Your Guide to

Patriot Salaried Retiree Medical Benefit Plan for Legacy Peabody Energy Corporation Retirees

January 2010

This document is a Summary Plan Description (SPD) and the legal Plan Document for the Medical Plan for eligible retired salaried employees of Patriot Coal Corporation ("Company" and "Plan Administrator") and certain designated affiliates and subsidiaries in effect as of January 1, 2010, in accordance with the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and U.S. Department of Labor Regulations. A complete list of participating employers may be obtained upon written request to the Plan Administrator, and may be examined at the principal office of the Plan Administrator and other worksites. This document supersedes any documents previously issued to you.

This document should be retained as part of your important records. Eligibility for benefits and the actual amount of benefit payments are determined by this document and laws that govern the Plan.

The Company intends to maintain this plan for eligible retired employees, but reserves the right to change or terminate the Plan at any time. This document is not a guarantee of benefits or an employment contract of any kind.

If a retiree speaks a language other than English, he or she may contact the local human resource office to request help with translating or interpreting the contents of this document.

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Salaried Retiree Medical and Prescription Drug Benefits

The Salaried Retiree Medical Plan ("Plan") coverage is offered to you and your eligible dependents after your retirement through a Preferred Provider Organization (PPO) Plan. The Plan is designed to encourage you to maintain your health and to help with health care expenses. The Plan provides coverage for preventive and medically necessary services and is administered by Blue Cross Blue Shield of Illinois (BCBS IL) if you and all your eligible dependents are non-Medicare eligible. If you and your eligible dependents are Medicare eligible, the Plan is administered by United Medical Resources (UMR).

Important Points

- You are eligible for two coverage options, one with a $250 deductible or one with a $1000 deductible
- If you are Medicare eligible, the Plan coordinates with Medicare who is primary
- Prescription drug coverage benefit is included in the Plan and is not applied to the annual deductible
- When you and/or your eligible dependents become Medicare eligible, you must enroll in Part A, Part B and Part D to continue your eligibility for this Plan. The Company auto-enrolls you in Medicare Part D
- The Plan includes a lifetime maximum benefit of $2 million per covered person
- The Plan includes a coverage limit for pre-existing conditions which may be offset by prior creditable coverage
- Only eligible dependents at the time of your retirement can be covered under the Plan
- Throughout this document you will find specific information that applies if your claims are administered by BCBS IL. As such, when these references are made, they do not apply to you if your claims are administered by UMR

Eligibility and Enrollment

Eligibility

This plan is available to certain retired employees of Patriot Coal Corporation and certain designated subsidiaries and affiliates of Patriot Coal Corporation after retirement. If you are classified as a retired salaried employee who retired from Peabody Energy Corporation between March 1, 1990 and if you were at least age 55 with ten years of service as of December 31, 2002 and retired on or before January 1, 2005, you and your eligible dependents may participate in this Plan.

Dependent Eligibility

Members of your family who are eligible for coverage include:

- Your legal spouse
- Your unmarried children under age 19 who reside with you and are principally dependent on you for support
- Your unmarried children up to the day they attain age 23, if they are full time students (enrolled for a minimum of 12 credit hours) at an accredited school, college or university, reside with you and are principally dependent on you for support. Proof of full time student status, such as a registrar's statement, must be submitted at the beginning of each semester
- Your unmarried children of any age who are incapable of supporting themselves due to a mental or physical disability that occurs before age 19, and are completely dependent upon you for financial support. The child must live with you or be confined to an institution for care or treatment. Proof of incapacity must be provided to the Benefits Department at **1-800-633-9005** within 31 days of the date coverage would otherwise end due to age

Dependent children include your biological children, stepchildren, legally adopted children or children placed in your home for adoption, or other children who live with you in a parent-child relationship, provided you have legal guardianship.

The Plan will also cover a child for whom coverage is required under a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the Plan's procedures for QMCSO determinations from the Benefits Department, free of charge.

In order to enroll your dependents, you will be required to certify and show proof of your spouse and dependent children's eligibility, with documentation such as a birth certificate, marriage license, other court documents and / or the applicable sections of your most recent year's tax return.

You must elect coverage under the Plan for yourself before you can elect coverage for any dependent. If you cancel or suspend coverage under the Plan for yourself, coverage for your dependents will also be cancelled or suspended.

Important Plan Provisions for Enrollment

- An enrollment form for the Retiree Medical Plan coverage will be available when you terminate employment if you meet the eligibility requirements. You may contact the Benefits Department at **1-800-633-9005** for an enrollment form
- If you have medical coverage through another employer-sponsored group plan at the time you end your employment with the Company or obtain other employer-sponsored group coverage after you end your employment, you may delay your participation in the Plan

until coverage ends. Within 31 days after the other coverage ends, you may elect coverage under the Retiree Medical Plan as long as you provide proof the other coverage has ended

- If such employment begins after you retire, you may temporarily suspend participation under the Plan. If you later lose that coverage, you may elect coverage under the Plan as long as you provide proof that you lost the other coverage
- This proof must be provided within 31 days of the date coverage was lost, and participation in the Plan must begin immediately thereafter. If you were not a participant in the company medical plan as an active employee because you had coverage through another employer-sponsored group plan, you may elect coverage under the Plan when you retire. You must provide proof of your other coverage at the time of your election. You may contact the Benefits Department at **1-800-633-9005** for an enrollment form
- Only eligible dependents at the time you end your employment with the Company can be covered under the Plan; new dependents (through marriage, birth or adoption, or are placed with you for adoption) cannot be added at a later date. If you have a dependent who is covered under another group health plan at the time you elect coverage under the Plan and that dependent later loses the coverage, that dependent can be added within 31 days of the loss of coverage provided they continue to meet the eligibility rules under the plan
- If you and /or your dependents are covered under two plans, coordination of benefits will apply. The Plan coverage will be primary for you, unless you are Medicare eligible. The Plan coverage may not necessarily be primary for your dependents if they are covered under another plan but are not Medicare eligible
- If you do not elect coverage under the Plan for yourself or your dependents within the applicable 31 day period described above, you will not be able to do so later.
- Retirees may not cover a spouse who is also an employee of the Company and has Patriot medical coverage or may not cover dependent children under more than one retiree/employee
- In the event of your death while covered under the Plan, your surviving dependents may continue coverage as long as they remain eligible
- When you end your employment, you may elect COBRA continuation under the Patriot medical plan you are participating in at the time of you end your employment. At the end of your COBRA continuation period, you may then elect coverage under the Plan

The Cost of Coverage

The enrollment form for the Plan will include the applicable monthly rates for coverage. You and other participants will be responsible for a monthly premium. The Company subsidizes the cost of your premiums which is reviewed annually. Your cost for coverage depends on the option you select and the number of family members you choose to cover. Premium costs will be payable to BeneFlex HR Resources, Inc., 3660 S. Geyer Road, Suite 340, St. Louis, MO 63127. You will receive a coupon booklet from BeneFlex HR Resources when you enroll, and you will also receive a coupon booklet at the beginning of each year during annual enrollment. You may contact the Benefits Department at **1-800-633-9005** if you have any questions. If required premiums are not paid when due, coverage will end and my not be reinstated.

Changing Your Coverage During the Annual Enrollment Period

An annual enrollment occurs in the fall of each year. If you previously elected coverage under the Plan during the annual enrollment period, you may cancel coverage for yourself and your eligible dependents or you may cancel coverage for your dependents and elect retiree-only coverage effective on the following January 1. However, coverage that is cancelled during the annual

enrollment period cannot be later reinstated unless there is a change in status. In addition, you cannot add any new dependents during an annual enrollment period, as also noted in the previous section.

Changing Your Coverage During the Year

Generally, you may not change your election to enroll for medical or decline coverage during the plan year. However, you may make a change to your election if you have a change in status (as described below) and the election change is on account of and consistent with the change in status.

The following events are considered changes in status for purposes of the Plan:

- Divorce, legal separation or annulment
- Death of a spouse or dependent child
- Your covered dependent child reaches the age limit for coverage or otherwise ceases to satisfy the dependent eligibility requirements
- You, your spouse or dependent child has a change in job status, such as termination or commencement of employment, commencement of or return from a leave of absence, change in worksite or another change that affects eligibility for coverage
- You, your spouse or dependent child has a change in residence which thereby affects access to a plan service area
- A judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody, including a qualified medical child support order or "QMCSO", that requires health coverage for your child under this Plan or another plan
- You, your spouse or child becoming entitled to, or losing eligibility for, Medicare or Medicaid benefits
- A significant change in cost or coverage with respect to benefits under this plan or a plan of your spouse's or dependent child's employer
- The enrollment period for a plan of your spouse's or dependent child's employer is different than this plan
- Loss of other group health coverage sponsored by a governmental or educational institution
- Any other events the Plan Administrator determines would permit a change of election

For all changes in coverage as described here for which you are eligible~~,~~ (outside of annual enrollment), you must complete a benefits enrollment form within 31 days of the change in status event. The election change will be effective the date the Benefits Department receives the completed form, except in the case of a QMCSO, in which case the effective date of coverage is the date the Plan determines a medical child support order is qualified. Your contribution level cannot be changed until your completed form is received, and the Company will not refund contributions you have made before the date your completed form is received. Note that regardless of your contribution level, the Plan does not provide coverage for a family member after the date the individual no longer qualifies as an eligible dependent, unless the individual is eligible for, elects and pays the cost of continued coverage under the law known as COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), as described in the "Continuation Coverage Rights Under COBRA" section.

Limitations for Pre-Existing Conditions

A pre-existing condition is any physical or mental condition (other than a condition related to pregnancy) for which medical advice, diagnosis, care or treatment (including prescription drugs) was recommended or received within 90 days before the individual's enrollment date. For this purpose, the "enrollment date" is the date coverage begins.

Charges related to a pre-existing condition generally are not covered during the 12-month period commencing on the individual's enrollment date, as defined above. The 12-month exclusion period for pre-existing conditions will be reduced to the extent that you have creditable coverage, as defined in the Health Insurance Portability and Accountability Act, from another medical plan on the date you enrolled in this Plan. Creditable coverage is explained in the next section.

In addition to the creditable coverage provision, the 12-month exclusion period for pre-existing conditions does not apply to:

- Pregnancy
- Prescription drugs

Creditable Coverage

The 12-month exclusion period for pre-existing conditions will be reduced by the amount of time an individual had creditable coverage. A person receives creditable coverage for previous periods of coverage under other group medical plans, individual medical insurance and certain state and federal health benefit programs. However, if you or your dependent had a period of 63 consecutive days with no creditable coverage, any periods of creditable coverage that occurred prior to that lapse will not be counted. Note that any period during which you or your dependents were satisfying a group health plan's waiting period is not counted as a lapse in creditable coverage.

You will be required to provide proof of creditable coverage. You should contact your previous group health plan or health insurer to obtain a Certificate of Creditable Coverage or other appropriate documentation. If you need assistance, you may contact the Benefits Department.

When your medical coverage or COBRA continuation coverage under this plan ends, you will receive a Certificate of Group Health Plan Coverage from the Plan Administrator or Claims Administrator. You may also request this certificate up to 24 months after your coverage ends. You may take this certificate to another health care plan to receive credit for your coverage with the Company. You will only need to do this if the other health care plan has a pre-existing condition limitation.

Option 250 Retiree Medical Plan

Benefits At A Glance

Feature	Coverage Network Provider	Coverage Non-Network Provider
Deductible	**$250** Per Individual	**$500** Per Individual
Co-insurance	**80%** if an in-network provider; *50% if a non-administrator provider	**60%** if a non-network provider; **50% if a non-administrator provider
Maximum out-of-pocket (includes deductible and co-insurance only)	Retiree $1,700 Retiree plus 1 $3,400 Family $5,100	Retiree $3,400 Retiree plus 1 $7,200 Family $10,200
Inpatient Services **Outpatient Services**	**80%** if an in-network provider; *50% if a non-administrator provider; after deductible is met	**60%** if a non-work provider; **50% if a non-administrator provider; after deductible is met
Doctor's office visits and services (Co-pays do not apply to deductible or maximum out-of- pocket)	Non-specialist MD **$20** Specialist MD **$50** (Any test, procedure, treatment, etc. in the office will be applied to deductible and co-insurance)	Non-specialist MD **$20** Specialist MD **$50** (Any test, procedure, treatment, etc. in the office will be applied to deductible and co-insurance)
Emergency Room	**80%** after deductible **$150** copayment (if non medically necessary)	**60%** after deductible **$150** copayment (if non medically necessary)
Chiropractic Care	80% with 30 visits per year maximum and/or $1200 maximum annual out of pocket	60% with 30 visits per year maximum and/or $1200 maximum annual out of pocket
Hospital Pre-cert Penalty	**$200**	**$200**
Mental Health and Chemical Dependency	Same as any physical illness	Same as any physical illness
Home Health Care	**80%** with 60 calendar days per yr. maximum	**60%** with 60 calendar days per yr maximum
Hospice	**80%** up to $10,000 / lifetime	**60%** up to $10,000 / lifetime
Physical Therapy	**80%**	**60%**
Occupational Therapy	**80%**	**60%**
Speech Therapy	**80%**	**60%**
Wellness Benefit	**100%** coverage up to $500 annual maximum per covered family member	**60%** after deductible up to $500 annual maximum per covered family member
Lifetime Maximum	$2 million	$2 million

*If you and your covered dependent's claims are processed by UMR, the non-network provisions of the plan do not apply.
** Subject to balance billing of non-discounted provider charge

Option 1000 Retiree Medical Plan

Benefits at a Glance

Feature	Coverage Network Provider	Coverage Non-Network Provider
Deductible	$1000 Per Individual	$2000 Per Individual
Co-insurance	**70%** if an in-network provider; *50% if a non-administrator provider	***50%** if a non-network provider; **50% if a non-administrator provider
Maximum out-of-pocket (includes deductible and co-insurance only)	Retiree $4,500 Retiree plus 1 $9,000 Family $13,500	Retiree $9,000 Retiree plus 1 $18,000 Family $27,000
Inpatient Services **Outpatient Services**	**70%** if an in-network provider; *50% if a non-administrator provider; after deductible is met	***50%** if a non-work provider; **50% if a non- administrator provider; after deductible is met
Doctor's office visits and services (Co-pays do not apply to deductible or maximum out-of- pocket)	Non-specialist MD **$20** Specialist MD **$50** (Any test, procedure, treatment, etc. in the office will be applied to deductible and co-insurance)	Non-specialist MD **$20** Specialist MD **$50** (Any test, procedure, treatment, etc. in the office will be applied to deductible and co-insurance)
Emergency Room	**70%** after deductible **$150** copayment (if non medically necessary)	**50%** after deductible **$150** (if non medically necessary)
Hospital Pre-cert Penalty	**$200**	**$200**
Mental Health and Chemical Dependency	Same as any physical illness	Same as any physical illness
Home Health Care	**70%** with 60 calendar days per yr. maximum	**50%** with 60 calendar days per yr maximum
Hospice	**70%** up to $10,000 / lifetime	**50%** up to $10,000 / lifetime
Physical Therapy	**70%**	**50%**
Occupational Therapy	**70%**	**50%**
Speech Therapy	**70%**	**50%**
Wellness Benefit	**100%** coverage up to $500 annual maximum per covered family member	**50%** after deductible up to $500 annual maximum per covered family member
Lifetime Maximum	$2 million	$2 million

*If you and your covered dependent's claims are processed by UMR, the non-network provisions of the plan do not apply.

