IRON ROAD HEALTHCARE

60/30 Plus Plan
Summary Plan Description and Plan Document

2023

PO Box 161020 • Salt Lake City, UT 84116-1020 • Phone: 1-800-547-0421 • Fax: 801-595-4399

Table of Contents

60/30 Plus Plan for Qualified Members

In 1870, visionaries at Union Pacific and other railroad companies recognized the need to treat sick and injured employees. From that need, railroad hospital associations were born. These associations flourished as the “iron road” crisscrossed the United States. At their peak, 35 different hospital associations served nearly 550,000 railroad employees with more than 3,700 hospital beds. Each employee was asked to contribute a fee of $0.50 to cover the cost of future care. These hospital associations were the forerunner to today’s health insurance plans. And their doctors and nurses made monumental contributions to the advancement of health care—especially in the field of emergency medicine.

The last 148 years have brought significant advancements in medicine and health care and have set the stage for today’s modern health plan. Union Pacific Health (Iron Road Healthcare) and its predecessors have been there every step of the way. In 1947, the hospital association separated from Union Pacific and became an independent entity dedicated to providing coverage and care for Union Pacific employees.

The face of Iron Road has evolved, but our commitment remains constant. Iron Road is one of only five remaining hospital associations in the country. Today, services are provided to members as part of a not-for-profit health plan using the Anthem Blue Cross Blue Shield and First Health provider network. We provide coverage from the first day of employment and into retirement through our comprehensive Medicare plans. As a result, 30,000 members in more than 30 states have access to some of the best and most convenient health care in the country.

Time and history have proven our dedication to our members. Iron Road is proud to be your Plan For Life.

GENERAL INFORMATION

This booklet is the plan document for the IRON ROAD Challenger Health Plan for Active Employees ("Plan"). It also serves as the Summary Plan Description ("SPD") of the Plan and is written to familiarize you with the benefits provided by the Plan. This booklet is effective January 1, 2022.

Read this booklet carefully and keep it in a safe place for future reference. Additional copies will be furnished at any time upon request to IRON ROAD Business Office. The booklet is also available online at ironroadhealthcare.com.

To reduce your out-of-pocket costs for medical care and to obtain the highest benefits from this Plan, you are urged to utilize the services of an available IRON ROAD Network Provider. IRON ROAD provides maximum benefits for treatment by physicians, surgeons, and other medical professionals who are in the Iron Road Provider Network, as more fully set forth in this booklet. The responsibility for obtaining the services of an available Iron Road Network Provider is entirely that of the Member, family, or personal representative.

The names and addresses of Iron Road Network Providers can be obtained from the Iron Road website at ironroadhealthcare.com. Pre-certification (pre-approval) is required for certain types of medical services and supplies. To request pre-certification or to file a health claim refer to Article VIII.

If you do not utilize the services of a Iron Road Network Provider, your level of benefits will be reduced and you will have to pay part or all of the expenses incurred for your care. However, there are provisions in this booklet which will reimburse you in certain situations for temporary emergency treatment when a Iron Road Network Provider is not available. However, these provisions are very limited and strictly enforced.

The Plan provides limited continuation of coverage when your employment terminates, when you are furloughed, or when you are on a leave of absence. In most instances, payment of Iron Road Premiums must be continuous to maintain eligibility for the Plan. If you are off the payroll for any full month and Premiums payments are not waived, it is your personal responsibility to make payment of your Iron Road Premiums directly to Iron Road in accordance with provisions contained in Article V of this booklet.

Members who are on an approved medical leave of absence and receiving Iron Road coverage as described in Article V, Section 2(e) of this Plan may be required to provide evidence of an ongoing qualifying medical condition to remain eligible for continued benefits during their leaves of absence.

Members planning to retire from the service of the Union Pacific Railroad, regardless of the reason, are required to promptly write, email, or call Iron Road for proper instructions. The contact information for Iron Road is:

Iron Road Healthcare
P.O. Box 161020
Salt Lake City, UT 84116-1020
801-595-4300
help@ironroadhealthcare.com

Remember, not all medical services and supplies are covered by this Plan. It is your responsibility to know your benefits under this Plan. If you are in doubt or have any questions whatsoever, you should contact Iron Road.

Members and their doctors should consult the Pharmacy Benefit Guide for pharmacy benefits in conjunction with this Plan.

Members who become eligible for Medicare, regardless of the reason, must accept Medicare coverage, both Part A and Part B, and are advised to promptly write or call Iron Road Healthcare for proper instructions. Failure to accept full Medicare coverage will result in the loss of your Iron Road Healthcare membership. The address is:

Iron Road Healthcare
P.O. Box 161020
Salt Lake City, Utah 84116

Phone: **(801) 595-4300**

Railroad line: **8-595-4300** or Toll free **1-800-547-0421**

An employee who applies for an annuity and has received Railroad Retirement Board (RRB) award notification, will not be eligible for benefits under the Challenger Health Plan for Active Members. Such a person is eligible for benefits under the Iron Road Healthcare Plan for 60/30 Plus Members.

PLAN TELEPHONE NUMBERS AND ADDRESSES

Hospital Admission or Inpatient Behavioral Health Care (ANTHEM)

PRE-CERTIFICATION REQUIRED
Telephone: 866-776-4793

Customer Service

P.O. Box 161020
Salt Lake City, UT 84116-1020
Telephone: 1-800-547-0421
801-595-4300
ironroadhealthcare.com
help@ironroadhealthcare.com

Mail Order Pharmacy (Depot Drug)

*(All states **except** Alabama, Alaska, Connecticut, Delaware, Hawaii, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Vermont, Virginia, West Virginia)*

Depot Drug Mail Order Pharmacy
P.O. Box 165090
Salt Lake City, UT 84116-5090
Telephone: 1-800-331-6353
Fax: 801-595-4440
ironroadhealthcare.com

E-prescribe: Depot Drug Salt Lake City, Utah

Mail Order Pharmacy (OptumRX)

(Residents of Alabama, Alaska, Connecticut, Delaware, Hawaii, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Vermont, Virginia, West Virginia)

OptumRx
P.O. Box 2975
Mission, KS 66201
Telephone: 1-800-880-1188
optumrx.com

E-prescribe: Optumrx

Walk-In Pharmacies

Depot Drug Pharmacy
221 S. Jeffers St. Suite 2
North Platte, NE 69101-5371

Telephone: 308-534-8886
Fax: 308-534-7825

E-prescribe: Depot Drug North Platte, Nebraska

Radiology Imaging (Preauthorization)

Telligen
Telephone: 877-654-1375
Web approval: https://myqualitrac.com

Complete Sleep Program

P.O. Box 161020
Salt Lake City, UT 84116
Telephone: 1-833-878-2727
Fax: 801-595-2051
https://thecompletesleepprogram.com/

ARTICLE I – DEFINITION OF TERMS

These terms have the following definitions for purposes of the Plan:

1) **Active Employee** means any full-time employee of the Company as determined by the criteria set out by the Company.

   a) The following are not considered Active Employees under this Plan:

   b) Non-Member – An employee of the Company who is not eligible for membership in Iron Road.

   c) Special Work Employee – An employee who would be an Active Employee, except that the person is employed part-time on special work.

   d) Part-time employee. Employees of the Company who are working on a part-time basis as determined by the Company.

2) **Board** means the Board of Trustees of Iron Road as described in Article IV hereof.

3) ***60/30 Plus Member*** *means a Pensioned Employee who retires from the ages of sixty (60) to sixty-four (64) with thirty (30) years or more of service. Coverage under this Plan terminates at the time the 60/30 Plus Member becomes eligible for Medicare benefits, at which time membership benefits of Iron Road Healthcare shall convert to Medicare Pensioner coverage for supplemental benefits.*

4) **Company** means the Union Pacific Railroad Company or its subsidiaries and affiliated companies whose eligible employees are now or may hereafter become Members of Iron Road by the payment of Premiums.

5) **Dismissed Employee** means a former employee of the Company who was a Member of this Plan as an Active Employee on the day before becoming a former employee (whether voluntarily or involuntarily) and who is not a Separated Employee.

6) **Domicile or Custodial Care** means the type of care, wherever furnished and by whatever name called, that is designed primarily to assist an individual in meeting his or her activities of daily living.

7) **Durable Medical Equipment** means equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury and is appropriate for use by the Member or in the home.

8) **Emergency** means a medical condition (1) manifesting itself by symptoms, including acute symptoms of sufficient severity (including severe pain), that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of

immediate medical attention would 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; (2) that is a serious impairment to bodily functions; or (3) that is a serious dysfunction of any bodily organ or part.

9) **Furloughed Employee** means any Active Employee who is a Member on the day before the start of a furlough (including furlough because of a reduction in force where seniority is retained).

10) **Home Health Care** means medical care received in the Member's home. Home Health Care requires pre-certification by an Iron Road Care Coordinator and is covered when deemed medically necessary. To be covered, Home Health Care must be part of a written plan of care prescribed, periodically reviewed, and approved by a physician (M.D. or D.O.). In the plan of care, the physician must certify that confinement in a hospital or Skilled Nursing Facility would be required without home health services. Services must be furnished and billed by a home health agency or Home Health Care provider that is Medicare-certified or is licensed or certified by the state it operates in. Services must be provided by a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a person with a master's degree in social work. Also included in this benefit are medical equipment and supplies provided as part of Home Health Care.

11) **Hospice** means a licensed agency that operates within the scope of such license providing palliative care and treatment of patients with a life expectancy of six (6) months or less where the focus is the acknowledgment of death and dealing with its physical and psychological aspects. Hospice must meet the following criteria:

    a) It is approved under any required state or governmental Certificate of Need.

    b) It provides service twenty-four (24) hours a day, seven (7) days a week.

    c) It is under the direct supervision of a licensed physician.

    d) It has a nurse coordinator who is a registered nurse with four (4) years of full-time clinical experience. Two (2) of these years must involve caring for terminally ill patients.

    e) It has a social service coordinator who is licensed in the area in which it is located.

    f) The main purpose of the agency is to provide Hospice services.

    g) It has a full-time administrator.

    h) It maintains written records of services given to the patient.

i) Its employees are bonded, and it carries malpractice and misplacement insurance.

j) It is established and operated in accordance with any applicable state laws.

12) **Hospital Pre-Certification Coordinator** means the person or entity to be contacted for pre-certification of hospital admissions under Article VI, Section 2.

13) **Medical Leave of Absence Employee** means any Active Employee who is a Member on the day before an authorized medical leave of absence for sickness, or injury (whether on-duty or off-duty), provided such leave of absence is not taken to engage in employment outside the Company. An Active Employee who is a Member on the day before being physically disqualified for work by the Company is also a Leave of Absence Employee.

14) **Personal Leave of Absence Employee** means any Active Employee who is a Member on the day before an authorized leave of absence for personal or business, provided such leave of absence is not taken to engage in outside employment.

15) **Medical Necessity or Medically Necessary** means health care services that a physician or other health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, disease, or its symptoms, and that are:

a) In accordance with the generally accepted standards of medical practice;

b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

c) Not primarily for the convenience of the patient or physician, other physician, or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

16) **Member** means any Active Employee, Dismissed Employee, Furloughed Employee, Leave of Absence Employee, Separated Employee or Suspended Employee who is paying Premiums to Iron Road or whose Premiums are waived by the Plan. It also includes certain employees of Iron Road, their spouses, and children up to age 26. The Board may also designate other persons as Members.

17) **Plan Allowable** means, for in-network providers, the amount allowed on the Iron Road fee schedule for services billed by a Iron Road Network Provider. For out-of-network goods or services, the Plan Allowable is the lesser of the billed charges(s) or the usual and customary charge as established by or on behalf of Iron Road for those goods and services in the area. Under no circumstances shall the Plan Allowable include any interest or other charge related to the period between when a good or service is incurred and when the Plan benefits for such good or service are paid or reimbursed by the Plan.

18) **Pensioned employee** means a former employee with 60 (sixty) months or more of compensated service with the Company or with a Labor Organization representing employees of the company who is also receiving an annuity under the Railroad Retirement Act (RRA) or Social Security (SS). To be eligible for Iron Road retirement plans a member must be in good standing at the time of his/her application for an RRA/SS annuity.

19) **Separated Employee** means any Active Employee who is a Member on the day before becoming a former employee (whether voluntarily or involuntarily) and who receives a separation allowance from the Company, provided such Active Employee has been a Member for five (5) years prior to termination of employment and is eligible to retire under the Railroad Retirement Act within ten (10) years of receiving such separation allowance.

20) **Skilled Nursing Facility** means an institution that meets the following criteria:

a) It is operated under applicable law and is Medicare certified.

b) It is under the supervision of a licensed physician or registered nurse (RN) who is devoted full-time to supervision.

c) It is regularly engaged in providing room and board and continuously provides twenty-four (24) hours a day skilled nursing care of sick and injured persons during the convalescent stage of an injury or sickness.

d) It maintains a daily medical record of each patient who is under the care of a duly licensed physician.

e) It is authorized to administer medication to patients on the order of duly licensed physicians.

f) It is not, other than incidentally, a home for the aged, blind or deaf, a hotel, a domiciliary care home, a maternity home or a home for substance abuse or mental health treatment.

21) **Suspended Employee** means any Active Employee who is a Member on the day before being suspended from employment by the Company.

22) **Iron Road** means Union Pacific Railroad Employes Health Systems.

23) **Iron Road Appeals Administrator** means the Director of Medical Services.

24) **Iron Road Care Coordinator** is a licensed registered nurse who works for Iron Road to help Members coordinate appropriate health care services for cases involving complicated illness and injury and who must be contacted for pre-certification or authorization of certain goods and services as set forth in the Plan.

25) **Iron Road Claims Administrator** means the person(s) described in Article VIII, Section 2(f) to make claims determinations under Article VIII.

26) **Iron Road Network Provider** means any physician, facility, or service in the Iron Road Provider Network. The term includes a Iron Road Physician and Iron Road Facility.

27) **Iron Road Prescription Drug Coordinator** is the Iron Road employee assigned responsibility by the President to make claims determinations about benefits covered by Article VI, Section 5 (Prescription Drugs).

ARTICLE II – OBJECT AND PURPOSE

Section 1 – Object and Purpose

The object and purpose of Iron Road under this Plan shall be to furnish benefits for certain preventive care services and for the diagnosis and treatment of illness and injury to sick and injured company retirees and their eligible spouses including dependents of certain Members as designated by the Board. . Iron Road provides medical benefits to Active Employees and their eligible family members under other plans.

Section 2 – Source of Funding

With the Premiums collected from or on behalf of its Members, Iron Road will endeavor to furnish comprehensive medical care to Members and others entitled to Plan benefits, subject to the limitations set forth in this Plan. Premiums are placed in a trust and Plan benefits are payable from such trust funds.

Section 3 – Lifetime Maximum

The 60/30 Plus plan has a lifetime maximum benefit of $500,000.

