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Your Medical Benefits

Your Medical Benefits
January 2007

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This is a summary plan description (SPD) of your medical benefits. This booklet describes the benefits provided in easy-to-read terms. It cannot cover every detail of the Plan.

If there is any conflict between the description in this SPD and any Plan documents that may govern the Plan now or in the future, the terms of the Plan documents will be followed.

The Plan Administrator maintains the absolute, sole and exclusive authority to interpret the terms of this Plan, and his or her interpretations will be final.

To the fullest extent allowed by law, the Company reserves the right to change or terminate the Plan at any time. This booklet is not a guarantee of benefits or any employment contract of any kind.

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Introduction

The Company maintains the Magnum Coal Company Medical Plan ("the Medical Plan.) It is the Company's philosophy to offer a competitive medical plan covering medical expenses incurred for treatment of a non-occupational illness or injury. The Company believes that a Company-sponsored medical plan should emphasize preventive care and protection from undue financial hardship as a result of catastrophic injury or illness. Medical Plan benefits are paid directly by the Company, as opposed to being insured. The Company utilizes a Claims Administrator to assist in the administration of the Medical Plan.

The Plan provides the following benefits based on the Plan (Platinum, Gold or Silver) that you choose during open-enrollment each year:

Hospital Care—Inpatient and Outpatient

This covers inpatient hospital charges and outpatient hospital charges for accidental injury, life-threatening emergency, and surgery. After you pay an annual deductible, the Plan pays a percentage of covered charges (refer to the Medical Plan Summary chart) when you use a PPO network hospital (or any hospital if you do not have a PPO network in your area). For non-network hospitals in PPO areas, you pay an annual deductible and a percentage of the charges until the annual out-of-pocket maximum is reached. Refer to the Medical Plan summary chart and the *Hospital Care—Inpatient* and *Hospital Care—Outpatient* sections for more information.

Medical Surgical Care

This covers physicians' charges for surgery, inpatient hospital visits and treatment of accidental injury or life-threatening emergency. After you pay an annual deductible the Plan pays a percentage of covered charges (refer to the Medical Plan Summary chart) when you use a PPO network physician (or any physician if you do not have a PPO network in your area). For non-network physicians in PPO areas, you pay an annual deductible and a percentage of the charges until the annual out-of-pocket maximum is reached. Emergency ambulance service is also covered under these benefits. Refer to the Medical Plan summary chart and the *Medical Surgical Care* section for more information.

Chemical Dependency/Substance Abuse Care

This covers inpatient and outpatient treatment of chemical dependency/substance abuse care. Certain limits apply to this benefit. Refer to the Medical Plan summary chart and the Chemical Dependency/Substance Abuse Care section for more information.

Preventive Care

This covers office visits, routine services, well child care for children under age 6, and immunizations related to preventive care. Refer to the Medical Plan summary chart and the *Preventive Care* section for more information.

Major Medical Services and Supplies

This covers office visits, outpatient care and other medical expenses. You pay an annual deductible and a percentage of the charges until the annual out-of-pocket maximum is reached. Refer to the Medical Plan summary chart and the *Major Medical Services And Supplies* section for more information.

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Hospice, Home Health Care, Chiropractic Care, Hearing Care, Maternity Care

Special benefits and limitations may apply to these benefits.

Prescription Drug Benefit

Benefits for prescription drugs are provided under a separate program administered by Systemed, a Medco Company (further referred to in this document as "Medco"). A mail service program is also available to allow you to purchase maintenance drugs on a convenient basis. Refer to the *Prescription Drug Benefit* section for more information.

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This section of your binder contains the information you will need to determine if you have coverage, the level of that coverage, and how qualified medical care can be accessed when you need it. To help you understand your benefits, certain terms are defined in the Glossary near the end of this summary.

Eligibility

If you are a regular, full-time Employee of the Company or have been granted extended coverage through an employment contract or severance agreement, you and your eligible dependents are eligible to participate in the Plan on your first day of active work.

Dependent Eligibility

Members of your family who are eligible for coverage include:

- Your spouse.
- Your children under age 19 who depend upon you for support and whose principal residence is with you.
- Your children from age 19 until the date they reach 23, if they are full-time students at an accredited school, college or university and depend on you for support. Full-time students are required to submit a registrar's statement every January and September verifying their full-time status.
- Your disabled child regardless of age provided he or she is incapable of self-support due to a mental or physical disability that occurs before age 19 or before age 23 if a full-time student.

Dependent children include your natural, step or foster, legally adopted, or in the process of being adopted, children or those dependent upon the employee by reason of permanent legal guardianship. **Your married children are not eligible for coverage under the Plan. Additionally, a dependent who is on active duty in the armed forces of any country cannot be covered under the Plan.**

You will be required to certify and show proof of your spouse and dependent children's eligibility. If you do not certify and show proof of eligibility, your spouse and/or dependents' coverage will discontinue. You will be required to reimburse the Plan for any claims submitted and paid on behalf of any spouse and/or dependent(s) who are ineligible for coverage under the Plan.

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 term "enrollment date" means, with respect to an employee who enrolls when first eligible, the first day of his or her employment as an eligible employee; in all other cases 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. However, the following exceptions apply:

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- The 12-month exclusion period for pre-existing conditions will be reduced to the extent that you have "creditable coverage" from another medical plan on the date you enrolled in this Plan. ("Creditable coverage" is explained in the following section.)
- The limitation for pre-existing conditions will not apply to pregnancy.
- The limitation does not apply to your dependent child if: (1) the child was enrolled in creditable coverage within 30 days of birth or placement for adoption and (2) the child has not had a subsequent lapse of "creditable coverage" for a period of 63 or more days. Coverage that a child had prior to placement for adoption is not taken into account.
- If your coverage ends because of a reduction in force and you return to work within six months, this limitation will not apply when your coverage is reinstated (except to the extent that benefits would have been limited if your coverage had been continuous). If you return to work following a reduction in force that lasts for more than six months, your coverage will become effective on the same basis as a newly hired employee, and the limitation for pre-existing conditions will apply.
- The limitation for pre-existing conditions will not apply to prescription drug benefits.

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 other 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, contact your Human Resources Representative.

When your medical coverage or COBRA continuation coverage ends, you will receive a Certificate of Group Health Plan Coverage from the plan's plan administrator or claims administrator. 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 limit.

When Coverage Begins

Your coverage will begin on the date you enroll, provided you submit your enrollment form and authorize any required contributions within 31 days of your hire date. If your enrollment form is not received within 31 days, you will not be able to obtain coverage for yourself or your dependents until the next annual enrollment period, with coverage effective the following January 1. However, you may also enroll if there is a change in your family status, as explained under *Changing Your Coverage.*

Newly acquired dependents are eligible for coverage as soon as they meet the definition of "dependent." For example, newborn children are covered from birth and new spouses are covered from the date of your marriage, provided you submit a new enrollment form and any required documentation within 31 days. If your enrollment form and/or eligibility documentation are not received within 31 days after a dependent first becomes eligible, you will not be able to cover the dependent until the next annual enrollment period, with coverage effective the following January 1.

