M E M O R A N D U M

TO: Human Resource Managers

FROM: J. C. Fox

DATE: October 23, 1990

SUBJECT: Salaried Employee Benefit Programs

Enclosed is a temporary Arch Mineral Corporation Salaried Employee Benefit book for your reference until you receive the remaining revised and updated benefit book sections for you and your employees.

We expect the receipt of the new printed benefit book sections within a month. I regret any inconvenience this situation may have caused you.

ARCH MINERAL CORPORATION
SALARIED EMPLOYEE
BENEFIT PROGRAMS

ARCH MINERAL CORPORATION

SALARIED EMPLOYEES

HEALTH CARE PLAN

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INTRODUCTION

In order to provide protection for you and your dependents against unexpected medical expenses caused by accident or sickness, Arch Mineral Corporation or a subsidiary Company or affiliate which adopts this program provides you with a Comprehensive Health Care Plan. The program is divided into four parts:

- The Hospital Expense Benefit, which covers a large part of your hospital and medical expenses.
- The Medical Surgical Services Benefit, which generally covers physicians' charges and related medical expenses.
- The Major Medical Benefit, which pays benefits in addition to those paid by the Hospital Expense and Medical Surgical Services Benefits, and
- Hearing Aid Benefits which pay the full cost of hearing aids for you and your dependents.

ELIGIBILITY

If you are a full-time salaried employee of Arch Mineral Corporation or a subsidiary Company or affiliate which adopts this program, you and your eligible dependents will be covered under the Health Care Program on your first day of work.

Your eligible dependents include:

- your spouse
- unmarried dependent children who have not reached their 19th birthday (or 25th birthday if attending school full-time). Dependent children mean your natural children, step-children, foster children, legally adopted children or a child for whom legal adoption proceedings have been started.

COST OF COVERAGE

Coverage under our Health Care Plan is provided to you and your eligible dependents at no cost. The Company pays the full cost of this benefit.

HOW TO ENROLL FOR COVERAGE

To enroll in our Health Care Plan, you simply complete, sign and return the enrollment form to your Human Resources Representative.

HOW THE HEALTH CARE PLAN WORKS

Your Health Care Plan is divided into four benefits which cover different expenses and pay different benefit amounts. Each of these benefits work together to provide you and your family with invaluable comprehensive protection.

The four benefits which make up your Health Care Plan are:

The Hospital Expense Benefit
The Medical Surgical Services Benefit
The Major Medical Expense Benefit, and
The Hearing Aid Benefit

Each will be discussed separately in this booklet. The benefits described in this booklet apply to charges for covered expenses. Covered expenses are limited to the Usual & Customary* allowance determined by the Plan and must be incurred while coverage is in effect.

HOSPITAL EXPENSE BENEFIT

This portion of the Health Care Plan provides coverage for you and your dependents during hospitalization.

PROVIEW PLUS

The Plan includes a pre-admission review program called PROVIEW PLUS. PROVIEW PLUS is a Hospital utilization review program administered through Provident Life & Accident Insurance Company. The PROVIEW PLUS Program provides pre-admission review with assignment of an appropriate length of stay and continued stay review on all Hospital admissions.

* See Glossary

PROVIEW NOTIFICATION PROCEDURES

The PROVIEW staff works with your doctor before you are admitted to the hospital for any non-emergency procedure.

- You inform your doctor. Before you or a covered family member are admitted to the hospital, tell your doctor you are a participant in the PROVIEW program.

- Your doctor calls PROVIEW. Ask your doctor to call PROVIEW and give the following information:

  - Name, address, telephone number, birthdate, and social security number of patient and employee
  - Your employer's name and address
  - Admitting diagnosis
  - Patient's signs and symptoms
  - Lab results and x-ray results
  - Scheduled procedure date and time of surgery
  - Scheduled admission date
  - Hospital name, address and telephone number

  Your doctor can call PROVIEW toll-free Monday through Friday between 8 a.m. and 4 p.m. in all time zones. The toll-free number is 1-800-621-4309. In Tennessee, the number is 1-800-228-6016.

- PROVIEW evaluates the request. The PROVIEW staff uses objective standards for medical care to determine if the proposed hospital admission is appropriate. Many times, a hospital stay is not appropriate because equally good, but less expensive, forms of medical treatment can be used. PROVIEW carefully checks all medical alternatives to make sure that you receive the best possible treatment.

- PROVIEW notifies you. You, your doctor, the hospital, and your group insurance claim office are notified in writing of PROVIEW's recommendation regarding your hospitalization. Your employer may also be notified.

QUESTIONS AND ANSWERS

What happens if I don't call PROVIEW?

Claims sent to Provident which should have been reviewed by PROVIEW Plus, but were not, will be sent to PROVIEW Plus on a retroactive basis.

PROVIEW Plus will decide whether the claims include excessive and/or unnecessary charges and will notify Provident of the claims and their conclusions.

If the claim is found to be correct (what would have been okayed by PROVIEW Plus had the phone call been made), it will be returned to Provident for processing and payment as usual.

If excessive and/or unnecessary charges are identified, Provident will not pay the excessive charges.

In summary, the processing of all claims not using the program will be delayed because of the retroactive review, and you will be personally liable for any charges PROVIEW deems to be excessive and/or unnecessary.

Is my doctor the only one who can call PROVIEW?

Your doctor or your doctor's representative should call PROVIEW with the necessary information. Your doctor's representative is any employee of your doctor who is approved to give this information.

What should I do if my doctor refuses to call PROVIEW?

If your doctor refuses to call, you should call PROVIEW yourself, explain the situation and provide as much information as you can concerning your admission. PROVIEW will then call your physician in order to complete the certification process.

What if emergency treatment is necessary?

If you are admitted to the hospital for emergency treatment, PROVIEW must be notified within two working days of the admission in order to ensure regular coverage under your benefits plan. Your doctor or your doctor's representative call the toll-free number: 1-800-621-4309. In Tennessee, the number is 1-800-228-6016.