** Subject to balance billing of non-discounted provider charge

The Prescription Coverage listed below is applicable to both Option 250 and Option 1000.

Prescription Coverage – CVS Caremark/Silverscript	
Retail Prescriptions – 30 day supply	
Tier 1 - generic	$5
Tier 2 - preferred brand	$25 or 30%, whichever is greater up to $75 maximum
Tier 3 - non-preferred brand	$50 or 50%, whichever is greater up to $200 maximum
Mail Order Prescriptions – 90 day supply	
Tier 1 - generic	$10
Tier 2 - preferred brand	$50 or 30%, whichever is greater up to a $150 maximum
Tier 3 - non-preferred brand	$100 or 50%, whichever is greater up to a $400 maximum

Using Your BCBS IL Coverage

When your coverage is administered by BCBS IL, you are required to follow all guidelines set forth in the Blue Care® Connection ("BCC") program as described herein. You receive a greater benefit when you use providers within the Blue Card PPO network.

Should you have questions regarding your coverage with BCBS IL, you may contact their customer service department at **1-888-873-2227**.

Using Your UMR Coverage

When your coverage is administered by UMR there are no set guidelines you must follow as your primary payer is Medicare and UMR is the secondary carrier. However, UMR does perform utilization management and case management to help control care costs and to provide appropriate and timely member care while increasing the member's understanding of the health care system.

Should you have questions regarding your coverage with UMR, you may contact their customer service department at **1-800-972-3023**.

Annual Deductible

The annual deductible is the amount of covered medical expenses you must pay for each covered individual each calendar year before the medical plan will pay benefits.

Deductibles are shown in the "Benefits at a Glance" chart. However, there are special features and exceptions:

- The deductible may be satisfied with a combination of network, out-of-network or non-administrator expenses
- The deductible does not apply to in-network preventive care services as shown in the "Benefits at a Glance" chart and as also explained in the "Wellness Benefits" section

Reasonable and Customary Charges

Payments for your covered medical expenses are based on reasonable and customary charges for services and supplies in a geographic area. The reasonable and customary charge is determined by the Claims Administrator based on the usual fees charges by a physician or other provider for the same or a similar service in a geographic area. In the event that there are no providers of comparable services or supplies in the same geographic area or in the event of an unusual service or supply, the Claims Administrator will determine the eligible expense.

Participating PPO providers' charges will not exceed the reasonable and customary amount. Any portion of the covered charge submitted by a non-administrator or out-of-network provider that is above the reasonable and customary charge is an ineligible expense and will not count toward your deductible or out-of-pocket maximum.

Out-of-network and non-administrator providers may bill you for any amount up to the billed charge after the Plan has paid its portion of the bill. You will be responsible for the amount over the reasonable and customary charges.

Non-Administrator Hospitals and Non-Administrator Provider Facilities

Non-administrator hospitals and non-administrator provider facilities are not contracting PPO providers or out-of-network providers, and are paid at 50% of reasonable and customary charges. Your coinsurance in these situations is 50% after your applicable deductible. Please keep in mind that receiving services from these providers could result in your out-of-pocket responsibility being significantly higher than if you had received services from a PPO provider or out-of-network provider. In order to determine if you are seeing a non-administrator provider, you should contact the BCBS IL customer service department by telephone at **1-888-873-2227**. The representative will provide more information to you about the financial impact of utilizing non-administrator

providers. If you are told your provider is out-of-network, specifically ask what your coinsurance will be. If you receive care from a non-administrator or out-of-network provider, you will be responsible for paying the balance of charges due to the provider.

Annual Out-of-Pocket Maximum

The out-of-pocket maximum provides additional protection for you by limiting the amount you are required to pay in one calendar year for each person's covered expenses. The out-of-pocket maximum also includes a family maximum, as shown in the "Benefits at a Glance" chart.

For most types of care, you pay a percentage (coinsurance) of the covered expenses after the deductible is met. If the amount you have paid in one calendar year for one person's covered medical expenses reaches the out-of-pocket maximum amount shown in the "Benefits at a Glance" chart, the Plan will pay 100% of any additional covered expenses incurred by that person for the rest of that calendar year.

Each family member must meet the individual deductible, however once the applicable annual out-of-pocket maximum has been met, no additional covered family members will be required to pay deductible or coinsurance amounts for that year.

The out-of-pocket maximum does not apply to the following:

- Expenses that aren't covered by the Plan
- Penalties for not complying with the Blue Care® Connection program
- Expenses that exceed the Plan's negotiated rates or other plan maximums
- Expenses that are over reasonable and customary charges
- Prescription expenses
- Office visit copays

Lifetime Maximum Benefit

For all covered expenses, the Plan pays a lifetime maximum benefit of $2 million for each covered person.

For hospice care expenses, there is a $10,000 lifetime maximum benefit per individual. Coverage may be increased if approved by Blue Care® Connection (BCC).

BlueCard Network

The Plan offers you the opportunity to obtain services for yourself and your family through a preferred provider organization ("PPO"). The PPO has been developed by BCBS IL and is called the Blue Card PPO, or "network". The Blue Card PPO links network doctors and hospitals throughout the United States. For a list of network doctors and hospitals, telephone **1-888-873-2227**, or visit ***www.bcbsil.com***. The network is designed to provide access to comprehensive health care at a reasonable cost.

You are not required to use the network to obtain health care, however, your benefits are reduced and your cost is higher when you use out-of-network or non-administrator providers. Several important advantages to using the network are:

- Your share of the cost will be less. If you choose an out-of network or non-administrator provider, you will pay more out of your own pocket for most expenses

- Because the providers who participate in the network have agreed to pre-arranged fees, your share of the cost will be discounted, and you won't be charged more for services than the negotiated rate approved by BCBS IL. When you receive care outside the network and

the fee is above what is considered reasonable and customary, you will have to pay the difference

- In most cases, you don't have to fill out claim forms when you use the network. When you visit a network provider present your Salaried Retiree Medical Plan ID card. Your claims will be filed automatically and BCBS IL will pay the provider directly

If you go to a network provider and are "balance billed", meaning you are billed an amount beyond the deductible or coinsurance, or you are charged the difference between the provider's full amount and the pre-arranged network amount, please call BCBS IL at **1-888-873-2227** and a representative will contact the provider.

Non-administrator providers

Non-administrator hospitals and non-administrator provider facilities are *not* contracting PPO providers nor are they out-of-network providers. If you receive care from a non-administrator or out-of-network provider, your coinsurance will be 50% of the eligible charges for covered services after you meet the deductible. This means that you will be responsible for paying the balance of charges due to the provider. To determine if the physician you are seeing is in-network, out-of-network or a non-administrator provider, contact the BCBS customer service department by telephone at **1-888-873-2227**.

If You Have an Emergency

If you have an emergency, you should seek medical help immediately, whether you have access to a network hospital or must go to an out-of-network or non-administrator provider.

In either case, if you are admitted to a hospital, you or someone on your behalf must call Blue Care® Connection ("BCC") within two working days of your admission, as described in the "Blue Care® Connection Program" section. If BCC is not notified, your benefits will be reduced by an additional penalty.

If the emergency visit meets the requirements of "emergency or urgent care" as defined by the Plan, then the covered charges will be treated as if they were from a network provider, even if you were treated by an out-of-network or non-administrator provider.

If you go to an in-network emergency room, and if you are billed for an out-of-network or non-administrator provider ER physician, radiologist or anesthesiologist that provided care at the in-network facility, contact your Benefits Department for assistance with having your claim adjusted.

If You Need Care Your Network Doctor Can't Provide

If there is no network doctor who provides a certain type of service, you may be able to go to an out-of-network or non-administrator provider and have your covered expenses paid at the in-network level. You must call BCBS IL at **1-888-873-2227** prior to receiving services, in order to determine if your situation applies.

Traveling in the United States

If you need emergency medical attention, go immediately to the nearest medical facility and follow standard emergency procedures. Refer to the "If You Have an Emergency" section.

If you are traveling and need non-emergency medical attention, call BCBS IL at **1-888-873-2227**. The representative will direct you to a network provider in the area if one is available. If you do not use a network provider when one is available, any covered expenses you incur will be paid at the out-of-network or non-administrator level.

If You or a Dependent Lives Outside the Network Area

If you or a covered dependent live outside the network area, medical benefits may be paid at the in-network level. Your eligibility records must be adjusted, or all claims will be processed at the

out-of-network or non-administrator level. This Outside the Network Area provision does not apply to prescription drug benefits. Contact your Benefits Department for information and forms.

Blue Care® Connection Program

Pre-Certification
The Blue Care® Connection ("BCC") program is administered by BCBS IL, and is designed to help you and the Company manage costs by reviewing, in advance, certain health care services. This allows BCC to "pre-certify" (authorize) certain types of care and make sure they are medically necessary and eligible under the Plan. In addition, the BCC program is designed to ensure that you receive the most appropriate and cost-effective care for your condition.

Pre-certification is required for all non-emergency hospitalizations and for the following extended care services:

- Home health care
- Private-duty nursing
- Hospice care
- Skilled nursing facility care
- Certain surgical procedures (refer to the "Surgical Charges" section)

If you use a network provider, in most cases the provider will handle pre-certification for you. However, it's still ultimately your responsibility to verify that the pre-certification process has been completed by calling BCC at **1-800-635-1928** before receiving care.

If you use an out-of-network or non-administrator provider, you or your provider must first call BCC for pre-certification.

If the pre-certification process is not completed, your benefits will be reduced by an additional $200 penalty for each admission or for extended care services that are not pre-certified. This pre-certification penalty is in addition to your annual deductible and coinsurance and does not count toward your annual out-of-pocket maximum.

If BCC determines that services are not medically necessary and eligible under the Plan, the Plan will not pay any benefits.

How to Contact Blue Care® Connection ("BCC")

When you need to contact Blue Care® Connection, please call **1-800-635-1928**.

If you're calling to request pre-certification, be sure to have the following information:

- Your identification number (from your Salaried Retiree Medical Plan ID card)
- The name and phone number of the provider
- The date of admission or start of extended care services
- The name of the hospital or treatment facility
- The reason for the admission or extended care services

If necessary, a professional registered nurse at BCC will contact your physician or hospital to obtain more information about your condition.

If possible, the reviewing nurse will give your physician or hospital a verbal decision immediately. However, if the nurse determines that the admission or outpatient care is not medically necessary, BCC will ask a consulting physician to review the case. After this consulting physician makes a

decision, BCC will notify your physician or treatment facility immediately and send you a letter informing you whether the admission or outpatient care has been approved.

Pre-Certification Does Not Guarantee Coverage

The purpose of pre-certification is to make sure health care services are medically necessary. It is not a guarantee of benefits or payment.

When BCC approves your admission or extended care services, this does not guarantee that the Plan will provide benefits for your expenses. The nurses at BCC check to determine the medical need for an inpatient admission or other care, but they cannot verify each covered person's benefits or coverage limitations before authorizing the care.

For example, the care could be for a cosmetic condition, and the Plan may pay only limited benefits or none at all. BCC may not learn that the care was for a cosmetic condition until it later reviews the patient's medical records. Therefore, please keep in mind that actual benefits cannot be determined until the patient's medical records are received.

When you request pre-certification, in most cases your admission will be approved. However, sometimes the reviewing nurse may suggest a less costly alternative, such as having a surgical procedure performed on an outpatient basis or in an ambulatory surgical center.

The reviewer will also try to make sure you aren't charged for a longer inpatient stay than is necessary, by:

- Suggesting that tests be performed on an outpatient basis before your inpatient admission
- Encouraging admission on the morning that surgery is to be performed

Pre-Certification for Inpatient Admissions

To request pre-certification, contact BCC as shown in the "How to Contact BCC" section. Registered professional nurses will carefully evaluate the proposed hospitalization. If the nurse determines that inpatient hospitalization does not meet the guidelines for medical necessity, a consulting physician will be asked to review the case and make a determination.

If you do not call BCC before you or a family member is admitted for an elective hospitalization, your covered hospital charges will be reduced by an additional $200 penalty. This amount does not count toward your annual deductible and coinsurance or your out-of-pocket maximum.

If the hospitalization is for an emergency, you do not have to notify BCC in advance, but must do so within two working days. Otherwise, the $200 penalty will apply.

To be considered an emergency, the patient must be admitted for a condition or bodily injury that occurs suddenly and requires immediate care because of impending danger to the patient's life.