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However, you may also enroll dependents if there is another change in your family status, as explained under *Changing Your Coverage.*

You also may enroll a child within 31 days of the date you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). A QMCSO is a court order that gives your child the right to be covered under the Plan, subject to the Plan's eligibility provisions. Coverage will end once the order is no longer in effect or if comparable coverage is provided to the child without interruption.

To make sure the right coverage is in effect for your dependents, please notify your Human Resources Representative whenever you have a change in the number or the status of your eligible dependents, within the required 31 days.

Changing Your Coverage

You have the opportunity to change your coverage once each year during the annual enrollment period, with changes effective the following January 1. After the annual enrollment period, you cannot enroll, cancel or change coverage for yourself or your dependents unless you experience a "change in status" that qualifies under the Plan's rules and IRS regulations.

The following rules apply to changing your medical coverage if you experience a qualified change in family status:

- If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you may enroll in the Plan or add dependents to your current coverage as long as you do so within 31 days of the date the person becomes your dependent. If you submit an enrollment form during this 31-day period, coverage will be effective on the date you submit the form and in the case of a marriage, a newborn, or an adopted child, the date you acquired the new dependent.

- If you need to drop a dependent from your coverage because of divorce or because a dependent child is no longer eligible, you can do so by submitting a new enrollment form within 31 days of the event. Your contribution level cannot be changed until your new enrollment form is received, and the Company will not refund contributions you have made before that date. 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 under *Continuation Of Coverage.*

- You may decide not to enroll yourself or your dependent(s) for the Plan because you have other coverage, such as through your spouse's employer. In this situation, you may enroll in this Plan or add dependents to your coverage if the other coverage ends because (1) you or your dependent are no longer eligible for the other coverage; (2) another employer stops making contributions toward the cost of the other plan; or (3) the coverage was provided under a COBRA continuation provision and the right to such coverage has ended. You must complete an enrollment form within 31 days after the other coverage ends. If you do, coverage will be effective on the day the other coverage ends.

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- You may cancel your coverage, or drop a dependent from your coverage, if you become covered under another medical plan during the year because your spouse has a change in employment, or because the enrollment period for your spouse's plan is different than the Company's Plan, or a new benefit option is offered under your spouse's plan. You must complete a new enrollment form within 31 days of the date you gain the other coverage.
- You may cancel your coverage, or drop a dependent from your coverage, if you or your dependent becomes covered under Medicare or Medicaid.

Any change in coverage must be consistent with the qualifying family status event. You will be required to provide written proof of the event that causes the change.

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The Cost Of Your Coverage

Any required monthly contributions are deducted from your paycheck on a pre-tax basis, unless you request otherwise. Contact your Human Resources Representative for current rates.

Medical Plan Summary

The following charts provide a summary of your Medical Plan features. Benefits are greater for medical care you receive from hospitals, physicians and other health care providers who participate in the preferred provider organization (PPO) network. If you live in an area where a PPO network is not offered or if you are Medicare eligible, you will receive network benefits for all covered medical care. See Out-Of-Area Coverage for details.

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Platinum Plan		
Annual Deductible (excluding prescription drugs)	$100 per person, $200 family limit	
Annual Out-of-Pocket Maximum (excluding prescription drugs)	$500 per person, $1,000 family limit	
Lifetime Maximum (excluding prescription drugs)	$2 million	
	PPO Network	**Non-Network**
Hospital Care Inpatient and outpatient (for surgery and certain emergency services)	90% after deductible	70% after deductible
Medical Surgical Care (physician's services for surgery, inpatient care, and certain outpatient services)	90% after deductible	70% after deductible
Preventive Care (annual maximum $400 per person)	100%, no deductible	80%, no deductible
Major Medical Expenses (includes office visits, outpatient X-ray and lab and other outpatient care)	90% after deductible	70% after deductible
Chiropractic Care (annual maximum 30 visits) 30 visits in a calendar year	90% after deductible	70% after deductible
Chemical Dependency/Substance Abuse Care Inpatient (up to 30 days per confinement, 90 days lifetime maximum)	90% after deductible	70% after deductible
Outpatient (annual maximum $3,000)	90% after deductible	70% after deductible
Prescription Drugs Pharmacy: 34-day supply per prescription	From a Medco retail pharmacy: You pay $5 for generic, $10 for Preferred Brand and $25 for Non-Preferred Brand. From non-network retail pharmacy: You pay as noted above plus the amount of the charge above the Medco price for the same drug.	
Mail Service: 90-day supply per prescription	From Medco mail service: You pay $15 for Generic, $25 for Preferred Brand and $62.50 for Non-Preferred Brand.	
Prescription Annual Out-of-Pocket Maximum	There is No Annual Out-of-Pocket Maximum for Prescription Drug	
The Cost of Your Coverage	Your required contributions will be deducted from your paycheck on a pre-tax basis, unless you request otherwise. The Company may establish contribution amounts on an annual basis. Contact your Human Resources Representative for more information.	

Note: PPO network providers agree to pre-negotiated fixed charges; benefits for other providers are limited to reasonable and customary charges. Charges above reasonable and customary levels are not paid by the Plan.

Benefits are reduced for hospital admissions and certain other types of services if the treatment is not pre-certified through the Utilization Review Program.

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Gold Plan

Annual Deductible (excluding prescription drugs)	$200 per person, $400 family limit	
Annual Out-of-Pocket Maximum (excluding prescription drugs)	$1,500 per person, $3,000 family limit	
Lifetime Maximum (excluding prescription drugs)	$2 million	
	PPO Network	**Non-Network**
Hospital Care Inpatient and outpatient (for surgery and certain emergency services)	85% after deductible	65% after deductible
Medical Surgical Care (physician's services for surgery, inpatient care, and certain outpatient services)	85% after deductible	65% after deductible
Preventive Care (annual maximum $400 per person)	100%, no deductible	80%, no deductible
Major Medical Expenses (includes office visits, outpatient X-ray and lab and other outpatient care)	85% after deductible	65% after deductible
Chiropractic Care (annual maximum 30 visits) 30 visits in a calendar year	85% after deductible	65% after deductible
Chemical Dependency/Substance Abuse Care Inpatient (up to 30 days per confinement, 90 days lifetime maximum)	85% after deductible	65% after deductible
Outpatient (annual maximum $3,000)	85% after deductible	65% after deductible
Prescription Drugs Pharmacy: 34-day supply per prescription	From a Medco retail pharmacy: You pay $7 or 10% (whichever is greater) for generic, $15 or 20% (whichever is greater) for Preferred Brand and $30 or 30% (whichever is greater) for Non-Preferred Brand. From non-network retail pharmacy: You pay as noted above plus the amount of the charge above the Medco price for the same drug.	
Mail Service: 90-day supply per prescription	From Medco mail service: You pay $17.50 for Generic, $37.50 for Preferred Brand and $75 for Non-Preferred Brand.	
Prescription Annual Out-of-Pocket Maximum	There is No Annual Out-of-Pocket Maximum for Prescription Drug	
The Cost of Your Coverage	Your required contributions will be deducted from your paycheck on a pre-tax basis, unless you request otherwise. The Company may establish contribution amounts on an annual basis. Contact your Human Resources Representative for more information.	

