interpret facts and administer the provisions of the Plan, and determine benefits payable under the Pharmacy Program. 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.

Right to and Payment of Benefits:

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

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

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

Claim and Appeal Process:

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

If you obtain prescription drugs from an Out-of-Network Retail Pharmacy, you will need to pay the entire cost of each Prescription Order or Refill at the time it is filled.

Unless your claim is for Urgent Care (defined below), you must then submit a claim to OptumRx, within 12 Calendar Months of the date you fill the Prescription Order or Refill. 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 MyQHealth at www.UPMyQHealth.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 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 where the application of the time periods for making non-urgent care determinations:

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

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

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

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

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

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

Pharmacy Claim Questions and Appeals:

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

Appeal of Non-Urgent Pharmacy Claims: To initiate a request for an appeal of a non-Urgent Care claim denial, you or your Doctor must provide in writing, your name, member ID, Doctor’s name and phone number, the prescription drug 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

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 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 first level appeal decision. You must submit a second level appeal in order to preserve your rights to bring a civil action under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) concerning the Plan’s denial of your claim.

To initiate a second level appeal, you or your Doctor must provide in writing, your name, member ID, Doctor’s name and phone number, the prescription drug 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 Attn: Appeals Request
OptumRx c/o Appeals Coordinator CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

Your second level appeal will be reviewed by OptumRx. OptumRx will notify you and your Doctor in writing within a reasonable period of time, but not later than 30 days of receipt of your written request for appeal. The decision of OptumRx made on your second level appeal is final and binding.

If your second level appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the prescription drug has not been approved for that use, the denial notice will include an explanation of this determination. The notice will describe your right to receive, upon request and at no charge, the information used to review your second level appeal. You have the right to bring a civil action under Section 502(a) of ERISA if your second level appeal is denied.

Appeal of Urgent Pharmacy Claims: You have the right to request an urgent appeal of an adverse determination if you request coverage of a claim that is urgent. Urgent 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 Attn: Appeals Request
OptumRx c/o Appeals Coordinator CA106-0286
3515 Harbor Blvd.
Costa Mesa, CA 92626

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

If your Urgent Care appeal is denied, the denial notice will explain the reason for denial and refer to the part of the Plan on which the denial is based. If an internal rule, guideline, protocol, or similar criterion was relied upon to deny your appeal, you will be notified of this fact and a copy of such internal rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request. If your appeal was denied because the prescription drug 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. You have the right to bring a civil action under Section 502(a) of ERISA if your Urgent Care appeal is denied.

Pharmacy Appeals Process: OptumRx will review all first level, second level, and Urgent Care appeals. Any review on appeal will not give deference to previous claim denials. You will have the right to submit documents and other information relating to your claim. Your second level appeal must specify each and every reason why you believe your claim should be approved. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim, nor a subordinate of the person who denied your claim. The review on appeal will take into account all comments, documents, records and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. If the initial denial is based in whole or in part on a medical judgment, OptumRx will consult with a healthcare professional with appropriate training and experience in the relevant medical field. This healthcare professional will not have consulted on the initial determination and will not be a subordinate of any person who was consulted on the initial determination. If OptumRx obtained advice from medical or vocational experts with respect to your claim, these experts will be identified, regardless of whether OptumRx relied on their advice when deciding your claim. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

TEMPORARY EXTENSION OF CLAIM AND APPEAL DEADLINES DUE TO COVID-19

The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak (“National Emergency Declaration”). The Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in the sections “How To File

Pharmacy Claims” and “Pharmacy Claim Questions and Appeals” – for you to submit or request any or all of the following:

- an initial claim for benefits; or
- an appeal (first level, second level or urgent care appeal) of your denied claim.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your right to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in the sections “How To File Pharmacy Claims” and “Pharmacy Claim Questions and Appeals” - you may have additional time to do so. Please contact OptumRx at (888) 403-3398 for more information.

Pharmacy Benefit Defined Terms:

Annual HDHP Deductible: See definition in the Medical Section, page 27.

Annual HDHP Coinsurance Maximum: See definition in the Medical Section, page 27.

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

Coinsurance Maximum: 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. For more information, see “Pharmacy Benefit Payment Information”, beginning on page 100.

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

In-Network Pharmacy: A pharmacy that has:

- Entered into an agreement with OptumRx or the OptumRx designee to provide Prescription Drug Products to Covered Persons,

- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products, and
- Been designated by OptumRx as 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. Optum Rx 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 Optum Rx’s sole discretion.

OptumRx develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services.

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

- The date it is assigned to a tier by the Prescription Drug List Management Committee.
- December 31st of the following Calendar Year.

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

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

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

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

Prescription Drug List: A list that identifies those Prescription Drug Products for which benefits are available under the Plan. This list is subject to periodic review and modification by OptumRx (generally on January 1st and July 1st). You may determine to which tier a particular Prescription Drug Product has been assigned at MyQHealth at www.UPMyQHealth.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.
- Neocate Infant Formula (if it is the sole source of nutrition).

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

Reasonable and Customary Charge: The usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

BCBS HDHP PPO PROGRAM: VISION CARE BENEFITS

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

What's Covered:

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

Vision Care Services	Member Cost
Exam with Dilation as Necessary	\$5 off routine exam \$10 off contact lens exam
Complete Pair of Glasses Purchase	Frame, lenses, and lens options must be purchased in the same transaction to receive full discount.
Standard Plastic Lenses	
Single Vision	\$50
Bifocal	\$70
Trifocal	\$105
Frames	Any frame available at Provider location: 35% off retail price
Lens Options:	
UV Coating	\$15
Tint (Solid and Gradient)	\$15
Standard Scratch-Resistance	\$15
Standard Polycarbonate	\$40
Standard Progressive (Add-on to Bifocal)	\$65
Standard Anti-Reflective Coating	\$45
Other Add-Ons and Services	20% discount
Contact Lens Materials: (Discount applied to materials only)	
Disposable	0% off retail price
Conventional	15% off retail price
Laser Vision Correction	15% off retail price or 5% off promotional price
Lasik or PRK	
Frequency:	
Examination	Unlimited
Frame lenses	Unlimited
Contact Lenses	Unlimited

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained Providers, this discount may not always be available from a Provider in your immediate location.

For a location near you and the discount authorization please call (877) 5LASER6 ((877) 552-7376).

Member will receive a 20% discount on those items purchased at participating Providers that are not specifically covered by this discount design. The 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Vision Care Provider's professional services or contact lenses. Retail prices may vary by location.

This discount design is offered with the EyeMed Vision Care Access panel of Providers.

Limitations/Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
- Services provided as a result of any Worker's Compensation law
- Discount is not available on those frames where the manufacturer prohibits a discount

How to access the Access Plan D Program:

- Call EyeMed Vision Care Member Service at (866) 723-0513. Representatives are available Monday through Saturday from 8:00 a.m. to 11:00p.m., and Sunday from 11:00 a.m. to 8:00 p.m. Eastern Time.
- After receiving your authorization for discounted eyewear, make an appointment with one of the participating Providers and advise them that you are authorized to purchase discounted eyewear through EyeMed Vision Care's Access Plan D Program.

Participating EyeMed Vision Care Providers:

EyeMed Vision Care has developed a network of retail locations, licensed optometrists, and ophthalmologists. Participating Providers have agreed to discounted fees. You may locate a participating Provider by following the instructions shown below:

1. Go to the EyeMed Vision Care website at <http://www.eyemed.com>
2. Follow the green bar to the right and click on "Member Login."
3. Under "Provider Locator," click on "Find a Provider."
4. Choose "Access" on the "Choose Network" drop down list. Then enter your ZIP code and click on "Get Results."

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

How to File Vision Claims:

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

Appeal of Denied Vision Claims:

A denied claim may be requested to be reviewed. To make this request, the member must send EyeMed a written letter of appeal no more than 180 calendar days after the date of the denied claim. The written letter of appeal should include the following:

1. The claim number, a copy of the EyeMed denial information, or a copy of the EyeMed Explanation of Benefits;
2. The item of vision coverage that the member feels was misinterpreted or inaccurately applied; and
3. Additional information from the eye care Provider that will assist EyeMed in completing its review of the appeal, such as documents, medical and/or financial records, questions or comments.

The written letter of appeal should be mailed to the following address:

FAA EyeMed Vision Care
 Attn: Quality Assurance Department 4000
 Luxottica Place
 Mason, OH 45040

Time Frames for Appealed Claims:

Activity	Time Frame
Claimant – Appeal of Adverse Determination	180 calendar days after the denial
Plan – Decision on Appeal	60 calendar days after receipt of appeal

EyeMed will review the appeal for benefits and notify the member in writing of its decision, as well as the reasons for the decision, with reference to specific plan provisions.

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

For more information on member rights and how to obtain further review under the Employee Retirement Income Security Act of 1974 as amended (“ERISA”), please refer to the ERISA section on page 163 of this document.