ARTICLE III – FUNDS AND PROPERTY OF IRON ROAD

No Member, former Member, employee, former employee, dependent, medical provider or other person or entity shall have any vested right in the funds or property of Iron Road. All funds and property shall belong to the Union Pacific Railroad Employes Health Systems and be used for the object and purpose of Iron Road as set forth in Article II hereof. No Member shall be entitled to any refund of Premiums because of leaving the service of the Company for any other cause except that upon request refunds will be made to next of kin when a Member dies for those amounts covering monthly Premiums beyond the month in which death occurred, which were paid in advance by such Member.

ARTICLE IV – ADMINISTRATION

Section 1 - Board of Trustees

The business and affairs of Iron Road are under the management and control of the Iron Road Board of Trustees that consists of no more than eleven (11) Members of Iron Road as follows:

1. Four (4) Trustees are appointed by the President of Union Pacific Railroad Company.

2. Five (5) Trustees are elected by the Union Pacific General Chairpersons Association.

3. Two (2) Trustees are General Chairpersons elected by the membership of the two (2) railway labor organizations that participated at the time of the merger of Iron Road with the Missouri Pacific Employees' Health Association that have the largest number of Members (or the designee of each such General Chairpersons).

The Board of Trustees shall have the right to use its full discretion in construing and resolving any discrepancies regarding the use or application of any term or provision of this Plan. Any interpretation made pursuant to such discretion shall be given full force and effect, unless it can be shown that the interpretation is arbitrary or capricious.

Section 2 - President

The Board shall appoint the President of Iron Road.

The President shall, under the direction of the Board, have immediate supervision of business affairs of Iron Road. All questions concerning the day-to-day business administration and professional services of Iron Road will be decided by the President.

ARTICLE V – OPERATING FUNDS AND COVERAGE

Section 1 – Source of Funds

The monthly premium for the Plan ("Premium") are amounts necessary to carry out the object and purpose of Iron Road and this Plan. These Premiums are paid to Iron Road by or on behalf of all Members, in the manner provided in this Plan. Payments to support Iron Road and the Plan are also made by the Company through agreements with the National Carriers Conference Committee and the Cooperating Railway Labor Organizations.

Section 2 – Payment of Premiums by a Pensioned Employee Member

Employees who apply for retirement (annuity), must also make a Pensioned Employee application to Iron Road Healthcare within thirty (30) days after the date of filing for disability or age retirement (annuity) with remittance of dues for the first three (3) applicable months as determined by the President for continued membership. If at any period of time coverage is incorrectly provided under the Challenger Plan when the Member should be in another Retiree Plan, Iron Road Healthcare shall apply all associated benefits incorrectly provided under the Challenger Plan to the appropriate Retiree Plan, taking into consideration the applicable benefits and/or lifetime maximum(s) for that Retiree Plan. Failure to make written application or failure to remit dues in advance within the time limits set forth, shall automatically and without notice terminate the right of the pensioned employee to thereafter contribute and receive benefits set forth in the appropriate Iron Road Healthcare Summary Plan Description(s).

PENSIONED EMPLOYEE means a former employee with 60 months or more of compensated service during the last period of service with the Company, Iron Road, or with a labor organization representing employees of the Company, who is receiving an annuity under the Railroad Retirement Act or Social Security, and who at the time of applying for annuity was:

1) In the service of the Company, Iron Road or such labor organization, or on furlough with seniority and rights to recall retained, or carried on a craft seniority roster with the designation "physically disqualified"; and,

2) Was, on the last day of service with the Company, Iron Road, or such labor organization, a member of Iron Road, (and who, in the case of an employee on authorized leave of absence, furlough or physical disqualification, continued membership by payment of dues during the period on leave, furlough or physical disqualification.) Time off on authorized leave of absence or during furlough when seniority and rights to return to service are retained, or for discharge in cases where employees are subsequently reinstated, will not constitute a break in service under this provision; provided, however, that no former employee will be considered to be a "Pensioned Employee" unless such employee has 12 months of continuous membership in Iron Road Healthcare immediately prior to the time of applying for annuity.

Section 3 – Collection of Premiums: Direct Payment of Premiums by Member

When paying Premiums directly, Iron Road Members shall make the check or money order payable to Iron Road Healthcare and send it to P.O. Box 161020, Salt Lake City, Utah 84116-1020. The Member must include with the Premiums payment a note or letter containing the following, as applicable:

1) The Member's name, address, telephone number and occupation

2) The Member's identification number on his or her Iron Road Insurance Card

"SPECIAL NOTICE" – Employees who apply for disability or age retirement (annuity) must also make application to the Iron Road within thirty (30) days after the date of fling for disability or age retirement (annuity) with remittance of Premiums for the first three (3) applicable months as determined by the President for continued membership. If at any period of time coverage is incorrectly provided under the Plan when the Member should be in another age retirement Plan, Iron Road shall apply all associated benefits incorrectly provided under the Plan to the appropriate Retiree Plan, taking into consideration the applicable benefits and/or lifetime maximum(s) for that Retiree Plan.

Failure to make written application or failure to remit Premiums in advance within the time limits set forth in this Section 3 shall automatically and without notice terminate the right of the pensioned employee to thereafter contribute and receive benefits set forth in the appropriate Iron Road Summary Plan Description(s).

ARTICLE VI – BENEFITS

Section 1 - Benefits

This Article describes the benefits of the Plan and the rules and exceptions regarding these benefits.

1) Except as otherwise provided by the Plan, goods or services received from a Iron Road Network Provider are payable at 100% of the Plan Allowable (contracted rate) less any applicable co-pay(s) and or co-insurance payable by a Member.

2) Except as otherwise provided by the Plan, benefits for goods or services received from a provider not in the Iron Road Network (an out-of-network provider), even if a Member is referred to an out-of-network provider by an Iron Road Network Provider, are paid at 40% of Plan Allowable. If Iron Road Network Providers are not available, exceptions may be made by contacting a Iron Road Care Coordinator in advance. In addition to the 60% coinsurance for goods and services provided by an out-of-network provider, you may be responsible for paying the out-of-network provider the difference between the provider's billed charges and the Iron Road Plan Allowable.

3) All benefit payments are subject to the Plan Allowable.

4) The Plan has a per Member per calendar year out-of-pocket limit of $$9,100 for in-network goods and services that qualify as "essential health benefits" under the Affordable Care Act. After the Member has paid $9,100 of in-network eligible out-of-pocket expenses, the Plan will pay 100% of covered benefits for essential health benefits. Certain out-of-pocket costs, such as premiums, prescription copayment assistance, goods and services not covered by the Plan, and penalties for not obtaining required pre-certification, do not count towards the out-of-pocket limit. Out-of-pocket expenses for non-essential health benefits (for example, bariatric surgery benefits, and hearing aids) do not count towards the out-of-pocket limit. Out-of-pocket expenses a Member incurs for out-of-network services and goods do not count towards the out-of-pocket limit and there is no out-of-pocket limit for out-of-network services and goods.

5) Iron Road Healthcare utilizes the Blue Cross/ Blue Shield network of providers. Members may locate Iron Road Network Providers by contacting the Iron Road office at 1-800-547-0421, by email at help@ironroadhealthcare.com or by searching the Iron Road website ironroadhealthcare.com. Provider lists are furnished automatically, without charge as a separate document upon request or may be accessed by going to https://www.bcbs.com/find-a-doctor

Section 2 – Hospital Benefits

The Member is responsible for obtaining pre-certification for all inpatient admissions and any co-payments or coinsurance required by the Plan. The co-payment for hospital benefits is $250 per stay.

1) Prior to admission to a hospital, except in case of an Emergency, pre-certification is required. The number for pre-certification is on the front of the Iron Road Health Insurance Card. Your provider or the hospital can obtain pre-certification on your behalf. The Plan imposes a monetary penalty if pre-certification is not obtained. To avoid this penalty, you need to confirm pre-certification was completed before your hospital admission.
2) In the event of an Emergency admission, pre-certification must be requested within one (1) working day (excluding weekends and holidays) of the Emergency admission.
3) You, your family or personal representative, the hospital, or your attending physician, whether an Iron Road Network physician or non-network provider, can obtain pre-certification.
4) Failure to comply with pre-certification requirements and recommendations will result in a 40% penalty. This means that (1) benefits for goods and services from Iron Road Network Providers are payable at 60% (instead of 100%) of the Plan Allowable and (2) benefits for goods and services from non-network providers are payable at 60% of the 40% (24%) of the Plan Allowable.

Section 3 – Services of Physicians

1) Lists of Iron Road Network Providers are available from the Iron Road office or on the website at ironroadhealthcare.com. Benefits for services and goods from out-of-network providers will be paid at 40% of the Plan Allowable amount.
2) The Member is responsible to pay the applicable co-payment required for each office visit ($30 for primary care visits and $45 for visits to specialists). The co-payment is to be made to the physician at the time of the visit.
3) Members are responsible to pay the applicable co-payment for each telemedicine visit with Doctor on Demand®. Iron Road only reimburses telemedicine through Doctor on Demand®. Member will be responsible for the entire cost of any other kind of telemedicine, video, Internet or other similar types of encounters with medical providers. Not all types of medical treatment can be provided via Doctor on Demand®. Types of services provided by Doctor on Demand® include treatment for cold and flu, sore throat, UTIs, travel illness, sports injuries, skin issues/rashes, diarrhea and vomiting, eye conditions, depression, anxiety and other mental health conditions.

Section 4 – Home Health Care

Home Health Care requires pre-certification by an Iron Road Care Coordinator and is covered when deemed medically necessary.

Section 5 – Prescription Drugs

Prescriptions written by a licensed medical provider are a covered benefit if they are listed on the Iron Road Healthcare pharmacy formulary for Active Members. A copy of the pharmacy formulary for this Plan is available from the Iron Road website at ironroadhealthcare.com. Benefits for prescription drugs are subject to the Plan's current co-payment amount for each prescription item ordered or refilled. There are no benefits for prescription drugs purchased at out-of-network pharmacies.

If the actual cost of a prescription drug is less than the Plan's co-payment amount for that drug, you will pay the actual cost-plus dispensing fee instead of the co-payment amount. Some drugs cost less under this rule so make sure that you use your Iron Road insurance card when obtaining prescription drugs.

Generic drugs have two tiers, each tier with a different co-pay. Tier 1 includes all low-cost generic drugs. Tier 1 generic drug co-payments are $9 for a ninety (90) day supply from Depot Drug Mail Pharmacy or $15 for a 30-day supply from participating retail in-network pharmacies.

Tier 2 includes more expensive generic drugs. Tier 2 generic drug co-payments are $10 for a thirty (30) day supply from the Depot Drug Mail Pharmacy and $20 for a thirty (30) day supply from participating retail in-network pharmacies.

Tier 3 includes preferred brand name drugs. Tier 3 drug co-payments are $20 for a thirty (30) day supply from Depot Drug Mail Pharmacy and $40 for a thirty (30) day supply from participating retail in-network pharmacies.

Tier 4 are non-preferred brand name drugs and generic drugs. Tier 4 drug co-payments are $75 for a thirty (30) day supply from Depot Drug Mail Pharmacy and $100 for a thirty (30) day supply from participating retail in-network pharmacies.

Some generic medications will be Tier 4 on the formulary. Drug manufactures will occasionally release a "Authorized Generic" of their branded medication. This is done to manipulate the market in their favor. There is not a cost saving by our using these medications and in many cases will cost the plan more to use them. We place these medications on Tier 4 to discourage their use.

Certain prescription drugs (and certain over-the-counter drugs for which a prescription has been written) that qualify as preventive care are available without a co-pay. For a complete list of these drugs, please see http://uphealth.com/pdfs/forms-publications/Iron_Road_Cur_$0_Copay_Meds_and_Prod.pdf

Tier 5 Specialty Drugs: Optum RX Specialty Pharmacy

If you are currently taking or newly prescribed a Tier 5 specialty drug, the Plan will pay benefits for the drug only if you use Optum specialty pharmacy. Your physician can fax your prescription

to OptumRx specialty pharmacy at **1-800-218-3223**, or you or your physician can call OptumRx specialty pharmacy at **1-800-850-9122**. OptumRx specialty pharmacy has trained specialists to help you and your physician obtain and manage your specialty drug through your course of treatment.

Tier 5 specialty drugs have a variable copayment. This variable co-payment can be offset by different co-pay assistance programs available to you. Manufacturers, some states, foundations, and Iron Road have co-pay assistance programs to assist Members. After the application of these co-pay assistance programs, members will not be responsible for more than $100 per prescription per month or per 30-day supply for a specialty medication.

For example, a tier 5 Specialty variable copayment is $100 per **30-day supply**, $200 per **60-day supply** or $300 per **90-day supply**. There are medications that are given as one injection but last more than one month. For example, Botox is an 84-day supply with one injection and the new copayment will be $300 since the medication is a 90-day supply. Other injections such as Stelara and Tremfya are one injection which last 56 day

Co-pay assistance programs are administered through the OptumRx specialty pharmacy and Members normally are not involved in the process of obtaining assistance. Most co-pay assistance programs from manufacturers and other entities have a set amount of funds for assistance. Members may run out of co-pay assistance from these entities over time.

Section 6 – Artificial and Surgical Appliances

1) Plan benefits will be paid for crutches, canes, walkers, artificial limbs, artificial eyes, braces, orthotics (Plan limit of one (1) per year) and compression stockings (Plan limit of two (2) per year) and other appliances of similar nature when deemed medically necessary by your attending medical provider and pre-certified by a Iron Road Care Coordinator. Plan benefits are paid at 100% of the Plan Allowable for in-network providers and 40% of the Plan Allowable for out-of-network providers, except as provided in b) and c) below.

2) Plan benefits will be paid for Positive Airway Pressure (PAP) and Bi-Level Positive Airway Pressure (BIPAP) units at 100% of the Plan Allowable when deemed medically necessary by your medical provider, pre-certified by an Iron Road Complete Sleep program coordinator and purchased through a vendor designated by Iron Road. Plan benefits will be paid for a replacement mask and supplies twice a year from the Iron Road mail-order pharmacy. A co-payment is required for the replacement supplies. **There are no Plan benefits for PAP and BIPAP units or supplies purchased from or through out-of-network providers or facilities. The number for the Complete Sleep Program pre-certification is on the Iron Road Insurance Card.**

3) **All Sleep Studies require pre-certification and must be arranged through the Complete Sleep Center at IRHC**. For most members, a home sleep study is the first step in treatment and diagnosis of sleep disorders. In some cases, where medical necessity can be justified, an in-lab sleep study where you are tested in a sleep lab, may be approved. ***Failure to obtain***

pre-certification for any sleep study will result in the claim being denied and you will be responsible to work with your provider to agree upon reimbursement. IRHC will grant a retroactive review of an in-network sleep study performed in a lab when medical necessity requirements have been met.