Note: PPO network providers agree to pre-negotiated fixed charges; benefits for other providers are limited to reasonable and customary charges. Charges above reasonable and customary levels are not paid by the Plan.

Benefits are reduced for hospital admissions and certain other types of services if the treatment is not pre-certified through the Utilization Review Program.

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Silver Plan		
Annual Deductible (excluding prescription drugs)	$500 per person, $1,000 family limit	
Annual Out-of-Pocket Maximum (excluding prescription drugs)	$3,000 per person, $6,000 family limit	
Lifetime Maximum (excluding prescription drugs)	$2 million	
	PPO Network	**Non-Network**
Hospital Care Inpatient and outpatient (for surgery and certain emergency services)	80% after deductible	60% after deductible
Medical Surgical Care (physician's services for surgery, inpatient care, and certain outpatient services)	80% after deductible	60% after deductible
Preventive Care (annual maximum $400 per person)	100%, no deductible	80%, no deductible
Major Medical Expenses (includes office visits, outpatient X-ray and lab and other outpatient care)	80% after deductible	60% after deductible
Chiropractic Care (annual maximum 30 visits) 30 visits in a calendar year	80% after deductible	60% after deductible
Chemical Dependency/Substance Abuse Care Inpatient (up to 30 days per confinement, 90 days lifetime maximum)	80% after deductible	60% after deductible
Outpatient (annual maximum $3,000)	80% after deductible	60% after deductible
Prescription Drugs Pharmacy: 34-day supply per prescription	From a Medco retail pharmacy: You pay $7 or 20% (whichever is greater) for generic, $20 or 30% (whichever is greater) for Preferred Brand and $40 or 40% (whichever is greater) for Non-Preferred Brand. From non-network retail pharmacy: You pay as noted above plus the amount of the charge above the Medco price for the same drug.	
Mail Service: 90-day supply per prescription	From Medco mail service: You pay $17.50 for Generic, $50 for Preferred Brand and $100 for Non-Preferred Brand.	
Prescription Annual Out-of-Pocket Maximum	There is No Annual Out-of-Pocket Maximum for Prescription Drug	
The Cost of Your Coverage	Your required contributions will be deducted from your paycheck on a pre-tax basis, unless you request otherwise. The Company may establish contribution amounts on an annual basis. Contact your Human Resources Representative for more information.	

Note: PPO network providers agree to pre-negotiated fixed charges; benefits for other providers are limited to reasonable and customary charges. Charges above reasonable and customary levels are not paid by the Plan.

Benefits are reduced for hospital admissions and certain other types of services if the treatment is not pre-certified through the Utilization Review Program.

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Helpful Information

PPO networks

The PPO network for your coverage is Aetna. You may access the network on the web at http://benefits.fiservhealth.com and click on the link, Aetna Signature Network for information regarding providers that are in the network.).

For transplant services, Aetna IOE Transplant Network is also available.

Filing medical claims

PPO providers submit claims directly to the Plan. For non-network providers, obtain a claim form from your Human Resources Representative and submit a claim to the following address:

- Fiserv Health - Harrington Benefit Services, P.O. Box 700, Pueblo, CO 81002-0700.

Questions about medical benefits or claim payments

Call or write to the Claims Administrator at Fiserv Health - Harrington Benefit Services, Inc., P.O. Box 700, Pueblo, CO 81002-0700. Telephone toll-free 1-800-972-3023. Website is http://benefits.fiservhealth.com.

Utilization Review Program

All hospital admissions and certain types of outpatient medical services must be reviewed under the Utilization Review Program. To contact the Utilization Review Program, call Harrington toll-free at 1-800-972-3023. Your benefits are reduced if you do not contact the Utilization Review Program for pre-certification before non-emergency treatment.

Prescriptions from Medco participating pharmacies

Medco pharmacies have agreed to preferred pricing. No claims to file. Plan pays providers directly.

Prescriptions from non-network pharmacies

Obtain a Medco prescription drug claim form from your Human Resources Representative and submit a claim to get updated address.

Questions about prescription drug benefits, claim payments, or Medco participating pharmacies

Call Medco at 1-800-705-3224 or visit their website at www.medco.com.

Medco Mail Service Program

You may have prescription drugs mailed to your home. Obtain a Medco mail order envelope and send it, along with your prescription and co-payment, to Medco Health Solutions of Net Park, P.O. Box 30493, Tampa, FL 33630-3493. For questions, call Medco at 1-800-705-3224.

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Preferred Provider Organization (PPO) Coverage

To reduce costs for both you and the Company, employees in most areas have the opportunity to receive care from a preferred provider organization (PPO). A PPO is a group of health care providers that have agreed to charge predetermined rates for services in exchange for increased patient volume. PPOs have been incorporated into our Medical Plan in an effort to help contain costs. The Plan allows you to choose any network provider, yet gives you the freedom to choose a non-network provider if you desire. However, the Plan will pay a higher percentage of your costs if you choose a network provider.

You may use any qualified provider you choose, whether network or non-network, to receive your health care and still receive benefits from the Plan. However, your cost will be lower when you use PPO network providers, although the higher network level of benefits will apply when you receive emergency care from non-network providers. Also, in most cases, you generally will have no claim forms to file. If you choose to use a non-network provider, you must file claim forms and you will be responsible for any charges that exceed reasonable and customary limits. A provider directory is furnished automatically at no cost to you. You may also obtain a directory from your Human Resources Representative and/or visit the PPO's website.

If you use an in-network facility and physician services for a given procedure, any assistant surgeon, anesthesiologist, radiologist, and pathologist charges in connection with that procedure will be payable at the in-network level of benefits even if rendered by non-network providers. Reasonable and customary charges will be reimbursed at in-network benefit levels but may be subject to balance billing by non-network providers.

If a PPO physician refers you to a non-network physician, claims will be processed at the in-network rate as long as the care is medically necessary and cannot be performed by a network provider in your area.

PPOs are not applicable for Medicare eligible participants.

PPO Provider Comparison	
PPO Network Providers	**Non-Network Providers**
• Discounted charges – no balance billing	• You pay charges above reasonable and customary limits
• Company pays more of your expenses	• Company pays less of your expenses
• Provider files claim for you	• You must file claim form

Out-Of-Area Coverage

Most employees will have convenient access to PPO network providers. However, if you reside in an area where no PPO network providers are located, you will still receive network benefits for all covered services. However, in order to be eligible for these benefits, you must contact your Human Resources Representative so that your out-of-area coverage can be verified and your eligibility records can be adjusted. All precertification requirements for the Medical Plan still apply. In addition, you must file claim forms and you will be responsible for any charges that exceed reasonable and customary.

If you are traveling outside the network area and you need emergency care, you will receive network-level benefits for services from any qualified provider, network or non-network.

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The Deductible

Your deductible is the initial amount of covered expenses you must pay each calendar year before the Plan will pay benefits for most medical services and supplies. Your deductible amount is shown in the Medical Plan summary chart. Preventive care and prescription drugs are covered without a deductible.