What if hospital care is proposed when the patient is away from home?

PROVIEW is available nationwide. PROVIEW may be contacted by doctors across the United States by calling this toll-free number: 1-800-621-4309. In Tennessee, call 1-800-228-6016.

What about maternity admissions?

PROVIEW must be notified. Maternity admissions are treated as an emergency. PROVIEW must be notified within two working days of the admission in order to qualify for regular coverage under your benefits plan. Also, PROVIEW must be notified if the newborn child is to remain hospitalized after discharge of the mother.

Can I request a re-examination of my case?

If there is a disagreement regarding a PROVIEW recommendation, you or your doctor may request a re-examination of your case.

PROVIEW: A VALUABLE PART OF YOUR HEALTH BENEFITS PLAN

PROVIEW can help you save money by reducing your health care costs and allowing for regular coverage under your medical benefits plan. Of course, saving money is important. But remember, your health and well-being is always the top priority. The professional staff at PROVIEW carefully evaluates each case to ensure the medical necessity of your hospital admission. PROVIEW can help you get quality health care while helping to lower your medical expenses.

WHAT IS COVERED UNDER THE HOSPITAL EXPENSE BENEFIT

When you or one of your covered dependents is admitted to a Hospital for an illness or accidental injury, the Hospital Expense Benefit will provide up to 365 days of care during any one period of hospitalization.

Each period of hospital confinement for you or your dependent will count toward the individual 365 day maximum. However, a new 365 day period will be allowed in the following cases:

- In your case as an employee, if you have returned to active work with Arch Mineral Corporation or a subsidiary Company or affiliate which adopts this Plan for at least one full day before the later confinement.

- In the case of your dependents when the two (2) confinements are due to the same or related cause and
  - your dependent fully recovers between them; or
  - the confinements are separated by six (6) months

- In the case of your dependents when the two (2) confinements are **not** due to the same or related cause and
  - your dependent recovers from the first disability before the later one begins; or
  - the confinements are separated by at least three (3) months

Under the Hospital Expense Benefit section of the Health Care Plan, coverage is provided for the following services:

- Room and Board*
- General Nursing Care
- Other Hospital Services and Supplies* including:
  - Operating, treatment and delivery rooms and equipment
  - Anesthesia
  - Drugs, medicines, and dressings
  - Oxygen and its administration
  - X-ray and other diagnostic examinations
  - Laboratory tests
  - Physical therapy
  - Electrocardiograms
  - Dressings and casts
  - Administration of blood or plasma
  - Special diets
  - Radium therapy
  - Intravenous injections and solutions
- Certain Outpatient Expenses
- Ambulatory Surgery

How Much the Hospital Expense Benefit Pays

Payment under the Hospital Expense Benefit depends upon the type of service you receive.

- Room and Board

  Charges for Room and Board and general nursing care will be paid at the lesser of the Hospital's most common semi-private room rate or the Hospital's most common private room rate, for up to 365 days.

* See Glossary

- Other Hospital Services and Supplies

  In addition to Room and Board and general nursing care, the Reasonable and Customary* charges for most other covered Hospital Services and Supplies are paid in full for up to 365 days during any one period of hospitalization.

  Maternity benefits are payable the same as for any other Sickness

- Outpatient Treatment

  The following benefits apply to outpatient services in a Hospital

Accidental Injury (within 72 hours of accident)	Same as for inpatient
Minor Surgery (at the time the operation is performed)	Same as for inpatient
Outpatient Diagnostic Services (Including Pre-Admission Testing) These include diagnostic testing, x-ray or laboratory exams, which are done outside of the Hospital. They can be performed in the doctor's office, outpatient department of the Hospital or in a separate testing facility.	Same as for inpatient

- Ambulatory Surgical Center
  Benefits are payable when the surgical procedure required because of an injury, Sickness or pregnancy, childbirth or related medical condition is performed in an ambulatory Surgical Center* on you or your dependent while covered. Payment will be made for the actual expense of the charges for services and supplies furnished by the center in connection with the procedure.

  a. within 72 hours from the procedure, and
  b. in case of diagnostic tests, within 7 days prior to the procedure.

* See Glossary

No payment will be made under this benefit for charges:

- for physician's services or private duty nursing services; or
- in connection with a procedure where a local anesthetic is not administered by or under the supervision of a physician anesthesiologist.

Other exclusions and limitations are listed under the heading "Expenses Not Covered Under the Health Care Program".

Services Not Covered Under the Hospital Expense Benefit

Services not covered under this portion of your Health Care Plan include:

- Physician's services or private duty nursing services
- Charges in connection with a procedure where a local anesthetic is not administered by or under the supervision of a physician anesthesiologist
- Prescription drugs while not confined in a Hospital

Additional exclusion are listed on page 18.

NOTE: These services may be covered under either the Medical Surgical Services or Major Medical Expense portions of the Plan. Refer to Pages 8 (below) and 13 for more details.

MEDICAL SURGICAL SERVICES BENEFIT

This portion of your Health Care Plan provides coverage for medically necessary surgical procedures in or out of the Hospital, certain services while in the Hospital and Physician* charges for 365 days while you or one of your dependents are hospitalized.