4) Plan benefits will be paid for TENS (transcutaneous electrical nerve stimulation) units at 100% of the Plan Allowable when deemed medically necessary, pre-certified by a Iron Road Care Coordinator and purchased through a vendor designated by Iron Road. If a Member otherwise leases or purchases such a unit and such lease or purchase is medically necessary, then Plan benefits will be equal to the lesser of (1) the Member's lease or purchase cost; or (2) the cost had the unit been purchased from a Iron Road designated vendor.

5) Plan benefits will be paid for implantation of penile prosthesis when (1) there is a diagnosis of erectile dysfunction due to organic disease process such as, but not limited to, diabetes, hypertension, peripheral vascular disease, radical pelvic surgery or trauma; (2) other treatment for erectile dysfunction has proved unsuccessful; (3) the prosthesis is medically necessary; and (4) the procedure has been pre-certified by Iron Road. (The pre-certification number is on the Iron Road Insurance Card.)

6) Plan benefits for the artificial and surgical appliances are limited to one (1) each. However, upon pre-certification by an Iron Road Care Coordinator, Plan benefits will be paid for renewals, replacements or repairs.

Section 7 – Additional Benefits Including Outpatient Treatment

The Plan pays benefits for the following.

1) Routine X-rays, radiation therapy, laboratory services, surgical dressings, splints, and casts. There is a $150 co-payment for some imaging services, payable to your medical provider at the time that the imaging is provided.

2) Anesthesiology services.

3) Physical and Occupational therapy limited to annual maximum of $1,500. Additional therapies beyond $1,500 require precertification by a Iron Road Healthcare RN Care Coordinator. The number for precertification is on the Iron Road Healthcare Health Insurance Card.

4) Chiropractic services including but not limited to adjustments, x-rays and lab will be paid at the rate of 80% of the Plan Allowable to a maximum of $600 per calendar year. Evaluation and management codes are excluded from this benefit.

5)

    i) .

6) Blood transfusions.

7) Care in an accredited Skilled Nursing Facility as that term is defined in Article I herein, but only if pre-certified by Iron Road.

8) Expense of repairs to teeth where such repairs are necessary to correct damage caused by an injury unless it was an on-the-job injury.

9) Skin tests for allergies.

10) Home oxygen therapy (Certificate of Medical Necessity required after 60 days)

11) Annual routine eye examinations.

12) Refractive eye surgery, limited to $1,520 per Member, per lifetime.

13) Mastectomy and related reconstructive surgery on both breasts to produce a symmetrical appearance. Prostheses and physical complications in all stages of mastectomy, including lymphedemas, are covered.

14) Hearing aid, hearing test, and hearing aid supplies, limited to $1200 per Member every 24 months. OTC Hearing Aids do not qualify for this benefit.

15) Oral contraceptives and other prescribed birth control devices for females. These benefits are paid as Preventive Benefits.

16) Benefits for the treatment of temporomandibular joint (TMJ) disorders require pre-certification by Iron Road and are limited as follows:

    a) Non-Surgical Benefit: Subject to a $50 deductible. Benefits are payable at 50% of the Plan Allowable up to a lifetime maximum of $1,250.

    b) Surgical Benefit: Pre-Certification required. Benefits are payable at 100% of the Plan Allowable up to $750. Amounts that exceed $750 are paid at 80% of the Plan Allowable.

    c) Anesthesia benefits are payable at 100% of the Plan Allowable up to $187.50, then are paid at 80% of Plan Allowable.

17) Benefits for an insulin pump require pre-certification. The Plan pays benefits for insulin pump supplies: the Member is responsible for a $50 co-payment for each ninety (90) day supply. Maximum benefit is $5,500 per year.

18) Enteral formula and feeding when it is the only form of nutrition for a Member.

19) The Plan pays benefits for an assistant in surgery who has one of the following medical credentials:

    a) MD Medical Doctor

b) DO Doctor of Osteopathic

c) CNS Clinical Nurse Specialist

d) PA-C Physician Assistant

e) NP (APRN) Nurse Practitioner

20) Plan benefits for Speech Therapy require pre-certification from Iron Road.

21) Plan benefits for a Sleep Study (Polysomnography) require pre-certification from Iron Road.

22) The Plan pays benefits for outpatient care including, but not limited to, surgical procedures, advanced imaging such as CT/PET scans, MRI/MRA, Nuclear, and Cardiac Imaging and other diagnostic and therapeutic procedures that are done at an outpatient hospital or ambulatory surgical center. Plan benefits are subject to an outpatient co-payment of $150. However, there is no co-payment for dialysis, laboratory tests, most other radiological exams, radiation therapy and chemotherapy. Pre-certification is required for some outpatient services. For a detailed pre-certification list go to ironroadhealthcare.com.

Unless otherwise provided above, the Plan pays benefits for services from in-network providers at 100% of the Plan Allowable and from out-of-network providers at 40% of the Plan Allowable. Lists of Iron Road Network Providers are available from the Iron Road office or on the Internet website at ironroadhealthcare.com.

Section 8 – Emergency and Urgent Care Benefits

"No Surprises Act" Protections for Members

When possible, you should seek medical care from an in-network provider. However, if you have an emergency medical condition you should go to the nearest emergency services provider regardless of network status. If you receive emergency services from a non-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing (copayment) amount.

You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless *you give written consent and give up your protections not to be balanced billed for these post-stabilization services.* The *No Surprises Act* defines emergency services to also include post-stabilization services provided in a hospital following an emergency visit. Post-stabilization care is considered emergency care until a physician determines that you can travel safely to another in-network facility using non-medical transport, that such a facility is available and will accept the transfer, and that the transfer will not cause you other unreasonable burdens. The No Surprises Act also requires that you must receive written notice and give written consent to be transferred.

You are never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network by using the Find Tool online provided by our network provider Anthem Blue Cross Blue Shield. **If you do consent to ongoing care after emergency and post-stabilization services from an out of network provider have been provided, you will be responsible for 60% of the allowed amount plus any balanced charged by the out-of-network provider. Remember the out of network facility is required to provide you post-stabilization services with no balance billing, unless you consent to be responsible for payment above what your health plan provides.**

The Plan pays benefits for emergency care at an in-network or non-network provider at 100% of the Plan Allowable, less the Plan's Emergency care co-payment. Iron Road will cover emergency services without requiring you to get approval for services in advance (also called prior authorization). Once you have received emergency and post-stabilization services as defined above, to continue reimbursement at 100% of the Plan Allowable, the Member or someone on their behalf should promptly request pre-certification from an Iron Road Care Coordinator.

The Iron Road Care Coordinator shall authorize continuing reimbursement at 100% of the Plan Allowable if it is medically necessary for the Member to continue receiving care from the non-network provider and if there is not an option to receive care from an in-network provider. The Iron Road Care Coordinator may make arrangements for the Member's transfer to an in-network provider. If it is not medically necessary or there are options for the Member to be transferred to an in-network provider, the Plan will pay benefits at 40% of the Plan Allowable and the member will be responsible for any balance owing to the non-network provider.

1) The Member is responsible for a copayment for each visit to the Emergency Room ("ER") of any hospital. The ER copayment applies to covered benefits for charges made by the hospital for Emergency care received in the ER. This ER copayment is waived if inpatient admission is required.

2) Examples of emergencies include:

Broken Bones	Uncontrolled Bleeding
Chest Pain	Shortness of Breath
Severe Pain	Loss of consciousness
Sudden Paralysis	Suspected overdose of medication
Slurred Speech	Poisoning

3) The Plan pays benefits for care and services received at an urgent care center. The Member is responsible for an office copayment for each visit to an urgent care center regardless of whether the urgent care center is in or out of network.

4) Urgent care includes injuries and illnesses that require prompt medical attention but aren't considered emergencies. Some examples are:

Bronchitis or Sinusitis	Ear or eye infections
Fever	Minor lacerations
Severe sore throat	Sprains or strains
Stomach flu	Urinary Tract Infections

5) Doctor on Demand is a telemedicine service with the same high -quality providers as the Iron Road Anthem network and are available at a $10.00 copayment. They treat hundreds of urgent conditions including behavioral health visits with Psychologists and therapists. To sign up log on to doctorondemand.com. And when prompted to enter your plan enter "Iron Road". You can also download the Doctor on Demand App in the Apple Store or Google Store.

6) In the event of an Emergency, ambulance service in the United States will be covered to the extent necessary to transport the injured or ill Member to the nearest facility where appropriate care can be rendered. Air ambulance will be covered only in cases with supporting medical necessity and then only to the nearest facility where appropriate care can be rendered.

7) All ambulance transfers from one facility to another must have the pre-certification of an Iron Road Care Coordinator, except for transfers due to an Emergency. **Emergency or routine medical air or ground transportation outside of the United States of America is not a covered benefit**.

8) Payment for treatment of an emergency or non-emergency will be limited to care provided in the United States of America or its territories. Members should consider purchasing travel insurance when travelling abroad. .

Section 9 – Behavioral Health, Mental Health, and Substance Abuse Treatment

Inpatient Treatment

Iron Road shall provide benefits for mental health and/or substance abuse treatment to Members under the following conditions:

1) Prior to admission to a hospital or other similar inpatient behavioral health facilities, except in case of an Emergency, the Member is required to call for pre-certification. The number for pre-certification is located on the Iron Road Insurance Card. The Member is responsible to pay the applicable co-payment.

2) In the event of an emergency admission to a hospital or other similar inpatient behavioral health facility, pre-certification is required within one (1) working day (excluding weekends and holidays) of the admission for the Emergency. It is the responsibility of the Member, the

Member's family or personal representative, the hospital or the Member's attending physician to obtain pre-certification.

3) The Plan pays benefits for accommodations and ancillary charges for inpatient, outpatient or intensive outpatient behavioral health treatment at hospitals or other behavioral health facilities. Benefits for in-network hospitals or other behavioral health facilities will be paid at 100% of the Plan Allowable. Benefits for out-of-network hospitals or behavioral health facilities will be paid at 40% of the Plan Allowable. The Member is responsible to pay the applicable co- payment of $250 per stay for each level of care whether inpatient or outpatient.

4) Failure to comply with pre-certification requirements and recommendations will result in a 40% penalty. This means that (1) benefits for goods and services from Iron Road ***Network*** Providers are payable at 60% (instead of 100%) of the Plan Allowable and (2) benefits for goods and services from ***non-network*** providers are payable at 60% of the 40% (24%) of the Plan Allowable.

Outpatient Treatment

Iron Road shall provide benefits for outpatient mental health and/or substance abuse treatment to Members. Members are responsible for co-payments to primary care and Specialty providers.

Section 10 – Pregnancy/Maternity

The Plan pays benefits for pregnancy-related claims of a Member. In accordance with the Newborns' and Mothers' Health Protection Act ("NMHPA"), group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours after vaginal delivery or 96 hours after a Cesarean section. In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the Plan of the insured for prescribing a length of stay not in excess of 48 hours after vaginal delivery or 96 hours after a Cesarean section. The Plan complies with these requirements of the NMHPA.

Section 11 – Organ and Tissue Transplants

The Plan will pay benefits for medically necessary expenses related to organ and tissue transplants under the following conditions:

1) Pre-certification is required.

2) A Member must use an in-network facility. There are no benefits under this Plan for organ and tissue transplants at an out-of-network facility.

Section 12 – Routine Physical

The Plan pays benefits for one (1) routine physical examination per calendar year at 100% of Plan Allowable for in-network providers and 40% Plan Allowable for out-of-network providers.

Section 13 – Preventive Health Care Services

Preventive health care services will be provided and limited to the following services.

These services are covered at 100% of the Plan Allowable if provided by an in-network provider and 40% of the Plan Allowable if provided by an out-of-network provider.

The Plan provides benefits for routine preventive care services as defined by the United States Preventive Services Task Force (USPSTF) A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures periodicity guidelines. Additional preventive care and screenings for women are covered as defined by the Health and Human Services Health Plan Coverage Guidelines for Women's Preventive Services.

The preventive care coverage includes, but is not limited to:

1) One routine physical per year, including medical history, physical exam, prostate exam, colonoscopy, weight/height, blood pressure, cholesterol screening, urinalysis, blood glucose, and EKG, as medically appropriate and as follows;

    a) one (1) proctosigmoidoscopy or colonoscopy every ten (10) years after age forty-four (44). Members with a family history of colon cancer may be entitled to more frequent screenings.

    b) one (1) prostate screening antigen (PSA) test every three (3) years after age forty-nine (49), and more frequently if recommended by a Iron Road Network Provider.

2) well woman care, including a routine gynecological exam, one routine Pap smear each calendar year, one baseline mammogram for female Members aged thirty-five (35) to thirty-nine (39), one mammogram each calendar year after reaching age 40 or more frequently if recommended by an Iron Road Network Provider;

3) female and male sterilization; male vasectomy limited to a lifetime benefit maximum of $750;

4) all FDA-approved methods of contraception for women (prescription or over the counter): hormonal, barrier, emergency, and implanted devices, oral contraceptives, and contraceptive devices; (*Condoms are excluded*)

5) preventive prescription drugs (including certain over-the-counter drugs for which a prescription is written): a complete list of these drugs can be found at http://ironroadhealthcare.com/pdfs/forms-publications/Iron Road_$0_Copay_Meds_and_Prod.pdf;

6) certain smoking cessation benefits; and

7) certain prophylactic/preventive immunizations.

Section 14 – Hospice Benefits

The Plan pays benefits for Hospice care as follows:

1) Pre-certification is required by an Iron Road Care Coordinator.

2) The physician must certify that the Member is terminally ill with six (6) months or less to live.

3) The benefit includes, but is not limited to, charges for room and board, Hospice care (including Hospice care in the Member's home), and services provided by a licensed social worker to the Member.

4) Any counseling services to the Member or immediate family member given in connection with Hospice services.

Section 15 – Bariatric Surgery

The Plan pays benefits for bariatric surgery for Members age 18 or older subject to the following rules. The Plan requires pre-certification, which can be obtained by calling the pre-certification number on the Iron Road Insurance Card. The pre-certification process will consist of an extensive evaluation, which will include, but is not limited to, the following:

1) The surgery must be recommended and performed by an in-network Iron Road bariatric surgeon who is board certified and has received the appropriate training to perform such surgery and must be performed in an in-network Iron Road facility.

2) The Member must obtain a second opinion for the surgery from a board-certified in-network Iron Road physician whose specialty is internal medicine.

3) After an in-network Iron Road physician recommends the surgery, the Member must undergo a psychological evaluation which documents that all psychosocial issues have been identified and addressed from an Iron Road Network Provider who is a licensed mental health professional.

The benefit is payable at 80% of the Plan Allowable up to a maximum of $16,000, which includes all surgery related fees and costs, post-surgery related fees and costs and fees and costs

associated with any complications that may arise because of such surgery, regardless of when such fees and costs are incurred by the Member. The benefit is limited to once per lifetime.