If BCC does not receive a request for pre-certification for inpatient care and later determines that the care was not medically necessary, the Plan will not pay any charges related to the hospital admission. If BCC determines that the care should have been provided on an outpatient basis, BCC will allow the charges that would have been covered for outpatient care. Any inpatient-related charges, such as charges for room, board and physician visits, will not be eligible for benefits.

Recertification for Extending an Inpatient Stay

When BCC authorizes an inpatient admission, the reviewing nurse may assign the number of days that are commonly needed for inpatient care. If a physician believes it is medically necessary for you to receive inpatient care longer than originally authorized, you are responsible for obtaining approval for the additional days through BCC. Refer to the "How to Contact Blue Care® Connection" section.

If Pre-Certification is Not Approved

If, through the pre-certification process BCC determines that care can be received on an outpatient basis and you receive inpatient care anyway, the Plan will only cover those charges that would have been covered if the care had been provided on an outpatient basis.

If, through the pre-certification process BCC determines that additional inpatient care days are not medically necessary, the Plan will not provide any benefits for the extra days.

If You Do Not Call for Recertification

If BCC approves a specific length of stay, but you stay for a longer period without requesting approval for the additional days, your benefits may be reduced for the additional days you receive care.

- If BCC later determines that the additional days of care were medically necessary, eligible expenses will be covered by the Plan
- If BCC later determines that the additional days of care were not medically necessary, the Plan will not cover expenses for those days

Maternity Admissions

For an admission due to pregnancy, you should call BCC by the end of the third month of pregnancy. However, group health plans generally may not, under federal law, restrict benefits or require a provider to obtain authorization from the Plan for prescribing a hospital length of stay in connection with childbirth for the mother or newborn child that does not exceed 48 hours for normal vaginal delivery or 96 hours for a cesarean section, as long as the patient is otherwise covered by the Plan and eligible for benefits. The law does not prevent your physician from discharging the mother or newborn before 48 hours (or 96 hours) if after consultation with the mother it is determined that hospital confinement is no longer necessary. However, for inpatient care that continues beyond 48 hours (or 96 hours for a cesarean section), BCC must be contacted for pre-certification before the end of this period.

For a non-emergency hospital confinement that is needed during pregnancy but before the admission for delivery, BCC must be contacted for pre-certification before the scheduled admission date.

Pre-Certification of Extended Care Services

You must call BCC for approval of the extended care services listed in the "Blue Care® Connection Program" section. You should call for pre-certification as soon as the provider recommends treatment, but you must pre-certify with BCC no later than one business day before the extended care services start. To request pre-certification, refer to the "How to Contact Blue Care® Connection" section. If the pre-certification process is not completed, but BCC determines the extended care services were medically necessary and the Plan pays benefits, your benefits will be reduced by the additional $200.

Concurrent Review

In many cases, BCC will review the medical necessity of an admission and the need for continued treatment while you are still hospitalized. This is called "concurrent review."

If it is determined that you no longer need inpatient care, BCC may recommend continued care in a less costly alternative setting such as a skilled-nursing facility or at home through a home health agency. BCC may determine that no medical necessity exists for inpatient or outpatient care.

In either case, BCC will issue a letter to you and the provider(s) explaining that the care is no longer necessary. You will be responsible for any charges you incur that begin the day after you receive the notification.

Retrospective Review

BCC may perform reviews of certain inpatient and outpatient claims after they are paid. This is called a "retrospective review." Retrospective reviews are done to ensure care was medically necessary and to see if any unusual patterns exist in the treatment.

Individual Case Management

In many cases, patients suffering from catastrophic or long-term illness do not require continuous acute inpatient hospital care. In fact, such a patient can often benefit from receiving care in a more comfortable setting, including his or her own home.

BCC will work with you, your physician, social workers and home health agencies, the hospital and your family to determine the most appropriate, cost-effective treatment options. This program is called "individual case management" and is a voluntary program. Individual case management may allow for continued, alternative treatment while preserving benefits.

Candidates for individual case management may be suggested by BlueCross BlueShield of Illinois (BCBS IL), physicians, hospital-discharge planners, other providers of care or even by the patient's family.

To be considered eligible for individual case management, this Plan must be your primary coverage.

If You Disagree with BCC's Decision

If you or your physician disagrees with any decision made by BCC, an appeal may be submitted in writing within 180 days to:

Blue Care Connection
P.O. Box 1220
Chicago, IL 60690-1220

To file an appeal, you should follow the guidelines outlined in your denial letter, Explanation of Benefits, or other correspondence from BCBS IL. Please refer to the "Claims Procedures and Review" section for complete information regarding your rights to appeal any BCC decision.

The Blue Care® Connection program offers you guidance to help coordinate care. It supports you in obtaining the most appropriate treatment and setting. BCC also provides educational assistance with health problems or questions and can help you become a wiser consumer of health care.

24/7 Nurseline

Blue Care Connection offers a **24/7 Nurseline** which can be accessed by calling **1-800- 299-0274**. Registered nurses are available 24 hours a day, 7 days a week for questions regarding topics including, but not limited to:

- Asthma
- Back pain or other chronic conditions
- Dizziness or severe headaches
- High fever
- Constant crying (infants)
- Cuts or burns
- Sore throat

The **24/7 Nurseline** also includes an option to learn about more than 1,200 health topics over the phone via an audio library system.

Blue Access for Members

The following information is available to you if you log on to *www.bcbsil.com* and create an account.

- Check the status of a claim
- Confirm your coverage and who is enrolled
- Receive an e-mail when a claim is finalized
- Choose to stop receiving paper claim statements
- Find a doctor or hospital in the network
- Get information about your health care benefit plan

You will also find health and wellness information from the Mayo Clinic including:

- Self-management tools to help with low back pain, headaches and other common health problems
- Interactive tools to help you lose weight, quit smoking and start exercising
- Information to help you understand medical treatments

Covered Medical Expenses

The Plan will only pay benefits for the services and supplies listed in this section. These services and supplies must be prescribed or performed by a physician and, except for wellness benefits, must be for the medically necessary treatment of a non-occupational illness, injury or pregnancy.

If your medical claims are administered by BCBS IL, the plan only provides benefits for covered expenses that do not exceed the charges negotiated for the BlueCross BlueShield network. Participating providers agree to accept these rates and will not bill you for covered expenses other than the deductible, copayment and your percentage share of expenses. For a non-participating or non-administrator provider, you must pay any amounts that exceed the BlueCross BlueShield negotiated rates in addition to the deductible, copayment and your percentage share of covered expenses.

Wellness Benefits

The Plan provides benefits for certain wellness and preventive care services. When received from a network provider, the Plan will pay 100% of covered wellness expenses up to $500 per person per calendar year with no deductible. For out-of-network providers, the Plan pays a coinsurance of covered wellness services after the deductible is satisfied, up to $500 per person per calendar year. Covered expenses in excess of the $500 maximum and covered wellness charges will be subject to deductible and coinsurance. Covered wellness expenses include:

- Routine well-child care for newborns and children under age 6, including routine immunizations
- Routine physician examinations, except for examinations required for admission to a school or for participation in sports
- Routine pediatric immunizations for children up to age 18 as recommended by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices

- Routine immunizations for individuals ages 19 and older as recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices
- Pap tests, mammograms, screenings for hypertension and diabetes, examinations for early detection of cancer and other screening procedures

Note that wellness benefits can be provided only for charges your physician identifies as routine. Services for which a diagnosis is provided or symptom indicated will be paid in accordance with regular plan benefits and will be subject to deductible and coinsurance.

Office Visit Copays

Office Visit copays cover the office visit only. Any test, procedure, treatment, etc. performed in the office will be applied to your deductible and coinsurance. Non-specialists ($20 copay) are MDs or DOs in general practice, family practice, family medicine, OB-GYN, pediatrics, obstetrics, gynecology, certified nurse specialist and certified nurse practitioner. Specialists ($50 copay) are MDs or DOs in cardiology, orthopedics, neurology, oncology, endocrinology, rheumatology, surgery, podiatry, urology, etc. The list of specialists is not all-inclusive but serves as examples.

Hospital Charges

Covered expenses include the following inpatient and outpatient hospital charges. For an inpatient hospital stay, BCC must approve the hospitalization, as explained in the "Blue Care® Connection Program" section:

- Room and board expenses in a semiprivate room, including expenses for intensive care or coronary care units. The cost of a private room may be eligible if medically necessary
- Special diets
- General nursing care
- Use of operating, delivery, recovery and treatment rooms and equipment
- Emergency room services
- All FDA-approved and appropriately prescribed drugs and medicines for use in the hospital, and covered drugs or medicines sent home following hospitalization, up to a 30-day supply
- Dressings, ordinary splints and casts
- X-ray examinations, X-ray therapy and radiation therapy and treatment
- Laboratory tests
- Physical therapy, occupational therapy and/or speech therapy
- Anesthesia and its administration
- Blood and blood derivatives, to the extent they are not donated without charge or the hospital's supply are not replaced by or for the patient
- Processing and administering of blood and blood plasma to the extent it is not donated by the patient
- Chemotherapy
- Renal dialysis therapy administered according to Medicare regulations
- Dental care due to accidental bodily injury or oral dental surgery when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition
- Oxygen and its administration

- Intravenous injections and solutions

Surgical Charges

Covered expenses include the following surgical services:

- Surgical procedures, including customary pre-operative and post-operative services, performed by a physician or surgeon. (Voluntary sterilization surgery is covered but reversal of sterilization surgery is not)
- The necessary services of an assistant surgeon who actively assists the physician in surgery when:
  - You or your covered dependent is hospitalized
  - The type of surgery requires assistance as determined by BCC
  - The services of interns, residents or other post-graduate medical personnel are not available
  - Payment for assistant surgeons will be at 25% of the primary surgeon's negotiated rate or, if services are provided by a non-administrator or out-of-network provider, the reasonable and customary charge
- Medical supplies required for surgery in a hospital, a hospital's outpatient department, a physician's office or a freestanding ambulatory surgical facility
- Administration of anesthesia when administered by a certified nurse anesthetist or a physician other than the surgeon or assistant surgeon
- When more than one surgical procedure is performed at the same operative session and through the same incision, payment for the secondary procedures will be limited to 50% of the BlueCross BlueShield negotiated rate that would apply if the procedures were performed independently. However, additional charges for "incidental surgery" are not covered. Incidental surgery is a procedure that is usually included in the primary surgery charge
- Oral dental surgery due to an accident or alveolectomy
- Surgical benefits for the following procedures may be covered, subject to prior approval by BCC:
  - Surgery for treatment of temporomandibular joint dysfunction ("TMJ") if necessary to reorient the joint
  - Reduction mammoplasty, if medically necessary (not cosmetic)
  - Obesity, if you or your covered dependent meets the medical necessity criteria as determined by BCC, and BCC has given prior authorization for the surgery
  - Human organ or tissue transplants for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney as follows:
    - If both the donor and recipient have coverage, each will have their benefits paid by their own program
    - If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, coverage will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits
    - If you are the donor for the transplant and no coverage is available to you from any other source, coverage will be provided for you. However, no benefits will be provided for the recipient
    - Coverage will be provided for inpatient and outpatient covered services related to the transplant surgery; the evaluation, preparation and delivery of the donor organ; the removal of the organ from the donor; the transportation of the donor

organ to the location of the transplant surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada

- Cosmetic or reconstructive surgery required for:
  - Repair of defects resulting from an accident
  - Following a mastectomy, reconstruction of the affected breast and reconstruction of the other breast to create a symmetrical appearance, including services required as a result of complications
  - Replacement of diseased tissue that was surgically removed
  - Treatment of a birth defect

The surgery must be performed within 12 months following the date of the accident, removal of diseased tissue or birth, or, if surgery must be delayed because of the patient's physical condition, it must be performed as soon as medically necessary and appropriate based on the patient's physical condition.

Important Information About Coverage for Reconstructive Surgery Following Mastectomies

Under federal law, group health plans that provide medical and surgical benefits for mastectomies must also provide coverage for the following services, which are to be provided in a manner determined in consultation with the attending physician and the patient:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications in all stages of the mastectomy, including lymphedemas

As with other covered services, the usual deductibles, copayments or percentage share of expense you are required to pay will apply.

Emergency Room

You will pay an additional $150 copayment for emergency room care that is not medically necessary for a true emergency or urgent situation, as defined by the Plan. The copayment is in addition to the annual deductible and coinsurance and does not apply to the annual out-of-pocket maximum.

If emergency services meet the requirements of "emergency or urgent care" as defined by the Plan, the covered charges are treated as if they were from a network provider, whether you go to a network, out-of-network or non-administrator provider. All hospitalization and certain other types of care must be approved by BCC. Benefits may be reduced if you don't comply, as described in the "Blue Care® Connection Program" section (this does not apply if your benefits are administered through UMR).

Urgent Care

The visit will be subject to the deductible and coinsurance or the specialist office visit co-pay depending on how the visit is coded by the provider.

Second Surgical Opinion

The Plan includes benefits for an additional opinion following a recommendation for elective surgery. Your benefits will be limited to one consultation and related diagnostic service by a physician, covered at 100% for PPO or non-PPO providers (deductible does not apply) of the covered charge.

Home Health Care

Covered expenses include home health care if approved in advance through BCC. Refer to the "How to Contact Blue Care® Connection" section. Home health care must be a necessary alternative to hospitalization and is limited to 60 days annually

Eligible expenses from an authorized home health care agency include:

- Part-time or intermittent nursing services
- Physical, occupational or speech therapy
- Medical and surgical supplies that would also be covered as a hospital inpatient expense
- Prescription drugs for IV infusion therapy or injections

However, the following coverage limitations apply:

- The home health care must be provided according to a plan of treatment established by the patient's physician and approved through BCC
- The patient must be homebound for health reasons, but the patient may leave home occasionally to obtain outpatient hospital care that cannot be provided at home, or to obtain care from a licensed health care professional

Home health care benefits are not provided for:

- Private-duty nursing
- Dietary services or food
- Homemaker services (housecleaning, preparation of meals, etc.)
- Convalescent, custodial, maintenance or domiciliary care
- Purchase or rental of dialysis equipment except for peritoneal dialysis if approved by BCC
- Care for mental illness, alcoholism or drug addiction

Hospice Care

Hospice care means care that relieves pain and meets the basic life-supporting needs of a covered person who is terminally ill and has a life expectancy of six months or less. The purpose of the service is to provide care for the patient without attempting to prolong his or her life.