What is Covered Under the Medical Surgical Services Benefit

Some of the surgical and anesthesia services covered are listed below:

- Surgeon's fees
- Charges for an assistant surgeon when services of interns or resident Physicians are not available

* See Glossary

- Administration of anesthesia by a Physician other than the operating surgeon or his assistant (local anesthesia is not included)
- Prolonged attendance by the Physician in furnishing constant bedside care to a critically ill bed patient
- Intensive medical services to a Hospital bed patient when unusual and additional time and attendance is required by the Physician
- Oral surgery which is necessary due to a tumor
- Emergency physician services or ambulance charges for accidental injuries within 72 hours of the accident
- Cosmetic Surgery or reconstructive surgery to:

  1. correct a defect for a child who has been covered since birth
  2. replace diseased tissue removed while covered under the Plan
  3. correct a defect caused by an accident which occurred while covered under the Plan provided surgery is performed within one year of the accident

- Diagnostic x-rays, laboratory examinations, and interpretations when confined to a Hospital, or, in the case of emergency illness or injury, in a Physician's office or the outpatient department of a Hospital
- Radiation therapy rendered in or out of the Hospital
- In-Hospital Physician's attendance
- Endoscopic Examinations in a Physician's office, Hospital and Ambulatory Surgical Center
- Medical, surgical or obstetrical consultations for a Hospital bed patient when requested by the attending Physician
- A Second Surgical Opinion* from a Board Certified Specialist*.

How Much the Medical Surgical Services Benefit Pays

You and your dependents will be fully reimbursed for up to 365 days for all Reasonable and Customary* charges for the above medical surgical and anesthesia services provided by a licensed Physician.

* See Glossary

Services Not Covered Under the Medical Surgical Services Benefit

The following will not be covered under this part of the Health Care Plan:

- Drugs and medicines dispensed by a licensed pharmacist while you or one of your dependents are not confined to a Hospital
- Hospital Room and Board and general nursing services
- Treatment of the teeth or supporting tissues of the teeth, except tumors. Additional exclusions are listed on page 18.

NOTE: These charges may be covered under the Hospital Expense Benefit or Major Medical Expense Benefit portions of the Plan. See Pages 2 and 13 for more details.

MANAGED SECOND SURGICAL OPINION PROGRAM

The increasing number of surgeries performed in the United States have led to the conclusion, after analysis both in and outside the medical community, that surgery is "overused" to alleviate medical problems. To help you avoid unnecessary surgical risks and costs, a non-emergency Second Surgical Opinion program has been included in the Plan.

The Managed Second Surgical Opinion program focuses on making you more aware of your condition so that you can make an informed decision when elective surgery has been recommended. Your doctor will be asked to call the toll-free MSSO number if the surgery recommended for you or one of your dependents is on the second surgical opinion list on page 11. It will be your responsibility to see that MSSO is notified in a timely fashion.

Your doctor may call the MSSO toll-free number from 8 a.m. to 4 p.m. (all time zones).

In Tennessee	1-800-228-6016
Outside Tennessee	1-800-621-4309

If the MSSO Review Unit determines that you do need surgery, your second surgical opinion requirement will be waived. When the MSSO Review Unit determines a second opinion is required, you will receive the names of two or three Board Certified Specialists who are within reasonable traveling distance.

A Board Certified Specialist is a Physician that has completed extra training for licensure in a particular specialty. The Board Certified Specialist

providing the Second Surgical Opinion should be neither professionally or financially associated with the first surgeon who recommended the surgery.

You must then select a Physician and obtain a second opinion. If the second Physician conflicts with the recommendation for surgery, you are not bound by the recommendation of the second surgical opinion. You may request a third surgical opinion, proceed with recommended surgery, or select the alternative treatment recommended by the second Physician.

If possible, have your doctor send your records (including x-ray and lab results) to the Physician providing the second opinion. This will avoid the time, cost and discomfort of repeating tests which have already been performed.

The Plan will pay 100% of the reasonable and customary fees charged for the second (and third, if necessary) opinion as well as any required diagnostic tests which are necessary as a part of the second opinion.

The following procedures require your Physician to call MSSO when surgery is performed on a non-emergency basis.

1. Blepharoplasty (Surgery on eyelids)
2. Rhytidectomy (Removal of excessive skin)
3. Mastectomy, Mammoplasty (Breast surgery)
4. Repair of knee joint
5. Repair of foot disorders
6. Surgery on the Spinal Column and/or Spinal Nerves
7. Revision of nasal structure
8. Coronary Artery By-Pass Surgery
9. Cholecystectomy (Gallbladder Surgery)
10. Herniorraphy (Hernia Repairs)
11. Tonsillectomy and/or Adenoidectomy
12. Hemorrhoidectomy (Removal of Hemmorrhoids)
13. Prostatectomy (Removal of Prostate)
14. Hysterectomy (Removal and/or Repair of Uterus, Tubes or Ovaries)
15. Dilation and Curettage of Uterus
16. Thyroid Surgery
17. Removal of Cataract
18. Stomach Surgery for Obesity

QUESTIONS AND ANSWERS

What happens if I don't call MSSO?

If the telephone call to MSSO is not made, is placed too late for MSSO to

adequately do their job, or if a second opinion is not received when recommended, your claim will be sent to MSSO for retroactive review after it is received by Provident for processing.

MSSO will review the claim, the diagnosis and treatment. If they agree with the treatment, the claim will be returned to Provident for processing. In this case, the only effect will be a delay in Provident claim processing time. It may take several additional weeks for reimbursement.

If MSSO reviews the claim diagnosis and treatment and determines that there are excessive and/or unnecessary charges, Provident will not pay the excessive and/or unnecessary amounts. For example, when MSSO reviews your claim for surgery after the actual surgery is performed and determines that the condition could have been treated on an outpatient basis or without surgery without reducing the quality of care, Provident would only pay for the reasonable and customary cost of treatment recommended by MSSO in their retroactive review. You, the patient, would be responsible for any unpaid amounts.

Please also note, MSSO must be notified even if the Arch Health Benefit Plan is not the primary insurer. If the spouse's insurance company or Medicare or any other plan pays the primary benefit, the phone call must still be made if any portion of the claim will be covered under the Arch Medical Benefit Plan.

Is my doctor the only one who can call MSSO?

Your doctor or your doctor's representative should call MSSO with the necessary information. Your doctor's representative is any employee of your doctor who is approved to give this information.