Section 16 – Sex Reassignment Surgery and Related Drug Hormone Therapy and Psychiatric Services

The Plan pays benefits for sex reassignment surgery, related drug hormone therapy and psychiatric services. Pre-certification by an Iron Road Care Coordinator is required.

ARTICLE VII – BENEFIT EXCLUSIONS

Section 1 – Benefit Exclusions

The Plan does not pay benefits unless they are of the type described in this Plan. In addition, the Plan will not provide benefits for any of the items listed in this Section, regardless of medical necessity or recommendation of a health care provider.

1) A Member and/or provider may be temporarily or permanently barred from obtaining or receiving Plan benefits in the following circumstances:

   a) A Member or provider who abuses Plan benefits.

   b) A Member or provider who knowingly files a fraudulent claim to the Plan.

   c) A Member or provider who knowingly makes a fraudulent statement to have a claim paid by the Plan.

   d) A Member or a provider who knowingly violates the Plan rules

2) Weight loss clinics, programs, instructions, activities, or drugs except for the benefits provided for diabetes education, for bariatric surgery as provided by the Plan, or as otherwise required by the Affordable Care Act.

3) Fertility drugs, diet medications, vitamins, minoxidil solution for topical use, or experimental drugs, regardless of intended use, except as follows: (1) prenatal vitamins are covered for pregnancy under the pharmacy benefit; (2) prescribed folic acid supplements for women who may become pregnant or if they qualify as preventive care under the Affordable Care Act; (3) any over the counter (OTC) drug except when coverage is required by the Affordable Care Act. Insulin, insulin syringes, blood glucose strips, and glucometers are Plan benefits only if ordered from the Iron Road mail-order pharmacy.

4) Any injury sustained which is the result of the commission of and/or participation in a felonious or otherwise illegal act unless the injuries are sustained as a result of domestic violence or as the result of a medical condition.

5) Wheelchairs, hospital beds, physical therapy equipment, eyeglasses, contact lenses, footwear, bedpans, urinals, hot water bottles, cold therapy (cryotherapy) equipment, blood pressure cuffs, thermometers, syringes (except insulin syringes) and similar articles.

6) Treatment of on-the-job duty injuries suffered while in the employment of any person, firm, company, organization, or other entity, including the Union Pacific Railroad Company and/or its subsidiaries and affiliated companies. After the Union Pacific Railroad has terminated on duty injury medical coverage (typically as the result of a settlement) of an on-duty injury for a Member, claims for medical services covered by the Plan provided after the Member's

workers' compensation coverage has terminated relating to the settled on-duty injury claim will be paid.

7) Benefits for the treatment of decayed, faulty, diseased, or damaged teeth; replacement of natural teeth or repairs to dentures or bridges except as otherwise specified in this Plan.

8) Cosmetic surgery or treatment.

9) Personal comfort items.

10) Supplies other than prescription drugs provided for the treatment of sexual arousal disorders or erectile dysfunction, regardless of cause, except as provided under the benefits for penile implant.

11) Reversal of any reproductive sterilization procedure unless medically necessary.

12) All fertility procedures and tests.

13) Experimental and/or investigational procedures, treatments, drugs, or surgeries.

14) Experimental procedures, treatments, drugs, surgeries, or tests that are performed or administered to discover or to demonstrate something that is not proven as an accepted standard of care.

15) Investigational procedures, treatments, surgeries, drugs, or health care services of which the safety and efficacy have not been proven.

16) Services furnished by or for the United States government, including a government hospital, or by any government facility. Services and/or supplies which are required by reason of past or present service of any Member in the armed forces of a government unless coverage is required by federal law.

17) Illness or injury as a result of participation in a civil revolution or a riot.

18) Illness or injury as a result of war as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared, unless coverage is required by federal law.

19) Nursing home, sanitarium rest home, Domicile or Custodial Care.

20) Expenses exceeding the Plan Allowable.

21) Services rendered by anyone other than a covered and licensed health care provider.

22) Treatment not prescribed or recommended by a health care provider.

23) Services, supplies or treatment not medically necessary including non-Emergency transport.

24) Expenses for preparing medical reports, itemized bills, or claim forms.

25) Mailing and/or shipping and handling expenses or sales tax.

26) Expenses for broken appointments or telephone calls, except as provided by the Doctor on Demand benefit.

27) Travel expenses of a physician or a Member, except in special circumstances and only if such expenses are pre-certified.

28) Any services received from a Health Maintenance Organization ("HMO") if the Member is a participant in the HMO.

29) Expenses incurred for services rendered prior to the effective date of coverage under this Plan.

30) Treatment or services rendered outside the United States of America or its territories, except for the initial (up to 24 hours) treatment of an Emergency. (See Section 8)

31) Complications arising from any non-covered surgery or treatment. However, complications due to a non-covered abortion will be considered.

32) Expenses for or related to the removal of breast or other prosthetic implants, except for breast reconstruction following a mastectomy as required under federal law, that were inserted in connection with cosmetic surgery, regardless of the reason for removal; or not inserted in connection with cosmetic surgery, but the removal of which is not currently medically necessary.

33) Massage therapy or Rolfing.

34) Acupuncture.

35) Surrogate expenses.

36) Adoption expenses

37) Marital, family or sex counseling.

38) Rapid opiate detoxification under general anesthesia.

39) Light therapy for mood disorders for seasonal patterns.

40) Biofeedback.

41) Hypnosis.

42) **Genetic counseling** is excluded from coverage.

43) Many types of **genetic testing** are experimental and investigational and are not a covered benefit. Medically necessary genetic testing is a covered benefit. Prior authorization is required. Medical necessity is determined by the most recent standards established through medical research.

44) Abortions, except as medically necessary.

45) Psychoanalysis.

46) Emergency or routine medical ground or air transportation outside of the United States.

47) **Clinical Trials:** Consistent with Centers for Medicare & Medicaid Services (CMS) policy and Patient Protection and Affordable Care Act (PPACA) requirements, Iron Road covers medically necessary routine patient care costs in clinical trials (in the same way that it reimburses routine care for members not in clinical trials) according to the limitations outlined below. All the following limitations apply to such coverage:

   a) All applicable plan limitations for coverage of out-of-network care will apply to routine patient care costs in clinical trials; and

   b) All utilization management rules and coverage policies that apply to routine care for members not in clinical trials will also apply to routine patient care for members in clinical trials; and

   c) Members must meet all applicable plan requirements for precertification, registration, and referrals; and

   d) To qualify, a clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled. Providers will not routinely be required to submit documentation about the trial to Iron Road, but Iron Road can, at any time, request such documentation to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approval(s).

   e) Iron Road covers costs of medically necessary treatments for conditions that result as unexpected consequences (complications) of clinical trials.

   f) Iron Road does not cover the following clinical trial costs:

   g) Costs of data collection and record keeping that would not be required but for the clinical trial; and

   h) Items and services provided by the trial sponsor without charge; and

   i) The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for

terminal illnesses in certain clinical trials according to IRHC's terminal illness policy (see benefit plan descriptions for details)); and

j) Travel, lodging and meals; and

k) Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs").

l) Over the Counter (OTC) Hearing Aids are excluded.

ARTICLE VIII – CLAIMS PROCEDURES

Section 1 – Period for Filing Claims

A claim for Plan benefits must be submitted to Iron Road within one (1) year from the date of service. Providers are required to submit claims by electronic filing with Payer ID #87042. Paper claims, black and white claims, and faxes will not be accepted from providers. Iron Road' payment of claims is determined when the claim is presented, not when eligibility is verified. Only services that are Plan benefits will be paid. We employ industry standardized edits which may reduce or deny specific charges based on the information submitted on the claim. Claims from in-network providers will be based on the network agreement and Plan benefits. Claim payments from out-of-network providers are paid at 40% of the Plan Allowable. Payments may be reduced for failure to obtain pre-certification when pre-certification is required by the Plan.

Section 2 – Definitions and General Information

1) A **claim** is a request for benefits from the Plan made pursuant to these claim procedures.

2) These claim procedures include the right of a Member to appeal an adverse benefit determination made by the Plan.

3) An **adverse benefit determination** (ABD) means a determination made by the Plan in response to a claim made by a Member involving a denial, reduction, or termination of, or a failure to provide or make payment (in whole or part), of a benefit under the Plan.

4) There are five (5) types of claims that a Member has the right to make under these claim procedures.

   a) Pre-Service Claims

      i) A pre-service claim means a claim before a medical service or good is obtained and for which the payment of Plan benefits in whole or part is conditioned upon pre-certification or other advance approval by the Plan. See Article VIII, Section 3(a).

   b) Urgent Care Claims

      i) A "claim involving urgent care" is any claim for medical care or treatment where the application of making non-urgent care determinations could seriously jeopardize a Member's life or health or the ability of a Member to regain maximum function, or in the opinion of a physician with knowledge of the Member's medical condition could cause severe pain and cannot be adequately managed without the care or treatment that is subject to the claim. See Article VIII, Section 3(b).

c) Post-Service Claims

i) A post-service claim means a claim for a good or service under the Plan that is not a pre-service claim or a concurrent care claim. See Article VIII, Section 3(c).

d) Concurrent Care – Extension Requests

i) A concurrent care claim means a claim regarding an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. A concurrent care claim is an extension request where a Member requests an extension beyond the initially approved period of time or number of treatments. See Article VIII, Section 3(d).

e) Concurrent Care – Reconsideration of Prior Approval

i) A concurrent care claim with reconsideration of a prior approval is a concurrent care claim as defined in the previous paragraph and the Plan advises a Member of a denial, reduction, or termination of a previously approved request for treatment over a period of time or number of treatments. See Article VIII, Section 3(e).

5) **Importance of Accurate and Timely Filing of Claims**: If a pre-service claim is incorrectly filed, the Member shall be notified of the error orally, unless the Member requests written notice, as soon as possible but no later than five (5) days following receipt of the incorrectly filed pre-service claim. If an urgent care claim is filed incorrectly, the Member shall be notified of the error orally, unless the Member requests written notice, as soon as possible but no later than twenty-four (24) hours following receipt of the incorrectly filed urgent care claim. In either instance, the Member will be informed of the proper procedures for filing the claim.

6) The Iron Road Claims Administrator is:

a) The Iron Road Care Coordinator in the case of any request for pre-certification or authorization of benefits assigned to such Coordinator by the Plan and for all claims for benefits under Article VI, Section 3 (Services of Physicians), Section 6 (Artificial and Surgical Appliances), Section 7 (Additional Benefits Including Outpatient Treatment), Section 8 (Emergency and Urgent Care Benefits), Section 9 (Behavioral Health, Mental Health, and Substance Abuse Treatment) Section 10 (Pregnancy/Maternity), Section 11 (Organ and Tissue Transplants), Section 13 (Preventive Health Care Services), Section 14 (Hospice Benefits) and Section 15 (Bariatric Surgery).

b) The Hospital Pre-Certification Coordinator (contacted through the number for pre-certification on the back of a Member's Health Insurance Card) for claims for benefits under Article VI, Section 2 (Hospital Benefits).

c) The Iron Road Prescription Drug Coordinator for claims for benefits under Article VI, Section 5 (Prescription Drugs).

d) **The Iron Road Appeals Administrator** is the Director of Medical Services. See Section 5 (Appeal Rights) of this Article.

7) **Claims and Appeals Administrators' Duties and Responsibilities:** The Iron Road Claims Administrator and the Iron Road Appeals Administrator are responsible for making claims and appeal decisions, respectively. They have the discretionary authority to interpret the Plan to make decisions in their sole discretion. They also have the discretionary authority to make factual determinations as to whether any Member is entitled to receive benefits under 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.

8) **Items to Be Considered During Claim Review Process:** In its consideration of the claim, the Iron Road Claims Administrator will consult the documents and instruments constituting the benefit and the Plan and all other documents that may have a bearing on the interpretation of the Plan benefit, including past interpretations or claims of the same general type. The Claims Administrator will also, where appropriate, consult the Internal Revenue Service, the Department of Labor, or other governmental or private publications or authorities that may assist them in interpreting Plan benefit language or administrative procedures. If in connection with the denial the Claims Administrator obtained on its behalf the advice of any medical or vocational experts, such expert(s) shall be identified, whether or not their advice was relied upon in the denial.

9) **Member Access to Claim Information**: Upon request, a Member has reasonable access to, and may obtain free copies of, all documents, records and other information that are relevant to the claim. A document, record or other information is considered to be relevant to a claim if it:

   a) was relied upon, submitted, considered or generated in the course of making the benefit decision;

   b) demonstrates compliance with the administrative processes and safeguards required in the making of the benefit decision; or

   c) constitutes a statement of policy or guidance with respect to the Plan concerning the benefit denied for the Member's diagnosis.

10) **Non-English Languages**: Notices and Services. In United States counties in which 10% or more of the population residing in the county is literate only in the same non-English language, all notices under this Article sent to addresses in such counties will contain a statement, in such non-English language, that (1) the Plan will provide, upon request, the notice in such non-English language; and (2) the Plan provides oral language services that include answering questions in such non-English language and assistance with filing claims and appeals (including external review appeals) in such non-English language.

Section 3 – Submission of Claims and Relevant Timelines

1) **Pre-Service Claims Rules and Timelines:** A pre-service claim, as defined by Article VIII, Section 2(d)(i), that is not an urgent care claim is subject to the following rules:

   a) A pre-service claim is made by a Member (or a provider or other person acting on behalf of the Member) submitting a claim in writing to the Iron Road Claims Administrator. A written claim must include the following information:

   b) Member's name and Iron Road Member number,

   c) Specific medical condition or symptom, and

   d) Specific treatment, service or good for which pre-certification or other advance approval is requested.

   e) The Iron Road Claims Administrator may request additional information as needed to decide the pre-service claim.

   f) Once all the information needed to decide the pre-service claim has been received, the Iron Road Claims Administrator will decide the pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than fifteen (15) days after receipt of such claim, unless the Iron Road Claims Administrator determines that for matters beyond the control of the Plan that the Iron Road Claims Administrator is not able to decide the claim within such period.

   g) In the event of matters beyond the control of the Plan, the Iron Road Claims Administrator may extend the period by fifteen (15) additional days, provided that the Member is notified in writing prior to the expiration of the initial fifteen (15) day period. Such notice must include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected.

   h) If a claim is not submitted with all the needed information, the Iron Road Claims Administrator may deny the claim or may take a fifteen (15) day extension of time, provided the Member is notified in writing prior to the expiration of the initial 15-day period that additional information is required and is given a period of no less than forty-five (45) days in which to supply the Iron Road Claims Administrator with the required information.

   i) The time for deciding the claim is suspended from the date the notice of missing information is received by the Member until the date the missing information is provided to the Iron Road Claims Administrator. If the requested information is provided, the Iron Road Claims Administrator shall decide the claim within fifteen (15) days of the receipt of the requested information. If the requested information is not provided within the specified time, the claim may be denied or otherwise decided without the requested information.