A hospice provider is a hospital, home health care agency or other provider that may legally provide hospice care.

The following special limitations apply to hospice care:

- All hospice care benefits are limited to a $10,000 lifetime maximum
- The care must be provided according to a physician's written treatment plan that has been approved in advance by BCC (this does not apply if your benefits are administered through UMR).
- . Refer to the "How to Contact Blue Care® Connection" section for more information

Benefits for hospice care are not provided for:

- Care given by volunteers who do not usually charge for their services
- Pastoral services
- Homemaker services (housecleaning, preparation of meals, etc.)

- Food or home-delivered meals
- Care to prolong life
- Expenses incurred by family members for temporary relief away from the patient (respite care)
- Funeral expenses

Skilled Nursing Facility

Covered expenses include care from an approved skilled nursing facility, subject to the following limitations:

- 120 day annual limit
- The care must be provided according to a physician's treatment plan and approved in advance by BCC
- Refer to the "How to Contact Blue Care® Connection" section for more information The care must be expected to result in a significant improvement in the patient's condition (custodial care is not covered)
- The degree of care must be more than can be given in the patient's home, but not so much as to require acute hospitalization

Other Medical Services

The following expenses are eligible for benefits:

- Expenses you incur at your home, a hospital, a clinic or your physician's office for the professional services of a physician or surgeon, including consultations by a qualified specialist
- Expenses you incur for the services of a physician's assistant or nurse practitioner
- Expenses incurred for the services of a registered nurse ("RN") or licensed practical nurse ("LPN"), when the skills of an RN or LPN are required
- The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye
- The fitting of diaphragms or the insertion or removal of an IUD
- Laboratory tests, radium therapy, X-rays and microscopic tests including the services of radiologist or pathologist
- Professional local ambulance services for transportation to a clinic, medical center, hospital, physician's office or skilled-nursing facility, when medically necessary
- Air ambulance charges are also covered for:
    - Medically necessary transportation from a remote area to the first, nearest hospital where treatment can be given
    - Transportation to a hospital in the event of a life-threatening accidental injury or sudden, life-threatening illness
- Prosthetic appliances to replace missing or nonfunctioning parts of the body. Covered expenses for an electronic prosthetic limb are limited to the cost allowed for a covered standard mechanical prosthesis to replace the same body part. Covered prosthetic appliances and supplies include:
    - Breast prostheses, internal and external (including two surgical brassieres per year), for reconstruction after a mastectomy
    - Cardiac pacemakers or electronic internal defibrillator

- Extraocular and intraocular lenses to replace either surgically removed or congenitally absent crystalline lenses of the eye
- Penile prostheses in men suffering impotency resulting from an organic disease or injury
- Artificial eyes
- Artificial limbs and stump socks
- Ostomy supplies and other equipment directly related to ostomy care
- Electronic speech aids & batteries after a laryngectomy
- Urinary collection and retention systems (Foley catheters, tubes, bags and so forth) in cases of permanent urinary incontinence
- Adjustments, repairs and replacement of the appliance

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- Orthopedic devices, including:
  - Braces and trusses
  - Custom-made and molded supportive orthotic appliances for the feet, when prescribed by a physician
  - Custom-made shoes when prescribed by a physician
  - Up to two pairs of surgical stockings per prescription in a six-month period, when prescribed by a medical physician for such conditions as thrombophlebitis or conditions resulting from surgery
- Rental of durable medical equipment for home use, up to its purchase price. In some cases, BCC may instead approve the outright purchase of the equipment if it is for long-term use
- Home oxygen equipment, including stationary and portable oxygen systems, will be eligible for coverage according to Medicare guidelines up to the purchase price
- Services of an inhalation therapist in the patient's home, under the orders of the attending physician
- Physical therapy by a licensed physical therapist that is expected to produce significant improvement within a two-month period. Benefits will no longer be paid when care has become maintenance. When the therapeutic goals of the treatment plan have been achieved and/or when no more measurable progress is expected, benefits will cease. Physical therapy coverage for temporomandibular joint syndrome ("TMJ") follows the same guidelines
- Speech therapy, by a licensed speech therapist, to restore speech that has been impaired as a result of illness, surgery or injury. Speech therapy will also be covered after surgery to correct birth defects. Developmental delays in learning to talk, the perfection of speech and educational services are not covered
- Occupational therapy for a physical or severe mental disability to restore the ability to perform ordinary tasks of daily living. Benefits will end when the therapeutic goals of a treatment plan have been achieved or when no more measurable progress is expected. Occupational therapy is not covered for most mental and chemical-dependency conditions. Development delays and educational services are not covered
- Private duty nursing in the home, unrelated to home health care, subject to $10,000 limit per calendar year
- Cardiac rehabilitation to restore health as much as possible, through exercise, education of the patient and reducing risk factors. To be eligible for benefits, cardiac rehabilitation must be provided within 12 months after one of the following:
  - An acute myocardial infarction (heart attack)
  - Coronary bypass surgery
  - Stable angina pectoris (heart-related chest pains)

- Diabetic education covered once per lifetime
- Biofeedback therapy, when reasonable and necessary for muscle re-education of specific muscle groups or for treating specific muscle abnormalities. This is not covered for treatment of ordinary muscle tension or for psychosomatic conditions
- Treatment of temporomandibular joint syndrome ("TMJ") to realign the joint and removable appliances and splints when medically necessary. Services or supplies in connection with crowning, wiring or repositioning the teeth, such as orthodontia, are not covered. There is a $1000 annual limit associated with this diagnosis
- Dental care for the initial repair of an accidental injury to sound natural teeth only if the services are received within 12 months after the date of the accident
- Diabetic supplies (also covered through CVS Caremark/SilverScript)
- Wigs and hairpieces if needed as a result of chemotherapy or radiation

Pregnancy

Necessary treatment of pregnancy is covered in the same way as an illness or injury for you or your spouse with the following exceptions:

- The pre-existing conditions limitation does not apply to pregnancy
- Pre-certification is not required for a hospital stay that does not exceed 48 hours for a normal delivery or 96 hours for a cesarean section. Refer to the "Blue Care® Connection Program and "Maternity Admission" sections for more information
- Pre-certification is required for a hospitalization associated with the pregnancy other than delivery

Termination of a pregnancy is covered when necessary to save the life of the mother.

Charges incurred by a newborn child for the hospital nursery and physician visits while both the mother and the child are in the hospital will be paid as part of the mother's claim. The Plan does not allow the addition of a dependent who is born after you end your employment with the Company. This Plan will not cover the baby should he/she require additional care and for continued coverage,

No benefits are provided for the pregnancy of a dependent child.

Maternity Stays

Special Beginnings is the prenatal program offered through Blue Cross Blue Shield of Illinois. Special Beginnings is designed to provide you with educational information and support throughout your pregnancy. This program offers:

- Educational materials specific to your needs
- Access to a 24-hour, toll-free BabyLine staffed by maternity nurses
- An email newsletter
- An online health information library

Be sure to call the number on the back of your ID card as soon as you find out you are pregnant. Once you are pre-certified for coverage, you will be contacted either by phone or mail with an invitation to enroll in the program and to complete a confidential health assessment.

Federal law requires medical plans to cover maternity hospital stays of at least 48 hours for the normal delivery of a baby, and at least 96 hours for a cesarean section. This coverage applies to both the mother and the newborn.

Inpatient Mental Illness and Substance Abuse

The Plan covers inpatient mental illness and substance abuse programs at the level shown for inpatient hospital expenses. Also, the inpatient care must be approved by the Blue Care® Connection program, as covered in the "Blue Care® Connection Program" section.

Outpatient Mental Illness and Substance Abuse

Covered expenses are covered at the level shown for most medical expenses. Covered Services include:

- Treatment by a registered psychologist, psychiatrist or licensed social worker who is under the supervision of a psychiatrist or psychologist
- Psychotherapy, psychological testing, counseling, group therapy and Medicare-approved alcoholism or drug rehabilitation programs which are medically necessary, if sources of free care are not available
- Treatment for alcoholism and drug abuse for emergency detoxification or any medical treatment required following detoxification
- Drugs and medicines requiring the written prescription of a physician and dispensed by a licensed pharmacist will be covered under the prescription drug benefit, and are not subject to the limitations that apply to other treatment of mental illness and substance abuse

Exclusions

Certain expenses are not covered by the Plan and will not be reimbursed in any way or applied to the deductible or out-of-pocket maximum.

The Plan does not pay benefits for any of the following:

- Convalescent care, custodial, domiciliary or sanitarium care or rest cures
- Travel expenses
- Expenses for any services you have no legal obligation to pay or for which no charge would be made if you had no medical coverage
- Expenses in excess of the rates negotiated by BlueCross BlueShield for network providers
- Expenses for the Plan's penalties for failure to pre-certify a hospital admission or for hospitalizations that exceed the length of stay approved by the Blue Care® Connection program
- Institutional care when the covered individual does not have to be an inpatient to receive medically effective care
- Services or supplies in connection with treatment that the Claims Administrator determines to be experimental or investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational if any of the following applies:
    - There is insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved

- When required by the FDA, approval has not been granted for marketing
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes
- The written protocol or written informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes

However, this exclusion will not apply if the Claims Administrator determines that both of the following apply:

- The disease can reasonably be expected to cause death within one year in the absence of effective treatment, and all other, more conventional methods of treatment have been exhausted
- The care and treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Claims Administrator will take into account the results of a review by a panel of independent medical professionals, selected by the Claims Administrator. Final decisions regarding coverage will be at the sole discretion of the Plan Administrator

- Any expenses which are not medically necessary for the treatment of an illness or injury (except as described for wellness benefits under the “Covered Medical Expenses” section)
- Procedures that are not needed when performed with other procedures or that are unlikely to provide a physician with additional information when used repeatedly
- Any services provided before the effective date of coverage or after coverage ends
- Accidental bodily injury or illness caused by participation in a riot or attempted felony or assault
- Accidental bodily injury or illness that is covered by any workers’ compensation or occupational disease law
- Except as required by law, expenses from a U.S. government hospital or any other hospital operated by a government unit, unless there is an expense that the covered individual is legally required to pay
- Services in connection with any treatment of the teeth, gums or alveolar process, except dental care for the initial repair of an accidental injury to sound natural teeth provided the care is received within 12 months following the date of the accident and hospital expenses when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition
- Surgery for the purpose of fitting or wearing dentures or dental implants
- Any medical observation or diagnostic study that is not medically necessary. This limitation does not apply to wellness benefits listed in the “Covered Medical Expenses” section
- Vision training, eyeglasses and contact lenses or examinations for their prescription or fitting, except the initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye, contact lenses, as long as the contacts are for the replacement of the eye’s lenses and vision training following eye surgery.
- Eye surgery for a condition that could be corrected with lenses instead, including, but not limited to, radial keratotomy, Lasik and PRK
- Physical, occupational and speech therapy that is educational in nature
- Supervised exercise programs that are not traditionally medical in nature, such as swimming, horseback riding, etc.

- Cosmetic treatment, except to repair defects resulting from an accident, replacement of diseased tissue that was surgically removed, treatment of a birth defect and following a mastectomy covered by the Plan, reconstruction of the affected breast and reconstruction of the other breast to create a symmetrical appearance, including services required as a result of complications. The surgery must be performed within 12 months following the date of the accident, removal of diseased tissue or birth, or if surgery must be delayed because of the patient's physical condition, it is performed as soon as medically necessary and appropriate based on the patient's physical condition
- Actual or attempted impregnation or fertilization that involves the covered individual as a surrogate or donor, or the pregnancy of a surrogate mother
- Expenses in connection with artificial insemination and/or assisted reproductive technology ("ART"). ART means any combination of chemical or mechanical means of obtaining gametes and placing them in a medium (whether internal or external to the human body) to improve the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer or pronuclear state tubal transfer
- Expenses for reversals of sterilization procedures
- Home obstetrical delivery
- Expenses for abortion, unless medically necessary to save the life of the mother
- Adoption expenses
- Hypnosis and acupuncture
- Naturopathic, homeopathic or holistic services
- Massage therapy or rolfing
- Treatment, instructions or activities for control or reduction of weight, except medical treatment approved by BCC or surgery for morbid obesity as described under the "Surgical Charges" section, and up to three dietician visits
- Expenses for telephone conversations with a physician in the place of an office visit, for writing a prescription or for medical summaries and preparing medical invoices
- Marriage counseling, encounter or self-improvement group therapy and school-related behavioral problems
- Any care that does not require the services of a specifically trained medical professional
- Routine foot care, including, but not limited to, treatment of corns and calluses, and non-surgical treatment of bunions
- Expenses for an autopsy or postmortem surgery
- Transportation for delivery of home health care
- Dentures, replacement of teeth or structures directly supporting teeth
- Electrical continence aids, anal or urethral
- Implants for cosmetic purposes
- Penile prostheses for psychogenic impotence
- Personal comfort or service items for use during confinement in a hospital, including, but not limited to, a radio, television, telephone and guest meals
- Services or supplies not specifically listed under the "Covered Medical Expenses" section including, but not limited to air conditioners, humidifiers, dehumidifiers, purifiers or tanning booths, over-the-counter orthopedic or corrective shoes and exercise equipment

- Medical care, services or supplies for any injury that may have been caused by the act or omission of a third party, unless the covered individual has fully complied with the Plan's subrogation provision. Refer to "The Plan's Right to Recover Payment from Third Parties and Subrogation" section for more information
- Services or supplies related to a pre-existing condition, as explained in the "Limitations for Pre-Existing Conditions" section
- Claims received more than 12 months after the date the services or supplies were received
- Disease contracted or injuries or conditions sustained as a result of war or any act of war (declared or undeclared), armed aggression, insurrection or release of nuclear energy
- Charges for residential treatment facility
- Expenses incurred outside the US or Canada unless you or your department is a resident of the US or Canada and the charges are incurred while traveling
- Any service performed by a close relative, including you, your spouse, your child, your sibling or sibling of your spouse, your parent or parent of your spouse or any person who normally resides in the patent's home, unless the service is approved in advance by the Plan Administrator
- Treatment or surgery to change gender or improve or restore sexual function
- Nutritional and diet supplements or diet programs
- Hearing aids

With the advancement in today's technology, new procedures are introduced to treat disease or symptoms of diseases that have not been treated in the past. New procedures are not automatically covered by the Plan.