For all claims and appeals for vision care benefits under the BCBS HDHP PPO Program, Union Pacific has delegated to EyeMed Vision Care the exclusive and discretionary authority to determine facts, interpret and administer the provisions of the Plan, and determine benefits payable under the Vision Care Program. 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 EyeMed Vision Care are conclusive and binding.

TEMPORARY EXTENSION OF CERTAIN DEADLINES DUE TO COVID-19

The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak (“National Emergency Declaration”). In response, the Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in the sections “How to File a Vision Claim” and “Appeal of Denied Vision Claims” – for you to submit an initial claim for benefits or request an appeal of a denied claim for benefits.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your rights to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in the sections “How to File a Vision Claim” and “Appeal of Denied Vision Claims,” you may have additional time to do so. Please contact EyeMed Vision Care at (866) 723-0513 for more information.

WHEN COVERAGE ENDS

BCBS HDHP PPO coverage provided to you and/or your covered Dependents under the Retiree Medical Program described in this document will end as of the last day of the month in which the earliest of the following events occurs:

- You stop making any required contribution;
- You are rehired and become eligible for medical benefits as an active employee;
- Your Dependent no longer meets the definition of an eligible Dependent;
- You become Medicare eligible;
- Your Dependent becomes Medicare eligible;
- The Plan is terminated or amended in a manner that causes your coverage to end;
- You die without a surviving Spouse covered by the Plan (unless your surviving Spouse has a right to later enroll in the Plan, as described in the Special Enrollment Periods section at the beginning of this document on page 9, and elects to do so); or
- Your surviving Spouse covered by the Plan dies.

Notwithstanding #3 above, BCBS HDHP PPO medical coverage provided to a Dependent on a Medically Necessary Leave of Absence* will not terminate until the end of the month in which the earliest of the following events occurs:

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

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

A Medically Necessary Leave of Absence is a leave of absence that:

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

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

Continuation of Coverage:

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

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

CONTINUATION OF COVERAGE UNDER COBRA

Introduction:

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

If you are a Medicare Eligible Participant, please see the section, “Retiree HRA for Medicare Eligible Retirees and Dependents” on page 129 for special continuation of coverage rules applicable to the Retiree HRA.

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

You may have other options available to you when you lose BCBS HDHP PPO 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 BCBS HDHP PPO 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 BCBS HDHP PPO coverage under the Plan is lost because of the qualifying event. Generally under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Other Qualifying Events:

For the other qualifying events (divorce or legal separation of the retiree and Spouse or a Dependent Child’s losing eligibility for BCBS HDHP PPO coverage as a Dependent Child), you must notify the Plan Administrator within 60 days of the date on which BCBS HDHP PPO coverage would end under the Plan because of the qualifying event. You must provide this notice by calling Union Pacific Workforce Shared Services at (877) 275- 8747. When providing this notice, you must provide your name, employee ID or Social Security number, a description of the qualifying event, the date the qualifying event occurred, and the names of the individual(s) losing BCBS HDHP PPO coverage as a result of the qualifying event. The retiree, Spouse or Dependent, or any person representing any of these individuals can provide this notification. Notification by the retiree, Spouse, or Dependent (or their representative) will satisfy this notification requirement with respect to all individuals who will lose BCBS HDHP PPO 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 BCBS HDHP PPO coverage as a result of the qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation

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

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

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

Termination of Continuation Coverage:

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

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

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

If You Have Questions:

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

Temporary Extension of Certain Deadlines Due to COVID-19:

The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak ("National Emergency Declaration"). The Internal Revenue Service and Department of Labor have issued rules for the temporary extensions of the following deadlines as expressed in this "Continuation of Coverage Under COBRA" section:

- the 60-day election period for electing COBRA continuation coverage;
- the date for making COBRA premium payments;
- the deadline for you to notify the Plan Administrator of a COBRA qualifying event (i.e., your divorce or legal separation, or a family member's loss of dependent status); and
- the deadline by which the Plan Administrator or COBRA Administrator must provide a COBRA election notice to a qualified beneficiary.

Generally speaking, the deadline extensions are intended to provide you with more time to make a COBRA election, pay COBRA premiums and provide the above-described COBRA-related information while the National Emergency Declaration is in effect. Deadlines applicable to these or other COBRA-related activities will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. Please contact PayFlex Systems USA, Inc. at 844-PAYFLEX (844-729-3539) for more information.

If you are unable to elect COBRA or pay COBRA premiums by the deadlines that ordinarily apply – as described in this "Continuation of Coverage Under COBRA" section – you may have additional time to do so. However, keep in mind that you do not have COBRA continuation coverage unless and until you elect it. If you incur

medical costs before you have elected COBRA, your medical provider may be advised that you have no coverage and may require you to pay those costs yourself. Also, if you elect COBRA and do not pay the required premium for a coverage month by the due date – generally speaking, the first day of the month – your COBRA coverage may be suspended subject to reinstatement provided you pay the premium by the end of the grace period as may be extended in accordance with the above-described rules. If you incur medical costs during a period in which your COBRA coverage is suspended, your medical provider may be advised that you have no coverage and may require you to pay these costs yourself.

Keep Your Plan Informed of Address Changes:

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:

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

COBRA Administration:

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

PayFlex Systems USA, Inc.
Attn: Benefit Billing
PO Box 953374
St. Louis, MO 63195-3374
Phone Number: 844-PAYFLEX (844-729-3539)

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

RETIREE HRA FOR MEDICARE ELIGIBLE RETIREES AND DEPENDENTS

Retiree HRA Components:

Retiree Medical Program coverage in 2021 for Medicare Eligible Participants consists of a Retiree Health Reimbursement Account (“Retiree HRA”). The Retiree HRA is self-insured by Union Pacific. This means that Union Pacific, not an insurance company, pays for expenses covered by the Retiree HRA. Union Pacific has contracted with ViaBenefits to administer Retiree HRAs.

If you are or your Dependent is a Medicare Eligible Participant and became a Medicare Eligible Participant prior to January 1, 2020, Union Pacific credits your Retiree HRA with an amount that may be used to pay certain medical expenses that are not otherwise reimbursed or reimbursable from any other source. Retirees are not permitted to contribute to a Retiree HRA. The amount credited to your Retiree HRA will depend upon the number of Medicare Eligible Participants you have enrolled in coverage under the Union Pacific Retiree Medical Program.

- Your HRA will be credited for the 2021 Calendar Year with \$1,000 if you, your Spouse or other Dependent is the only Medicare Eligible Participant enrolled in the Retiree Medical Program (“Single Retiree HRA Coverage”). Your HRA will be credited for the 2021 Calendar Year with \$1,500 if both you and your Spouse are Medicare Eligible Participants, or if you (or your Spouse) and at least one other of your Dependents are Medicare Eligible Participants (“Family Retiree HRA Coverage”).
- If you have a Dependent who is not Medicare eligible, medical coverage for such Dependent is provided under the UHC HDHP PPO or the BCBS HDHP PPO (depending on your residential address ZIP code) until he/she attains age 65 or otherwise becomes eligible for Medicare, assuming he/she otherwise remains eligible for Retiree Medical Program coverage. If during the 2021 Calendar Year you or your Dependent reach age 65, or otherwise become Medicare eligible, coverage under the BCBS HDHP PPO (or UHC HDHP PPO, as applicable) for the person becoming Medicare eligible will cease and Retiree Medical Program coverage instead will be provided by the Retiree HRA. This change in coverage will be effective the first of the month in which the person is eligible for Medicare coverage. If this change from PPO coverage to Retiree HRA coverage causes your level of Retiree HRA coverage to change from Single Retiree HRA Coverage to Family Retiree HRA Coverage, your Retiree HRA will be credited with an additional amount equal to the prorated difference between the \$1,500 credit for Family Retiree HRA Coverage and the \$1,000 credit for Single Retiree HRA Coverage. For example, if your Retiree HRA Coverage changes from Single to Family on July 1, 2021, an additional \$250 will be credited to your Retiree HRA. This additional amount is 6/12ths of the difference between the \$1,500 Family coverage credit and the \$1,000 Single coverage credit.
- If an event occurs in a Calendar Year that results in your Retiree HRA coverage level changing from Family Retiree HRA Coverage to Single Retiree HRA Coverage (e.g., death of your Spouse), the amount credited to your Retiree HRA for such Calendar Year will not be reduced as result of such change. The amount credited for Single Retiree HRA Coverage in a subsequent Calendar Year will equal the Single Retiree HRA Coverage credit amount determined by Union Pacific for such subsequent Calendar Year.