2) **Urgent Care Claims Rules and Timeline:** An urgent care claim, as defined by Article VIII, Section 2(d)(ii), is subject to the following rules:

   a) An urgent care claim is made by a Member (or a provider or other person acting on behalf of the Member) submitting a claim in writing or orally to the Iron Road Claims Administrator. A written or oral claim must include the following information:

      i) Member's name and Iron Road Member number,

      ii) Specific medical condition or symptom, and

      iii) Specific treatment, service or good for which pre-certification or other advance approval is requested.

   b) The Iron Road Claims Administrator may request additional information as needed to decide the urgent care claim.

   c) Once all the information needed to decide the urgent care claim has been received, the Iron Road Claims Administrator shall decide an urgent care claim as soon as possible, considering the medical exigencies, but no later than seventy-two (72) hours after receipt of the claim.

   d) If a claim is not submitted with all the needed information, the Iron Road Claims Administrator shall notify the Member, orally or in writing if requested by the Member, as soon as possible, but not later than twenty-four (24) hours following receipt of the claim about the missing information.

   e) The Member shall be given a period of no less than forty-eight (48) hours in which to supply the Iron Road Claims Administrator with the missing information.

   f) The Iron Road Claims Administrator shall decide the claim as soon as possible, but not later than forty-eight (48) hours after the earlier of receipt of the specified information or the end of the period provided to submit the missing information.

   g) The Iron Road Claims Administrator may provide the Member with an oral decision, provided that a written decision, whether or not the decision is adverse, is furnished not later than three (3) days after the oral notice.

3) **Post-service Claims Rules and Timeline.** A post-service claim, as defined by Article VIII, Section 2(d)(iii), is subject to the following rules:

   a) A post-service claim is made by a Member submitting a claim in writing to the Iron Road Claims Administrator. If services or goods are received from a Iron Road Network Provider, there is no need for the Member to file a claim. The network provider is responsible for filing claims. Iron Road pays the network provider directly.

b) A written claim must be printed on a CMS-1500 (Physician) or HCFA-1450 (Hospital) Form or they may be submitted electronically.

c) The Iron Road Claims Administrator shall decide a post-service claim as follows:

i) If a claim is submitted with all needed information, the claim will be decided within a reasonable time, but no later than thirty (30) days after receipt of such claim, unless the Iron Road Claims Administrator determines that for matters beyond the control of the Plan that the Iron Road Claims Administrator is not able to decide the claim within such period.

ii) In the event of matters beyond the control of the Plan, the Iron Road Claims Administrator may extend the period for deciding the claim by fifteen (15) additional days, provided that the Member is notified in writing prior to the expiration of the initial fifteen (15) day period. Such notice must include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected.

iii) If a claim is not submitted with all the needed information, the Iron Road Claims Administrator may deny the claim or may take a fifteen (15) day extension of time, provided the Member is notified in writing prior to the expiration of the initial fifteen (15) day period that additional information is required and is given a period of no less than forty-five (45) days in which to supply the Iron Road Claims Administrator with the missing information.

iv) The time for deciding the claim shall be suspended from the date the extension notice is received by the Member until the date the missing information is provided to the Iron Road Claims Administrator.

4) **Concurrent Care Claim - Extension Request Rules and Timeline:** A concurrent care claim – extension request, as defined by Article VIII, Section 2(d)(iv), is subject to the following rules:

a) If the concurrent care claim is also a pre-service claim, but not an urgent care claim, the claim decision will be made under the rules set forth in Article VIII, Section 3(a), or

b) If the concurrent care claim is also a post-service claim, the claim decision will be made under the rules set forth in Article VIII, Section 3(c).

c) A concurrent-care claim requesting an extension beyond the initially approved period of time or number of treatments is an urgent care claim as defined in Article VIII, Section 2(d)(ii) and is subject to the following rules:

i) The claim shall be made by a Member (or a provider or other person acting on behalf of the Member) submitting a claim in writing or orally to the Iron Road Claims Administrator. A written or oral claim must include the following information:

(1) Member's name and Iron Road Member number,

(2) Specific medical condition or symptom, and

(3) Specific treatment, service or good for which pre-certification or other advance approval is requested.

d) The Iron Road Claims Administrator may request additional information as needed to decide the pre-service claim.

e) The Iron Road Claims Administrator shall decide the claim within twenty-four (24) hours of receipt of the claim if a claim is submitted with all the needed information at least twenty-four (24) hours prior to the expiration of the initially approved period of time or number of treatments.

f) If a claim is submitted less than twenty-four (24) hours prior to the expiration of the initially- approved period of time or number of treatments with all needed information, the claim will be decided as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim.

g) If a claim is submitted less than twenty-four (24) hours prior to the expiration of the initially- approved period of time or number of treatments **without** all the needed information, the Iron Road Claims Administrator shall notify the Member, orally or in writing if requested by the Member, as soon as possible, but not later than twenty-four (24) hours following receipt of the claim, about the missing information.

h) The Member shall be given a period of no less than forty-eight (48) hours in which to supply the Iron Road Claims Administrator with the missing information. The Iron Road Claims Administrator shall decide the claim as soon as possible, but not later than forty-eight (48) hours after the earlier of receipt of the specified information or the end of the period provided to submit the missing information.

i) The Iron Road Claims Administrator may provide the Member with an oral decision within the time frames set forth above, provided that a written decision, whether or not adverse, is furnished not later than three (3) days after the oral notice. A decision is adverse if it denies, reduces, terminates, or fails to provide or make payment (in whole or part) for a good or service.

5) **Concurrent Care Claim – Reconsideration of Prior Approval Rules and Timeline** A concurrent care claim – reconsideration of prior approval, as defined by Article VIII, Section 2(d)(v), is subject to the following rules:

a) If the concurrent care claim is not an urgent care claim and is an appeal from a concurrent care determination by the Plan reducing or terminating a previously approved request for treatment over a period of time or number of treatments, the claim is subject to the following rules:

i) If the concurrent care claim is also a pre-service claim, the claim will be decided under the rules set forth in Article VIII, Section 3(a).

ii) If the concurrent care claim is also a post-service claim, the claim will be decided under the rules set forth in Article VIII, Section 3(c).

Section 4 – Notification of Benefit Determination

a) For all claims except urgent care claims, the Iron Road Claims Administrator shall provide the Member with a written decision, if the decision is adverse. If the claim is an urgent care claim, the Iron Road Claims Administrator may provide the Member with an oral decision, provided that a written decision, whether or not the decision is adverse, is furnished not later than three (3) days after the oral notice.

b) Timelines for notification of decisions by the Claims Administrator are outlined in Article VIII, Section 3.

c) A decision is adverse if it denies, reduces, terminates, or fails to provide or make payment (in whole or part) for a good or service. The written decision of an adverse determination shall include the following, in a manner calculated to be understood by the Member:

   a) Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of (1) the diagnosis code and its corresponding meaning, and (2) the treatment code and its corresponding meaning;

   b) A statement of the specific reason(s) for the decision, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

   c) Reference(s) to the specific Plan provision(s) on which the decision is based;

   d) A description of any additional material or information necessary to perfect the claim and why such information is necessary;

   e) A description of the Plan provisions and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court;

   f) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision and a copy of such (or a statement that such information will be provided free of charge upon request);

   g) The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman;

h) If the decision is based on medical necessity or experimental treatment or similar exclusion or limit, and the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Member's circumstances or a statement that such explanation will be provided at no charge upon request; and

i) Any other information required by applicable law to be included.

Section 5 – Appeal Rights

1) A Member shall have the right to appeal an adverse determination by the Iron Road Claims Administrator in writing to the Iron Road Appeals Administrator, subject to the following rules:

   a) A Member shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Member's claim. If the advice of a medical or vocational expert was obtained in connection with the initial decision, the names of each such expert shall be provided on request by the Member, regardless of whether the advice was relied upon by the Iron Road Claims Administrator.

   b) An appeal of an adverse determination must be filed within 180 days following the Member's receipt of the initial notice of adverse determination.

   c) An appeal is made when a Member submits a written notice to:

      Iron Road Appeals Administrator
      P.O. Box 161020
      Salt Lake City, UT 84116-1020

   d) A Member's written appeal may include documents, comments, or other information in support of the appeal. A written or oral claim must include the following information:

      i) Member's name and Iron Road Member number,

      ii) Specific medical condition or symptom, and

      iii) Specific treatment, service or good for which pre-certification or other advance approval is requested.

   e) The Iron Road Appeals Administrator shall decide an appeal from an adverse initial determination regarding a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than the following schedule:

      i) **Urgent Care and Concurrent Claims**: Seventy-two (72) hours after receipt of the appeal.

ii) **Pre-Service Claims:** Thirty (30) days after receipt of the appeal.

iii) **Post-Service Claims**: Sixty (60) days after receipt of the appeal.

f) The review by the Iron Road Appeals Administrator shall consider all the information submitted by the Member, whether or not presented or available at the initial determination.

g) The Iron Road Appeals Administrator shall give no deference to the initial determination.

h) In the case of a claim denied on the grounds of medical judgment, the Iron Road Appeals Administrator shall consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal shall not be the same individual who was consulted, if any, regarding the initial determination or a subordinate of that individual.

i) The Iron Road Appeals Administrator shall provide the Member with a written decision, whether or not the decision is adverse. The written decision of an adverse determination shall include the following, in a manner calculated to be understood by the Member:

i) Information sufficient to identify the claim involved (including the date of service), the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of (1) the diagnosis code and its corresponding meaning, and (2) the treatment code and its corresponding meaning;

ii) The specific reason(s) for the appeal decision;

iii) A reference to the specific Plan provision(s) on which the decision is based;

iv) A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);

v) A statement of the right to sue in federal court and information relating to the other appeals available to the Member, including a statement that such appeal will not impact the Member's rights to any other benefits under the Plan, the rules for fling such an appeal, and the Member's right to representation on appeal;

vi) A statement indicating entitlement on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination;

vii) If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the Member's medical circumstances or a statement that such explanation will be provided at no charge upon request;

viii) The following statement: "You and Your Plan may have other voluntary alternate dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency"; and

ix) Any other information required to be included by applicable law.

Section 6 – Mandatory Appeal to Iron Road Appeals Committee

If a Member's appeal has been denied in whole or in part, at the conclusion of a Member's appeal to the Iron Road Appeals Administrator, the Member may file an appeal to the Iron Road Appeals Committee. A Member must complete the appeal to the Iron Road Appeals Administrator and to the Iron Road Appeals Committee before the Member may request a review before an External Review Organization under Section 7 of this Article or before the Member may sue in federal court. A Member or a Member's authorized representative may file the appeal to the Iron Road Appeals Committee. The Member must file the appeal to the Iron Road Appeals Committee within sixty (60) days after receiving the final decision of the Iron Road Appeals Administrator. If a Member files an appeal to the Iron Road Appeals Committee, any applicable statute of limitations will be tolled while the appeal is pending.

- Members wishing to appeal to the Iron Road Appeals Committee must do so in writing, and the appeal must contain:

- The specific reason(s) for the appeal and copies of all past correspondence with the Plan concerning the topic of the appeal; and

Relevant information, if any, that the Member did not previously present to the Iron Road Claims Administrator or the Iron Road Appeals Administrator.

Members of the Iron Road Appeals Committee will review the appeal and issue a decision within sixty (60) days of the date of receipt of the appeal. If more time is necessary, the Iron Road Appeals Committee may take an additional sixty (60) day period. The Chairperson of the Iron Road Appeals Committee will notify the Member in advance of this extension. The Appeals Administrator (See Article VIII Sec 2(f)(iv) will notify the Member of the final appeal decision. The written notice will give the Member the reason for the decision and what Plan provisions apply.

An expedited appeal to the Iron Road Appeals Committee is available for an urgent care claim. The appeal of an urgent care claim determination must state the need for a decision on an expedited basis and must include documentation necessary for the decision on appeal. Expedited appeals are reviewed by the Iron Road Appeals Committee. Members and their representatives will be given the opportunity (within the constraints of the expedited appeals time frame) to participate via telephone and/or provide written materials to the Iron Road Appeals Committee. A verbal and written notice of the Iron Road Appeals Committee decision will be provided to the

Member and the Member's representative as soon as possible after the decision, but no later than twenty-four (24) hours of receipt of the appeal.

If a Member disagrees with the decision made by the Iron Road Appeals Committee on an urgent care claim (or a pre-service claim and the Member reasonably believes that the pre-service claim is clinically urgent), the Member may request an expedited external appeal to an External Review Organization ("ERO") under Section 7 of this Article. The criteria for an expedited external appeal to an ERO are the same as described above for a non-urgent external appeal. The procedures for expedited external appeals to the ERO are the same as those for non-urgent external appeals, except that the Member's request for an expedited external appeal will be reviewed by the Iron Road Appeals Administrator immediately, and the ERO will provide notice of its decision as expeditiously as the Member's medical condition or circumstances require, but in no more than seventy-two (72) hours after the ERO receives the request for an expedited external appeal. If the ERO's notice is not in writing, the ERO will provide written confirmation of the decision within forty-eight (48) hours of providing that notice.

Section 7 - Voluntary External Appeal to External Review Organization ("ERO")

An appeal to an ERO is available only after the Member has exhausted his or her first appeal to the Iron Road Appeals Administrator and second appeal to the Iron Road Appeals Committee, or if the Iron Road Appeals Administrator and/or the Iron Road Appeals Committee has failed to provide the Member with a decision on appeal within the applicable time frames described in this Article VIII.

Until such time as otherwise required by federal law, external appeals are not available for eligibility determinations, and are only available for other benefit claims if the adverse benefit determination involves (1) medical judgment as determined by the ERO; or (2) a rescission of coverage (a retroactive termination of coverage).

The Iron Road Appeals Administrator or designee coordinates the external appeal, but the decision is made by the ERO at no cost to Members. External appeals must be initiated in writing. An external appeal, including expedited appeals, must be pursued within four (4) months of a Member's receipt of the Iron Road Appeals Committee decision on appeal. If a Member does not appeal to the ERO within this time period, the Member will not be able to continue to pursue the external appeal process.

Within five (5) days following receipt of a written request for an external appeal, the Iron Road Appeals Administrator will complete a preliminary review of the request to determine whether it is eligible for an external appeal. Within one (1) business day after completing the preliminary review, the Iron Road Appeals Administrator will notify the Member of its determination. If the request is complete but not eligible for external review, such notification will include the reason for its ineligibility. If the request is not complete, the notification will describe the information or materials needed to make the request complete and that the Member will be allowed to perfect

the request for an external appeal within the four (4) month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

If a Member is eligible for an external appeal, the Iron Road Appeals Administrator will assign an ERO for the appeal. The ERO will timely notify the Member in writing that the request has been accepted for an external appeal. The notice will explain that the Member has ten (10) business days to submit in writing any additional information the Member wishes the ERO to consider. The ERO is required to consider information the Member submits within ten (10) business days. The ERO may, but is not required to, accept and consider additional information submitted after ten (10) business days.