The Plan reserves the right to limit or exclude expenses for other services or supplies.

Prescription Drug Benefits

The table below shows what your prescription benefits are under both options of the Plan. Whether your medical claims are administered by BCBS IL or UMR, or whether you are "Network" or "Out-of-Network", the coinsurance under your prescription drug benefits is the same. However, if you use an out-of-network pharmacy you will be required to pay for the prescription in full and submit a claim for reimbursement to CVS Caremark. You will be reimbursed for the cost of the prescription, in accordance with the provisions of the Plan, minus the applicable coinsurance amount. Prescription drug expenses as described here are not subject to the annual deductible and do not count toward your annual out-of-pocket maximum.

Prescription Coverage – CVS Caremark/Silverscript	
Retail Prescriptions – 30 day supply	
Tier 1 - generic	$5
Tier 2 - preferred brand	$25 or 30%, whichever is greater up to $75 maximum
Tier 3 - non-preferred brand	$50 or 50%, whichever is greater up to $200 maximum
Mail Order Prescriptions – 90 day supply	
Tier 1 - generic	$10
Tier 2 - preferred brand	$50 or 30%, whichever is greater up to a $150 maximum
Tier 3 - non-preferred brand	$100 or 50%, whichever is greater up to a $400 maximum

Participating Provider Pharmacy Program

Prescription drug benefits under the Plan are administered by CVS Caremark/SilverScript. Persons covered by the medical plan will receive discounts from retail pharmacies that participate in the CVS Caremark retail pharmacy network. In addition to the discounts, you generally do not have to file a claim.

If you purchase prescriptions from a pharmacy that is not a member of the network, you will have to pay the full cost of the drug up front and file a claim for reimbursement through CVS Caremark/SilverScript.

You can access much of the information about your plan by creating an account at ***www.caremark.com***. You will need your CVS Caremark or SilverScript ID card number as well as your date of birth. You will then be asked to create a username as well as a password.

Generic Substitution

When you have a prescription filled, the coinsurance amount you pay is based on whether you receive a generic, preferred brand or non-preferred brand name drug. Generic drugs have the same chemical make-up and produce the same effect on the body as their brand-name equivalents and they usually cost less. If you or your physician requests a brand-name drug when a generic is available, you will pay the difference in cost, in addition to your regular generic coinsurance amount.

Brand Name

Brand name drugs are divided into two categories: “preferred brand” and “non-preferred brand.”

- Preferred brand name drugs are those that appear on the Plan’s preferred drug list. Your coinsurance expense for a preferred brand name will be higher than the generic copayment
- Non-preferred brand name drugs are those where there is typically a less expensive but effective alternative. These drugs, therefore, may have a higher coinsurance expense. The drug you choose is up to you and your doctor, but your costs and the Company’s costs may be higher if you use non-preferred brand name drugs. You can contact Caremark Customer Care at **1-866-407-5154** or log on to your account at *www.caremark.com* to compare prices of the preferred and non-preferred drugs and discuss the choices with your doctor. If you have SilverScript coverage through Medicare Part D, you can reach SilverScript Customer Care at **1-888-626-7677**.

*The preferred drug list may change from time to time due to new drugs coming on the market, older drugs becoming available in generic form, etc. Log on to your account at **ww.caremark.com** for an up-to-date list or call CVS Caremark Customer Care at **1-866-407-5154**.*

Using CVS Caremark Network Pharmacies

To locate a network pharmacy near you, contact CVS Caremark Customer Care at **1-866-407-5154** or log on to your account at ***www.caremark.com***. If you have SilverScript coverage through Medicare Part D, you can reach SilverScript Customer Care at **1-888-626-7677**.

Non-Network Pharmacies

If you purchase prescriptions from a pharmacy that is not a member of the network, you will have to pay the full cost of the drug up front and file a claim for reimbursement through CVS Caremark.

You can obtain prescription drug claim forms by logging on to your account at ***www.caremark.com.*** You may also call CVS Caremark Customer Care at **1-866-407-5154**. If you have SilverScript coverage through Medicare Part D, you can reach SilverScript Customer Care at **1-888-626-7677**.

Mail Service Pharmacy

If you are enrolled in the Plan, you may use the CVS Caremark Mail Service Pharmacy for maintenance prescription drugs. These would normally be medications you take for periods of 30 days or longer for chronic health conditions such as diabetes, asthma, arthritis, high blood pressure and heart disease.

Using the mail service allows you to receive up to a 90-day supply of your maintenance medication. To use the mail service program, you should ask your physician to write a prescription for up to a 90-day supply of your maintenance drug. Complete the order form; then mail the prescription, order form and your payment in the pre-addressed envelope. You may obtain an order form and instructions by logging on to your account at ***www.caremark.com.*** You may also call CVS Caremark Customer Care at **1-866-407-5154.** If you have SilverScript coverage through Medicare Part D, you can reach SilverScript Customer Care at **1-888-626-7677**.

As with the retail program, if a brand name drug is dispensed when a generic drug is available, you will be required to pay the generic coinsurance amount plus the difference in cost between the generic and brand-name drug. Also, the coinsurance amount you pay may be more for a non-preferred brand name drug than a preferred brand-name drug.

Your prescription will be reviewed by a pharmacist, checked for adverse drug interactions, and verified by quality-control personnel before it is sent to your home by first-class mail or UPS. You should allow 14 days from the date you mail your order for delivery, although you may pay an

additional charge if overnight delivery is requested. Overnight delivery charges are not covered by the Plan. If you need medication immediately, ask your physician to write two prescriptions, one for a 30-day supply and the other for a 90-day supply. The 30-day prescription can be filled at a retail pharmacy for medication for your immediate use until your first mail order arrives.

After your initial order, you can request a refill of the same prescription by logging on to your account at ***www.***caremark.com or you may also call **1-866-407-5154**. If you have SilverScript coverage through Medicare Part D, you can reach SilverScript Customer Care at **1-888-626-7677**.

To use this service, you'll need your CVS Caremark member number from your prescription plan ID card and your credit card number.

FastStart®

CVS Caremark has a program called FastStart® which will contact your physician for you to obtain a 90-day prescription for mail order. You can access this program by calling FastStart® at **1-800-875-0867** or by logging on to the website, registering and selecting Prescription Coverage and then FastStart®. For either method, have your doctor's name, office telephone number, the names of your medications with dosage information and guidelines for taking the medication. FastStart® will then coordinate with your physician.

Maintenance Medication Surcharge

For certain maintenance medications (drugs prescribed for periods of 30-days or longer for chronic conditions), if you obtain a refill for the third time from a retail pharmacy, you will be required to pay a $10 surcharge for a generic drug or a $20 surcharge for a brand drug in addition to your regular coinsurance if you do not use the CVS Caremark Mail Service Pharmacy to obtain your medications. (Does not apply to Medicare Part D Coverage)

Maintenance Medications Filled at CVS Caremark Pharmacies

You may obtain a 90-day mail order refill from your local CVS Caremark pharmacy for the same price as mail order, if you are not covered by Medicare Part D. If switching from a 30-day prescription to a 90-day prescription, your physician will need to be contacted for the prescription to change. You can either contact your physician directly or call FastStart®.

Prior Authorization

The Plan requires that certain medications meet medical necessity criteria and be approved in advance. These include but are not limited to the following drug categories. Please note that not all drugs in the categories listed below require prior authorization.

- ADHD
- Anabolic Steroids
- Antiobesity
- Antipsoriatics
- Botulinum toxin
- Certain diabetic meds
- Narcotic analgesics
- Erectile dysfunction
- GI motility
- Migraine
- Narcolepsy
- Testosterone
- Topical acne

Keep in mind the above list is not all inclusive and may change from time to time. Log on to your account at ***www.caremark.com*** for a current list of medications requiring prior authorization.

(Click on Health Tools and select Prior Authorization.) To determine if your medication requires a prior authorization; you may also contact CVS Caremark Customer Care at **1-866-407-5154.** If you have SilverScript coverage through Medicare Part D, you can reach SilverScript Customer Care at **1-888-626-7677**.

If your doctor prescribes a drug that requires prior authorization, the following will occur:

- Your physician must contact the CVS Caremark Customer Care prior authorization department to request approval; otherwise the drug will not be covered under the Plan. You may still purchase the medication by paying 100% of the cost
- CVS Caremark Customer Care will verify your medical condition with your physician to ensure that the medication is appropriate
- You will be notified in writing if the medication is not approved for payment under the Plan. Once your physician provides the required information, the prior authorization process usually takes less than 48 hours

To request prior authorization, have your physician call **1-800-294-5979** or fax a request to **1-888-836-0730**.

You can check the status of a prior authorization request at any time by calling the CVS Caremark Customer Care at **1-866-407-5154**. If you have SilverScript coverage through Medicare Part D, you can reach SilverScript Customer Care at **1-888-626-7677**.

Step Therapy

The Plan requires you to try a first line medication (generally a generic medication) before the brand name drug is tried. The therapeutic classes affected by step therapy are:

Depression
Overactive bladder
Insomnia
Osteoporosis

The specific medications change due to changes in the pharmaceutical industry and in the Plan design. Contact CVS Caremark Customer Care at **1-866-407-5154** for the most current listing.

Drug Optimization

If you are prescribed and/or taking a non-preferred brand prescription and you have not tried a generic within that therapeutic class within the past 24 months, the Plan requires that you try a generic. The therapeutic categories affected are;

Stomach acid overproduction
High cholesterol
Pain and inflammation
High blood pressure

The specific medications change due to changes in the pharmaceutical industry and in the Plan design. Contact CVS Caremark Customer Care at **1-866-407-5154** for the most current listing. (Does not apply to Medicare Part D)

Quantity Limit

The Plan has quantity limits for certain medications. You will need to have your physician file an appeal if your prescription is written for more than the limit. Contact CVS Caremark Customer Care at **1-866-407-5154** for the most current listing. If you have SilverScript coverage through Medicare Part D, you can reach SilverScript Customer Care at **1-888-626-7677**.

Specialty Medications

The Plan requires that if you have been prescribed a specialty medication, you obtain your 30-day prescription through CVS Caremark Specialty Pharmacy. This program provides you with greater convenience, including express delivery, follow-up care calls and expert counseling. To find out more, contact Caremark Connect at **1-800-237-2767** or go online at www.caremark.com to begin the enrollment process.

Glucose Monitor Program

Non-Medicare eligible Plan participants can receive a blood glucose meter kit if they:

- Have diabetes or are required by their doctor to test their blood sugar levels
- Use the diabetic test strips that are covered by the mail service plan
- Order a 90-day supply (or their plan limit) of the test strips through the mail service plan

Those Plan participants may call the Caremark Diabetic Meter Team toll-free at **1-800-588-4456** on weekdays between 6:00am and 4:00pm MT. Customer Care Representatives can help them choose one of five available meters and order a 90-day supply (or their plan limit) of test strips (and lancets if necessary). For added convenience, a representative can request and process a prescription from the Plan participant's physician. You are able to obtain one monitor every three years.

Diabetes supplies for retirees and dependents who are not Medicare eligible

By simply presenting your ID card at a participating pharmacy or by obtaining a prescription and using mail order, you may purchase the following diabetes supplies through the prescription drug program:

- Insulin injection devices
- Insulin – needles and syringes
- Inhaled insulin supplies
- Lancets and devices
- Urine testing strips - glucose
- Blood testing strips – glucose
- Acetone testing strips
- Ketone testing strips
- Glucagon Emergency Injection Kit
- Glucose (oral)

Diabetes supplies when Medicare is the primary payer

Diabetes supplies, including glucose test monitors, blood glucose test strips, lancing devices, lancets, insulin pumps and control solution are covered by Medicare Part B, which is the primary plan for all diabetes supplies. The Company plan will pay second. However, to receive coverage under Medicare Part B, you must purchase supplies from a provider who is authorized to bill Medicare Part B directly. You should use a Medicare-approved provider or ask if your local pharmacy is Medicare-approved.

Because Medicare Part B is primary, your claim for diabetic supplies must be sent to Medicare first. Then this plan will pay the balance of the cost not covered by Medicare—up to the amount the Company plan would have paid in the absence of Medicare.