What should I do if my doctor refuses to call MSSO?

If your doctor refuses to call, you should call MSSO yourself, explain the situation and provide as much information as you can concerning your admission. MSSO will then call your physician in order to complete the certification process.

What if emergency treatment is necessary?

If you are admitted to the hospital for emergency treatment, MSSO must be notified within two working days of the surgery in order to ensure regular coverage under your benefit plan. Your doctor or your doctor's representative can call the toll-free number: 1-800-621-4309. In Tennessee, the number is 1-800-228-6016.

What if surgery care is proposed when the patient is away from home?

MSSO is available nationwide. MSSO may be contacted by doctors across the United States by calling this toll-free number: 1-800-621-4309. In Tennessee, call 1-800-228-6016.

Can I request a re-examination of my case?

If there is a disagreement regarding an MSSO recommendation, you or your doctor may request a re-examination of your case.

Remember, the purpose of a second opinion is to give you more information about your medical condition and more choices in treating it. The final decision is up to you.

If you have any questions regarding these rules, please contact your Human Resources Manager.

MAJOR MEDICAL EXPENSE BENEFITS

The Hospital Expense and Medical Surgical Services Expense Benefits provide coverage for almost all the Hospital and surgical expenses and some medical expenses that you and your covered dependents might incur. However, when a serious accident or Sickness strikes, expenses may exceed the coverage provided under these Benefits. That's when your Major Medical Expense Benefit comes into play to protect you and your family against those additional and often heavy expenses.

The Major Medical Expense Benefit supplements the Hospital Expense and Medical Surgical Services Expense Benefits by covering expenses while not hospitalized, such as medical services of Physicians, nursing services, prescription drugs and medicines, emergency ambulance service, Pap smears and Child Health Care.

What is Covered Under the Major Medical Expense Benefit

Covered expenses include any Reasonable and Customary* charges for medical services and supplies which are performed or prescribed by a qualified Physician or surgeon. These expenses may be incurred in or out of the Hospital and include:

* See Glossary

- Medical and surgical services of legally qualified Physicians or surgeons, including specialists, except as indicated for Mental and Nervous* conditions.
- Services of a trained nurse other than a nurse who ordinarily lives in your home or who is a member of your immediate family
- Prescription drugs and medicines
- Emergency ambulance service to and from the nearest facility where care can be given
- Hospital charges for Room and Board, up to the Hospital's semi-private room rate, after the Hospital Expense Benefit coverage has been exhausted
- Charges for Hospital Services and Supplies*
- Oxygen and its administration
- Diagnostic x-rays and laboratory examinations
- Annual Pap smears, routine mammograms and related tests
- Child Health Care up to age six (for your dependent children)
- Anesthetics and their administration
- Surgical supplies
- Rental, or purchase if more cost effective, of an iron lung or other durable equipment manufactured solely for the treatment of a medical condition
- Initial purchase of artificial limbs or other prosthetic appliances if the loss occurs due to a surgical procedure or accident which occurs while covered under this Plan
- Radiation therapy, x-ray, radon, radium and radioactive isotopes
- Physiotherapy prescribed by your doctor and performed by a duly qualified physiotherapist
- Cost of blood or blood plasma

* See Glossary

- Initial pair of eyeglasses or contact lens following cataract surgery performed while covered under the Plan
- Speech therapy to restore impaired speech due to stroke, surgery, accident or congenital defects which occur while covered under the Plan
- Convalescent Facility Care if admitted to the facility immediately following a hospital confinement of at least five (5) days
- Ambulatory Surgical Center services rendered within 72 hours from and in connection with a surgical procedure, or within 7 consecutive days before diagnostic procedures. This does not include the services of a Physician or private nurse

How Much the Major Medical Expense Benefit Pays

You and each of your covered dependents pay the first $50 of covered medical expenses (the deductible) over and above those paid by the Hospital Expense Benefit and Medical Surgical Services Benefit. The $50 deductible must be satisfied once each year (January 1 - December 31) for each covered person before benefits under Major Medical will be paid.

Once you and your dependents have satisfied the required deductible, the Major Medical Expense Benefit will pay 80% of the Reasonable and Customary* charges for covered medical expenses up to a lifetime maximum of $1,000,000 per covered person. In any calendar year, covered Major Medical Expenses will automatically be restored up to $4,000 for the following year. (This does not apply to Mental and Nervous* conditions.) The full $1,000,000 maximum may be restored upon request by providing satisfactory evidence of insurability.

Deductible Carryover

The deductible, as described above, is an out-of-pocket expense that you must pay before eligible medical expenses under Major Medical Benefits are reimbursed.

However, any Covered Expenses incurred in the last three months of any calendar year that are used to satisfy that year's deductible will also be used to reduce the following year's deductible. This means that a completely new deductible does not have to be met in the following year. For example, if you incur $20 of covered expenses between January and September and incur an

* See Glossary

additional $30 between October 1 and December 31, the $30 can also be applied to the following year's deductible.

Common Accident Provision

If two or more members of your family are injured in the same accident, only one $50 deductible will apply to the expenses resulting from that accident during the calendar year in which the accident occurs.

A Special Provision of the Major Medical Expense Benefit

Under the Major Medical Expense Benefit, Mental and Nervous* Disorders are paid as follows:

Mental or Nervous Disorders or Biofeedback

In-Hospital expenses and convulsive therapy expenses are paid on the same basis as any other illness.

Out of hospital expenses are paid at $50 after deductible. Charges in excess of $50 per visit and 50 visits per calendar year are not covered.

The maximum payable under the Major Medical part of this Plan is $2500.00 per calendar year for all benefits paid in connection with a Mental or Nervous disorder.