Urgent care claims are eligible for expedited appeals to the ERO. The criteria for an expedited external appeal to an ERO are the same as described above for a non-urgent external appeal. The procedures for expedited external appeals to the ERO are the same as those for non-urgent external appeals, except that the Member's request for an expedited external appeal will be reviewed by the ERO immediately, and the ERO will provide notice of its decision as expeditiously as the Member's medical condition or circumstances require, but in no more than seventy-two (72) hours after the ERO receives the request for an expedited external appeal. If the ERO's notice is not in writing, the ERO will provide written confirmation of the decision within forty-eight (48) hours of providing that notice.

The ERO will review all the information and documents timely received and reach a decision that is not based on the decision of the Iron Road Appeals Administrator who decided the appeal. The ERO must provide written notice of its decision on the external appeal within forty-five (45) days after the ERO receives the request for the external appeal. The ERO's notice will contain the following:

1) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);

2) the date the ERO received the request for an external appeal, and the date of the ERO's decision;

3) references to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;

4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

5) a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to a Member;

6) a statement that judicial review may be available to the Member;

7) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman; and

8) any other information required to be included by applicable law.

ARTICLE IX – EXCEPTIONAL CASES

Cases or circumstances may arise for services not otherwise covered by the Plan from the nature of which it would be impractical to prescribe specific regulations. In such cases, the facts should be fully and promptly reported to the President as the case indicates for instructions. Iron Road will not be responsible for any expenses incurred that are not authorized by these regulations or by express instructions from the President.

ARTICLE X – ACCESS TO MEDICAL AND HOSPITAL RECORDS

Unless prohibited by law from doing so, Iron Road will provide access to a Member's medical records under Iron Road's control (1) to the Member who requests the Member's records in writing or to a third party as directed by the Member in writing; or (2) upon receipt by Iron Road of a valid HIPAA authorization signed by the Member authorizing the disclosure to the person or entity listed in the HIPAA authorization. Iron Road may also require other forms to be signed and filed as required by applicable law.

ARTICLE XI – SUBROGATION, REIMBURSEMENT AND THIRD PARTY RECOVERY

Section 1 - General

If a Member of the Plan becomes ill or is injured caused by the act or omission of a third party and a third party is or may be responsible for such illness or injury, the Plan may advance payment of Plan Benefits for such injury or illness provided that the requirements of this Article XI are satisfied. By accepting Benefits under the Plan, the affected Member or covered person agrees to be subject to the terms and conditions of this Article XI regarding Subrogation, Reimbursement and Third-Party Recovery. The Plan provisions require that the responsible parties and the Member pay Plan Benefits advanced to the Member back to the Plan if such advance payment is made. The purpose of the Plan is to pay covered expenses if they are not paid or payable by anyone else, in accordance with the terms of the Plan.

In these circumstances, the Member may have a claim against a Third Party, its insurer, or against the Member's own insurer for payment of the medical expenses. Accepting Benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the Member may have to Recovery payments from any Third Party or an insurer of the Third Party or the Member in the amount of such Benefits. This subrogation right allows the Plan to pursue any claim that the Member has against any Third Party or such insurers, whether or not the Member chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount of the Recovery of the Member whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

Section 2 - Definitions

The following definitions shall apply to this Section ("Subrogation, Reimbursement and Third Party Recovery"):

Benefits. All payments related to an injury or illness, including, but not limited to, medical expenses and other compensation under the Plan.

Member. References to "Member" in this Article XI include the Member, the Member's estate, and the Member's heirs, guardians, executor, agent, or other legal or personal representatives and/or heirs.

Plan or Plan Document. This Plan Document and Summary Plan Description.

Recovery. Any and all payments from another source to which the Member is entitled (including, but not limited to, any payments made under any insurance policy, and amounts allocated to a trust set up by or for the Member or on the Member's behalf) as a result of the

Member injury or illness, including any judgment, award, or settlement regardless of how the recovery is termed, allocated, or apportioned and regardless of whether any amount is specifically included or excluded as medical expenses. Recovery further includes, but is not limited to, recoveries for attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages, and any other recovery of any form of damages or compensation whatsoever.

Reimbursement Amount. The amount of Benefits paid by the Plan to or for the Member or on the Member's behalf for the injury or illness for which a Third Party is or may be responsible and that the Member is obligated to pay back to the Plan out of any Recovery.

Third Party. The term "Third Party" includes any of the following entities: person; corporation; association; government; insurance coverage, including underinsured, uninsured, no-fault, disability, or similar coverage; med pay provisions of an insurance policy; and workers' compensation coverage. It includes any insurance company of the Member and/or any other insurance company that may or has paid insurance proceeds to the Member because of the injury or illness.

Section 3 - Subrogation and Reimbursement Rights

The Plan Administrator, acting within its discretionary authority under the terms of the Plan, may agree to advance payment of Benefits for a Member's illness or injury for which a Third Party is or may be responsible provided that the Member agrees to repay the Plan in full resulting from any monetary award or recovery. As a condition for advancing payment of Benefits for such injury or illness, the Member and the Member's attorney (if one is retained) may be asked to sign the Plan's Subrogation and Reimbursement Agreement. If the Plan advances payment of Benefits to the Member for an injury or illness for which a Third Party is responsible, the Plan is entitled to reimbursement in full for any Benefits made to or on behalf of the Member. The Plan shall be subrogated to all the Member's rights of recovery against the Third Party to the full extent of Benefits advanced by the Plan.

If the Member is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any Recovery funds. If the injury or condition giving rise to subrogation involves wrongful death of a Member, this provision applies to the parent, guardian, executor, agent, or other personal representative of the estate.

1) The Plan shall be reimbursed first and in full out of any Recovery without any amounts deducted for attorneys' fees, costs, or future medical expenses, unless the Plan Administrator, acting within its discretionary authority under the terms of the Plan, agrees to do so in writing prior to the final settlement or resolution of the matter.

2) The Plan shall be entitled to reimbursement in full for any Benefits it advances to, or on behalf of, Member for expenses related to an injury or illness for which a Third Party is, or may be, responsible without regard to the common fund doctrine, make whole doctrine, or

any other common law doctrine or state statute that purports to restrict the Plan's right to reimbursement in full. The Member further specifically agrees and acknowledges that the "make whole" doctrine, the "made whole" doctrine, and the "common fund" doctrine are completely abrogated under this Plan and will not affect the Plan's rights. Members agree, as a condition to receiving Benefits under the Plan, not to bring or assert any of these doctrines or a collateral source or other apportionment action or claim in contravention of the Plan's rights under this Section. The reimbursement to the Plan shall be made directly from the Third Party or from the Member or the Member's attorney out of any Recovery.

3) The Plan's right to reimbursement shall apply even if the Recovery is not sufficient to fully compensate the Member for his or her illness or injury and even if liability is not admitted or found.

4) The Plan shall have the right to bring, join or intervene in any suit or claim against a Third Party brought by the Member or on the Member's behalf.

5) The Plan shall have the right to information about any suit or claim brought by the Member or on the Member's behalf.

Section 4 – Member's Subrogation and Reimbursement Responsibilities

The Plan may deny claims related to an injury or illness that was or may have been caused by a Third Party, or it may recoup the costs of claims already paid for such injury or illness, if any of the following requirements are not satisfied:

1) The Member shall notify the Plan of the existence of the injury or illness for which a Third Party may be responsible immediately and no later than one (1) year of incurring such injury or illness.

2) The Member shall comply with all the Plan's claim procedures and cooperate fully with the Plan in the recovery of the Benefits advanced by the Plan and the Plan's exercise of its reimbursement and subrogation rights.

3) The Member shall complete and submit to the Plan any documents requested and/or required by the Plan. The Subrogation and Reimbursement Agreement, if one is requested by the Plan, shall be reviewed and signed by the Member or covered person's attorney.

4) The Member agrees to reimburse the Plan in full, in first priority and on a first dollar basis, from any Recovery in an amount equal to the full amount of Benefits advanced by the Plan for the Member's injury or illness, regardless of whether the Member is made whole by the Third Party. The Member also agrees that the common fund doctrine, make whole doctrine, and any other common law doctrine or state statute that purports to restrict the Plan's right to full reimbursement shall not be applicable to the Plan's right to full reimbursement of the amount of Benefits it advances to a Member under this Section.

5) The Member shall provide all information about the Member's

6) illness or injury as requested by the Plan.

7) The Member shall keep the Plan advised of any changes in the status of the

8) Member's suit and/or claim against the Third Party.

9) The Member shall refrain from doing anything to impair, prejudice or compromise the Plan's subrogation and reimbursement rights without prior written agreement by the Plan Administrator.

10) The Member shall notify the Plan before any settlements of the Member's suit or claim is concluded and before any trial or other material hearing concerning the suit or claim is held.

11) The Member shall be solely responsible for the Member's attorneys' fees. The Plan shall not be liable for any costs or attorneys' fees incurred by the Member in pursuing the Member's suit or claim, regardless of any common fund, make whole, or any other common law doctrine or state statute that requires the Plan to pay a portion of the Reimbursement Amount to the Member or the Member's attorney for the legal fees incurred in the collection of the Recovery. The Member shall defend/indemnify and hold harmless the Plan from any claims by the Member's attorney against the Plan seeking attorneys' fees or costs.

12) The Member shall inform the Plan as to whether he or she has received a Recovery related to the Member's illness or injury before accepting any accident or injury related benefits under the Plan. If the Member has received a Recovery before accident-related benefits are claimed or paid, the Plan shall not be responsible for any further Benefits for claims related to the illness or injury.

13) Any claims for a Member's illness or injury may not be paid until the Plan has received a completed copy of the Subrogation and Reimbursement Agreement signed by both the Member and the Member's attorney if such Subrogation and Reimbursement Agreement is requested to be executed by the Plan. If the Plan inadvertently advances payment for claims before receiving the completed and signed Subrogation and Reimbursement Agreement, the Plan may not be obligated to advance payment for any further claims until it has received the fully completed and signed Subrogation and Reimbursement Agreement and the Plan may be entitled to reimbursement for the claims that it had inadvertently paid regardless of whether the completed and signed Subrogation and Reimbursement Agreement is submitted to the Plan.

Section 5 - Subrogation and Reimbursement Procedures

The Member shall be responsible for compliance by his or her representative and/or agents and attorneys with the procedures set forth in this Article. If the Member receives a Recovery, the Member or the Member's attorney shall hold the Recovery funds separately from other assets until the Plan's reimbursement rights have been satisfied. The Plan shall hold a claim, equitable lien, and constructive trust over the Recovery funds and those funds shall remain segregated and under the Member's or Member's agent's control. Once the Plan's reimbursement rights have

been determined, the Member shall make immediate payment to the Plan out of the Recovery proceeds. If a Member does not pursue a suit or claim against the Third Party, the Plan may be entitled to assert the suit or claim in the Member's name or on the Member's behalf in the Plan's name and the Member shall cooperate with the Plan's prosecution of any such suit or claim.

Section 6 - Noncompliance

If the Member receives a Recovery but does not promptly segregate the Recovery funds and reimburse the Plan in full from those funds, the Plan shall be entitled to take action to recover the Reimbursement Amount. Such action may include, but shall not be limited to:

1) Initiating an action against the Member and/or the Member's attorneys to compel compliance with this Section and/or the Subrogation and Reimbursement Agreement;

2) Withholding or suspending Benefits payable to or on behalf of the Member until the Member complies or until the Reimbursement Amount has been fully paid to the Plan; or

3) Initiating other appropriate equitable or legal actions.

If the Member does not reimburse the Plan within sixty (60) days of receiving the Recovery, the Member shall be responsible for paying the Plan 1% interest per month on the Reimbursement Amount until the Plan receives reimbursement in full. The Plan shall also be entitled to reimbursement of any costs or fees it incurs in efforts to enforce its rights and the terms of the Plan provisions against the Member and/or the Member's attorney.

Section 7 - Venue

Any Member filing a legal action in connection with this Section shall be required to file suit in the United States District Court for the District of Utah, located in Salt Lake City, Utah, which is also the jurisdiction in which the Plan headquarters is located and the Plan is administered.

Section 8 - Conclusion of Claim

Once a Member has settled or received an award or judgment or any type of Recovery on a claim or suit against a Third Party, (1) the Member shall hold any proceeds of a Recovery in trust until the Plan's rights and interests in such Recovery have been resolved and satisfied and (2) no further medical expenses associated with that injury or illness may be paid by the Plan unless the Plan Administrator, within its discretionary authority under the terms of the Plan, agrees in writing that future medical expenses related to that injury or illness will be covered. In exercising their discretion with respect to the payment of future medical expenses, the Plan may, but is not required to, consider, among other things, whether the settlement is sufficient to cover future medical expenses.

ARTICLE XII – AMENDMENTS/TERMINATIONS

The Plan may be amended as deemed necessary by the Board, in accordance with the Board rules for such actions. While Iron Road intends to continue the Plan indefinitely, it reserves the right to terminate or amend the Plan for any reason and at any time. If Iron Road terminates or amends the Plan, benefits under the Plan could cease or change. Iron Road may also increase the required Dues at any time.

ARTICLE XIII – OTHER PLAN PROVISIONS

Section 1 – Discretionary Authority of Plan Administrator

The Plan Administrator shall administer this Article of the Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Member's rights and obligations, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable and related to an accident, injury, or condition. Benefits under this Plan shall be paid only if the Plan Administrator decides, in its discretion, that a Plan Member or covered person is entitled to them. The Plan Administrator has the final authority to determine the amount, manner, and time of payment of any Plan benefits.

The Plan Administrator also has the following powers and duties:

1) to prescribe procedures to be followed by Members and medical providers in obtaining benefits;

2) to receive from Members and others information that may be necessary for proper administration of the Plan;

3) to keep and maintain documents and all other records pertaining to the Plan;

4) to appoint and supervise all third-party service providers for the Plan;

5) to perform all necessary reporting as required by applicable law;

6) to delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and

7) to perform each function necessary for or related to the Plan's administration.

The Plan Administrator's decisions relating to the Plan will be final and binding on all persons except to the extent found to be arbitrary and capricious.

Section 2 - Information to Be Furnished

Members are required to sign documents and to provide the Company and the Plan Administrator with information and evidence as may reasonably be requested from time to time for the purpose of administration of the Plan.

Section 3 - Refunds

If it is determined that a payment or overpayment of benefits to which a Member is not entitled has been paid by the Plan, the Plan may deduct the amount of such payment or overpayment from future payments of claims otherwise payable under the Plan to the Member. If the Plan for any reason is not able to make such a deduction, the Member agrees, as a condition to receiving benefits from the Plan, upon demand, to repay such payment or overpayment to the Plan. Members not complying with this Section may, in the discretion of the Plan Administrator, lose eligibility to participate in the Plan.