Here's How it Works:

Your Retiree HRA can be used to pay for any eligible out-of-pocket medical expense listed in the Expense Item Table in the next few pages, which is incurred by the Medicare Eligible Participant after such individual begins Retiree HRA coverage. For families in which at least one eligible participant is not a Medicare Eligible Participant, claims reimbursed from the Retiree HRA for expenses incurred by the non-Medicare Eligible Participant are limited to dental or vision out-of-pocket expenses.

If you do not use all of your Retiree HRA balance during the Calendar Year, any balance remaining is carried over and can be used to pay eligible medical expenses in a later Calendar Year, provided the Retiree HRA coverage remains in effect. However, eligible medical expenses incurred in one Calendar Year cannot be reimbursed using amounts credited to your Retiree HRA in a subsequent Calendar Year.

Claims and Carryover Provisions: Only eligible expenses incurred while you (or your eligible Dependent) are covered by the Retiree HRA may be reimbursed from the Retiree HRA. An eligible expense is incurred when the services are provided and not when you are formally billed, charged or pay for the services. (See "How to File a Claim" on page 152). A balance in your Retiree HRA that is not used to pay for eligible expenses incurred in the Calendar Year is carried over and can be used to pay for eligible expenses incurred in the following Calendar Year(s), provided the Retiree HRA coverage remains in effect. Any balance remaining at your death after claims run-out is forfeited, unless you have a Spouse or other Dependent(s) covered under the Plan at the time of your death. The claims run-out period is 180 days after your date of death, during which time your representative can submit claims incurred by you prior to your death for reimbursement from the Retiree HRA.

Coverage If You Relocate:

You should notify Union Pacific Workforce Shared Services if you relocate. However, your Retiree HRA coverage is not affected by your relocation.

When Retiree HRA Coverage Ends and Retiree HRA Continuation of Coverage:

In addition to closing the Retiree HRA, the Company has decided to terminate Retiree HRA coverage effective December 31, 2023. Any balance remaining in your Retiree HRA on that date will be forfeited, subject to any post-year end Retiree HRA claim processing run-out period available to you at that time.

Retiree HRA coverage provided to you and/or your covered Dependents may end earlier than December 31, 2023. Retiree HRA coverage will end as of the last day of the month of the first to occur of the following events, if the event occurs before December 31, 2023:

1. You are rehired and become eligible for medical benefits as an active employee;
2. Your covered Dependent no longer meets the definition of “Dependent”;
3. You die without a surviving Spouse covered by the Plan (However, if your surviving Spouse is not Medicare eligible at the time of your death, he or she has a right to later enroll in Retiree Medical Program coverage offered to non-Medicare eligible Surviving Spouses if the conditions required for special enrollment are met. See the “Special Enrollment Periods” section of this Guide for more information.);
4. Your surviving Spouse covered by the Plan dies; or
5. The Plan is terminated or amended in a manner that causes your coverage to end prior to December 31, 2023.

Assuming the Retiree HRA is not terminated or amended in a manner which causes coverage to end earlier, Retiree HRA coverage will continue beyond the date described in events 2 – 4 above in the circumstances described below. **However, in no circumstance will Retiree HRA coverage extend beyond December 31, 2023.**

- Your surviving covered Spouse will be permitted to continue Retiree HRA coverage after your death until the earlier of: a) your surviving Spouse’s death; or b) December 31, 2023. A Child of a deceased retiree who meets the definition of a covered Dependent will continue to be eligible as a Dependent of a surviving covered Spouse. If your surviving Spouse dies, any remaining covered Dependents will be permitted to continue Retiree HRA benefits until the earlier of: a) 36 months after the end of the month of your surviving Spouse’s death; or b) December 31, 2023. If, upon the death of the retiree, there is no surviving covered Spouse, any remaining covered Dependents will continue to be eligible for benefits under the Retiree HRA until the earlier of: a) 36 months after the end of the month of your death; or b) December 31, 2023.
- In the event you become divorced or legally separated from your covered Spouse, your former Spouse may continue Retiree HRA benefits under a separate Retiree HRA that will be established to pay eligible claims of your former Spouse. Coverage under the former Spouse’s Retiree HRA will begin the first of the month following the month in which your divorce decree is entered by the court or legal separation occurred. The amount available for coverage in the former Spouse’s Retiree HRA at such time will equal the amount available in your Retiree HRA at the end of the month in which the divorce decree is entered by the court or legal separation occurred. Coverage under the former Spouse’s Retiree HRA will continue until the earlier of: a) 36 months after the end of the month in which your divorce decree is entered by the court or legal separation occurred; or b) December 31, 2023.

- Except in the case where your covered Dependent continues Retiree HRA coverage as a result of being on a Medically Necessary Leave of Absence^{*}, in the event your covered Dependent no longer meets the definition of a Dependent, your Dependent may continue Retiree HRA benefits under a separate Retiree HRA that will be established to pay eligible medical claims of your Dependent. A separate Dependent Retiree HRA will be established for each Dependent that no longer meets the definition of a Dependent. Coverage under the Dependent's Retiree HRA will begin the first of the month following the month in which your Dependent no longer meets the definition of a Dependent. The amount available for coverage in the Dependent's Retiree HRA at such time will equal the amount available in your Retiree HRA at the end of the month in which your Dependent no longer meets the definition of a Dependent. Coverage under the Dependent's Retiree HRA will continue until the earlier of: a) 36 months after the end of the month in which your Dependent no longer meets the definition of a Dependent; or b) December 31, 2023.
- If your Dependent is no longer your Dependent because he/she is no longer attending an accredited post-secondary educational institution on a full-time basis in accordance with the institution's policies and is no longer eligible to continue coverage as a result of being on a Medically Necessary Leave of Absence^{*}, a separate Dependent Retiree HRA will begin the first of the month following the month in which such Dependent is no longer eligible to continue coverage as a result of being on a Medically Necessary Leave of Absence. The amount available for coverage in the Dependent's Retiree HRA at such time will equal the amount available in your Retiree HRA at the end of the month in which your Dependent is no longer eligible to continue coverage as a result of being on a Medically Necessary Leave of Absence. Coverage under such Retiree HRA will continue until the earlier of: a) 36 months after the end of the month in which your Dependent's Retiree HRA coverage terminated as a result of being on a Medically Necessary Leave of Absence; or b) December 31, 2023.

When any one of the above events occurs, you, your Spouse, or Dependent (or any representative of these individuals) must notify the Plan Administrator. This notice must be provided within 60 days following the end of the month in which the event occurred. Failure to provide such notice will result in your Spouse or Dependent not having a separate Retiree HRA. This notice must be provided by calling Union Pacific Workforce Shared Services at (877) 275-8747. When providing this notice, you must provide your name, Employee ID or Social Security number, a description of the event, and the date the event occurred.

^{*}A Medically Necessary Leave of Absence is a leave of absence 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 and which:

- commences while the individual is suffering from a serious illness or Injury;
- is Medically Necessary;
- results in the individual losing student status at such educational institution; and
- 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 Workforce Shared Services within 30 days of the commencement of the leave of absence.

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

If You Have Questions:

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

Keep Your Plan Informed of Address Changes:

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

Plan Contact Information:

For general information about the Plan and continuation coverage, you may contact Union Pacific Workforce Shared Services, 1400 Douglas Street, STOP 0320, Omaha, NE 68179-0320, or at (877) 275-8747.

Eligible Expenses: Expenses that are eligible for reimbursement from the Retiree HRA include the following:

- Non-group plan Medical premiums.
- Medicare premiums.
- Non-group plan Dental premiums.
- Non-group plan Vision and hearing premiums.

- Medical deductibles, copayments or coinsurance.
- Dental deductibles, copayments or coinsurance.
- Prescription drug deductibles, copayments or coinsurance.
- Certain over-the-counter expenses.

Individual health insurance coverage that is paid for by the Retiree HRA, if any, is not subject to the rules and consumer protections of ERISA. You should contact your state insurance department for more information regarding your rights and responsibilities if you purchase individual health insurance coverage.

