

# Healthy Standard Appeals Form

*This communication applies to both BBU and Bimbo QSR non-union associates.*

## Instructions for Associates:

We encourage all associates and families to take an active role in managing their health. As part of our program, all salaried and non-union hourly associates and their spouses who are enrolled in a Bimbo Bakeries USA (BBU) or Bimbo QSR (referred to collectively as "Company") medical plan are eligible to participate in a voluntary Wellness Screening. The Company rewards individuals for understanding their health status by participating in a Wellness Screening and provides a medical plan premium discount just for obtaining the screening. The Company also provides medical plan premium discounts for achieving certain Healthy Results, such as:

| Test Name (Health Measure)             | Healthy Results                                                                                               | Alternatives                                                                                                                                                                                                                                                                                   |
|----------------------------------------|---------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Height, weight and waist circumference | BMI under 30, or Waist circumference less than or equal to 35" for female; less than or equal to 40" for male | Complete the Well onTarget® Program, a six week self-guided weight loss program with interactive coaching sessions, by September 30, 2027. Associates/spouses who qualify for this program will receive a personal communication with details on this program starting in first quarter, 2027. |
| Serum Cotinine (nicotine by-product)   | Tobacco-free                                                                                                  | To complete the Pelago tobacco cessation program, participants must complete the <b>Essentials 1</b> learning module in the mobile app and complete at least <b>six coaching engagements</b> (minimum of one per week for a total of six weeks) by September 30, 2027.                         |

If your physician confirms it is not medically appropriate for you to obtain a venipuncture blood test or achieve healthy results between August 1 – September 30, 2026, (or January 1 – January 31, 2027 if eligible for 2<sup>nd</sup> round screening) we will waive the blood test requirement to earn the Wellness Screening discount.

The Company understands that an individual, in some instances, may not be able to participate in a venipuncture blood test or meet one or more of the Healthy Results due to circumstances beyond their control. **If it is NOT medically appropriate for you to achieve one or more of the above Healthy Results or Alternatives, please share this form with your physician to receive an appropriate Physician Alternative for the applicable health measure(s).**

## Instructions for Physician:

- **If appropriate, this visit should be coded as preventive, not diagnostic.**
- For individuals covered under a Company medical plan, all in-network preventive care is covered at 100% for one annual preventive screening every calendar year.

## Questions?

- For questions about Healthy Results (BMI, Tobacco-free), please call Quest Diagnostics at 1-855-623-9355.
- For questions about completing this form or Physician Alternatives, contact the Benefits Department at **HRBenefitSolutions@grupobimbo.com**.
- For questions about billing or to verify preventive benefits, please call Blue Cross Blue Shield of Illinois' Customer Service at 1-877-239-7449.

**To Submit Form: You must email this form by September 30, 2026 (or January 31, 2027 if eligible for 2<sup>nd</sup> round screening).**

**Email to:** HRBenefitSolutions@grupobimbo.com

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Complete this form only if your Wellness Screening results do not meet the Healthy Results criteria and you are requesting a Physician Alternative; or if you are requesting a venipuncture blood test waiver.

## Patient Information

Associate Name: \_\_\_\_\_

Associate ID #: \_\_\_\_\_

Associate Email: \_\_\_\_\_

Patient Name: \_\_\_\_\_

I authorize my physician to release the private health information contained in this form to the Company. (Important: The patient requesting the alternative must sign below.)

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Physician to Complete:

**Please review this form carefully, attest to the appropriate information, and if applicable, indicate your recommended Alternative and then sign and date this form.**

As the treating physician, I hereby attest that it is NOT medically appropriate for the patient to **(please initial only those that apply)**:

1. \_\_\_\_\_ Complete the Well onTarget® Program for weight loss by September 30, 2027.
2. \_\_\_\_\_ Complete the Pelago tobacco cessation program by September 30, 2027.
3. \_\_\_\_\_ Participate in a blood test or have blood drawn via venipuncture (No Alternative required)

### Physician Weight Alternative (please supply):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ Please check if an Alternative is not medically appropriate.

### Physician Tobacco Alternative (please supply):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ Please check if an Alternative is not medically appropriate.

**NOTE TO PARTICIPANT:** You are only eligible to receive discounts for those items your physician initials and provides a recommended Alternative, unless your physician indicates an Alternative is not medically appropriate.

By signing this form, I certify that the above information is true and correct.

Physician's Name (print): \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Date: \_\_\_\_\_

**Attention Associate or Spouse: Please retain a copy of this form for your records.**