Section 4 - Facility of Payment

In the event any benefit under the Plan is payable to a person who is incapacitated or under other legal disability so as to be unable to manage his or her financial affairs, the Plan Administrator may direct payment of the benefit to a duly appointed guardian or other legal representative of such person. In the absence of a guardian or legal representative, the Plan Administrator may direct payment to a custodian for such person under the Uniform Gifts to Minors Act or to any relative of such person by blood or marriage, for such person's benefit. Any payment made in good faith pursuant to this provision shall fully discharge the Company, the Plan, and the Plan Administrator of any liability for such payment in the amount of such payment.

Section 5 - Notices to Members

All notices, statements, reports, and other communications from the Plan to any Member of this Plan shall be deemed to have been duly given when delivered to such Member or when mailed by first-class mail, postage prepaid, addressed to such Member at the address last appearing on the Plan's records.

Section 6 - Severability

If any provision of this document is held illegal or invalid for any reason, such determination shall not affect the remaining provisions of the Plan, which shall be construed as if the illegal or invalid provision had never been included.

Section 7 - Legal Actions

Unless otherwise specifically provided by law, no action at law or in equity may be brought to recover under this Plan unless brought within two (2) years after the date of the claim for benefits is made.

Section 8 - Non-Covered Services

If a Member incurs medical expenses for which the Plan does not provide or pay benefits, the Member will be responsible for paying the medical provider of such services in accordance with applicable law and contractual arrangements, if any, between the Member and the medical provider.

Section 9 - Conclusiveness of Records

The records of the Plan and the Company with respect to age, continuous service, employment history, compensation, absences, illnesses, and all other relevant matters shall be conclusive for purposes of the administration of, and the resolution of claims arising under, the Plan to the extent permitted by law.

Section 10 – End Stage Renal Disease and Mandatory Enrollment in Medicare

IRHC will pay for expenses related to ESRD as the primary payor and coordinate with Medicare as the secondary payor during the 30-Month coordination period. The 30-month coordination period begins the date the member becomes entitled to enroll in Medicare because of ESRD. If enrollment does not occur, the 30-month period begins on the date the individual was first entitled to enroll in Medicare due to ESRD.

A member of the Plan is required to enroll with Medicare if a regular course of dialysis has been prescribed by a physician when the person has reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life.

IRHC will pay as the primary payer during the 30-month coordination period and secondary after the 30-month coordination period. A member who declines to apply for Medicare ESRD coverage will assume primary financial responsibility for the costs associated with ESRD that would have been Medicare's responsibility had the Plan member enrolled.

Medicare entitlement ends if the member is without dialysis for six months, or 36 months have passed since a successful kidney transplant.

APPENDIX A – COORDINATION OF BENEFITS

If you are covered under any other group insurance contract or plan (referred to as the "Other Plan"), the benefits under this Plan and those of the Other Plan will be coordinated in accordance with this Appendix A.

1) The term "Other Plan" as used in this Section shall mean any group insurance policy, plan program paid for in whole or in part by any employer and which provides medical, surgical, hospital or dental benefits by:

    a) Group, blanket, or franchise insurance coverage,

    b) Group, National Health & Welfare Plan, group practice and other prepayment group coverage,

    c) Any labor management trustee plan, union welfare plan, employer organization plan or employee benefit plan or

    d) Any governmental program or any coverage under automobile insurance including no-fault insurance.

2) When you are covered by this Plan and an Other Plan, either this Plan or the Other Plan will be primary and will pay its benefits first or "primary." Payment is determined in the following order:

    a) The plan with no coordination of benefits provisions will be primary.

    b) If the primary plan was not established by (i), the plan covering the Member as an employee or former employee will be primary to a Plan covering the Member as a dependent.

    c) If the primary plan was not established by (i) or (ii), the plan covering the Member as an Active Employee will be primary to a Plan covering the Member as a retiree or former employee.

    d) If the primary plan was not established by (i), (ii) or (iii), then the plan which covers the Member as a dependent of the person whose birthday is earlier in the calendar year will be primary to a plan which covers that Member as a dependent of a person whose birthday is later in the calendar year.

    e) If the primary plan was not established by (i), (ii), (iii) or (iv), the plan covering the Member as an actively working employee at the time of their injury or onset of their illness will be primary.

f) If the primary plan was not established by (i), (ii), (iii), (iv) or (v), the plan that has covered the person for the longer period of time will be primary.

3) Whenever any payment in excess of the maximum amount payable under this Section shall have been made by the Plan, the Plan shall have the right to recover such payment or payments to the extent of such excess from any one or more of the following, as the Plan shall elect:

   a) Any person to or for whom such payment or payments were made.

   b) Any insurance company.

   c) Any other association, organization, or corporation.

4) When this Plan is primary, it pays benefits without regard to the benefits received by the Member from the Other Plan. When this Plan is secondary, it pays benefits equaling 100% of allowed medical charges, minus the benefits paid by the Other Plan as the primary plan. These coordination of benefit rules are meant to ensure that a Member will not receive payment for more than 100% of the Plan's allowed medical charges. However, the total payment received by the Member from all plans will never be less than if this coordination of benefit did not apply.

5) Medicaid: Notwithstanding the foregoing, benefits paid on behalf of a Member will be made in accordance with any assignment of rights made by or on behalf of the Member that is required under a state's Medicaid law. The Plan will not consider a Member's eligibility for Medicaid for purposes of enrollment or paying benefits under the Plan. To the extent payment has been made under Medicaid for medical assistance to a Member 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 Member for such payment for benefits.

6) Medicare: This Plan pays primary to Medicare only to the extent required by federal law to do so. In all other instances, this Plan pays secondary to Medicare. The provisions below outline the member's responsibility to enroll in Medicare A and B even when covered by the Challenger, 60/30+ and ERMMB plan to avoid a member incurring additional financial responsibility for health expenses.

   a) **Members on Disability Leave 65 or older**: If a Member is on a leave of absence from active employment due to a disability, even if the Member retains a right to return to active employment, the Plan will pay primary to Medicare only for the first 6 months of disability leave. After this 6-month period, Medicare will become the primary payor and the Plan will be the secondary payor until such time, if ever, that the Member returns to active employment.

   b) **Members on Disability Leave 64 or under:** If a Member is on a leave of absence from active employment due to a total disability, even if the Member retains a right to return to

active employment, the Plan will pay primary to Medicare only for the first 24 months from the date of disability or until the member reaches age 65, whichever comes first. After this 24-month period, or the member reaches age 65, Medicare will become the primary payor and the Plan will be the secondary payor until such time, if ever, that the Member returns to active employment

c) **End-Stage Renal Disease**: For Members who are eligible for coverage under the Medicare program by reason of end-stage renal disease, the Medicare program will be the primary payor and this Plan the secondary payor, except that during the first thirty (30) month period that such Members are eligible for Medicare benefits solely by reason of end-stage renal disease, this Plan will be the primary payor and Medicare the secondary payor.

d) When this Plan is the secondary payor under federal law in accordance with paragraphs a and b above, the Plan will pay as the secondary payor if the Member is enrolled and receiving benefits from Medicare Parts A and B, and it will also pay as the secondary payer if the Member is not enrolled in and receiving benefits from Medicare if the individual is eligible for Medicare Parts A and B but has not enrolled, or has declined enrollment. This means that if a Member described in paragraph a or b above who receives benefits under this Plan does not enroll in and begin receiving benefits from Medicare Parts A and B when the Member is eligible for Medicare, the benefit that Member receives from the Plan will still be reduced as if the Member were enrolled in and receiving benefits from Medicare Parts A and B. **Thus, it is important that the Members described in paragraph a or b enroll in Medicare Parts A and B as soon as they are eligible to do so if they want to avoid having to pay for expenses for benefits that this Plan does not pay due to the Plan's coordination of benefits provisions with Medicare Parts A and B.**

e) If the Plan is the secondary payor under federal law in accordance with paragraph a or b above, the Member must give the Plan notice within 60 days after either: 1) the date as of which a Member is enrolled and receiving benefits from Medicare Parts A and B or 2) the date as of which the Member is eligible for Medicare Parts A and B but has not enrolled, or has declined enrollment. The Member must also provide to the Plan any information reasonably requested by the Plan that is necessary to implement the Plan's coordination of benefits provisions with Medicare Parts A and B.

APPENDIX B – NOTICE UNDER CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ("COBRA")

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage available under the Plan in certain circumstances when coverage would otherwise end. **This Section generally explains COBRA continuation coverage when it may become available to you and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). This notice does not fully describe COBRA coverage or other rights under the Plan. For additional information about your rights and obligations under COBRA, the Plan and federal law, contact Iron Road Customer Service at **1-800-547-0421** or **801-595-4300.**

You May Have Other Options Available to You When You Lose Group Health 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 thirty (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.

If you are leaving employment with the Company to serve in one of the United States Armed Forces, you may be eligible for up to twenty-four (24) months of Plan continuation coverage under another federal law, the Uniformed Services Employment and Reemployment Rights Act of 1994. For more information, please contact Iron Road Customer Service at **1-800-547-0421** or **801-595-4300**.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage for you when coverage would otherwise end because of a life event known as a "qualifying event." There are two qualifying events under this Plan: You lose coverage because (1) your hours of employment are reduced; or (2) your employment ends for any reason other than your gross misconduct.

Except in certain situations, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage when the Plan has been notified that a qualifying event has occurred. Your employer must notify Iron Road of the qualifying event.

How Is COBRA Coverage Provided? How Long Does It Last?

Once the Plan receives notice of your qualifying event, COBRA continuation coverage will be offered to you.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of employment or a reduction of the employee's number of hours of employment, COBRA continuation coverage generally lasts for up to a total of eighteen (18) months. However, as explained more fully below, it can end before eighteen (18) months.

If you are determined by the Social Security Administration/RRB to be disabled during the first sixty (60) days of your COBRA continuation coverage, and you notify the Plan in a timely fashion, you may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. Notice of your disability determination must be made in writing to Iron Road and addressed as follows:

Iron Road Healthcare
ATTN: Member Services
P.O. Box 161020
Salt Lake City, UT 84116-1020

The notice of disability determination must be provided no later than sixty (60) days after the latest of the following dates:

1) the date of the Social Security Administration/RRB determination of the disability;

2) the date on which the qualifying event occurs that gives rise to your right to elect COBRA; or

3) the date on which coverage is lost as a result of a qualifying event.

The notice must also be given by you to Iron Road prior to the end of your initial eighteen (18) month COBRA continuation period.

Notice of disability determination must contain your name, account or Social Security number, and include a copy of the Social Security Administration/RRB determination of disability. The employee or any person representing the employee can provide the notice. The disability would have to have started at some period before the 60th day of COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of continuation coverage. During the additional eleven (11) months of continuation coverage, the premium for that

coverage may be approximately 50% higher than it was during the preceding eighteen (18) months.

If you are receiving extended continuation coverage because of a disability determination, you must also notify the Plan within thirty (30) days of any final determination by the Social Security Administration/RRB that you are no longer disabled. Notice must be made in writing and addressed as follows: Iron Road Healthcare, P.O. Box 161020, Salt Lake City, Utah 84116-1020. The notice must contain your name, account or social security number, and include a copy of the Social Security Administration/RRB determination. You or any person representing you can provide the notice.

Premium for COBRA Coverage

You will be notified as to the amount of your required premium when you receive the notice of our rights to continue coverage. You will be required to pay the premium due, including any retroactive premiums within forty-five (45) days after the day continued coverage is elected. The required premium is adjusted each year to reflect actual and anticipated claims experience; thus, your required contribution may change during the continuation period. There is a grace period of thirty (30) days for payment of the regularly scheduled premium.

Termination of Continuation Coverage

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

1) The employer no longer provides group health coverage for any of its employees;

2) The premium for your continuation coverage is not paid within thirty (30) days of the due date;

3) You become covered after the date you elect COBRA coverage under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition you may have;

4) You become entitled to Medicare benefits; or

5) You have the additional eleven (11) month extended disability continuation coverage and you are determined to be no longer disabled by the Social Security Administration or by the RRB.

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 this coverage. The Plan 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 twenty-nine (29) months from the date coverage was lost under the Plan as a result of the qualifying event.

If You Have Questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, the Health Insurance Portability and Accountability Act ("HIPAA"), 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 or visit the EBSA website at http://www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.) For more information about coverage that may be available at the Marketplace, visit https://www.healthcare.gov/.

Keep Your Plan Informed of Address Changes

To protect your rights, you should keep the Plan informed of any changes in your address. You should also keep a copy, for your records, of any notices you send the Plan.

Plan Contact Information

For general information about the Plan and COBRA continuation coverage, you may contact

Iron Road Customer Service
P.O. Box 161020
Salt Lake City, UT 84116-1020

or

1-800-547-0421 or 801-595-4300.

Your spouse and dependents may also be entitled to COBRA continuation coverage in certain situations; however, since the National Health & Welfare Plan provides medical benefits for most dependents, any information regarding COBRA continuation coverage for them should be addressed to:

National Health & Welfare Plan
Benefits Department Railroad Administration COBRA
One Tower Square
Hartford, CT 06183-6006

APPENDIX C – OTHER IMPORTANT PLAN NOTICES

HIPAA Special Enrollment Rights

Under the special enrollment provisions of HIPAA, you may be eligible in certain situations to enroll in the Plan during the year, even if you previously declined coverage.

You will be eligible to enroll in the Plan if, during the year you have lost coverage under another plan because coverage in the other plan ended due to:

1) Termination of employment;

2) Divorce;

3) Death

4) Employer contributions to the other plan stopped;

5) The other plan was terminated; or

6) COBRA coverage under the other plan ended.

However, if you lost coverage in the other plan due to failure to pay premiums on a timely basis, or for cause, you do not have a special enrollment right to join the Plan.

You may also enroll in the Plan during the year, even if you previously declined coverage, in the following two situations:

1) Loss of Medicaid Coverage. If you lose Medicaid coverage, you may be able to enroll in this Plan if you request enrollment within sixty (60) days after the date of termination of Medicaid coverage. You do not have this special enrollment right if the loss of Medicaid was due to the failure to pay required premiums for such coverage.

2) Eligibility for Premium Assistance. If you become eligible for a state program under which Medicaid will provide assistance to pay a portion of the cost of your Plan contributions, you may be able to enroll yourself in this Plan. However, you must request enrollment within sixty (60) days after the date you become eligible for such assistance. Coverage for persons enrolled under this Special Enrollment for Eligibility for Premium Assistance is effective on the first day of the month following the request, unless otherwise required by law.