Listed below are national or regional supplies of diabetic supplies which can also be used:

DiabeticSupplies.com *www.diabeticsupplies.com* Phone 1-877-787-7543 7:30am – 4:30pm PST Monday through Friday

Guthries Pharmacy – (Warrick county, IN)

Phone: 1-812-925-3347 9:00am – 6:00pm CST Monday through Friday; 9:00am – 1:00pm CST Saturday

Liberty Medical Supplies – Serve all 50 states & accepts Medicare assignment. *www.libertymedical.com* Phone 1-888-288-9833

Walgreens Pharmacies - *www.walgreens.com* Phone 1-888-727-8265

WalMart Pharmacies - *www.walmart.com* Phone 1-800-WAL-MART (1-800-925-6278)

Drugs Not Covered by the Plan

- Cosmetic products
- Any drug that is experimental or investigational, or one that is being used for a treatment that has not receive final approval from FDA
- Any drug covered by workers' compensation, federal, state or local programs
- Refills before 75% of the prescription is used
- Smoking cessation prescriptions in excess of a 180-day program within any 12-month period (over-the-counter products are not eligible)
- Drugs that have an over-the-counter equivalent
- Expenses for which you failed to submit a claim to the Plan within one year
- All prescription non-sedating antihistamines

More Information about Prescription Drugs

You also may obtain educational information about your prescription drugs by visiting the CVS Caremark website at ***www.caremark.com***. If you have other group health coverage for prescription drugs (through your spouse's employer, for example), refer to the "Claims Procedures" section for information about how to submit your claims.

Resources for Prescription Coverage Information

CVS Caremark Important Phone Numbers To Know	
Caremark Member Services	Phone: 1-866-407-5154
SilverScript Member Services	Phone: 1-888-626-7677
Mail Service Pharmacy	Phone: 1-866-407-5154
Web site	www.caremark.com
Prior Authorization	Phone: 1-800-294-5979
FastStart®	Phone: 1-800-875-0867

Filing Claims

BlueCross BlueShield participating providers and CVS Caremark participating pharmacies will file their claims directly with the appropriate Claims Administrator. If your medical claims administration is through UMR, Medicare will process the claim first and an Explanation of Benefits (EOB) will be submitted to UMR automatically. Upon receipt of such EOB, UMR will process the claim on a secondary basis.

For all other providers, you must file claims for medical and prescription drug expenses using the process outlined below. You must submit the claim within one year of the date you incur an expense. If you also have coverage through another plan that is your primary plan (as described in the "Coordination of Benefits" section), you may also claim secondary benefits using this process.

1. Obtain a claim form
    a. BCBS IL claim forms may be obtained from the Benefits Department or by logging onto *www.bcbsil.com/member/pp/medical_coverage.htm* and selecting "Download a Claim Form"
    b. Claims for prescription drugs must be filed using the CVS Caremark claim form. You can obtain prescription claim forms by contacting your Benefits Department or by contacting CVS Caremark directly at **1-866-407-5154.** If you have SilverScript coverage through Medicare Part D, you can reach SilverScript Customer Care at **1-888-626-7677**.
2. Securely attach your itemized bills and/or prescriptions to the claim form. Check your bills to make sure the information on the bill includes the:
    - Patient's name
    - Diagnosis (for medical claims)
    - Date and type of service

- Itemized charges
- Name of the provider, provider tax identification number and address

Do not send cash register receipts, balance-due statements, proof of payment receipts or canceled checks in place of an itemized bill.

3. Be sure to sign the claim form and complete all the sections that apply
4. If you or your dependents are also covered by another medical plan (including Medicare) that is the primary payer, you must attach a copy of the other plan's explanation of benefits ("EOB") to your bill before submitting it. Refer to the "Coordination of Benefits" section for more information. Remember, you should keep a copy of all bills and EOBs that you submit
5. Submit medical and prescription drug claims to the address shown on the appropriate BlueCross BlueShield of Illinois or CVS Caremark claim form

Payment of Benefits

If you use a BlueCross BlueShield participating provider, the benefit payment will be made directly to the provider.

If you use a non-participating or non-administrator provider, the benefit payment will be made to you.

If your medical claims administration is with UMR, the benefit payment will be made directly to the provider unless documentation has been submitted indicating that you have paid the service in full. In those cases, payment will be made directly to you.

The Plan will not pay more than it would usually pay because you have indicated that it should pay the provider directly. Once the Plan has made a payment in good faith, it is no longer obligated for payment of that claim, even if it turns out the payment was sent to the wrong person or organization.

Recovery of Excess Payments

If the Plan pays more than necessary under the Plan provisions, then the Plan has the right to deduct the excess amount from future payments or to require that it be repaid by the person or organization that received it.

The Plan's Right to Receive and Release Necessary Information

To determine the benefits for your claim, the Plan may require additional information such as itemized bills, a statement from your provider medical records of anyone making a claim, a medical examination, and so forth.

By participating in this plan, you (and your covered dependents) agree that the Plan may provide or obtain any information necessary to carry out the Plan's provisions without having to give any person notice or obtain anyone's agreement. When you submit a claim for benefits, you must provide all the information needed to carry out the Plan's provisions.

Payment of Benefits to Persons Other Than You

Under normal conditions, benefits are paid to you or to the provider of services. Under conditions where you would normally receive a payment but are incapable of handling your affairs, the Plan may pay benefits to any individual or organization that has assumed the costs of your care or financial support.

In the event of your death, the Plan may also continue to honor decisions you made about payment of benefits.

Once the Plan has made its payments under this provision, the Plan is no longer liable to you or any other person for benefits.

Right to Audit

The Company reserves the right to inspect and analyze, for audit purposes, the claim files held by the Claims Administrator.

Coordination of Benefits

Like most group health plans, your medical plan includes a coordination of benefits (COB) provision. This provision applies if you or your dependents are covered by more than one group plan.

Under COB, one plan is considered “primary” and the other “secondary.” The Plan that is primary pays first and usually pays its normal plan benefits.

The primary plan is determined as follows:

- Any plan that does not contain a coordination of benefits provision is primary
- If a plan covers the patient as an employee, that plan is primary and any plan covering the patient as a dependent is secondary
- If the patient is a dependent child whose parents are not divorced or legally separated, the Plan of the parent whose birthday is earlier in the calendar year is primary
- If the patient is a dependent child whose parents are divorced or legally separated, the following rules apply:
    - A plan is primary if it covers a child as a dependent of a parent who is required by a court decree to provide health coverage
    - If there is no court decree that requires one parent to provide health coverage to a dependent child, the Plan of the parent who has custody of the child is primary. (The Plan of the custodial parent’s spouse is secondary and the Plan of the other biological parent is third)
- If a plan covers a person as an active employee, that plan is primary, and any plan that covers that person as a retired or former employee is secondary. If a plan covers a person as a dependent of an active employee, that plan is primary, and any plan that covers that person as a dependent of a retired or former employee is secondary
- If a plan covers a person because of federal or state continuation-of-coverage laws, that plan is secondary to a plan that covers the person on any other basis
- If none of the above rules applies, the Plan that has covered the individual the longest period of time is primary

However, if the person is a Medicare eligible beneficiary, see the “Effect of Medicare on Benefits for Retired Employees” sections.

When another plan is primary, the benefits paid by the Company plan will be reduced by the amount of the other plan’s payment.

In other words, if the primary plan’s payments are equal to or greater than the amount the Company plan would pay for the same expenses, then the Company plan will pay nothing for that claim. On the other hand, if the primary plan’s benefits are less than what the Company plan would normally pay, then the Company plan will pay the difference. For example:

- If your other plan’s benefit for a claim is $500, and the Company plan would pay $500 for the same claim, then the Company plan will pay nothing

- If your other plan's benefit is $400, and the Company plan would pay $500 for the same claim, then the Company plan will pay $100

These rules apply only when another plan is primary and the Company plan is secondary. If the Company plan is primary, its benefits are determined as if no other plan is involved; however, a secondary plan may pay additional benefits.

To make sure you receive the benefits to which you are entitled under both plans, it is important to submit your claims properly. For example, when you file a claim for your spouse, be sure to file under his or her plan first. After you have received payment from that plan, then you can submit for payment to our Company plan. When you submit a claim to the second plan, be sure to include the explanation of benefits from the primary plan, as well as another copy of the itemized bill.

Primary Coverage through an Active Benefit Plan if Eligible for Medicare

Retirees and their eligible dependents covered under an active employer group benefit plan are required to submit claims first to the active plan. This plan will be your primary coverage and Medicare will be your secondary coverage.

Effect of Medicare on Benefits for Disabled or Retired Employees

For disabled or retired employees and their dependents who are eligible for both Medicare and the Salaried Retiree Medical Plan, Medicare is the primary plan and the Salaried Retiree Medical Plan is secondary. Medicare must first process medical claims. Then, the Company's third party administrator will process medical claims as secondary payer.

In order for the Company plan to process medical claims as a secondary payer, disabled or retired employees and any dependents eligible for Medicare are required to enroll in all available Medicare products – Parts A, B, and Part D or in Medicare Advantage (previously known as Medicare Part C). As new Medicare options become available, the Company will coordinate all Medicare plan options with the Company welfare benefit plans as allowed by law.

If you or any of your dependents are enrolled in Parts A, B and D of Medicare, benefits under the Company plan will be reduced by the amount of benefits paid by Medicare in the same way that the Plan coordinates with other group health plans that are primary, as explained at the beginning of the "Coordination of Benefits" section. If you and your dependents are eligible to receive benefits under Medicare and do not enroll, the Salaried Retiree Medical Plan will not pay benefits. For this reason, retired employees and any dependents should enroll for coverage under all Medicare options as soon as they are eligible. Medicare provides a special enrollment period for employees who are covered by an employer-sponsored group health plan when they stop working. Contact your Social Security office for more information. You and your covered dependents are responsible for all Medicare premiums.

When you receive the Medicare statement showing what Medicare has paid, you should submit a copy of the statement to the Company plan, along with copies of your bills and a properly completed claim form covering the same medical expenses.

If you enroll in Medicare Advantage, an alternative to traditional Medicare, your benefits under the Company plan will be reduced by the amount of benefits that would have been payable under the Medicare Advantage Plan if you had followed all applicable rules to obtain benefits.

Plan participants eligible to receive benefits under Medicare are not required to access PPO providers or to obtain pre-certification as outlined in the "Blue Care® Connection Program and Hospital Pre-Certification" section.

For disabled or retired employees and any dependents entitled to Medicare because of end-stage renal disease, after 30 months of coverage, the Salaried Retiree Medical Plan will be secondary and Medicare will be primary.

The Plan's Right to Necessary Information

To carry out the Plan's provisions for coordination of benefits, the Plan Administrator may provide or obtain any information it considers necessary. This information can be given to or obtained from any insurance company or other organization or person, and the Claims Administrator does not have to give any person notice or obtain anyone's agreement. Any person enrolled in the Company plan automatically agrees to this provision.

The Plan's Right to Make Payments to Other Organizations

If any other plan makes a payment that should have been made by the Salaried Retiree Medical Plan, the Plan has the right to pay the other plan any amount necessary to satisfy the terms of the provision for coordination of benefits.

These amounts the Salaried Retiree Medical Plan pays will be considered benefits paid under the Plan (for example, they will count toward benefit maximums). Once the payment is made, the Plan will no longer be liable for payment for that claim.

The Plan's Right to Recover Payment from Third Parties and Subrogation

If you or a dependent have medical expenses as a result of an injury or accident, a third party may be liable for those expenses. In this case, the Plan may advance payments for the medical expenses that are covered charges under the Plan. These advance benefit payments are conditional, however, because they are subject to the Plan's "right of recovery" provisions. For purposes of this provision, a "third party" includes, but is not limited to, any person, insurance company or other entity that is in any way responsible for the illness or injury, or is in any way responsible for providing compensation, indemnification, or benefits for the illness or injury; any law or policy of insurance or accidental benefit plan providing no-fault, uninsured, underinsured or general group or individual liability coverage; any medical reimbursement insurance whether or not purchased by you or your dependents who are submitting the claim or on behalf of the person submitting the claim; any specific risk accident or health coverage or insurance, including without limitation premises or homeowners medical reimbursement coverage, and student, student-athletic or student-team coverage insurance.

The Plan has the right to recover the conditional benefit payments out of the proceeds of any settlement or judgment that you or your dependent receives from the liable third party, or from the third party's insurer, or from any insurer providing you or your dependent with indemnity against the acts of third parties before any other amounts are deducted from the recovery (first lien). If you or your dependents receive settlement or judgment proceeds, then the Plan may recover its conditional benefit payments directly from you or your dependent. This is the Plan's right of reimbursement and it means that you or your dependents must reimburse the Plan for the benefits previously provided. Any settlement or judgment proceeds held by you, your dependent, your or your dependent's attorney or any other person or entity shall be held in constructive trust for the benefit of the Plan until such time as the obligations described in this section are fully satisfied.

In addition, the Plan has the right to recover the conditional benefit payments directly from the liable third party or insurers. The Plan pursues this right of recovery directly against the third party or insurers as your subrogee. This means that the Plan is subrogated (substituted) to all of your or your dependent's claims, demands, actions against the liable third parties and insurers to the full extent of the Plan's right of recovery for the benefits it previously provided plus the attorney's fees and costs the Plan incurs pursuing the claim against the third party or insurers. The Plan may assert its claim against any third party even if you or your dependents do not, or the Plan may join any action you or your dependents bring against a third party. The Plan does not waive any of its rights to reimbursement by not independently asserting its claim against any third party or by not joining in any action brought by you or your dependents against any third party.

The Plan does not recognize the "make whole" doctrine and may recover the conditional benefit payment amounts owed to it regardless of the description or characterization of any recovery or whether: (a) the settlement or judgment or other recovery specifically includes medical expenses; (b) you or your dependent have been fully indemnified for your losses; or (c) the Plan's recovery

results in you or your dependent receiving only a partial recovery (or no recovery) for damages. The Plan also does not recognize the “common fund” doctrine and shall not contribute to or in any way be responsible for, and the amount of any reimbursement to which the plan is entitled shall not be reduced for any contribution to, any attorneys’ fees or other costs incurred in pursuit of any claim.

Example: Suppose you are injured in an automobile accident that was the other driver’s fault. The Plan pays most of the cost of your hospital bills. Later, the other driver’s insurance company also pays you for your medical bills. So now you have essentially been paid twice for your medical bills as a result of this accident, once from the Plan and once from the other driver. The “right of recovery” provisions now come into play, and the Plan is entitled to a refund of the benefits paid. The Plan may also pursue recovery directly from the third party.