The table below includes specific details regarding eligible and ineligible expenses:

Expense Item	Eligible?	Claim Details
Abortion	Yes	
Acne products - Products specifically marketed for and used to treat acne	Yes	
Acne products - Products used for general hygiene such as facial wash, cleansers, toners, and medicated makeup	No	
Acupuncture - Treatment for a medical condition	Yes	
Additional card expense	No	
Advance payments - Nonrefundable advance payments to a private institution for Lifetime care, treatment, and training of a physically or mentally impaired dependent after the death or disability of a legal guardian	Yes	You must provide a statement of medical necessity from a Doctor documenting the disability or mental impairment
Alcohol or drug addiction - Payments to a treatment center for alcohol or drug addiction, including meals and lodging	Yes	
Allergy prevention products - Products purchased or used to alleviate allergies, such as a pillow, mattress, or vacuum	Yes	You must provide a statement of medical necessity from a Doctor documenting the diagnosed allergy and that the expense is for a product that will help alleviate the allergy symptoms
Allergy testing and shots	Yes	
Ambulance service	Yes	
Arch support - Supportive foot products prescribed by a Doctor to treat a medical condition	Yes	
Artificial limbs	Yes	
Automobile insurance premiums	No	
Automobile modifications - Modifications include special hand controls and other equipment installed in an automobile for a person with a disability	Yes	You must provide a statement of medical necessity from a Doctor documenting the disability

Expense Item	Eligible?	Claim Details
Birth control pills - Prescribed birth control pills	Yes	
Birth control products - Prescribed devices such as diaphragms, IUDs, and Norplant, in addition to over-the-counter items such as home pregnancy tests, condoms, gels, and foams	Yes	
Blood donation - Costs associated with blood donation, including self-administered blood donations, storage fees, and processing fees	Yes	
Blood pressure monitors - Costs include electronic monitors and replacement blood pressure cuffs	Yes	
Body scans	Yes	
Bottled water	No	
Braille books and magazines - Costs are limited to those that exceed regular printed editions	Yes	You must provide a receipt or advertisement with the price of the regular printed version of the book or magazine and a receipt of the <u>Braille material</u>
Breast augmentation - Examples include implants and injections	No	Surgery or procedures that aren't <u>Medically Necessary</u> aren't eligible
Breast pumps - Pump prescribed by a Doctor for a medical reason	Yes	Breast pumps used for nursing and routine post-partum care aren't <u>eligible</u>
Chelation therapy - Therapy used to treat a medical condition, such as lead poisoning	Yes	
Childbirth classes - Classes necessary to reduce pain during labor and delivery. An example is Lamaze	Yes	Expenses related to parenting techniques, infant CPR, and breast feeding are not covered
Chiropractor - Treatment for a medical condition	Yes	
Christian science Practitioner - Medical expenses paid to a Practitioner for medical care	Yes	
COBRA premiums - Premiums paid on an after tax basis for continuation of group medical, dental, or vision coverage	No	

Expense Item	Eligible?	Claim Details
Contact lenses and solutions - Products include saline solution and enzyme cleaner	Yes	
Cosmetic services and products - Surgery that isn't Medically Necessary. Examples include liposuction, hair transplants, electrolysis, laser treatments, and face-lifts	No	
Cosmetic services and products - Those necessary to improve a deformity related to a congenital abnormality or an Injury resulting from an accident, trauma, or disfiguring disease (post-mastectomy Reconstructive Surgery, for example)	Yes	You must provide a statement of medical necessity from a Doctor documenting the deformity, disfigurement or Injury
Counseling - Marriage or family counseling	No	Other types of counseling, such as mental health and psychiatric services, are eligible
Crutches	Yes	
Dental coinsurance - Amounts not covered by your or your spouse's dental plans	Yes	
Dental copayments	Yes	
Dental debit card - Dental Debit Card Expense	No	
Dental deductibles - Deductibles under your or your spouse's dental plans	Yes	
Dental expenses - Examples include fees for X-rays, fillings, braces, extractions, crowns, and orthodontia	Yes	
Dental implants - Fees for insertion of artificial tooth, bone grafting, and follow-up care	Yes	You must provide either a statement of medical necessity from a provider indicating that dental implants are the only course of treatment for the condition or an explanation of benefits indicating the amount paid by an insurance plan

Expense Item	Eligible?	Claim Details
Dental reasonable/customary - Amounts not paid by a dental plan that exceed reasonable and customary limits	Yes	
Dentures	Yes	
Diaper service - Cost for an agency that delivers and picks up cloth diapers	No	
Diapers (adult) - Diapers necessary as a result of a medical condition	Yes	
Diapers (child)	No	
Dietician services - Fees paid to a dietician when referred by a Doctor for treatment of a medical condition	Yes	
Disability construction costs - Examples include constructing entrance or exit ramps, adding handrails, or modifying stairways at a personal residence for disability of an employee or dependent	Yes	You must provide a statement of medical necessity from a Doctor documenting the disability
Disability equipment - Equipment installed in the home or car for use by a disabled employee or dependent	Yes	You must provide a statement of medical necessity from a Doctor documenting the disability
DNA testing - DNA testing for paternal responsibility	No	
Ear wax removal materials - Kits and ear drops must be prescribed by a Doctor for a medical condition	Yes	You must provide a statement of medical necessity from a Doctor describing the medical condition
Earplugs - Plugs must be prescribed by a Doctor for a medical condition	Yes	You must provide a statement of medical necessity from a Doctor describing the medical condition
Erectile dysfunction - Medication prescribed by a Doctor to treat a medical condition	Yes	Nonprescription medications require a statement of medical necessity from a Doctor describing the medical condition
Exercise equipment - Equipment recommended by a Doctor for the treatment of a medical condition	Yes	You must provide a statement of medical necessity from a Doctor describing the medical condition, such as a cardiac condition
Exercise equipment - Equipment used for general health purposes or prevention of an undiagnosed disease	No	

Expense Item	Eligible?	Claim Details
Eye examinations	Yes	
Eye Surgery - Surgery to correct defective vision	Yes	
Eyeglass tinting and coating	Yes	
Eyeglasses - Costs include prescription glasses and nonprescription reading glasses	Yes	
Flu shots	Yes	
Fluoride treatment - Costs include prescription or nonprescription fluoride and installation and monthly rental charges of a home water unit when recommended by a Dentist	Yes	
Food (prescribed) - Foods prescribed by a Doctor to treat a medical condition. Examples are baby formula and gluten- free and lactose-free foods. Costs are limited to those that exceed common versions of the product	Yes	You must provide a statement of medical necessity from a Doctor describing the medical condition. You must also provide a receipt or advertisement with the price of the commonly available version of the food and a receipt of the prescribed food
Funeral and burial expenses	No	
Future payments - Down payments or payments for services that have not been rendered or products not received	No	Lump-sum payments for future orthodontia services are an eligible exception; once the service is rendered, an itemized bill indicating the service date is required for the expenses to be eligible
Guide dog	Yes	
Health club or YMCA dues - Examples include membership and personal trainer fees	No	
Hearing aids	Yes	
Guide dog	Yes	
Health club or YMCA dues - Examples include membership and personal trainer fees	No	
Hearing aids	Yes	
Hearing coinsurance - Amounts not covered by your or your spouse's hearing plans	Yes	

Expense Item	Eligible?	Claim Details
Hearing copayments	Yes	
Hearing debit card - Hearing Debit Card Expense	No	
Hearing deductible - Deductibles under your or your spouse's hearing plans	Yes	
Hearing expenses - Costs include examinations and hearing aid batteries	Yes	
Hearing reasonable/customary -		
Hearing-impaired phone tools - Telephone equipment that allows a hearing-impaired person to communicate over a regular telephone	Yes	
Hearing-impaired TV equipment - Equipment that displays the audio part of television programs as subtitles for a hearing-impaired person	Yes	
Herbal remedies - Remedies that are prescribed by a Doctor for a medical condition	Yes	You must provide a statement of medical necessity documenting that the herbal remedy is necessary to treat a medical condition, Injury, or Illness and is not for general health purposes
Hospital care - Inpatient care, including the cost of a private room	Yes	Fees for personal convenience items, such as a television, telephone, and concierge services, aren't eligible
Household help - Expenses for help with physical housework, even if recommended by a Doctor, due to an inability of employee, dependent, or retiree	No	
Humidifiers - Cost of portable units prescribed by a Doctor for treatment of a medical condition	Yes	
Hypnosis - Hypnosis prescribed for medical reasons	Yes	
Illegal medical treatment - Including Surgery	No	

Expense Item	Eligible?	Claim Details
Immunizations	Yes	
Ineligible expense - Not covered	No	
Infertility - Treatments for infertility, including artificial insemination, in-vivo or in-vitro fertilization, embryo placement, egg and sperm storage, and ovulation monitors	Yes	
Laboratory and X-ray fees	Yes	
Laetrile - Anti-cancer drug	No	
Language training - Training for a child with dyslexia or other learning disabilities. Fees for regular schooling aren't eligible	Yes	
LASIK Surgery	Yes	
Lead-based paint removal - Costs for residences with children who have or had lead poisoning	Yes	
Legal fees - Fees paid to authorize treatment for mental illness, excluding guardianship or estate management fees	Yes	
Lens replacement insurance - Insurance to replace eyeglass or contact lenses	No	
Life insurance premiums - Premiums paid for the following policies: life insurance, repayment for loss of earnings, and accidental loss of life, limbs, or sight	No	
Lodging - Cost of lodging not provided in a Hospital or similar institution while away from home if primarily for and essential to medical care (limited to \$50 per person per night)	Yes	The \$50 is applicable to only the patient and caregiver (\$100 limit per night); you must provide a statement of medical necessity from a Doctor documenting the medical condition
Long-term care premiums - Premiums paid on a policy for future long-term care needs	Yes	Fees for Doctors, therapists, and other medical Practitioners are eligible, but fees for the long-term care facility aren't eligible
Long-Term Care Facility	No	Expenses for room and board at a long-term care facility