Medicare Prescription Drug Notice

TO: All Members Who Have Medicare or Will Become Eligible for Medicare in the Next Twelve (12) Months

Important Notice About Your Prescription Drug Coverage Under This Plan and Medicare Prescription Drug Coverage

This notice is applicable to Medicare eligible participants ONLY. If you are not Medicare eligible or will not be within the next twelve (12) months, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Plan and your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is provided at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage is available to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. The coverage is sometimes referred to as "Medicare Part D" prescription drug coverage. In general, Medicare Part D coverage provides coverage for prescription drugs not covered under Medicare Parts A and B. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some Medicare benefits may also offer more coverage for a higher monthly premium.

2. The Plan has determined that the prescription drug coverage offered under the Plan is, on average for all Members, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage under Medicare. If you are enrolled in this Plan, because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. However, in most instances, the value of a Medicare prescription drug plan is greatly reduced because the Plan pays prescription drug benefits before, or primary to, the benefits of a Medicare prescription drug plan.

It is important that you make an informed and deliberate decision concerning whether to enroll in a Medicare Part D prescription drug plan. Do not enroll in a Medicare Part D prescription drug plan "just in case." For most Members, there is little or no added value in purchasing Medicare prescription drug coverage while you are covered by this Plan. The exception to this rule may be for those with limited incomes and assets who qualify for extra help with prescription drug costs.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Plan and do not join a Medicare drug plan within sixty-three (63) continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go sixty-three (63) continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen (19) months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage, contact Iron Road for further information. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if health plan options under the Plan change. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

- Visit medicare.gov.

- Call your state Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone number) for personalized help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug plans is available through the Social Security Administration. For more information about this extra help, visit the Social Security Administration online at socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium amount.

Date:	September 1, 2019
Name of Entity/Sender:	Iron Road Healthcare/Challenger Plan
Contact-Position/Office:	**Andrea Puff-Newberry**
Address:	**1040 N. 2200 W, Salt Lake City, Utah 84116**
Telephone Number:	**1-801-595-4337**

Women's Health and Cancer Rights Act of 1998

This federal law requires health plans to provide coverage for reconstructive surgery and related services that may follow a mastectomy.

In accordance with this law, if you are receiving or received Plan benefits in connection with a mastectomy, coverage will be provided as determined in consultation with your attending physician for the following procedures:

- Reconstructive surgery for the affected breast;

- Surgery on the other breast to achieve symmetry;

- Prostheses; and

- Treatment for complications from the mastectomy, including lymphedema.

Benefits for the above medical services and supplies are subject to the same limitations as for other services, supplies and procedures that are covered by the Plan.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (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 insurance issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

APPENDIX D – Information Required by the Employee Retirement Income Security Act ("ERISA")

Name of Plan: **Iron Road Healthcare Challenger Health Plan for Active Employees (the "Plan")**

Plan Sponsor: **Union Pacific Railroad**

Plan Identification Numbers:

Employer Identification Number (EIN): **87-0427760**

Plan Number (PN): **H-4652**

Plan Administrator:

Iron Road Healthcare
P.O. Box 161020
Salt Lake City, UT 84116-1020
Telephone: 801-595-4300
Fax: 801-595-4399

Type of Plan:

Health Care Benefit Plan

Plan Trustee:

Iron Road Board of Trustees

PO Box 161020
Salt Lake City, Utah 84116-1020

Agent for Service of Legal Process:

Legal process may be made upon the Plan Administrator or the Trustee listed above.

Sources of Employer and Employee Contributions to the Plan:

The Railroad National Carriers Conference Committee sets employer contributions for the Plan each year. The employee contribution is then calculated through the collective bargaining process. Employer and employee contributions to the Plan are held in a trust until needed to pay Plan benefits.

Plan Year:

Calendar year, ending each year on December 31

Type of Administration of Health Care Benefits Provided by the Plan:

The Plan is administered by the Plan Administrator. The Plan's health care benefits are provided by the Plan and are not insured by an outside entity.

Rights and Protections under ERISA:

As a Member in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

1) Examine, without charge, at the Plan Administrator's office and at other specified locations all Plan documents, including 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 EBSA.

2) Obtain copies of all documents governing the operation of the Plan, copies of the latest annual report (Form 5500 series) and an updated SPD. The Plan Administrator may make a reasonable charge for the copies. In addition, participants and beneficiaries may obtain from

the Plan Administrator, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

3) Continue health care coverage for yourself, spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

4) 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.

In addition to creating rights for Plan participants, ERISA imposes duty upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health care benefit or exercising your rights under ERISA. If your claim for a health care benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of all documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. If your claim is denied, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, before filing a lawsuit you must first exhaust all appeals required by the Plan.

In addition, if you disagree with a decision of the Plan or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the 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 you 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.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the EBSA, 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 NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

APPENDIX E – NOTICE: Nondiscrimination in Health Insurance Programs Section 1557 of the Affordable Care Act

Iron Road complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Iron Road does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Iron Road provides free aids and services to people with disabilities to communicate effectively with us, such as:

1) Qualified sign language interpreters

2) Written information in other formats (large print, audio, accessible electronic formats, other formats)

3) Free language services to people whose primary language is not English, such as:

    a) Qualified interpreters

    b) Information written in other languages

If you need these services, contact the Iron Road Civil Rights Coordinator at the number given below.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, gender, disability, or sex, you may send a complaint to:

Iron Road Civil Rights Coordinator
1040 North 2200 West Suite 200
Salt Lake City, UT 84074
Telephone: **1-800-547-0421, TTY711**
Fax: **801-595-2069**
Email: help@uphealth.com

You can file a complaint in person or by mail, fax or email. If you need help filing a complaint or need this information in another format like large print, please call our Member Services at **1-800-547-0421, TTY711**. A representative will be able to assist you.

You can also file a complaint directly with the U.S. Department of Health and Human Services online, or by phone or mail:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at https://www.hhs.gov/hipaa/filing-a-complaint/index.html.

Telephone: Toll-free **1-800-368-1019**, 1-**800-537-7697** (TTY)
Mail: U.S. Department of Health and Human Services
200 Independence Avenue SW Room 509F, HHH Building
Washington, DC 20201

APPENDIX F – Compliance with HIPAA

SECTION 1 - Privacy and Security of Individual Health Information

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") protects the privacy of certain types of individual health information and regulates the use of such information by the Plan and imposes certain security protection measures concerning electronic health information. The Department of Health and Human Services has issued regulations on this subject that can be found at 45 CFR Parts 160 and 164 ("HIPAA Regulations"). The individual health information that is protected ("Protected Health Information" or "PHI") is any information created or received by the Plan that relates to:

1) a Member's past, present or future physical or mental health or a Member's past, present or future physical or mental condition;

2) the provision of health care to Members; or

3) the past, present, or future payment for health care.

However, HIPAA allows medical information, including PHI, to be disclosed by the Plan to the Plan Sponsor and to be used by the Plan Sponsor. The permitted disclosures to and uses by the Plan Sponsor of medical information are as follows:

1) The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of (1) obtaining premium bids for providing insurance coverage; or (2) modifying, amending, or terminating the Plan ("Summary Information"). The Plan Sponsor may use Summary Information so received from the Plan only for these two (2) listed purposes.

2) The Plan may disclose to the Plan Sponsor, and the Plan Sponsor may use, information on whether an individual is participating in the Plan or a Plan benefit or is enrolling or disenrolling in the Plan or a Plan benefit.

3) The Plan may disclose PHI to the Plan Sponsor and/or the Plan Sponsor may use such PHI if the Member has specifically authorized in writing such disclosure and/or use.

4) The Plan may disclose PHI to the Plan Sponsor and the Plan Sponsor may use PHI to carry out Plan administration functions, such as activities relating to:

    a) obtaining premiums or determining or fulfilling responsibility for coverage and provision of benefits under the Plan;

    b) payment, or obtaining or providing reimbursement, for health care services; and

c) determining eligibility for, or eligibility for one or more types of coverage or benefits provided under, the Plan;

d) coordination of benefits or determination of copayments or other cost-sharing mechanisms;

e) adjudication and subrogation of claims, billing, claims management, collection activities and related health care data processing;

f) payment under a contract for reinsurance;

g) review of health care services with respect to medical necessity, coverage under the Plan, appropriateness of care, or justification of charges;

h) utilization review activities, including pre-certification and pre-authorization of services and concurrent and retrospective review of services;

i) disclosure to consumer reporting agencies of any of the following PHI regarding collection of premiums or reimbursement: name and address, date of birth, Social Security number, payment history, account number and name and address of the Plan;

j) medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

k) business planning and development, such as conducting cost-management and planning-related analyses relating to managing and operating the Plan, including formulary development and administration and/or the development or improvement of methods of payment;

l) resolution of internal grievances;

m) prosecution or defense of administrative claims or lawsuits involving the Plan or the Plan Sponsor;

n) conducting quality assurance and improvement activities, case management and care coordination;

o) evaluating health care provider performance or Plan performance;

p) securing or placing a contract for reinsurance of risk relating to health care claims and other activities relating to the renewal or replacement of stop-loss or excess of loss insurance; and

q) contacting health care providers and patients with information about treatment alternatives.

These uses and disclosures are consistent with the HIPAA Regulations.

The Plan Sponsor has agreed (and the Plan has received a certification from the Plan Sponsor evidencing such agreement) to the following restrictions:

1) The Plan Sponsor will not use or further disclose the PHI except (1) as described above; or (2) as otherwise required by law.

2) Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides PHI will agree to the same restrictions and conditions on the use and disclosure of PHI that apply to the Plan Sponsor. Any agents or subcontractors of the Plan Sponsor to whom the Plan Sponsor provides electronic PHI must agree to implement reasonable and appropriate security measures to protect the information.

3) The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other non-health benefit of the Plan Sponsor, except as part of coordination of benefits.

4) The Plan Sponsor will report to the Plan any use or disclosure of the PHI that is inconsistent with the permitted uses and disclosures of which the Plan Sponsor becomes aware. The Plan Sponsor will report to the Plan any security incident of which the Plan Sponsor becomes aware.

5) The Plan Sponsor will give you access and provide copies to Members of your PHI in accordance with the HIPAA Regulations.

6) The Plan Sponsor will allow you to amend your PHI in accordance with the HIPAA Regulations.

7) The Plan Sponsor will make available PHI to you in order to make an accounting of PHI in accordance with the HIPAA Regulations.

8) The Plan Sponsor will make available its internal practices, books and records relating to the use and disclosure of PHI received from the Plan to the Secretary of Health and Human Services (or the Secretary's designee) for determining compliance by the Plan with the HIPAA Regulations.

9) The Plan Sponsor will, if feasible, return or destroy all protected PHI received from the Plan and retain no copies of the PHI when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, it will limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

10) The Plan Sponsor will ensure that adequate separation between the Plan and Plan Sponsor is established.

11) No PHI will be disclosed to a Member's employer unless compelled by a court of competent jurisdiction.

12) The Plan Sponsor will ensure that this adequate separation is supported by reasonable and appropriate security measures to the extent that these individuals have access to electronic PHI.

13) The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan, except enrollment/disenrollment information and Summary Information, which are not subject to these restrictions.

14) The access to and use by the employees of PHI is limited to the Plan administration functions that the Plan Sponsor performs for the Plan. Employees who violate this Section are subject to disciplinary action, including, but not limited to, reprimands and termination.

The Plan has issued a Privacy Notice which explains the Plan's privacy practices and a Member's rights under HIPAA. This Privacy Notice is available by contacting Iron Road.

APPENDIX G – Preventive Care Benefits Under the Affordable Care Act [1]

Get many checkups, screenings, vaccines, prenatal care services, contraceptives and more with no out-of-pocket costs.

IMPORTANT: These services are free only when delivered by a doctor or other provider in your plan's network.

Preventive care benefits for adults

1) Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked

2) Alcohol misuse screening and counseling

3) Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk

4) Blood pressure screening

5) Cholesterol screening for adults of certain ages or at higher risk

6) Colorectal cancer screening for adults 45 to 75

7) Depression screening

8) Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese

9) Diet counseling for adults at higher risk for chronic disease

10) Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting

11) Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.

12) Hepatitis C screening for adults at increased risk, and one time for everyone born 1945–1965

13) HIV screening for everyone ages 15 to 65, and other ages at increased risk

[1] https://www.healthcare.gov/coverage/preventive-care-benefits/

14) Immunization vaccines for adults — doses, recommended ages, and recommended populations vary:

15) Diphtheria

16) Hepatitis A

17) Hepatitis B

18) Herpes Zoster

19) Human Papillomavirus (HPV)

20) Influenza (flu shot)

21) Measles

22) Meningococcal

23) Mumps

24) Pertussis

25) Pneumococcal

26) Rubella

27) Tetanus

28) Varicella (Chickenpox)

29) Lung cancer screening for adults 55-80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years

30) Obesity screening and counseling

31) Sexually transmitted infection (STI) prevention counseling for adults at higher risk

32) Statin preventive medication for adults 40 to 75 at high risk

33) Syphilis screening for adults at higher risk

34) Tobacco use screening for all adults and cessation interventions for tobacco users

35) Tuberculosis screening for certain adults without symptoms at high risk

Preventive care benefits for children

1. Alcohol, tobacco, and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
4. Bilirubin concentration screening for newborns
5. Blood pressure screening for children ages: 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years
6. Blood screening for newborns
7. Cervical dysplasia screening for sexually active females
8. Depression screening for adolescents beginning routinely at age 12
9. Developmental screening for children under age 3
10. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish for all infants and children as soon as teeth are present
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years
15. Height, weight and body mass index (BMI) measurements for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
16. Hematocrit or hemoglobin screening for all children
17. Hemoglobinopathies or sickle cell screening for newborns
18. Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S.-born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11–17 years

19. HIV screening for adolescents at higher risk
20. Hypothyroidism screening for newborns
21. Immunization vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
    a) Diphtheria, Tetanus, Pertussis (Whooping Cough)
    b) Haemophilus influenza type b
    c) Hepatitis A
    d) Hepatitis B
    e) Human Papillomavirus (HPV)
    f) Inactivated Poliovirus
    g) Influenza (flu shot)
    h) Measles
    i) Meningococcal
    j) Pneumococcal
    k) Rotavirus
    l) Varicella (Chickenpox)
22. Iron supplements for children ages 6 to 12 months at risk for anemia
23. Lead screening for children at risk of exposure
24. Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits
25. Medical history for all children throughout development ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
26. Obesity screening and counseling
27. Oral health risk assessment for young children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
28. Phenylketonuria (PKU) screening for newborns

29. Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk

30. Tuberculin testing for children at higher risk of tuberculosis ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years

31. Vision screening for all children

Services for pregnant women or women who may become pregnant

1. Anemia screening on a routine basis
2. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
3. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
4. Folic acid supplements for women who may become pregnant
5. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
6. Gonorrhea screening for all women at higher risk
7. Hepatitis B screening for pregnant women at their first prenatal visit
8. Preeclampsia prevention and screening for pregnant women with high blood pressure
9. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
10. Syphilis screening
11. Expanded tobacco intervention and counseling for pregnant tobacco users
12. Urinary tract or other infection screening