Special features include the following:

- Your deductible may be satisfied with a combination of network and non-network expenses.
- The deductible must be satisfied with expenses incurred in the current calendar year.

Annual Out-Of-Pocket Maximum

If your share of covered medical expenses (coinsurance) for one person reaches the individual out-of-pocket maximum in one calendar year, the Plan pays 100% of any additional covered expenses incurred by that person for the rest of that year. The individual out-of-pocket maximum amount is shown in the Medical Plan summary chart.

If your share of covered medical expenses (coinsurance) for all covered family members combined reaches the family out-of-pocket maximum in one calendar year, the plan pays 100% of any additional covered expenses incurred by any family member for the rest of that year. The family out-of-pocket maximum amount is shown in the Medical Plan summary chart.

The out-of-pocket maximum does **not** apply to:

- Expenses that are not covered by the Medical Plan, such as charges in excess of reasonable and customary limits, other plan maximums and/or other non-covered services.
- Penalties for not complying with the Utilization Review Program.
- Prescription drug expenses. (See *Prescription Drug Benefit* for information about the separate annual out-of-pocket maximum for prescription drugs.)
- Chemical Dependency/Substance Abuse expenses.

Lifetime Plan Maximum

Plan benefits are limited to a lifetime maximum of $2 million for each covered person.

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 Plan Administrator based on the usual fees charged 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 Plan Administrator will determine the eligible expense.

PPO providers' charges will never exceed the reasonable and customary amount. Any portion of the covered charges by a non-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.

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Necessary Medical Care

You can receive benefits only for charges incurred by a covered individual for the services and supplies listed in the following sections. These services and supplies must be prescribed or performed by a physician or other qualified medical provider for the medically necessary treatment of a non-occupational sickness or injury or covered preventive care, and provided based on generally accepted medical practice. The amount the Plan pays for each type of covered expense is shown in the Medical Plan summary chart.

Utilization Review Program

The Company requires that you precertify all hospital admissions and certain other outpatient procedures. This Utilization Review Program is designed to help you and the Company manage costs by reviewing, in advance, the health care services you receive. Physicians from all medical specialties, psychologists, registered nurses and other health care professionals review the medical necessity and appropriate setting for your care.

If you don't contact the Utilization Review Program before you receive the health care services listed in the following sections, you will pay an additional $150 of the charges, which will not count toward your deductible or out-of-pocket maximum. Also, if the Utilization Review Program determines that your care is not medically necessary, the Plan will not pay benefits for your expenses.

Pre-certification does not apply to Medicare eligible participants.

Hospitalization

If your physician recommends hospitalization, follow these steps:

- Call the pre-certification number shown on your Medical Plan identification card **(at least 10 business days before you are scheduled to receive care)** for hospitalization.
- For situations that require immediate hospitalization, you, your doctor or a family member must call within 48 hours (or the next business day) after your hospital admission.

Situations that require immediate hospitalization include accidental injuries or medical conditions that are life-threatening or may cause serious injury to bodily functions and require you or a family member to seek immediate medical care. Some examples include heart attacks, car accidents, loss of consciousness or respiration and other similarly acute conditions.

Other Services Requiring Pre-certification

If your physician recommends the services listed below, follow these steps:

- Call the pre-certification number shown on your Medical Plan identification card **at least 10 business days before you are scheduled to receive care** for the following:
  - MRI
  - Home Health
  - Skilled Nursing
  - Convalescent care
  - Hospice

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- ➢ Durable Medical Equipment (DME) in excess of $1,000

- Call the pre-certification number shown on your Medical Plan identification card before the first visit before receiving care for the following:
  - ➢ Physical therapy
  - ➢ Speech therapy
  - ➢ Occupational therapy
  - ➢ Mental health care
  - ➢ Chemical dependency/substance abuse care

in first document, chiropractic was listed. This one isn't.

It is recommended that you call for pre-certification before any elective surgery, to be sure that your treatment will be considered medically necessary by the Plan.

Maternity Care

For maternity care, follow these steps:

- To receive information about how you can participate in the prenatal care program, you may call the pre-certification number shown on your Medical Plan identification card as soon as you or your spouse begins to receive regular maternity care. This is a voluntary program designed to identify and prevent premature births. It is recommended that you call no later than the seventh month of pregnancy. More information about this program is included under Maternity Care.
- You are not required to call for pre-certification for a hospital stay that is less than 48 hours following a normal delivery, or 96 hours following a cesarean section. However, if the mother or newborn must remain in the hospital for longer than these periods, you must call the pre-certification number.

How The Utilization Review Program Works

The Utilization Review specialist will ask you for the following information:

- The name and location of your employer.
- Your name and Social Security number.
- The patient's name, birth date, address and telephone number.
- The admitting physician's name, address and telephone number.
- The hospital name, address and telephone number.
- The proposed date of hospitalization and/or surgery or other care.
- The diagnosis.

A qualified health care professional will contact your physician to review your proposed care and evaluate the medical necessity. You, your physician and/or the hospital will be notified of the decision in writing.

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How Your Benefits Are Affected

If you do not follow the Utilization Review Program guidelines, your benefits will be limited as follows:

- If you do not call the Utilization Review Program for pre-certification when required, you will pay an additional $150 of your health care expenses. This $150 penalty will not apply to your deductible or out-of-pocket maximum under the Plan.
- Hospital room and board benefits will **not** be paid in the following circumstances:
  - If you proceed with a hospital stay or treatment which the Utilization Review Program cannot confirm as medically necessary.
  - If you proceed with an inpatient admission and treatment could have been provided on an outpatient basis.
  - If your hospital stay exceeds the number of days that have been approved.
- No benefits will be paid by the Plan for the following services if you proceed with a treatment program that the Utilization Review Program cannot confirm as medically necessary:
  - Diagnostic procedures that require pre-certification.
  - Outpatient mental health or chemical dependency/substance abuse visits, physical therapy, speech therapy, and occupational therapy.
  - Home health care, skilled nursing services, hospice care, durable medical equipment in excess of $1,000, or convalescent facility care (custodial care is not covered).

The penalties or benefit reduction amount you experience for not following the Utilization Review Program and guidelines will be in addition to any regular Plan deductibles or co-payments for that expense.

Coordinated Care/Individual Case Management

When a sickness or injury is severe enough to require more intensive or prolonged medical treatment, the Coordinated Care/Individual Case Management Program is available to help you through the medical care system.

A case manager will help to ensure that you receive the right care, in the most appropriate setting at the right price. The case manager can coordinate the efforts of the various health care professionals involved in your case, act as your advocate, help you locate special settings for continued care, help arrange the transfer, and assist in the handling of arrangements for your discharge from the hospital.

To access this program, you, a family member or your physician may call the pre-certification number shown on your Medical Plan identification card.

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Hospital Care—Inpatient

Covered inpatient hospital care includes hospital daily room and board (up to the regular semi-private room rate), general nursing care, intensive care and the following services and supplies furnished by a hospital during confinement:

- General nursing care
- Operating, treatment and delivery rooms and equipment
- Anesthesia
- Drugs, medicines, and dressings (excluding take-home drugs, which are covered under Major Medical Services and Supplies)
- Oxygen and its administration
- Laboratory tests, X-ray and other diagnostic examinations
- Electrocardiograms
- Dressings and casts
- Administration of blood or plasma
- Special diets
- Radium therapy
- Chemotherapy
- Intravenous injections and solutions

The Utilization Review Program must be contacted 10 business days before any non-emergency admission occurs or within 48 hours (or the next business day) after an emergency admission.