The following applies under the right of recovery provisions and relates to plan benefits and plan benefit payments for medical expenses incurred as a result of the accident or injury:

- You and your dependents must notify the Plan, in writing, whenever plan benefits may be subject to the Plan’s rights of recovery
- The Plan is not obligated to pay benefits for any medical expenses incurred until you or your dependents promise in writing to include the expenses in any claim you or your dependents are making, to reimburse the Plan if you recover the medical expenses or any other proceeds related to your losses or damages, and to cooperate fully with the Plan in its attempts to recover the conditional benefit payments from liable third parties and insurers
- You must cooperate fully with any reasonable requests made by the Plan in connection with its rights of reimbursement and subrogation. If you do not fulfill these obligations, then the Plan is not obligated for any benefits or covered expenses incurred by you or your dependents
- You must inform the Plan in advance of any settlement proposals advanced or agreed to by any liable third parties or insurers and obtain written consent from the Plan prior to settling any claim to which this plan is subrogated
- You must provide the Plan with notice if you or your dependents assert a claim or claims against any third party and keep the Plan informed as to the status of such claim or claims
- You must notify the Plan of any compensation you or your dependents receive from any third party in connection with the injury or illness and immediately reimburse the Plan upon receipt of such compensation
- You must take no actions to compromise or impair the Plan’s rights to recovery
- In the event you or your dependents fail or refuse to provide whatever assignment, form or document is requested by the Plan or its Claims Administrator, the Plan will be relieved of all legal, equitable or contractual obligations contained in this plan for any benefits or covered expenses incurred by you or your dependents
- If you or your dependents receive any settlement or judgment proceeds, then within 30 days of the recovery you must fully reimburse the Plan for any conditional benefit payments it previously provided. If this reimbursement is not timely made, then the Plan is not obligated to pay benefits for any future medical expenses incurred by you or your dependents

Further, the Plan may sue you or your dependents, or as applicable, your heirs, guardians, executor or other representative in order to recover the amount due the Plan under these provisions. Where the Plan is successful, in whole, or in part, the Plan shall also be entitled to reimbursement from you or your dependents all costs of collection, including reasonable attorney’s fees. The Plan’s obligation will resume when both of the following have occurred: (a) the Plan receives full reimbursement for any conditional benefit payments previously provided; and (b) arrangements satisfactory to the Plan have been made with regard to its rights of recovery for future covered medical expenses.

When Coverage Ends

Coverage for you and your dependents (if applicable) will end on the date the earliest of the following occurs:

- The Plan is terminated
- You elect to terminate coverage because of a change in status
- You elect to terminate coverage during the annual enrollment period effective January 1 of the next year. In this case, coverage will end on the December 31 of the current year
- You fail to pay the required contribution for coverage, if any. Coverage will end on the last day of the month for which you have paid the premium
- Your dependents are no longer eligible (for example, you divorce or your child reaches the limiting age or marries). Coverage will terminate on the date the dependent becomes ineligible for benefits. However, if your dependent child who is covered under the Plan due to full-time student status ceases to be a student due to a medically necessary leave of absence, coverage for your child may continue for up to one year following the commencement of the leave or, if earlier, the date coverage would otherwise terminate under the terms of the Plan
- If you should die, your surviving spouse and his or her eligible dependents may continue to be covered under the plan dependent on premium payment. If your spouse dies or remarries, he or she is no longer eligible to be covered. If there is no surviving spouse eligible for benefits, coverage for your dependent children will end.

Notwithstanding the above, the Plan Administrator may, in its sole discretion, cause the participation of you or your dependents to terminate if you or your dependents provide false information or make misrepresentations in connection with a claim for benefits; permit a non-participant to use a membership or other identification card for the purpose of wrongfully obtaining benefits; or obtain or attempt to obtain benefits by means of false, misleading or fraudulent information, acts or omissions.

COBRA

Continuation Coverage Rights Under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. Qualified beneficiaries who elect coverage must pay for COBRA continuation coverage.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health coverage under the Plan when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you are a retiree, you will become a qualified beneficiary if your coverage under the Plan because is lost or substantially eliminated within one year before or after a proceeding in bankruptcy under Title 11 of the United States Code is filed with respect to the Company.

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

- Your spouse dies
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)
- You become divorced or legally separated from your spouse

A retiree's *dependent children* will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occurs:

- The parent-retiree dies
- The parent-retiree becomes entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- The child stops being eligible for coverage under the Plan as a "dependent child"

When Is COBRA Continuation Coverage Available?

Qualified beneficiaries will be offered COBRA continuation coverage only after your Benefits Department has been notified that a qualifying event has occurred.

You Must Give Notice of Some Qualifying Events

When the qualifying event is divorce, legal separation or annulment of the retiree and spouse or a dependent child's losing eligibility for coverage as a dependent child, you or your eligible dependent must notify your Benefits Department in writing within 60 days after the event.

The notification must include the retiree's name and Social Security number, the name of the spouse and/or dependent child, the nature of the qualifying event (for example, divorce, legal separation or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or legal separation or the date the dependent child reached the Plan's limiting age, married or lost full-time student status).

In the case of a divorce or legal separation, when notifying the Benefits Department, the qualifying individual should also include the first and last page of either the divorce decree or the legal separation court approval.

A notice mailed to the Plan will be deemed provided on the date of mailing.

Failure to provide notice during this 60-day notice period will result in the loss of the opportunity to elect COBRA continuation coverage.

Electing COBRA Continuation Coverage

Once the Benefits Department receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. You and/or Your spouse and dependent children will have 60 days in which to elect COBRA continuation coverage. This 60 day election period begins on the later of:

- The date coverage would end because of the qualifying event
- The date the COBRA Administrator provides notice of the right to elect COBRA

A COBRA election mailed to the COBRA Administrator will be considered made on the date of mailing.

If COBRA continuation coverage is not elected during the 60 day election period, the right to elect continuation coverage will be lost.

You and/or your spouse may elect COBRA continuation coverage for all qualifying family members. However, each qualified beneficiary has an independent right to elect continuation

coverage. Thus, both you and your spouse may elect continuation coverage, or only one of you may do so. You may also elect to continue coverage on behalf of your dependent children only.

Paying for COBRA Continuation Coverage

You must pay the full cost of COBRA continuation coverage. Your first payment must be made within 45 days of the date that the COBRA election was made. If payment is not received within this 45 day period, your coverage will be terminated retroactively to the qualifying event date.

After the initial premium payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30 day grace period. A premium payment that is mailed will be considered made on the date of mailing. If the full amount of the premium is not paid by the due date or within the 30 day grace period, COBRA continuation coverage will be canceled retroactively to the first day of the month with no possibility of reinstatement.

Generally, the amount of the premium for COBRA continuation coverage will not exceed 102 percent of the cost of the group health plan (including both employer and retiree contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

The Trade Adjustment Assistance Reform Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage. For more information, call the Health Coverage Tax Credit Customer Contact Center toll-free at **1-866-628-4282**. TTD/TTY callers may call toll-free at **1-866-626-4282**. More information about the Trade Act is also available at *www.doleta.gov/tradeact.*

Duration of COBRA Coverage

The duration of the coverage depends on the nature of the qualifying event. When the qualifying event is:

- the death of the retiree, the retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or a dependent child's losing eligibility as a dependent child, coverage under COBRA may be continued for up to 36 months from the date of the qualifying event
- filing a proceeding in bankruptcy, coverage under COBRA may be continued for the life of the retiree and, if the retiree's spouse and/or dependent children survive the retiree, up to an additional 36 months after the retiree's death. If the retiree is not living at the time of this qualifying event but the retiree's surviving spouse is covered under the Plan, coverage under COBRA for the surviving spouse may be continued for his/her life

When COBRA Continuation Coverage Ends

A qualified beneficiary's COBRA continuation coverage will end upon occurrence of any of the following events:

- The maximum COBRA coverage period expires
- The required premium is not paid in full in a timely manner
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the qualified beneficiary may have
- After electing COBRA, the qualified beneficiary becomes entitled to Medicare. However, coverage will not end upon the occurrence of this event if the qualifying event is a bankruptcy filing

- The Company no longer provides group health coverage to any of its retirees

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage, such as fraud.

If You Have Questions

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Benefits Department as indicated below. For more information about your rights under ERISA including COBRA, 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 *www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

How to Contact the Plan Administrator

Benefits Department
Patriot Coal Corporation
12312 Olive Boulevard, Suite 400
St. Louis, MO 63141

You can also call the Patriot Coal Benefits Department at **1-800-633-9005**, or send an email to *benefits@patriotcoal.com*.

Keep the Company Informed of Address Changes

In order to protect your family's rights, you should keep the Benefits Department informed of any changes in the addresses of you and/or your family members. A written notice is required. You should also keep a copy, for your records, of any notices you send to the Benefits Department or the COBRA Administrator.

Terms and Definitions

Ambulatory Surgical Facility

An institution, either freestanding or as part of a hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures for which a patient is admitted and discharged within a brief period.

Claims Administrator

The organization retained by the Company for granting or denying claims and providing pre-certification, currently BlueCross BlueShield of Illinois (for those wherein all members enrolled are not enrolled in Medicare), United Medical Resources (for those wherein all members enrolled are Medicare eligible) and CVS Caremark for prescription drug claims.

COBRA Administrator

The organization retained by the Company as the COBRA Administrator is:
BeneFLEX HR Resources
3660 South Geyer Road, Suite 340
St. Louis, MO 63127
1-800-631-3539

Company

Patriot Coal Corporation and its subsidiaries and affiliates.

Custodial Care

Care provided primarily for the convenience of the patient or his or her family, the maintenance of the patient, or to help the patient carry out the activities of daily living, rather than primarily for therapeutic value in the treatment of a condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, supervising the self-administration of medications not requiring the constant attention of trained medical personnel, or acting as a companion or sitter.

Durable Medical Equipment

Equipment that meets all of the following conditions:

- It can withstand repeated use
- It is primarily and customarily used in the therapeutic treatment of sickness or injury
- It is generally not useful to a person in the absence of a sickness or injury
- It is appropriate for use in the home

- It is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature
- It is not primarily for the convenience of the person caring for the patient
- It is not used for exercise or training

Educational Institution

Any state-accredited high school, college or university, including other recognized educational institutions such as nursing schools, trade schools and so forth, with full-time curriculums. Correspondence schools, night schools or schools requiring less than full-time attendance are not included.

Emergency or Urgent Care

A serious medical condition resulting from injury or sickness that arises suddenly and requires immediate medical care to avoid serious physical impairment or loss of life, and for which you seek medical attention after the onset.

Home Health Care

Services provided by either:

- A hospital-based home health care agency that is licensed by the state and approved by the Joint Commission on Accreditation of Healthcare Organizations
- A community home health care agency approved by Medicare

Home Health Care Agency

A home health care agency is a federally certified public or private organization that meets all the following conditions:

- It is primarily engaged in providing skilled-nursing and other therapeutic services
- It has policies established by associated professional personnel, including at least one physician and one RN, which govern the services provided under the supervision of the physician or nurse
- It maintains medical records on all patients
- It is licensed and approved by state or local law
- It is a hospital certified by the state public health law to provide home health services

Hospital

An institution that meets all of the following conditions:

- It is primarily engaged in providing diagnostic and therapeutic facilities for compensation on an inpatient basis for surgical and medical diagnosis under the supervision of a staff of physicians
- It provides 24-hour nursing services by registered nurses
- It is not a rest home, home for the aged, facility to treat drug or alcohol addiction, nursing home, hotel or similar institution

- It is licensed by the state and approved by, or under the waiting period for accreditation by, the Joint Commission on Accreditation of Healthcare Organizations

For purposes of mental illness and substance abuse benefits, the definition of a hospital also includes:

- A facility approved by the Claims Administrator for inpatient or outpatient treatment of chemical abuse
- Psychiatric hospitals classified and accredited by the Joint Commission on Accreditation of Healthcare Organization

Illness

Any disease or disorder of the body, or pregnancy. Pregnancy includes normal delivery, cesarean section, miscarriage, complications resulting from pregnancy or termination of pregnancy if medically necessary, certified and performed by a physician.

Injury

An accidental bodily injury caused directly and exclusively by sudden and violent means.

Medically Necessary

A service or supply that is ordered by a physician and which the Plan Administrator (or a person or organization designated by the Plan Administrator) determines as meeting all the following conditions:

- It is provided for the diagnosis or direct treatment of an injury or illness
- It is appropriate and consistent with the diagnosis and treatment of the injury or illness
- It is provided in accordance with generally accepted medical practice on a national basis at the time it is provided
- It is the most appropriate supply or level of service that can be provided on a cost-effective basis
- It is not provided in connection with medical or other research
- It is not experimental, educational or investigational

The fact that a physician prescribes services or supplies does not automatically mean such services or supplies are medically necessary and covered by the Plan. The treatment must also meet the Plan's other provisions.

Medicare

The health insurance program for aged and disabled persons under Title XVIII of the Social Security Act, as amended and currently in effect.

Mental Illness

A psychotic disorder, a psychophysiological autonomic or visceral disorder, a psychoneurotic disorder, a personality disorder, or any other mental, emotional or functional nervous disorder classified as a mental disorder in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Physician or Surgeon

An individual licensed to diagnose and treat illnesses, prescribe and administer drugs and medicines, or perform surgery. The definition also includes:

- A licensed dentist who is operating within the scope of his or her license to provide dental work or treatment that is covered under the medical plan
- A podiatrist operating within the scope of his or her license for certain covered podiatry services that are common to both medicine and podiatry
- A certified, registered psychologist providing diagnosis or treatment of a mental and nervous condition

Provider

Any healthcare facility, person or entity duly licensed to render services to you

Qualified Medical Child Support Order

As defined in Section 609(a) of ERISA, added by the Omnibus Budget Reconciliation Act of 1993, effective August 10, 1993, a “QMCSO” is a court order which creates or recognizes the existence of your child’s right to, or assigns to your child the right to, receive medical benefits under the Plan.