Services Not Covered Under the Major Medical Benefit

Charges for the following services will not be covered under this part of the Health Care Plan:

- Care and treatment of teeth and gums except due to an injury to natural teeth and for removal of tumors (see the Dental Care Plan)
- Eye refraction and eyeglasses (see the Vision Care Plan)
- Those caused by war or an international armed conflict
- Services by any person who is a member of your immediate family or who resides in your home
- No benefits will be paid for charges for an injury or illness which began prior to the effective date of a person's coverage. This also applies to pregnancy, but does not apply to Complications of Pregnancy* which occur after the effective date of a person's coverage.

* See Glossary

This provision will not apply to an injury or illness with which a child is born, provided the child is born while a parent is covered under the Plan.

Additional exclusions are listed on page 18

HEARING AID BENEFIT

What Is Covered/How Much The Plan Pays

As good hearing is essential to happy health living, we are providing this excellent benefit to you and your covered dependents.

When recommended by a medical doctor, one hearing aid for each ear is allowable every two years. The Plan will pay benefits in the amount of 80% of Reasonable and Customary* charges.

AN EXAMPLE OF HOW THE HEALTH CARE PLAN WORKS

Here is an example of how the Hospital Expense Benefit, Medical Surgical Services Benefit and the Major Medical Expense Benefit work together to provide you with Health Care Expense protection.

Let's suppose an employee is hospitalized for a serious heart problem and stays in a semi-private room for 30 days. His expenses and benefits might look like this:

Expenses in Hospital

	Expenses	Hospital Expense Plan Pays	Medical Surgical Plan Pays	Major Medical Plan Pays
30 days room & board @ $240	$ 7,200	$ 7,200	-0-	-0-
Hospital services & supplies	$10,000	$10,000	-0-	-0-

* See Glossary

	Expenses	Hospital Expense Plan Pays	Medical Surgical Plan Pays	Major Medical Plan Pays
20 Days Private Nursing Care @ $80 per day	$1,600	-0-	-0-	$1,240*
Surgery	$3,000	-0-	$3,000	-0-
Physician's charges	$1,000	-0-	$1,000	-0-
Anesthesia	$1,750	-0-	$5,750	$1,240
	$24,550	$17,200	$ 5,750	$ 1,240

* There is a $50 deductible under the Major Medical Plan

To Summarize: The Total Expenses are $24,550

The Hospital Expense Plan
paid $17,200 - the total Room and Board and general service charges

The Medical Surgical Services
paid $5,750 - the total surgery related charges

The Major Medical Plan
paid $1,240 - 80% of the applicable charges after a $50 deductible

So, out of a total bill of $24,550, the Plan paid $24,190. The employee was only required to pay $360.

EXPENSES NOT COVERED UNDER THE HEALTH CARE PLAN

The following expenses are not covered by any part of the Health Care Plan:

- Routine health check-ups (except annual Pap smears, routine mammograms and Child Health/Supervision Services described on page 14)
- Eyeglasses or examinations for prescriptions or fittings (see Vision Care Plan)

- Charges that you or your dependents are not required to pay where payment is received as a result of legal action or settlement (if benefits have been paid for expenses that are later recovered through legal action or settlement, the covered person will be required to reimburse the Plan Administrator for such benefits)

- Services which are or may be obtained without cost in accordance with laws or regulations of any government

- Diseases contracted or injuries or conditions sustained as a result of war, or any act of war, declared or undeclared

- Charges for an injury or illness which began prior to the effective date of a person's coverage. This also applies to pregnancy, but does not apply to Complications of Pregnancy* which occur after the effective date of a person's coverage.

  This exclusion will not apply to an injury or illness with which a child is born, provided the child is born while a parent is covered under the Plan.

- Charges for education, training and bed and board while you or your dependent are confined in an institution which is primarily a school or other institution for training, a place of rest, a place for the aged or a nursing home.

- Charges for custodial care

- Charges incurred for immunizations and medical examinations or tests of any kind not incident or necessary to the treatment of a covered injury, sickness or pregnancy

- Services incurred before coverage begins or after coverage ends

- Cosmetic surgery or reconstructive surgery unless necessary to:
  1. correct a birth defect for a child who has been covered since birth
  2. replace diseased tissue removed while covered under the Plan
  3. correct a defect caused by an accident which occurred while covered under the Plan provided surgery is performed within one year of the accident

- Expenses incurred outside the United States or Canada unless you or your dependent is a resident of the United States or Canada and the charges are incurred while traveling

* See Glossary

- Services performed by:
  1. you or your spouse; or
  2. you or your spouse's parent, sister, brother or child; or
  3. any person who normally resides in the patient's home
- Radial keratotomies
- An injury arising from any employment or occupation
- An illness covered by Workers Compensation
- Experimental and/or Investigational Services
- Services or supplies for which you are not required to pay
- Elective abortions unless the life of the mother would be in danger if pregnancy continued
- Treatment or surgery to change gender or improve or restore sexual function
- Procedures to reverse sterilization or birth control measures
- Treatment or surgery for obesity, weight reduction or weight control
- Treatment of intentionally self-inflicted injury or treatment of conditions resulting from or in any way related to that injury
- Food supplements
- Equipment or supplies made or used for physical fitness, athletic training or general health up-keep
- Usual and normal home medical supplies or first aid items

If you receive any payment (for medical services or otherwise) by award, settlement or for a condition, disease or injury resulting from employment, you must reimburse the Plan Administrator in full for all benefits received for such sickness or injury.

WHEN YOU ARE ELIGIBLE FOR MEDICARE

If you are an active employee when you and/or your spouse reach age 65, you and/or your spouse must choose whether you want primary coverage under either Medicare or the Arch Mineral Corporation Health Care Plan. If you and/or your

spouse choose to be covered under the Arch Plan, Arch will be the primary payer and Medicare will pay secondary benefits. If Medicare is chosen, you and/or your spouse will not be eligible for any additional benefits under the Arch Mineral Corporation Plan to supplement coverage that is provided by Medicare. Also, if you or a covered dependent qualify for Medicare because of a disability, you or your covered dependent will have the same choice with respect to the Arch Mineral Corporation Health Care Plan and Medicare as an individual who has reached age 65. However, this will not apply to individuals eligible for Medicare due to renal (kidney) failure.