Expense Item	Eligible?	Claim Details
Long-Term Care Facility Fees - Fees for room and board at a long-term care facility	No	
Massage therapy - Therapy prescribed by a Doctor to treat an Injury or trauma	Yes	You must provide a statement of medical necessity documenting that massage therapy is necessary to treat a medical condition, Injury, or Illness and is not for general health purposes
Mastectomy-related bras - Bras prescribed by a Doctor	Yes	
Maternity care - Service and supplies from Doctors, midwives, clinics, Hospitals, and laboratories	Yes	3D and 4D ultrasounds are not eligible
Maternity clothes	No	
Mattresses - Mattresses prescribed by a Doctor to treat a medical condition	Yes	You must provide a statement of medical necessity documenting that the mattress is necessary to treat a medical condition, Injury, or Illness and is not for general health purposes
Medic alert identifications - Bracelet or necklace prescribed by a Doctor in connection with treating a medical condition	Yes	
Medical coinsurance - Amounts not covered by your or your spouse's medical plans	Yes	
Medical conference - Admission and transportation costs	Yes	
Medical contract fees - Annual contract costs for exclusive provider care	No	Itemized expenses for services provided are eligible
Medical copayments	Yes	
Medical debit card - Debit Card Medical Expense	No	
Medical deductibles - Deductibles under your or your spouse's medical plans	Yes	

Expense Item	Eligible?	Claim Details
Medical equipment - Costs to buy or rent durable equipment prescribed by a medical Practitioner to alleviate or treat a medical condition. Examples include medical beds, nebulizers, and sleep therapy devices	Yes	
Medical information - Amounts paid to a medical information plan for storage and retrieval of medical information	Yes	
Medical reasonable/customary - Amounts not paid by a medical plan that exceed reasonable and customary limits	Yes	
Medical services - Services provided by Doctors, surgeons, specialists, or other medical Practitioners	Yes	
Medical supplies - Over-the- counter items such as bandages, thermometers, and heating pads	Yes	
Medicare Part B Premiums	Yes	
Medicare Part D Premiums	Yes	
Menstrual Products	Yes	
Mental health - Includes psychoanalysis or amounts paid to a psychiatrist, psychologist, Hospital, clinic, or mental health facility for medical care	Yes	
Mentally handicapped home - Costs of keeping a mentally retarded person in a special home, as recommended by a psychiatrist, to help the person adjust from life in a mental Hospital to community living	Yes	You must provide a statement of medical necessity documenting that the special home or facility is necessary to assist the person in adjusting from life in a mental Hospital to community living
Nursing or retirement home fee - Medical care portion of a fee for an eligible dependent	Yes	Fees for Doctors, therapists, and other medical Practitioners are eligible, but fees for the nursing or retirement home facility aren't eligible

Nursing services - Wages and other amounts paid for nursing services to a patient at home or in a facility, such as a nursing home or rehabilitation center	Yes	Home healthcare and private duty nursing are eligible
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Expense Item	Eligible?	Claim Details
Nursing services for newborns - Services by a Nurse or attendant to care for a normal and healthy newborn at a Hospital or at home	No	
Nutritional supplements - Supplements taken for general health purposes. Examples include protein supplements, energy bars, and sports drinks	No	You must provide a statement of medical necessity documenting that the nutritional supplement is necessary to treat a medical condition, Injury, or Illness and is not for general health purposes
Occupational therapy - Therapy received as medical treatment	Yes	
Organ donor - Surgical, Hospital, laboratory, and transportation expenses for an organ donor, if you paid the donor's expenses	Yes	
Orthodontic fees - Orthodontic fees paid in a lump sum and in monthly installments	Yes	
Orthopedic shoes and orthotics - Shoes and orthotics prescribed by a Doctor for a medical condition	Yes	
Over-the-counter medications - Medications taken for general health purposes	No	
Over-the-counter medications - Medications taken to relieve pain, colds, and medical conditions	Yes	
Oxygen or oxygen equipment - Costs for rental or purchased equipment to relieve breathing problems caused by a medical condition	Yes	
Pain relievers	Yes	
Personal-use items - Includes toiletries and cosmetics, unless used to prevent or ease a physical or mental defect or Illness; In this case, only the excess of cost over the normally used item is reimbursable	No	

Expense Item	Eligible?	Claim Details
Personal-use items - Personal- use item used to prevent or ease a physical or mental defect or illness. Costs are limited to those that exceed common versions of the product	Yes	
Physical examinations - Routine physical examinations and related charges	Yes	
Physical therapy - Therapy prescribed by a Doctor as treatment for a medical condition	Yes	
Post Tax Dental Premiums - Premiums paid on an after-tax basis for any type of dental insurance coverage, including premiums for private insurance not provided by an employer	Yes	
Post Tax Medical Premiums - Premiums paid on an after-tax basis for any type of medical insurance coverage, including premiums for private insurance not provided by an employer	Yes	
Post Tax Vision Premiums - Premiums paid on an after-tax basis for any type of vision insurance coverage, including premiums for private insurance not provided by an employer	Yes	
Premiums for medical insurance - Premiums paid on an after-tax basis for any type of medical insurance coverage, including premiums for private insurance not provided by an employer	Yes	You must provide indication that the medical premium is after-tax when a payroll or retirement statement is used to document the medical premium expense - handwritten or verbal confirmation won't be accepted
Pretax Dental Premiums - Premiums paid on a before-tax basis for any type of dental insurance coverage.	No	

Expense Item	Eligible?	Claim Details
Pretax Vision Premiums - Premiums paid on a before-tax basis for any type of vision insurance coverage.	No	
Prenatal vitamins - Vitamins prescribed by a Doctor for use during pregnancy	Yes	
Prescription debit card - Prescription Debit Card Expense	No	
Prescription drugs - Exceptions may apply to drugs prescribed for cosmetic or general health purposes	Yes	Claims for reimbursement of drug or medicine expenses must include a copy of your prescription
Prosthetics	Yes	
Psychiatric care - Medical costs for psychiatric care	Yes	
Psychiatric expenses - Includes psychoanalysis or amounts paid to a psychologist for medical care	Yes	
Sales taxes - Sales and service taxes on eligible medical care or products	Yes	
School (alternative) - Costs of sending a problem child to an alternative school for benefits the child may receive from the course of study and disciplinary methods	No	
School payments for disabled - Expenses paid to an alternative school for a child with a severe learning disability if the main reason is using the school's resources for relieving the disability	Yes	You must provide a statement of medical necessity documenting the school is necessary to relieve the child's learning disability
Shipping - Charges to ship an eligible medical product	Yes	
Social activities - Activities such as dancing or swimming lessons, even if recommended by a Doctor for general health improvement	No	
Speech therapy - Speech therapy costs when prescribed as treatment for medical conditions such as autism, dyslexia, developmental delays, and rehabilitation.	Yes	

Expense Item	Eligible?	Claim Details
Sterilization - Costs of sterilization (vasectomy or tubal ligation) and reversal of sterilization operations	Yes	
Stop-smoking program	Yes	
Sunglasses - Sunglasses prescribed by an eye Doctor for light sensitivity	Yes	You must provide a statement of medical necessity documenting that the sunglasses are necessary to treat a medical condition, Injury, or Illness and are not for general health purposes
Support hose - Hose prescribed by a Doctor for a medical condition	Yes	The hose must be primarily manufactured and marketed for relief of a medical condition - however, hosiery primarily marketed for fashion isn't eligible
Taxes - Social Security and Medicare taxes paid for a Nurse, attendant, or other person who provides medical care	Yes	
Teeth whitening or bonding - Costs include bleaching and special whitening toothpaste. These expenses are always considered cosmetic and aren't eligible	No	
Toothbrush - Any type of toothbrush even if recommended by a Dentist or orthodontist	No	
Transportation expenses - Costs to receive medical care - including airfare, parking, tolls, taxis, rental cars, buses, gas for your car, or mileage	Yes	You must provide a statement of medical necessity from a Doctor documenting the medical condition for any expense \$100 or more if no diagnosis has been submitted previously
Tutoring - Tutoring fees, recommended by a Doctor, for a child who has severe learning disabilities caused by a mental or physical impairment, including nervous system disorders	Yes	You must provide a statement of medical necessity from a Doctor documenting the medical condition