Charges by a physician, the cost of blood, and treatment of chemical dependency/substance abuse are covered under different sections of the Plan.

Hospital Care—Outpatient

Covered outpatient hospital care includes:

- Charges by a hospital for outpatient treatment of an accidental injury or life-threatening emergency.
- Charges by a hospital or an ambulatory surgical center in connection with outpatient surgery. Ambulatory surgical center services are eligible only if provided within 48 hours from and in connection with a surgical procedure, or within 10 consecutive days before diagnostic procedures are scheduled to take place.

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Medical Surgical Care

Covered medical surgical care includes the following:

- Physician's services for hospital visits during a covered hospital confinement.
- Diagnostic X-rays, laboratory examinations and interpretations provided during a covered hospital admission or in connection with outpatient surgery, accidental injury and life-threatening emergency.
- Physician's services for surgery and anesthesia services performed in or out of the hospital, including:
    - Surgeon's fees (including endoscopic examinations).
    - When medically necessary, charges for an assistant surgeon if services of interns or resident physicians are not available.
    - Administration of anesthesia by a physician other than the operating surgeon or his or her assistant (local anesthesia is not included).
    - Oral surgery which is necessary as the result of a tumor.
    - Sterilization surgery (reversal of elective sterilization surgery is not covered).
    - Cosmetic or reconstructive surgery, when used to correct a birth defect for a child, replace diseased tissue, or correct a defect caused by an accident. The surgery must be performed within one year of the birth, removal of diseased tissue, or accident, unless the surgery must be delayed because of the patient's physical condition and it is performed as soon as medically necessary and appropriate. In the case of a mastectomy covered by the Plan, reconstructive surgery and surgery on the unaffected breast to produce a symmetrical appearance, including all complications, will also be covered.
- Physician's services or ambulance charges for emergency treatment of accidental injuries within 48 hours of the accident, or for life-threatening emergencies.
- Physician's services for radiation therapy or chemotherapy received while a hospital inpatient. (Inpatient hospital charges are covered under the Hospital Care Inpatient Benefit. All outpatient charges for radiation therapy or chemotherapy are covered under Major Medical Services and Supplies.)
- A second surgical opinion by a board certified specialist. The opinion must be given prior to the date surgery is scheduled to be performed and must be rendered by a board certified specialist other than the surgeon who is to perform the operation.

Transplant Services

The Plan will cover eligible expenses related to medically necessary, non-experimental organ transplants. If you or an eligible family member requires a transplant, you are encouraged to utilize the Aetna IOE Transplant Network. The Aetna IOE Transplant Network facilities have a proven track record of successful outcomes and experience in specific organ transplants. When approved transplant services are performed at a Aetna IOE Transplant Network facility, eligible benefits will be paid at the in-network rate.

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Approved transplant services are covered health services and supplies provided at a Aetna IOE Transplant Network transplant facility which are related to transplantation and approved in writing by the Plan prior to the delivery of any services. Such services include, but are not limited to, hospital charges, physician charges, and ancillary services rendered for the following transplants:

- Heart
- Lung
- Heart/Lung
- Kidney
- Pancreas
- Kidney/Pancreas
- Liver
- Allogeneic Bone Marrow
- Autologous Bone Marrow
- Any other transplant determined by the Plan to be medically effective.

When approved transplant services are performed at a Aetna IOE Transplant Network facility, the Plan will cover some travel expenses. If the transplant patient resides more than 100 miles from the Aetna IOE Transplant Network, the Plan will reimburse reasonable actual travel, lodging, and meal expenses for the patient and one companion to accompany the patient not to exceed $200/day. These travel expenses are only eligible to those who utilize the Aetna IOE Transplant Network for approved transplant services.

Contact the Utilization Review Program as soon as you are aware that a transplant is needed. The Utilization Review case manager will coordinate with Aetna IOE Transplant Network.

Mental Health Care

Covered mental health care expenses include the following:

- Inpatient hospital and physician's charges during a covered period of confinement are eligible. All inpatient treatment must be pre-approved through the Utilization Review Program.
- Outpatient charges by a hospital, physician or other qualified facility, provided the treatment is approved through the Utilization Review Program **before the first visit.**

Chemical Dependency/Substance Abuse Care

Covered chemical dependency/substance abuse care expenses include the following:

- Inpatient hospital charges are eligible for up to 30 days per confinement, but no more than 90 days per lifetime. Physician's charges during a covered period of confinement are also eligible. All inpatient treatment must be pre-approved through the Utilization Review Program.
- Outpatient charges by a hospital, physician or other qualified facility, provided the treatment is approved through the Utilization Review Program **before the first visit.** There is a maximum benefit of $3,000 for all outpatient charges incurred by one person in one calendar year. See the Medical Plan summary chart.

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Preventive Care

Covered preventive care expenses include the following:

- Annual physical exam.
- Bloodwork analysis.
- Annual mammogram after age 35.
- Annual pap smear and pelvic exam.
- Routine sigmoidoscopy on or after age 50.
- Routine colonoscopy.
- Immunizations.
- Annual prostate exam and prostate specific antigen test (PSA) after age 40.
- Rectal exam and fecal occult blood test.
- Well child care for children under age 6.
- Office visits related to the above.

For these preventive care expenses, you can receive up to $400 in benefits per person each calendar year with no deductible.

The following charges will be eligible for "Major Medical" benefits (see *Major Medical Services And Supplies* below), subject to the deductible and regular Plan percentage rates:

- Charges for listed preventive care services in excess of the $400 annual maximum preventive care benefit.
- Pap tests, sigmoidoscopies, colonoscopies, mammograms or prostate exams recommended by your physician at earlier ages or more frequently than provided under preventive care benefits because of your family history or other medical conditions.
- Medically necessary diagnostic testing required for existing conditions or their symptoms.

Major Medical Services And Supplies

Major medical benefits are provided for office visits, outpatient care and certain other expenses that are not eligible under other sections of the Plan.

This provision does not include prescription drugs or any services and supplies that are covered under other sections of this Plan.