WHEN YOU RETIRE

While you are an active employee, if you elect Normal Retirement and have earned at least one year of Pension Credited Service in the Arch Mineral Salaried Employees Pension Plan, you retain the same coverage as an active employee as a supplement to Medicare Parts "A" and "B" for yourself and eligible dependents. This coverage is provided at no cost to you. You pay for Medicare Part "B" premiums.

While you are an active employee, if you elect Early Immediate Retirement and have earned at least one year of Pension Credited Service in the Arch Mineral Salaried Employees Pension Plan, you retain the same coverage as an active employee until your normal retirement age. At your normal retirement date, your coverage is handled the same as Normal Retirement benefits.

NOTE: If you terminate your employment with the Company for any reason, including layoff, prior to your Normal Retirement Date without electing Early Immediate Retirement, your benefits will terminate the day you stop active work.

NOTE: The Company may terminate or amend this Plan at any time.

WHEN YOUR COVERAGE TERMINATES

Your coverage under the Health Care Plan will terminate on the earliest of:

- The date you stop active work as a result of termination of employment for any reason, including lay-off; or
- No later than 182 days from the day last worked if off due to disability caused by an illness or injury if you have less than 15 years of service as a full-time employee before termination;

- The date this plan is terminated.

Dependent coverage will terminate on the earliest of:

- The date they no longer qualify as eligible dependents
- Three months after the date of your death. However, if you die after you retire or are eligible for Early Immediate, Normal or Disability Retirement, coverage on your spouse will be continued until
  1. The date your surviving spouse remarries;
  2. the date your surviving spouse becomes eligible for Medicare. The Arch Plan will then be secondary.
- The date this Plan is terminated.

NOTE: The Company reserves the right to terminate or amend this Plan at any time.

YOU MAY CONTINUE YOUR COVERAGE (COBRA)

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the new law. (Both you and your spouse should take the time to read this notice carefully.)

(i) As an employee...

As an employee, you may choose this continuation coverage if you lose your group health coverage because of reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part) or if your employer files for Chapter 11 reorganization.

(ii) As a spouse...

If you are the spouse of an employee, you may choose continuation coverage if you lose group health coverage under this plan for any of the following reasons:

- The death of your spouse;

- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- Your spouse's employer files for Chapter 11 reorganization;
- Divorce or legal separation from your spouse;
- Your spouse becomes entitled to Medicare.

(iii) As a child...

A dependent child of an employee may choose continuation coverage if group health coverage is lost for any of the following reasons:

- The death of a parent;
- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment; or
- The parent's employer files for Chapter 11 reorganization; or
- Parents' divorce or legal separation; or
- A parent becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the terms of the plan.

Under the law, you or a family member has the responsibility to inform your Human Resources Representative of a divorce, legal separation, or a child losing dependent status under the group health plan within 60 days of the event which caused the loss of coverage.

(iv) You have 60 days to elect coverage

When the Human Resources Department is notified that one of these events has occurred, you will be notified of your right to choose continuation coverage. Complete instructions on how to elect coverage will be included. Election of continuation coverage must be made within 60 days. If continuation coverage is not elected, all group health, vision and dental benefits will cease according to regular plan provisions.

(v) Continuation coverage will end under certain circumstances

If continuation coverage is elected, the coverage provided will be identical to the coverage provided under the plan to employees or family members who have not lost their coverage. Coverage may continue for a period of 3 years unless coverage was lost due to termination of employment or a reduction in hours. In that case, coverage may continue for a period of 18 months. This 18 months may be extended to 36 months if other events (such as death, divorce, legal separation, or Medicare entitlement) occur during that 18 month period.

The 18 months may be extended to 29 months if an individual is determined to be disabled (for Social Security disability purposes) and the Plan Administrator is notified of that determination within 60 days. Under the law, the plan has the right to charge an increased premium for the additional eleven (11) month period. The affected individual must also notify the Plan Administrator within 60 days of any final determination that the individual is no longer disabled. In no event will continuation coverage last beyond 3 years from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

Continuation coverage may be terminated for any of the following reasons:

- The company no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time;
- You become covered under another group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition
- You become entitled to Medicare;
- Your coverage has been extended for up to 29 months due to your disability and there has been a final determination by the Social Security Administration that you are no longer disabled.

(vi) Cost of Continuation Coverage...

You do not have to provide evidence of good health to choose continuation coverage. However, under the law, you may be required to pay all or part of the cost of the continuation coverage.

At the end of the 18 month or three year continuation coverage period, you will be allowed to enroll in an individual conversion health plan. The cost of the one-time conversion fee will be paid by the plan. You will be responsible for the payment of the necessary premiums.

(vii) Disability/Survivor Dependent Coverage

COBRA Continuation coverage is not in addition to the extended coverage which is provided for disabled employees or for surviving dependents of a deceased employee/retiree. The maximum length of coverage allowed under COBRA will be reduced by the amount of coverage provided due to disability or death of the employee.

COORDINATION OF BENEFITS (COB)

The purpose of the Health Care Plan is to help you meet the covered expenses that you and your dependents actually incur. Sometimes, though, because a husband and wife are both working, members of a family may be covered under more than one group health care plan. This kind of duplicate coverage can frequently result in two plans paying benefits for the same expense. This kind of overpayment unnecessarily raises the cost of the insurance.

To help guard against overpayments so that we can ensure you obtain maximum benefits at a minimum cost, our Plan has a Coordination of Benefits provision. The important point to remember about "Coordination of Benefits" is that its purpose is to ensure that you receive all the benefits you are entitled to under all group plans. In addition, this provision keeps the cost of your coverage reasonable by preventing anyone from being reimbursed for more than 100% of their total medical expenses.