Expense Item	Eligible?	Claim Details
Umbilical cord storage - Costs to collect, freeze and store umbilical cord blood only when a medical condition is present. Storage when no medical condition is present isn't eligible	Yes	You must provide a statement of medical necessity from a Doctor documenting the medical condition
Uniforms	No	
Unknown debit card MCC Code - Medical Debit Card Expense	No	
UVR treatments - Ultraviolet radiation treatments recommended by a Doctor for a medical condition, such as chronic psoriasis	Yes	
Vacation or travel - Time off or travel for general health purposes	No	
Vaccinations - Amounts paid for vaccinations or immunizations against disease	Yes	
Varicose vein Surgery - Expenses associated with the removal of varicose veins prescribed by a Doctor for treatment of a medical	Yes	You must provide a statement of medical necessity from a Doctor documenting the medical condition
Veneers - Only when covered by an insurance plan or recommended by a Dentist as the only course of treatment	Yes	You must provide either a statement of medical necessity from a provider indicating that veneers are the only course of treatment for the condition or an explanation of benefits indicating the amount paid by an insurance plan
Vision coinsurance - Amounts not covered by your or your spouse's vision plans	Yes	
Vision copayments	Yes	
Vision debit card - Vision Debit Card Expense	No	
Vision deductibles - Deductibles under your or your spouse's vision plans	Yes	
Vision expenses - Costs not covered by a vision plan	Yes	

Expense Item	Eligible?	Claim Details
Vision reasonable/customary - Amounts not paid by a vision plan that exceed reasonable and customary limits	Yes	
Vitamins - If prescribed by a Doctor to cure a medical condition; not eligible if simply taken for general health purposes	Yes	You must provide a statement of medical necessity from a Doctor documenting the medical condition
Vitamins - Taken for general health purposes	No	
Warranties - Warranties purchased for health-related equipment	No	
Weight loss - Program for general health	No	
Weight loss - Program to cure a medical condition and must be prescribed by a Doctor	Yes	Examples include medical costs and program fees for support groups and non-medically supervised programs; eligible programs include Weight Watchers, NutriSystem, and Medifast (food is often a part of these programs; however, the fees associated with food are not eligible). You must provide a statement of medical necessity from a Doctor documenting the medical condition.
Wheelchair	Yes	
Wigs - Wigs purchased with Doctor's recommendation for the mental health of a patient who has lost all of his or her hair from	Yes	
Work transportation expenses - Transportation costs to and from work, even though a physical condition may require special means of transportation	No	
Work-related medical expenses - Costs for an accident or illness not covered by workers' compensation or another medical plan	Yes	

Restriction on Eligible Expenses for non-Medicare eligible Retirees or Dependents: For families in which at least one eligible member is not a Medicare Eligible Participant, claims allowable for reimbursement from the Retiree HRA for the non-Medicare member are limited to Dental or Vision out-of-pocket expenses. This restriction is designed to allow non-Medicare members enrolled in the BCBS HDHP PPO to maintain eligibility to contribute to a Health Savings Account (HSA).

Only eligible expenses incurred while you (or your eligible Dependent) are covered by the Retiree HRA may be reimbursed from the Retiree HRA. Claims for reimbursement from the Retiree HRA may be filed as eligible expenses are incurred. An eligible expense is incurred when the services are provided and not when you are formally billed, charged or pay for the services. Reimbursement of eligible expenses will be paid only after the services are rendered. You may request reimbursement of eligible expenses **up to the remaining balance in your Retiree HRA** at any time after the eligible expense is incurred. After a claim is filed, ViaBenefits will make a benefit determination as set forth in the “Benefit Determinations” section below.

You are responsible for notifying Union Pacific Workforce Shared Services at (877) 275-8747, within 30 days after an event that disqualifies the individual from being considered a Dependent.

RETIREE HRA CLAIMS AND APPEALS:

You have the flexibility to submit HRA claims two ways – online or manually (paper claim form) in order to obtain benefits from your Retiree HRA. Please see “How to File a Claim” below.

In addition, for your convenience, certain insurance carriers have arranged with ViaBenefits to provide you with the option of the insurance carrier submitting claims on your behalf through a process called “Auto Reimbursement.” ViaBenefits can identify for you which insurance carriers provide this option. If you are covered by such an insurance carrier and elect to participate in auto reimbursement, after you have paid your insurance premium to the carrier, the carrier will notify ViaBenefits and thereby generate an HRA claim on your behalf in the amount of the premiums you have paid. Upon claim approval, ViaBenefits will automatically send you the reimbursement amount without you having filed a claim form.

If your claim for benefits is denied, you will receive written notice regarding the reason. The notice will point out what (if any) additional information is needed to possibly change the claim denial. The notice also will explain how to have the decision reviewed.

How to File a Claim: This section provides information about how and when to file a claim. Please note that claim and appeal decisions are based only on whether or not benefits are available under the Retiree HRA for the expense.

To receive a reimbursement from your Retiree HRA, you must file a claim, along with appropriate proof of expenses unless your claim is filed using the “Auto Reimbursement” process described above. Retiree HRA claims forms are available online at <https://my.viabenefits.com/unionpacific> or by calling ViaBenefits at (800) 935-7780.

Paper Claim Form Submissions:

- Complete the information on the front of the claim form.
- Prepare your supporting documentation:
 - If you are submitting a claim for your monthly premiums, attach a copy of the premium invoice from your plan or a copy of your bank statement/cashed check that can verify the payment. When submitting a claim, use the cover period start date as the date of service, not the date of payment. For example, if you are requesting reimbursement of January premiums, use January 1st as the service date.
 - For other healthcare expenses, attach copies of the corresponding itemized receipts or Explanation of Benefits (EOB) from your health plan. The receipt must include the following information:
 - Date of service.
 - Name of provider or supplier.
 - Name of patient.
 - Identification of product or description of service
 - Amount paid.
 - If you are submitting a claim for a drug or medicine, include a copy of your prescription for such drug or medicine.
- Sign and date your form.
- Submit your claim(s) by mail or fax:
 - Mail your claim form and supporting documents to:
ViaBenefits
P.O. Box 2396
Omaha, NE 68103-2396
 - Fax your claim form and supporting documents to (855) 321- 2605. Your claim should be page 1 of your fax, followed by the copy of your receipts or other supporting documents. You do not need to include a cover sheet.

Online Claim Form Submission:

- Log onto <https://my.viabenefits.com/unionpacific>.
- Under **My Account**, click **Login**. **Note:** If you are a first time user, you will need to create a new account by clicking on **Register**.)
- Go to the **Funds & Reimbursements** section and select the **File Reimbursement Requests** link.
- Select the **Financial Center** tab, then the **File a Spending Account Request** under the **My Account Actions** section.

- To enter your reimbursement, select the expense type, enter the date you incurred the expense, and the amount of the expense. If you have more than one reimbursement, click the **Add Another Expense** button and enter the information. Once you have finished entering all of your reimbursements, click **Next**.
- Confirm the details of your reimbursement(s), and then click **Next**. To edit your reimbursement(s), click **Previous**.
- Please select a method to submit your receipts for this reimbursement. We recommend uploading your receipts/documentation, as this will expedite the processing of your reimbursements. You may also fax or mail your receipts/documentation.
- To submit your receipts online, check the **Signature** box, then click the **Upload** button, and then follow the directions provided. Note that receipts submitted online must be in PDF format and less than 5 megabytes.
- To submit your receipts by fax, click the Fax button, and then follow the directions provided to create your coversheet. Print and sign your coversheet, and then fax it and your documentation to the number provided on the coversheet. Be sure to include all of your receipts and supporting documentation. A reimbursement is not considered complete and cannot be approved until all of its supporting documentation is received.
- To submit a reimbursement through the mail or fax, use the ViaBenefits reimbursement request form. Please follow the instructions carefully and use the address or fax number listed on the reimbursement request form. Remember to include your receipts or other documents you need to support your reimbursement request.

Note: Once your claim and receipts have been received and approved, you will generally receive payment within 14 days. If you are set up on direct deposit, payment will generally be issued within 2 to 3 days of the claim approval. Visit the ViaBenefits website at <https://my.viabenefits.com/unionpacific> for the most current status of your claim.

Assistance with your reimbursement funding: An Authorization to Release Protected Information (ARPI) form allows you to designate someone of your choice to see your allocation and fund balance, submit reimbursement requests and check on the status. This permits the person you designated to speak on your behalf without your presence on the telephone.

To print a copy of the ARPI from your online account, go to the **Funds & Reimbursements** section and select the **File Reimbursements Requests** link. Next select the **Resource Center** tab where you will find the list of available forms including the ARPI form to download and print. You can also call ViaBenefits, and we will send you a copy of the form. Once the form is filled out, send it to ViaBenefits using the contact information on the form. You may cancel this form at any time by calling ViaBenefits.

If your claim is approved, ViaBenefits will process a payment from your Retiree HRA in an amount equal to the lesser of the following amounts:

- The amount of the eligible expenses approved for reimbursement; or
- The remaining balance in your Retiree HRA.