Covered major medical services and supplies include the following items:

- **PHYSICIANS' SERVICES,** including specialists, for visits in the physician's office or elsewhere.
- **DIAGNOSTIC X-RAY OR LABORATORY TESTS** performed in the physician's office, the outpatient department of a hospital or in a separate testing facility.
- **SKILLED NURSING SERVICES** (other than the services of a nurse who ordinarily lives in your home or who is a member of your immediate family) **for care that is approved through the Utilization Review Program.**

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- **AMBULANCE** service to and from the nearest facility where care can be given.
- **HOSPITAL CHARGES FOR SEMI-PRIVATE ROOM AND BOARD** and other hospital services and supplies used during confinement (after the hospital Inpatient benefit coverage has been exhausted).
- **OUTPATIENT HOSPITAL SERVICES AND SUPPLIES** that are not covered by hospital outpatient benefits, such as outpatient chemotherapy, radiation therapy and kidney dialysis. Benefits for other therapy services may be limited or require approval by the Utilization Review Program.
- **PHYSICAL THERAPY** prescribed by your physician and performed by a qualified physiotherapist. **The Utilization Review Program must approve the medical necessity of the treatment prior to the first visit.** Benefits will end when the therapeutic goals of the treatment program have been achieved and/or when continued measurable progress is not expected.
- **OCCUPATIONAL THERAPY** prescribed by your physician. **The Utilization Review Program must approve the medical necessity of the treatment prior to the first visit.** Work-related expenses are not covered.
- **THERAPY BY A QUALIFIED SPEECH THERAPIST** to restore impaired speech due to stroke, surgery, accident or congenital defects. Treatment of developmental delays in learning to talk and educational services are not covered. **The Utilization Review Program must approve the medical necessity of the treatment prior to the first visit.**
- **CARDIAC REHABILITATION** for up to 12 weeks, provided the therapy is provided within 12 months following an acute myocardial infarction (heart attack), coronary bypass surgery or stable angina pectoris (heart-related chest pains). The rehabilitation program must be performed in the appropriate setting by a qualified provider.
- **OXYGEN AND EQUIPMENT** for its administration.
- **SERVICES OF AN INHALATION THERAPIST** in the patient's home, under the direction of the attending physician, if medically necessary.
- **PREVENTIVE CARE SERVICES** as described under the section *Preventive Care.*
- **SURGICAL SUPPLIES.**
- **OSTOMY SUPPLIES.**
- **DIABETIC SUPPLIES** (other than test strips, syringes, and needles, which are covered under the Prescription Drug Plan).
- Rental or purchase, if determined to be more cost effective by the Claims Administrator, of **DURABLE MEDICAL 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 and the appliance is received within 12 months of the loss. The Plan covers replacement when necessary if a change in condition occurs.
- **A BRACE OR TRUSS** (including custom-made shoes if part of the brace, custom-made orthotic appliances for the feet, and surgical stockings if medically necessary).

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- **RADIATION THERAPY,** X-ray, radon, radium and radioactive isotopes provided on an outpatient basis.
- **CHEMOTHERAPY** provided on an outpatient basis.
- **WIGS OR HAIRPIECES,** if needed as a result of radiation or chemotherapy.
- **INITIAL LENS REPLACEMENT** following cataract surgery performed while covered under the Plan.
- **CONVALESCENT FACILITY CARE** if admitted to a covered facility immediately following a hospital confinement of at least five days. **Care must be approved in advance through the Utilization Review program and must be necessary in lieu of continued hospital stay.** Charges for custodial care are not covered.
- **DENTAL TREATMENT** for accidental injury to sound natural teeth.
- Charges for **PROCUREMENT OF A TRANSPLANTABLE HUMAN ORGAN,** including surgery to remove an organ from a donor, transportation and storage, **provided the transplant is approved by the Utilization Review Program and is covered by the Plan.**
- **VENIPUNTURE** charges are eligible for payment under the Medical Plan.

Home Health Care And Hospice Care

After any applicable deductible, the Plan pays a percentage of covered charges (refer to the Medical Plan Summary chart)of reasonable and customary charges for home health care and hospice care for up to 60 days per calendar year for home health and up to 120 days lifetime for hospice. For home health care, one day is equivalent to 8 hours of care.

The care must be provided by a home health care agency or hospice care program that is federally certified or affiliated with a hospital. Also, the care must be medically necessary and pre-approved through the Utilization Review Program as an alternative to hospitalization. Coverage may extend past the maximums only if recommended/approved by case management. Charges for custodial care are not covered.

Chiropractic Care

Covered chiropractic care expenses include services prescribed or performed by a doctor of chiropractic (D.C.). The Plan will cover a maximum of 30 visits each calendar year. Refer to the Medical Plan summary chart for reimbursement levels.

Hearing Care

After any applicable deductible the Plan pays covered hearing care expenses at a percentage of covered charges (refer to the Medical Plan Summary chart) of the reasonable and customary charge, for one hearing aid per ear every two years. The hearing aid must be recommended by a physician. Benefits will be provided for replacement hearing aids only if a new aid is needed because of a change in the patient's condition or if the hearing aid no longer functions properly. Benefits for necessary repair and maintenance, except the replacement of batteries, will be provided after the expiration of the warranty period. Hearing Care services that are covered by Workers' Compensation are not covered under the medical plan.

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Maternity Care

Covered maternity care for a covered employee or dependent is covered in the same way as a sickness. However:

- The limitation for pre-existing conditions does not apply to pregnancy.
- Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of these periods. Nothing precludes the mother or newborn child from being discharged earlier if the mother and attending physician agree to the discharge. **If the mother or newborn must remain in the hospital for longer than these periods, you must call the Utilization Review Program for pre-certification.**

Termination of pregnancy is covered only when necessary to protect the life of the mother.

Prenatal Care Program

Maternity care includes a program to help you avoid the medical complications, health risks and expenses associated with premature birth. Designed to identify those at risk for premature delivery, the program offers the information and support needed to delay and even prevent pre-term labor and delivery. In addition to working with you and your physician, the program provides practical advice and direction should preterm labor begin.

To participate in the prenatal care program, you or your physician simply contacts the Utilization Review Program as soon as you begin receiving treatment, but no later than the seventh month of pregnancy. When you call, you will be asked several questions about yourself and your medical history in order to perform a risk assessment. If this preliminary screening indicates a risk for premature delivery, you and your physician will be asked additional questions in order to identify any problem areas or special needs you may have.

If your responses confirm the risk for premature delivery, a registered nurse will be assigned to your case to work with you throughout your pregnancy. Acting as your advocate, the nurse will teach you how to recognize the signs of premature labor and understand what to do if premature labor occurs. In addition, the nurse will be available to answer your questions, direct you to medical services and, together with you and your physician, help you develop a home care plan to reduce the risks of premature delivery.

Newborn Care

Charges incurred by a covered newborn child for the hospital nursery and physician visits while both the mother and child are confined will be paid as part of the mother's claim. The baby's other charges will be subject to the annual deductible and all other provisions of the Plan.

Well child care is covered up to age 6 as described under *Preventive Care* and *Major Medical Services and Supplies.*

Charges for a newborn of your dependent child, whether your dependent child is married or unmarried, are not covered.

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The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act, which was effective January 1, 1999, requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery after a mastectomy.

Under this federal law, group health plans and health insurance issuers that provide medical and surgical benefits for mastectomy must, under federal law, provide certain additional benefits related to breast reconstruction. In the case of a covered individual who is receiving mastectomy benefits and who elects breast reconstruction in connection with a mastectomy, this must include coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications in all stages of the mastectomy, including lymphedemas.

The law calls for these benefits to be provided in a manner determined through consultation between the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan.