If you or any member of your family is covered under more than one plan, the Coordination of Benefits provisions will be applied. "Plan" means any plan providing health care benefits on a group basis, whether such plan is insured, self-insured or non-insured. "Plan" also means any pre-payment plan, government plan, and no-fault automobile coverage.

Under this provision, one of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plans then make up the difference up to the total Allowable Expenses. No plan will pay more than it would have paid without the special provisions. If one plan has no Coordination of Benefits provision, it automatically is Primary.

A plan may be Primary if it covers the individual as an employee and secondary if it covers the individual as a dependent. When both parents cover a dependent child, the plan which covers such an individual as a dependent of a male person will be primary.

If the parents are separated or divorced, the plan of the parent with custody will be primary. If the parent with custody has remarried, the plan of the step-parent will be secondary. The plan of the parent without custody shall pay last. However, if a divorce decree stipulates that one parent shall have financial responsibility for the health care expenses of a child, then the plan of that parent will be Primary.

Also, if the above conditions do not apply, a plan may be Primary if it covers the individual for a longer period of time and Secondary if it covers the individual for a shorter period of time.

CONVERSION PRIVILEGE WHEN COVERAGE ENDS

An individual policy providing Hospital and Surgical benefits may be obtained within 31 days after termination of coverage:

- By you, if your coverage is terminated due to termination of your employment;
- By your surviving spouse, if your dependent coverage is terminated due to your death;
- By your child, when he or she ceases to be an eligible dependent while your dependent coverage is still in force, or when your dependent's coverage is terminated due to termination of your employment or death if this child is then age 19 or older.

The rules of the Plan Administrator and the laws of the jurisdiction you live in at the time you make an application for an individual policy will determine the type of policy you obtain under this provision. The benefit amounts under the policy will not necessarily be identical to those provided by Arch Mineral Corporation.

HOW TO FILE FOR BENEFITS

Your Human Resources Representative will assist you in filing your claim. Any question as to procedures should be directed to him or her.

Forms for filing claims may be obtained in the Human Resources Department. You or your provider should complete these forms and mail them with itemized bills to the Provident claim office.

(d) It provides at least two operating rooms and at least one postanesthesia recovery room; is equipped to perform diagnostic x-ray and laboratory examinations; and has trained personnel and necessary equipment available to handle foreseeable emergencies, including but not limited to a defibrillator, a tracheotomy set, and a blood bank or other blood supply.

(e) It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating room and in the postanesthesia recovery room.

(f) It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement.

(g) It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a pre-operative examination report, medical history and laboratory test and/or x-rays, an operative report and a discharge summary.

(2) **Board Certified Specialist**

A physician who has been certified by a Medical Board as a specialist in the field in which he or she practices. If a "Board Certified Specialist" is not available in your area, a physician who is (a) qualified to perform surgery and (b) a member of the staff of an approved hospital may be utilized.

(3) **Care of Spinal Conditions** - Care connected with the detection or correction by manual or mechanical means of:

(a) structural imbalance;
(b) distortion; or
(c) subluxation

where such care is for purposes of removing nerve interference and its effect, where interference is the result of or related to distortion, misalignment or subluxation of or in the spinal column.

(4) **Complications of Pregnancy** - "Complications of Pregnancy" means:

(a) conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are

Any such request should be accompanied by documents or records in support of the appeal. You or a legally authorized representative may review all pertinent documents and submit issues and comments in writing.

The Plan Administrator will review the claim and within 60 days (or 120 days in special circumstances) will provide a written response to the appeal explaining the reasons for the decision with specific reference to the Plan provisions on which the decision was based.

GLOSSARY

The following definitions will help you to better understand your coverage under the Health Care Plan.

(1) **Ambulatory Surgical Center**

A specialized facility where patients can have minor surgery performed without having to be confined overnight. Such centers could include an ambulatory surgery unit of a Hospital, a free-standing ambulatory surgery facility, a minor emergency center, or a Physician's office:

(A) Where coverage of such a facility is required by law, and has been licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction where it is located; or

(B) Where coverage of such a facility is not required by law but meets all of the following requirements:

(a) It is established, equipped and operated according to the laws in the area where it is located primarily for the purpose of performing surgical procedures.

(b) It is operated under the full-time supervision of a staff of physicians. In addition, it permits a surgical procedure to be performed only by a duly qualified Physician, who at the time the procedure is performed, is allowed to perform such a procedure in at least one Hospital (as defined) in the area.

(c) It requires, in all cases other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist or a certified registered nurse anesthetist administer the anesthetic and remain present throughout the surgical procedure.

(d) It provides at least two operating rooms and at least one postanesthesia recovery room; is equipped to perform diagnostic x-ray and laboratory examinations; and has trained personnel and necessary equipment available to handle foreseeable emergencies, including but not limited to a defibrillator, a tracheotomy set, and a blood bank or other blood supply.

(e) It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating room and in the postanesthesia recovery room.

(f) It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement.

(g) It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a pre-operative examination report, medical history and laboratory test and/or x-rays, an operative report and a discharge summary.

(2) **Board Certified Specialist**

A physician who has been certified by a Medical Board as a specialist in the field in which he or she practices. If a "Board Certified Specialist" is not available in your area, a physician who is (a) qualified to perform surgery and (b) a member of the staff of an approved hospital may be utilized.

(3) **Care of Spinal Conditions** - Care connected with the detection or correction by manual or mechanical means of:

(a) structural imbalance;
(b) distortion; or
(c) subluxation

where such care is for purposes of removing nerve interference and its effect, where interference is the result of or related to distortion, misalignment or subluxation of or in the spinal column.

(4) **Complications of Pregnancy** - "Complications of Pregnancy" means:

(a) conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are

adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

(b) non-elective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which viable birth is not possible.