ViaBenefits will send this payment to you either via mailed check to your address of record or by direct deposit to the bank account of your choice. If you wish to setup direct deposit you may receive instructions how to do so by calling ViaBenefits at (800) 935-7780 or through the ViaBenefits website at

<https://my.viabenefits.com/unionpacific>.

Explanation of Payment (EOP) Statements: Each time ViaBenefits processes a request for reimbursement, you will be sent an Explanation of Payment (EOP). This statement includes a summary of your paid reimbursements, available balance, and the amounts you have been reimbursed. A check will be included with the EOP for those without direct deposit. The EOP will list the reason for denial when a reimbursement request is denied.

If you have a question concerning your claim, you can contact ViaBenefits at (800) 935-7780.

Benefit Determinations: If your claim is denied, you will receive a written notice from ViaBenefits within a reasonable period of time, but not later than 30 days of receipt of the claim as long as all needed information was provided with the claim. ViaBenefits will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension for not longer than 15 days, pending your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, ViaBenefits will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

If Your Claim is Denied: If your claim is denied, ViaBenefits will send you a written notice of denial. The 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 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. The notice will describe any additional material or information needed to perfect your claim and an explanation of why the material or information is important, provide the claim appeal procedures and time limits applicable to such procedures, and provide a description of your right to request all documentation relevant to your claim.

You must first exhaust your appeal right (described below) before you have a right to bring a civil action under ERISA regarding your denied claim.

Retiree HRA Questions and Appeals:

This section provides information to help you with the following:

- You have a question or concern about your Retiree HRA benefits.
- You are notified that a claim has been denied and you wish to appeal such determination.

To resolve a question or appeal, follow these steps:

What To Do First:

You may informally contact ViaBenefits at (800) 935-7780 before requesting a formal appeal. If the ViaBenefits Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in “How to File a Claim” on page 152, you may appeal it as described below without first informally contacting ViaBenefits Customer Service. If you first informally contact ViaBenefits Customer Service and later wish to request a formal appeal in writing, you may do so by filing an appeal with the Plan Administrator as described below.

How to Appeal a Claim Decision:

If you disagree with a claim determination after following the above steps, you can contact the Plan Administrator in writing to formally request an appeal. All appeal requests must be sent to:

Union Pacific HR Benefits Attn:
Retiree HRA Appeals
1400 Douglas Street, STOP 0320
Omaha, NE 68179-0320

This written appeal must include your name, a description of the claim determination that you are appealing, a statement of each and every reason you believe the claim should be paid, and any written information to support your appeal. You may include information that was not submitted as part of your original claim. You should also include a copy of your claim form and supporting documentation.

Your appeal request must be submitted to the Plan Administrator within 180 days after you receive the claim denial.

Any review on your appeal will not give deference to the previous claim denial. The Plan Administrator (or delegate) will review your appeal request and take into account all documents and other information you submit relating to your appeal, regardless of whether such documents or information was submitted or considered in the previous claim decision. 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 and appeal for Retiree HRA benefits. The Plan Administrator (or delegate) will notify you in writing of its decision regarding your appeal within a reasonable period of time, but not later than 60 days from receipt of your request for review of the claim denial. The decision of the Plan Administrator (or delegate) on your appeal is final and binding. 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. The notice will describe your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim and appeal. In addition, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act, as amended (“ERISA”) if your appeal is denied.

TEMPORARY EXTENSION OF CLAIM AND APPEAL DEADLINES DUE TO COVID-19

The President of the United States declared a national emergency beginning March 1, 2020 as a result of the COVID-19 outbreak (“National Emergency Declaration”). The Internal Revenue Service and Department of Labor have issued rules providing for temporary extensions of the deadlines – as expressed in the section “Retiree HRA Claims and Appeals” – for you to submit or request any or all of the following:

- an initial claim for benefits; or
- an appeal of your denied claim.

Generally speaking, the deadline extensions are intended to provide you with more time to make these submissions and requests while the National Emergency Declaration remains in effect. Deadlines applicable to these or other actions related to your right to claim benefits will be extended as necessary to comply with applicable Federal requirements in effect during 2020 - 2021 in response to the COVID-19 outbreak. If you are unable to make one of the above-described submissions or requests by the deadline that ordinarily applies – as described in the section “Retiree HRA Claims and Appeals” - you may have additional time to do so. Please contact ViaBenefits at (800) 935-7780 for more information.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND OTHER FIDUCIARIES

In carrying out their respective responsibilities under the Retiree HRA Program and the Plan, the Plan Administrator, the third party claims administrator of the Retiree HRA and other plan fiduciaries shall have discretionary authority to determine facts, interpret and administer the terms of the Retiree HRA, and determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Retiree HRA and 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.

RETIREE MEDICAL PROGRAM - THIRD PARTY LIABILITY/SUBROGATION

Third Party Liability:

The Plan does not cover any expenses for which a third party is responsible as a result of having caused or contributed to a Sickness or Injury. The Plan may nonetheless pay the benefits that would otherwise be payable hereunder 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 a sickness or 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 a sickness or 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 a sickness or 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 BCBS (for BCBS HDHP PPO Program medical benefits and mental healthcare/Substance Use Disorder benefits), OptumRx (for BCBS HDHP PPO Program prescription benefits), EyeMed Vision Care (for BCBS HDHP PPO Program vision care benefits), or ViaBenefits (for Retiree HRA 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 retiree or Dependent will be made in accordance with any assignment of rights made by or on behalf of such retiree or Dependent that is required under a state’s Medicaid law. The Plan will not take into account the eligibility of a retiree or Dependent for Medicaid for purposes of enrollment or paying benefits under the Plan. To the extent payment has been made under Medicaid for medical assistance to a retiree or Dependent covered by the Plan and the Plan has a legal liability to pay for such medical assistance, payment of benefits under the Plan will be made in accordance with any state law which provides that the State has acquired the rights with respect to such retiree or Dependent to such payment for benefits.

REFUND FOR OVERPAYMENT OF BENEFITS

BCBS, EyeMed Vision Care, OptumRx, or ViaBenefits have the right to a refund of any Medical, Mental Healthcare/Substance Use Disorder, Vision Care, Prescription Benefits or Retiree HRA benefits, respectively they paid to you if you or your Dependents did not pay for those expenses or if you or your Dependents were reimbursed for any of those expenses by a source other than BCBS, EyeMed Vision Care, OptumRx, or ViaBenefits. The refund is the difference between the amount of benefits actually paid and the amount that should have been paid under the terms of the Plan. In addition, the Plan has a right to a refund of any benefit amount paid in excess of the benefit amount you are entitled to receive under the terms of the Plan.

If you do not promptly refund the required amount, BCBS, EyeMed Vision Care, OptumRx, or ViaBenefits may, in addition to other rights they may have, reduce the amount of any future benefits payable under the BCBS HDHP PPO or Retiree HRA and under any group benefits plan they issued to your employer by the amount of the refund.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

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 use your benefits and understand your rights under the Plan and ERISA.

Summary Plan Description:

ERISA requires that you receive easily understood descriptions of your benefits, called summary plan descriptions. The information about your benefits described in this document, together with 2021 UHC Retiree Medical Guide, Retiree HRA Guide and documents pertaining to the medical programs provided to certain retirees of Alton & Southern Railroad constitute the Summary Plan Description under ERISA.

Plan Sponsorship:

The Plan's coverage is sponsored by:
Union Pacific Corporation
1400 Douglas Street, Stop 0320
Omaha, NE 68179

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

Plan Administrator:

The official Plan Administrator of the Plan is the Executive Vice President & Chief Human Resources Officer, Union Pacific Railroad Company. The Plan Administrator administers the Plan and makes decisions about how Plan provisions apply in specific cases. To contact the Plan Administrator, forward your correspondence to:

Executive Vice President & Chief Human Resources Officer
Union Pacific Railroad Company
1400 Douglas Street, Stop 0350
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 Workforce Shared Services with any questions.

Your ERISA Rights:

As a participant in the Plan, 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 Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of the documents governing the operation of the Plan, including insurance contracts, copies of the latest annual reports (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

You may continue health care coverage for yourself, your Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event.

You, your Spouse or your dependents may have to pay for such coverage. Review the terms of the applicable retiree medical coverage option and any other documents governing the Plan on the rules regarding your COBRA continuation coverage rights.

Maternity and Newborn Infant Coverage:

- For those Retiree Medical Program options that provide maternity or newborn infant coverage, those options 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 Retiree 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 Physician and the patient. Such coverage is subject to Annual Deductibles, Coinsurance and Copay provisions, and other provisions that are applicable to the other benefits of the Retiree Medical Program option.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the plans or exercising rights under ERISA.

Enforce Your Rights:

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

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

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

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

Assistance with Your Questions:

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

Claiming Your Benefits:

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

How You Can Appeal:

If your claim is denied, you have the right to appeal that decision. You may also submit in writing reasons why you think your claim should not be denied. Please refer to the claims and appeals sections regarding how you can appeal.