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Medical Expenses Not Covered

Certain medical expenses are **not** covered by the Plan including the following, among others:

- **EMERGENCY ROOM** expenses for care that is routine or for non-emergency services.
- **ACUPUNCTURE** services.
- **DENTAL WORK** or any treatment of the teeth or tissues supporting the teeth, such as, but not limited to, orthodontics, bridgework/dentures, crowns or equilibrations, whether done for dental or medical reasons. Treatment of accidental injury will be covered under *Major Medical Services and Supplies.* Inpatient hospital charges when medically necessary because of a concurrent medical condition will be covered under *Hospital Care—Inpatient,* and oral surgery for tumors will be covered under *Medical Surgical Care.* For information about benefits for dental care, see the Dental Plan section of your binder.
- Non-surgical treatment of **TEMPOROMANDIBULAR JOINT DYSFUNCTION** (TMJ).
- Surgery for the purpose of **FITTING OR WEARING DENTURES OR DENTAL IMPLANTS.**
- Services or supplies that are **NOT MEDICALLY NECESSARY,** as defined by the Plan.
- Services in **EXCESS OF REASONABLE AND CUSTOMARY CHARGES.**
- **EYEGLASSES, CONTACT LENSES** or examinations for prescriptions or fittings, except following cataract surgery as provided under *Major Medical Services And Supplies* (see the Vision Care Plan for additional coverage information).
- Services for **EYE EXERCISES** and surgical correction of eye refraction such as **LASIK, RADIAL KERATOTOMY OR KERATOPLASTY.**
- Charges that you or your dependents are **NOT REQUIRED TO PAY** or 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 for such benefits. Refer to the *Right To Recovery/Subrogation* section).
- Except as required by law, services which may be obtained with or without cost under a **GOVERNMENT PROGRAM**.
- Diseases contracted or injuries or conditions sustained as a result of **WAR, OR ANY ACT OF WAR** (declared or undeclared), insurrection, riot or release of nuclear energy.
- **PRE-EXISTING** illness or injury during the first 12 months of coverage, except as described under the *Pre-existing Conditions* section.
- Charges for education, training and room and board while you or your dependents are confined to 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 **RESIDENTIAL TREATMENT FACILITIES.**

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- Charges **INCURRED MORE THAN ONE YEAR BEFORE A CLAIM FOR THE EXPENSES IS SUBMITTED TO THE PLAN.**
- **TRAVEL** expenses, except ambulance service and those related to a transplant at a Aetna IOE Transplant Network facility, as provided under the terms of the Plan.
- **HYPNOSIS.**
- Naturopathic or **HOLISTIC** services.
- **MASSAGE** therapy or rolfing.
- Charges for **TELEPHONE CONVERSATIONS** with a physician in place of an office visit, for writing a prescription, for **MEDICAL SUMMARIES,** and for preparing **MEDICAL INVOICES.**
- **ENCOUNTER OR SELF-IMPROVEMENT** group therapy.
- Any services that **DO NOT REQUIRE THE SKILLS OF A SPECIFICALLY TRAINED MEDICAL PROFESSIONAL.**
- Services for **ROUTINE FOOT CARE,** including but not limited to treatment of corns and calluses, flat feet, and non-surgical treatment of bunions.
- **CORRECTIVE SHOES** (unless custom-made and attached to a brace) or orthotics (unless custom-made).
- Physical or speech therapy for treatment of a **DEVELOPMENTAL DELAY** or for educational purposes.
- **WIGS OR HAIRPIECES,** when not associated with chemotherapy or radiation.
- **PERSONAL COMFORT ITEMS,** including but not limited to television, telephone and guest meals provided while confined to a hospital.
- Charges incurred for care, services, or treatment required as a result of **COMPLICATIONS FROM ANY SERVICES OR TREATMENT EXCLUDED UNDER THE PLAN.**
- Any other charges, services or procedures **NOT SPECIFICALLY LISTED** as covered in any section of this Plan.

Also, with the advancement in today's technology, new procedures are introduced to treat diseases or symptoms of diseases that were never treated in the past. New procedures are not automatically covered by the Plan.

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Prescription Drug Benefit

If you participate in the Company's Medical Plan, you may purchase prescription drugs using your drug card. Prescriptions may be purchased from a Medco participating pharmacy or another pharmacy. Medco pharmacies agree to provide preferred pricing to participants in the Company Medical Plan. The Medco network includes more than 55,000 pharmacies nationwide. You may call Medco to find out about Medco network pharmacies in your area at 1-877-705-3224 or visit their website at www.medco.com.

Mandatory Generic Drug Provision

A generic drug is the chemically identical copy of a brand-name prescription drug and costs about 50% less. Coverage under the Medco card program and the Medco mail order program is limited to generic drugs when they are available.

If you or your physician requests a brand-name drug when a generic is available, you will pay the applicable preferred or non-preferred co-pay.

Using Your Medco Drug Card

The maximum amount you may purchase at a retail pharmacy at one time for each prescription is a 34-day supply.

Using Medco Pharmacies

If you use your drug card at a participating **Medco** pharmacy, you will pay based on the Plan that you are enrolled:

Plan	Generic	Preferred Brand	Non-Preferred Brand
Platinum	$5	$10	$25
Gold	$7 or 10% (whichever is greater)	$15 or 20% (whichever is greater)	$30 or 30% (whichever is greater)
Silver	$7 or 20% (whichever is greater)	$20 or 30% (whichever is greater)	$40 or 40% (whichever is greater)

When you use your drug card at a participating Medco pharmacy, you do not have to file a claim for benefits. You simply pay the pharmacy your share of the cost when your prescription is filled. If you do not use your drug card, you must file a prescription drug claim with Medco.

Using Non-Participating Pharmacies

If you have a prescription filled at a non-participating pharmacy, you will have to pay the full cost of the drug and file a claim with Medco for reimbursement. Reimbursement will be based on the price a Medco pharmacy would charge for the same drug (or the generic equivalent, if available). You will pay the difference in cost between your pharmacy's charge and the Medco price, in addition to your co-payment.

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Medco Mail Service Drug Program

Mail service through Medco is available in addition to the prescription card plan. Mail service is a more effective way for you to receive up to a 90-day supply of long-term therapy drugs. (These are drugs taken on a regular basis for chronic conditions such as high blood pressure, arthritis and diabetes). Your prescriptions will be filled within 48 hours from the date received and then mailed directly to your home.

The co-pay for mail order prescriptions is based on the Plan of which you are enrolled:

Plan	Generic	Preferred Brand	Non-Preferred Brand
Platinum Plan	$15	$25	$62.50
Gold Plan	$17.50	$37.50	$75
Silver Plan	$17.50	$50	$100

To use the mail service program, you simply send your prescription in a Medco mail order envelope with the appropriate co-payment to Medco at the address shown on the envelope.

Covered Prescription Drugs

Covered prescription drugs include medicine required by federal law to be dispensed only with an authorized prescription. Injectable insulin, diabetic test strips, needles and syringes needed to administer insulin are also covered.

The Plan also provides coverage for prescription smoking cessation products, up to three consecutive months. The Plan will cover one treatment program per calendar year. Note that if a smoking cessation product becomes available without a prescription, it will no longer be covered by the Plan.