Registered Psychologist

A person providing registered psychological services for diagnosis or treatment of mental, psychoneurotic or personality disorders. The psychologist must qualify, in the jurisdiction in which he or she is practicing, in the following ways:

- If state licensing or certification exists, he or she must hold a valid license or certificate as a psychologist
- If state licensing or certification does not exist, he or she must hold a valid, non-statutory (professional) certification established by that area’s recognized psychological association
- If neither statutory or non-statutory licensing nor certification exists, the psychologist must hold a statement of qualification by a committee established by that area’s psychological association. If no committee exists, he or she must hold a diploma in the appropriate specialty from the American Board of Examiners in Professional Psychology

Skilled Nursing Facility

A facility that is qualified to participate in and receive payments from Medicare. In addition, the facility must do all the following:

- Operate legally in the area it is located

- Be accredited as a skilled-nursing facility by the Joint Commission on Accreditation of Healthcare Organizations
- Regularly provide room and board
- Provide 24-hour-a-day skilled-nursing care
- Maintain a daily medical record of each patient under the care of a physician
- Be authorized to administer medications ordered by a physician

Spouse

Your legal partner of the opposite sex in marriage by a civil or religious ceremony

Step Therapy Program

A program (approach) that requires you to try more traditional and proven medications before trying the newest, more costly medications.

Plan Administration Information

Plan Name
The Patriot Coal Corporation and its designated affiliates Welfare Benefit Plan

Type of Plan
Medical, dental, vision, flexible spending accounts, employee assistance, life insurance, accidental death and dismemberment, business travel accident and disability benefits.

Dental, flexible spending accounts, employee assistance, life insurance, accidental death and dismemberment, business travel accident and disability benefits are described in separate documents.

Employer Identification Number
The employer identification number assigned to the Company by the Internal Revenue Service is 20-5622045

Plan Number
501

Plan Year
January 1 to December 31

Plan Sponsor
Patriot Coal Corporation

Direct correspondence to:
Benefits Department
Patriot Coal Corporation
12312 Olive Boulevard, Suite 400
St. Louis, MO 63141

Plan Administrator
Patriot Coal Corporation
12312 Olive Boulevard, Suite 400
St. Louis, Missouri 63141
(314) 275-3600

The Plan Administrator is the sole judge of the application and interpretation of this Welfare Benefit Plan and has discretionary authority to construe the provisions of the benefit plans, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate this authority to service providers.

With respect to the medical and prescription drug benefits, the Plan Administrator has delegated this authority to Blue Cross Blue Shield of Illinois, United Medical Resources and CVS Caremark, the Claims Administrators, respectively.

Claims Administrator
Blue Cross Blue Shield of Illinois
300 East Randolph Street
Chicago, IL 60601-5099
1-312-653-6000

United Medical Resources

P.O. Box 30548
Salt Lake City, UT 84130-0548
1-800-972-3023

CVS Caremark
P.O Box 832407
Richardson, TX 75083
1-800-378-9442

Agent for Service of Legal Process
The Plan Administrator is the agent for service of legal process.

Direct correspondence to:
Plan Administrator
Patriot Coal Corporation
12312 Olive Boulevard, Suite 400
St. Louis, MO 63141

Funding and Disbursements
Medical and prescription drug benefits are self funded by Patriot Coal Corporation and certain subsidiaries and affiliates, and, where required, by participating retirees and are not guaranteed under a policy or contract of insurance. When Medicare eligible, Patriot Coal Corporation and certain subsidiaries and affiliates are self-funded as a secondary plan to Medicare.

ERISA

Your Rights As A Plan Member

As a participant in this Plan, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

Receive Information About the Plan and Benefits

- Examine, free of charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, a copy of the Plan's Qualified Medical Child Support Order procedures, copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The Plan Administrator may charge a reasonable fee for the copies

- Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of these Summary Annual Reports

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or 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 Summary Plan Description and the documents governing the Plan for information concerning your COBRA continuation coverage rights

- Reduce or eliminate any exclusionary periods of coverage for pre-existing conditions under the group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion or limitation, as described in the Summary Plan Description

Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for you, ERISA imposes duties upon the people who are responsible for operating the employee benefit plan: The people who govern your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and solely in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you 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 which is denied or ignored, in whole or in part, you have the right to file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If 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 sued to pay court costs and legal fees. If you lose, the court may order you to pay the costs and fees; for example, if it finds your claim is frivolous.

Assistance with Questions
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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Employee Benefits Security Administration by telephone at 1-866-444-EBSA (3272), or by mail at Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, D.C 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration, or you may visit *www.dol.gov/ebsa* for more resources.

Claims Procedures and Review

Types of Claims

- *Pre-service claim:* A claim for a benefit that requires prior approval under the terms of the Plan, such as inpatient admission pre-certification
- *Urgent care claim:* A type of pre-service claim which, if the regular time periods for handling pre-service claims were followed: (1) could seriously jeopardize your life or health or your ability to regain maximum function, or (2) would, in the opinion of a health care provider with knowledge of your condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim
- *Post-service claim:* A claim for a benefit that does not require prior approval under the terms of the Plan. A post-service claim involves a claim for payment or reimbursement for medical care or supplies that have already been received

Submitting claims

- *Pre-service, urgent care claims.* A pre-service claim, including an urgent care claim, will be considered submitted when a request for prior approval is received by BCC or any other organization authorized to pre-certify certain types of medical care on behalf of the Plan
- *Incorrectly submitted claims.* If you do not follow the Plan's procedures for filing a pre-service claim, you will be notified of the appropriate procedures if: (1) the request for prior approval

was received by someone who customarily is responsible for handling benefit matters and (2) the communication identifies the claimant, the specific treatment, service or product for which approval is requested and the medical basis for the request. Notice of an incorrectly submitted claim will be provided no more than 24 hours (for urgent care claims) or five calendar days (for all other pre-service claims) after the incorrectly submitted claim is received. This notice may be oral unless you request written notification

- *Post-service claims.* Participating providers and pharmacies will generally submit their claims for payment directly to the Claims Administrator. If you obtain services from an out-of-network or non-administrator provider or pharmacy, or if you do not present your identification card when you receive services, you must pay the full cost of the service or prescription and then submit a claim for reimbursement as described in the "Filing Claims" section. The amount of the reimbursement will be reduced by the amount of any applicable deductible, coinsurance or copayments

Claim forms are available from your Benefits Department. A claim will be considered submitted when it is received by the Claims Administrator.

Initial Claims Determinations

The timeframes for making the initial decision regarding a claim and the procedures for notifying you about that decision depend on the type of claim.

- *Urgent care claims.* You will be notified whether your urgent care claim (including a request for prior approval of a prescription drug) has been approved or denied as soon as possible, but in no event later than 72 hours after the claim is received. If more information is needed in order for a determination to be made, you will be advised of the specific information necessary to complete the claim within 24 hours after receipt of the claim. You will be allowed at least 48 hours to provide the necessary information. You will be notified of the determination within 48 hours after the earlier of: (1) the Plan's receipt of the requested information or (2) the end of the period you were given in which to provide the information. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information

- *Pre-service claims*. You will be notified whether your pre-service claim has been approved or denied within a reasonable period of time appropriate to the medical circumstances involved, but in no event more than 15 days after the claim is received. The 15-day period may be extended an additional 15 days if the extension is necessary due to matters beyond the control of the Plan and you are notified of the extension before the initial 15-day period expires. If the extension is required because you failed to submit information necessary to decide the claim, the extension notice will specifically describe the information needed to complete the claim. You will be given at least 45 days from the time you receive the notice to provide the requested information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information

Previously Approved Medical Treatments

- If BCC previously approved an ongoing course of medical treatment that was to be provided over a period of time or that involved a specified number of treatments and you wish to extend the course of treatment beyond that which had been approved, you may request an extension. If the claim involves urgent care, you will be notified whether the extension has been approved or denied no more than 24 hours after your request for the extension is received, provided that you make such request at least 24 hours before the end of the previously approved period of time or before you received all of the previously approved treatments. If the request for an extension is made less than 24 hours before the expiration of the prescribed period of time or number of treatments, the request will be treated as a new urgent care claim and decided under the general timeframe applicable to

urgent care claims. If the claim does not involve urgent care, the extension request will be treated as a new pre-service claim and will be decided within the timeframe applicable to pre-service claims as described above

- If BCC previously approved an ongoing course of treatment that was to be provided over a period of time or that involved a specified number of treatments, any decision by the Plan to reduce or terminate that course of treatment (other than by plan amendment or termination) before the end of such period of time or before all approved treatments have been received will be considered a benefit denial. You will be notified sufficiently in advance of such reduction or termination to allow you to appeal and obtain a determination on the appeal before the benefit is reduced or terminated

- *Post-service claims*. The appropriate Claims Administrator will decide a post-service claim within a reasonable period of time, but not later than 30 days after the claim is received. This time period may be extended for an additional 15 days when necessary due to matters beyond the control of the Plan or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period and a determination will be made no more than 45 days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will specifically describe the information needed to complete the claim and you will be allowed 45 days from receipt of the notice to provide the information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information

If Your Claim Is Denied

If your claim is denied in whole or in part, you will receive a written notice that will provide:

- The specific reasons for the denial
- A reference to the specific plan provision on which the determination was based
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
  - Your right to submit written comments and have them considered
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal
- If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
  - A description of the specific rule, guideline, protocol or criterion relied on
  - A statement that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request
- If the basis for the denial was medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your circumstances
  - A statement that such an explanation will be provided free of charge upon request
- In the case of a denial of an urgent care claim, a description of the expedited review process applicable to such claim

Review of Denied Claims

You have 180 calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal the determination. Appeals of claims involving pre-service, urgent care claims, or post-service claims should be submitted to the appropriate Claims Administrator. Except in the case of an appeal involving an urgent care claim, your appeal must be in writing. *If you do not file an appeal within this 180-day period, you will lose the right to appeal the determination.*

Expedited procedures for urgent care claims

You may request an expedited appeal of a denial involving an urgent care claim. This request may be oral or in writing. Under these expedited procedures, all necessary information, including the determination on appeal, may be transmitted to and from BCC by telephone, facsimile or other available similarly expeditious method.

Your appeal should set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim. You may also request the Plan to identify any medical or vocational expert from whom it received advice in connection with the benefit determination, regardless of whether it relied on such advice in making the initial benefit determination.

Determinations on Appeal

The timeframe for making a decision on the appeal depends on the type of claim:

Urgent care claims

In the case of an urgent care claim, you will be notified of the determination on appeal as soon as possible, taking into account the medical urgency of the situation, but in no event more than 72 hours after your appeal is received by the Plan.

Pre-service claims

You will be notified of the determination on appeal within a reasonable period of time but no longer than 15 days after it is submitted. If you are not satisfied with the decision, you have the right to file a second level appeal with the Plan Administrator. This appeal should be submitted to:

Director, Benefits
Patriot Coal Corporation
12312 Olive Boulevard, Suite 400
St. Louis, Missouri 63141

Your second level appeal request must be submitted within 60 days of receipt of first level appeal decision. The Plan Administrator will make a determination on your appeal no more than 15 days after your second level appeal is submitted.

Post-service claims

The Claims Administrator will review and decide your appeal within a reasonable period of time but no longer than 30 days after it is submitted. If you are not satisfied with the decision of the Claims Administrator, you have the right to file a second level appeal with the Plan Administrator. This appeal should be submitted to:

Director, Benefits
Patriot Coal Corporation
12312 Olive Boulevard, Suite 400
St. Louis, Missouri 63141

Your second level appeal request must be submitted within 60 days of receipt of first level appeal decision.

The Plan Administrator will make a determination on your appeal no more than 30 days after your second level appeal is submitted.

The review at each level of appeal will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination or at a lower level of appeal. The review will not give deference to the initial denial or to the decision at a lower level of appeal. In addition, the individual who decides your appeal will not be the same individual who initially decided your claim or made a decision at a lower level of appeal and will not be that individual's subordinate.

A health professional may be consulted in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the initial benefit determination or at a lower level of appeal nor be a subordinate of the health professional who was involved.

Except in instances in which notice is provided pursuant to the expedited procedures for urgent care claims described above, you will be notified in writing of the decision on appeal. If the decision upholds the denial of your claim, the notification will provide:

- The specific reason or reasons for the denial
- Reference to specific plan provisions on which the determination was based
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim
- If the denial was based on medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:
    - An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your circumstances, or
    - A statement that such an explanation will be provided free of charge upon request
- If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
    - A description of the specific rule, guideline, protocol or criterion relied on, or
    - A statement that a copy of such a rule, guideline, protocol or criterion will be provided free of charge upon request
- A statement of your right to bring a civil action under Section 502 of ERISA

The decision of the Plan Administrator (or the Claims Administrator in the case of urgent care claims) shall be final and binding on all individuals dealing with or claiming benefits under the Plan.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. Generally, this authorization must be in writing and signed by you; however, in the case of an urgent care claim, a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law and who has knowledge of your medical condition will be acknowledged as your authorized representative even if no written designation is submitted. Any reference in these claims procedures to "you" is intended to include your authorized representative.

An assignment to a health care provider for purposes of payment does not constitute appointment of an authorized representative under these claims procedures.

Amending the Plan

The Plan is adopted with the intention that it will be continued for the benefit of eligible present and future retired employees of the Company and certain designated affiliates and subsidiaries. However, the Company reserves the right to terminate the Plan, change required contributions or modify this plan in whole or in part at any time or for any reason, including changes in any and all of the benefits provided.

This may cause retired employees to lose all or a portion of their benefits under the Plan, but will not affect the right of any retired employee to be reimbursed for any covered expense that has already been incurred.

This means that a retired employee cannot have a lifetime right to any plan benefit or to the continuation of this plan simply because this plan or a specific benefit is in existence at any time. This plan will comply with all requirements of the law and will be amended, if necessary, in order to meet any such requirements.