Besides having the right to appeal, you or your authorized representative can examine any Plan documents (except legally privileged information) related to your claim.

Serving Legal Process:

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

Executive Vice President & Chief Human Resources Officer
Union Pacific Railroad Company
1400 Douglas Street, Stop 0350
Omaha, NE 68179
Telephone: (402) 544-5000

Future of the Plan:

Union Pacific 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 retiree contributions at any time. Similarly, a participating employer can take such actions with respect to its retirees. Reasonable efforts will be made to provide Plan participants with notice of any such change.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to determine facts, interpret the terms of the Plan, and 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:

The following chart lists the employer identification number, policy numbers and plan number for the Plan. It also lists the Plan Year, the twelve-month period for which Union Pacific maintains financial records for the Plan.

Technically, the Plan is known as a welfare benefit plan.

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

PLAN NAME	PLAN NO.	INSURANCE CARRIER, ADMINISTRATOR OR TRUSTEE	CONTRACT OR POLICY NO.	PLAN YEAR	CONTRIBUTION SOURCES
Union Pacific Corporation Group Health Plan Retiree Medical Program	502 Group Health Plan			1/1 - 12/31	Retirees & Employers
1. BCBS HDHP PPO Program –		BlueCross/ BlueShield Fifth Avenue Place, 120 Fifth Avenue Pittsburgh, PA 15222			
a. Medical & Mental Healthcare/ Substance Use Disorder		Quantum Health 7450 Huntington Park Drive Columbus, OH 43235			
b. Pharmacy		OptumRx 11000 Optum Circle Eden Prairie, MN 55344			
c. Vision Care		EyeMed Vision Care LLC 4000 Luxottica Place Mason, OH 45040	9235524 – Vision Care		
Union Pacific Corporation Group Health Plan Retiree Medical Program	502 Group Health Plan				
2. UHC HDHP PPO Program –		UMR 115 W Wausau Ave Wausau, WI 54401			
a. Medical & Mental Health /Substance Use Disorder		Quantum Health 7450 Huntington Park Drive Columbus, OH 43235			
b. Pharmacy		OptumRx 11000 Optum Circle Eden Prairie, MN 55344			
c. Vision Care		EyeMed Vision Care LLC 4000 Luxottica Place Mason, OH 45040	9235524 – Vision Care		
3. Retiree HRA		ViaBenefits 10975 South Sterling View Drive, Suite A-1 South Jordan, UT 84095			

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 **(HIPAA)**

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

Entities Responsible for HIPAA Compliance:

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

Availability of Notice of Privacy Practices:

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

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

Permitted and Required Uses and Disclosure of Protected Health Information:

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

1. The Group Health Plan receives proper written authorization from the participant or the participant's representative. The authorization must specifically authorize the use or disclosure. A proper authorization form is required for uses by or disclosure to Union Pacific if the use or disclosure does not meet the condition described in Paragraphs 2, 3, or 4 below;
2. The Group Health Plan discloses information to Union Pacific that is, for purposes of HIPAA's privacy rule, enrollment or disenrollment information;
3. The Group Health Plan provides Union Pacific with Protected Health Information in the form of Summary Health Information for the purposes of obtaining premium bids, or determining whether to modify, amend or terminate the Group Health Plan provided, however, that such Protected Health Information used for 'underwriting purposes' (as defined in the HIPAA regulations) shall not include Protected Health Information that is 'genetic information' (as defined in the HIPAA regulations); or

4. The Group Health Plan receives a signed certification from Union Pacific that the Group Health Plan documents restrict the use and disclosure of the Protected Health Information as required by the HIPAA regulations on privacy and confidentiality, and Union Pacific agrees to comply with the restrictions, and the information has been requested to carry out administrative functions (i.e., payment or health care operations functions) which Union Pacific performs for the Group Health Plan, and the uses and disclosures of Protected Health Information by Union Pacific will be restricted to plan administration functions performed by Union Pacific on behalf of the Group Health Plan in accordance with the Group Health Plan document.

Conditions of Disclosure:

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

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

retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- j. Ensure that the adequate separation between the Group Health Plan and Union Pacific required in the HIPAA regulations is satisfied.

Adequate Separation between Group Health Plan and Plan Sponsor:

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

- Executive Vice President & Chief Human Resources Officer, Union Pacific Railroad Company
- Assistant Vice President Talent Management, Union Pacific Railroad Company
- Union Pacific Workforce Resources Services
- Union Pacific Workforce Resources Benefits Group
- Union Pacific Workforce Resources Compensation Group
- Union Pacific Workforce Resources Information Systems Group
- Union Pacific Payroll Group
- Union Pacific Audit Group

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

Reports of Non-Compliance:

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

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

Definitions:

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

“Protected Health Information” means “individually identifiable health information” that is maintained or transmitted by the Group Health Plan. Protected Health

Information does not include individually identifiable health information in employment records held by Union Pacific.

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

- 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.

GLOSSARY

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.

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.

Balance Billing (or Bills) - A billing from a medical provider that is usually for an amount that the BCBS Health Plan did not pay. Most often, the member is financially responsible for balance bills, but in some instances, the provider could be Balance Billing in error. For instance, network, or contracted, providers are prohibited from Balance Billing, when the balance results from charges that exceed contractually agreed-upon rates.

Benefit Year - The 12-month period beginning January 1 and ending December 31. All Annual Deductibles, Coinsurance Maximums and benefit maximums accumulate during the Benefit Year.

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 RN 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 - a period that starts on any January 1st and ends on the next December 31st.

Covered Services - Benefits, 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.

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 Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn Child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

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 Retiree Medical 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/Investigational, you or the Hospital and/or professional provider may contact BCBSNE's Member Service 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 a 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 according to 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.

Lifetime - The periods of time you or your eligible Dependents participate in this Plan.

Maximum Benefit Amount - A maximum amount determined by BlueCross/BlueShield of Nebraska or a BlueCard Program On-site Plan to be reasonable. The Maximum Benefit Amount will be the amount agreed upon between BlueCross/BlueShield of Nebraska and BluePreferred and Preferred Providers of the covered service, or the maximum amount agreed upon by the On-site and its contracting providers. If no amount has been established for a covered service, BlueCross/BlueShield of Nebraska may consider the charges submitted by providers for like procedures, a relative value scale which compares the complexity of services provided, or any other factors deemed necessary.

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

Medically Necessary (Medical Necessity) - 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 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 patient's 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 health care provider; and
 - e. Not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.
 5. Not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

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

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 - A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care, specifically designed for the diagnosis and active treatment of a Mental/Nervous Disorder when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or Hospitalization.

Partial Hospitalization programs must provide diagnostic services; services of social workers; psychiatric Nurses and staff trained to work with psychiatric patients; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

The facility providing the Partial Hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a Doctor.

Plan Administrator - The Plan Administrator is the Executive Vice President & Chief Human Resources 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 BlueCross/BlueShield or other persons under the terms of the Plan.

Plan Sponsor - Union Pacific Corporation.

Plan Year - The 12-month fiscal period for BlueCross/BlueShield 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.

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 UnitedHealth Pharmaceutical Solutions 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 large group of Healthcare Providers constructed and contracted BlueCross/BlueShield to provide certain services for which benefits are considered at special levels.

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 Use Disorder or tuberculosis, except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of mental/nervous conditions or Substance Use Disorder 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 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;
 - 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 - 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 Use Disorder Treatment Facilities, Chemical Dependency/Substance Use Disorder Day Treatment Facilities, Rehabilitation Facilities, and Residential Treatment Facilities, as those terms are specifically listed in Covered Medical 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.

Substance Use Disorder Treatment Facility(ies) - A public or private facility licensed and operated according to the law, which provides:

- A program for diagnosis, evaluation and effective treatment of substance use disorder;
- Detoxification services;
- Professional nursing services provided by licensed practical Nurses who are directed by a full-time RN; and
- The facility must have a Doctor on staff or on call.

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

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.

BENEFIT CONTACTS

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

- Care Coordinator/Customer Service.....(855) 649-3855
- Website - MyQHealth.....www.UPMyQHealth.com

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

- Toll-Free.....(877) 275-8747
Fax Number.....(402) 233-2736
Email Address.....HRSC@up.com
Mailing Address.....1400 Douglas Street, Stop 0320, Omaha, NE 68179
- All General Nonagreement or Retirement Benefit Questions
 - Medical/Dental/Vision
 - Pension
 - Service Awards/Retirement Awards

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

- Website/Provider Directory.....www.eyemed.com
- Member Services.....(866)723-0513

ViaBenefits (for Medicare Eligible Participants)

- Website.....https://my.viabenefits.com/unionpacific
- Retiree HRA claims and other questions.....(800) 935-7780
- Voluntary decision support services to choose individual Medicare plan coverage.....(800) 935-7780



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