(5) **Convalescent Facility**

A legally operating institution or a distinct part of one which:

(a) is supervised by a resident Physician or a resident registered graduate nurse;

(b) requires that the health care of each patient be under the supervision of a Physician;

(c) requires that a Physician be available to furnish necessary medical care in emergencies;

(d) provides 24 hour nursing service;

(e) is approved or is qualified to receive approval for payment of Medicare benefits; and

(f) keeps clinical records on all patients.

(6) **Custodial Care**

Services, including room and board, or supplies provided to a person which consists primarily of that basic care given to maintain life and/or comfort with no reasonable expectation of cure or improvement of that injury or illness.

(7) **Experimental and/or Investigational Services**

Services which have not been clinically proven to be safe and effective based upon available professional assessments. Arch reserves the right to make the final determination in case a dispute should arise.

(8) **Hospital**

As used in this booklet, the term Hospital means an institution which is engaged primarily in providing medical care and treatment of sick and injured people on an in-patient basis at the patient's expense and which meets the tests listed below:

(1) It is an institution legally operating as a Hospital

(2) (a) It is a hospital accredited by the Joint Commission on Accreditation of Hospitals

or

(b) It is a Hospital, a psychiatric Hospital or a tuberculosis Hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare

(3) It is an Institution which fully meets all of the following tests:

(a) It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured people by and under the supervision of a staff of duly qualified physicians and

(b) It continuously provides on the premises 24 hour a day nursing service by or under the supervision of registered graduate nurses and

(c) It is operated continuously with organized facilities for operative surgery on the premises except that benefits for:

(i) psychiatric disorders
(ii) mental or nervous conditions;
(iii) alcoholism;
(iv) drug dependence; or
(v) the medical complications of mental illness or mental retardation

shall not be denied because of confinement in a particular facility if the facility has a bona fide arrangement with a Hospital that has facilities for operative surgery on the premises.

In no event will "Hospital" include any institution:

(a) which is run mainly as a rest, nursing or convalescent home or residential treatment center;

(b) for which any part is mainly for the care of the aged; or

(c) which is engaged in schooling of its patients.

(9) **Injury**

Accidental bodily injury, which requires treatment by a Physician

(10) **Medicare**

Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is now or as it may be amended.

(11) **Mental or Nervous Disorder**

Neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

(12) **Other Hospital Services and Supplies**

Services and supplies furnished and required for treatment other than Room and Board, the professional services of any Physician and any private duty or special nursing services (including intensive nursing).

(13) **Physician**

(a) a legally licensed Physician or Surgeon; or

(b) any other legally licensed practitioner of the healing arts rendering services:

(i) which are covered under the Plan;
(ii) for which benefits are required by law to be provided when rendered by such a practitioner; and
(iii) which are within the scope of the individual's license.

(14) **Room and Board**

Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the Hospital, but not including professional services of Physicians or special nursing services rendered outside of an intensive care unit.

(15) **Second Surgical Opinion**

An assessment by a Board Certified Specialist regarding the medical necessity of a listed procedure. The opinion must be given prior to the date surgery is performed and must be rendered by a Board Certified Specialist other than the surgeon who is to perform the operation.

(16) **Sickness**

A bodily sickness or disease, including a mental disorder of any kind, which requires treatment by a Physician and includes with respect to a female employee or dependent, the terms pregnancy, childbirth, abortion, miscarriage and complications of pregnancy unless otherwise limited by the Plan.

(17) **TMJ and Related Care**

Non-surgical care connected with the detection or correction of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves, and other tissues related to that joint. TMJ and Related Care does not include dental work, such as, but not limited to, orthodontics, fixed or removable bridgework/dentures, inlays, onlays, crowns or equilibrations, whether done for dental or medical reasons.

(18) **Usual and Customary Charge and Usual and Customary Fee**

For any service or supply, the Usual and Customary Charge or the Usual and Customary Fee will not exceed the lesser of:

(a) the amount customarily charged by the provider for it; and

(b) the charge for the service or supply made by providers of comparable services or supplies in the same locality.

A special provision will apply when there are no providers of comparable services or supplies in the same locality, or in the event of an unusual type of service or supply. When this happens, Provident will decide whether the charge is appropriate, based on:

(a) the complexity involved;

(b) the degree of professional skill required;

(c) the cost of supplies; and

(d) other pertinent factors.

Provident may decline to pay flat rate charges when procedures, fees and/or time involved are not itemized.

GENERAL INFORMATION

This summary data applies to all parts of the Health Care Plan.

Name of Plan:	Arch Mineral Corporation Health Care Plan
Type of Plan:	Hospital, Medical/Surgical, Major Medical, Hearing Aid, Dental and Vision Benefits
Plan Sponsor:	Arch Mineral Corporation or a subsidiary Company or affiliate which adopts this Program CityPlace One CityPlace Drive St. Louis, MO 63141 Telephone: (314) 994-2700
Plan Administrator:	Arch Mineral Corporation Vice President - Human Resources CityPlace One CityPlace Drive St. Louis, MO 63141 Telephone: (314) 994-2700
Plan Number:	501
Plan Costs:	Paid by Employer
Plan Coverage:	Employees of Arch Mineral Corporation or a subsidiary or affiliate Company which adopts this program
Plan Identification Number:	43-0921172

Type of Plan Administration:	Administrative Services only with specific and aggregate reinsurance through Provident Life and Accident Insurance Company, Fountain Square, Chattanooga, Tennessee 37402
Plan Year:	January 1 - December 31
Agent for Service of Legal Process:	The Plan Administrator
Funding:	Unfunded plan benefits paid from general assets of employer, but administered by Provident Life and Accident Insurance Company, Fountain Square, Chattanooga, Tennessee 37402
Claim Administrator:	Provident Life and Accident Insurance Company, Fountain Square, Chattanooga, Tennessee 37402