The drugs/devices listed below are **not** covered through the drug card or mail service programs:

- Certain genetically engineered drugs.
- Fertility drugs.
- Devices and appliances.
- Prescriptions covered without charge under federal, state or local programs, to include Workers' Compensation.
- Any charge for the administration of a drug or insulin.
- Investigational or experimental drugs.
- Unauthorized refills.
- Immunization agents, biological sera, blood or plasma.
- Medication for an eligible employee or dependent confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity.
- Medication prescribed to treat a condition that is not approved by the FDA.

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- Nutritional and diet supplements or programs.
- Over-the-counter drugs*.
- Drugs prescribed and distributed by your physician without charge.
- Charges for writing a prescription.
- Cosmetic products.
- Lifestyle medications (such as drugs for hair loss and erectile dysfunction).
- Expenses for which you fail to submit a claim to the Plan within one year.

***Note** that if a drug becomes available without a prescription, it will no longer be covered by the Plan. Also, with the advancement in today's technology, new medications are introduced to the market. Some of these new medications may be used to treat diseases that were never treated by medication in the past. New medication is not automatically covered by the Plan.

Formulary Program (Preferred or Non-Preferred Drug)

The Medco Formulary Program concentrates its efforts on promoting quality prescription drugs in a cost effective manner. The Medco Preferred Medication list is a listing of "preferred drugs." Medications reflected on this list are determined to be both safe and effective by Medco's Pharmacy and Therapeutic Committee. Often times, alternate drugs are available with the same therapeutic effect, yet are less costly for both you and the Company.

The Company encourages you to discuss the preferred/formulary medication list with your treating physician. You and your physician may visit Medco's website for the full formulary listing at www.medco.com. The listing is updated regularly.

Note that simply because a drug is reflected on the formulary list does not necessarily mean that it is an eligible expense under the Company's Plan.

Specialty Injectable Medications

Specialty injectable medications are medications that need to be injected (rather than swallowed or applied topically) to be effective. These are biotech drugs that are used to treat chronic diseases. In general, these medications are not covered under the medical plan and must be purchased through the prescription drug benefit. In addition, some medications are subject to Prior Authorization (PA) and Quantity Level Limits (QLL). Drugs in the injectable, PA and QLL are subject to change as a result of a new drug introductions, new FDA indications or clinical research. Contact Medco for a current list of covered drugs.

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Prior Authorization

The Company's Prior Authorization program is administered through Medco. Medco will send a message to your dispensing pharmacist that a Prior Authorization is required to fill the prescription and to call the Medco Customer Service. Medco will first verify if the drug is covered by the Plan. If so, Medco will ask for the physician's name and phone number. Medco will contact your physician to obtain the diagnosis and other information concerning the use of the medication. If the diagnosis and/or condition(s) for use are not approved by Medco, the claim will be rejected. The following list contains the listing of drugs that are subjected to Prior Authorization. This list is current as of the time of this SPDs printing. This list is subject to change as a result of new drug introductions, new FDA indications, or new clinical research.

- Adipex (phentermine)
- Amevive
- Aranesp (darbepoetin alfa)
- Avita
- Bontril (phendimetrazine)
- Botox (Botulinum Toxin Type A)
- Didrex (benzphetamine)
- Epogen (epoetin alpha)
- Fastin (phentermine)
- Forteo
- Genotropin
- Geref (semorelin)
- Humatrope
- Increlex
- Iplex
- Meridia (sibutramine)
- Myobloc (Botulinum Toxin Type B)
- Noridtropin
- Nutropin
- Penlac Solution
- Procrit (epoetin alpha)
- Raptiva
- Retin-A
- Revatio
- Saizen
- Sanorex (mazindol)
- Serostim
- Tazorac (Tazarotene)
- Tenuate (diethylpropion)
- Tev Tropin
- Tretin X
- Xenical (orlistat)
- Xolair
- Zorbtive

Quantity Level Limits

The Company also participates in the Medco program designed to address appropriate utilization of a limited number of drugs. Medications covered in this program have set limits on the number of tablets/capsules that a participant is able to obtain within a certain defined time period. These limitations are based on the manufacturers' guidelines, testing, FDA approvals, and clinical research. For most medical conditions, it is not necessary to use a dose of medication greater than the FDA approved doses. The following list contains the most common drugs subjected to quantity level limits.

This list is current as of the time of this SPDs printing. Contact Medco for the most current list. This list is subject to change as a result of new drug introductions, new FDA indications, or new clinical research.

- Chantix
- Diflucan
- Lamisil
- Nicorette Gum/lozenge
- Nicotine Inhalation System
- Nicotine Nasal Spray
- Nicotine Transdermal Systems
- Sporanox
- Zyban

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How To File A Claim

Participating providers file their claims directly with the Plan. However, if you reside in an area where no PPO exists or if you use non-network providers, you must file a claim. Forms for filing claims may be obtained from your Human Resources Representative. In addition, you also must file a claim if you have a prescription filled at a non-participating pharmacy or if you do not use your drug card. Timely filing of your claims will ensure prompt reimbursement. You must file your claim within one year from the date the charges are incurred for the services provided. Claims filed after this date will not be accepted, and the charges will not be eligible for benefit consideration.
The following chart provides a brief summary of what you need to provide with your claim form:

Benefit	Claims Process
PPO network providers and Medco pharmacies	No claims to file. Provider is paid directly by the Plan. You are responsible for any non-covered charge, medical deductible, and/or any co-payment.
Medical expenses from non-network providers	You send medical claim form plus original receipt or bill from the provider showing the name of the patient, the diagnosis, the service or care provided and the date of care. Submit claims to the address shown on your Medical Plan ID card. You are responsible for any non-covered charge, deductible, co-payment and/or any amount above reasonable and customary.
Prescription drugs from non-network providers	You send Medco claim form plus original receipt or bill from the pharmacy showing date dispensed, drug name and cost. Submit claims to the address shown on the Medco claim form and ID card.
Medco mail service drug	You send original prescription, co-payment, and Medco mail order envelope to the program address shown on the envelope.

Benefit Payment

In most situations, benefits will be paid shortly after the claim form and the supporting material are provided. If you use a PPO provider, in most cases, benefits are paid directly to the provider.

If you use a non-PPO provider, or if you reside in an area where no network exists, payment of Plan benefits is made directly to you unless you assign benefits to the provider.

The following provisions apply to the payment of benefits:

- The Plan will not pay more than it would usually pay because you have indicated that it should pay the provider directly.
- 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 you or the person or organization that received it.
- 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, information from another group plan providing benefits and so forth.

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- If any other plan makes a payment that should have been made by this Plan under the Coordination of Benefits provision, this Plan has the right to pay the other plan any amount necessary to satisfy the terms of that provision.
- Under conditions where you normally would receive a payment from the Plan but you 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.

Contractual Arrangements With Providers

The contracts that the PPO networks have with providers and administrators may provide for additional discounts, allowances, fees, incentives, adjustments or settlements to be paid to or retained by such PPO networks. The PPO networks may retain any such payments or they may distribute or share these amounts with providers, administrators or the Company. However, all claims submitted will have co-payments, deductibles and/or coinsurance which are your responsibility, calculated without regard to such payments. Some providers and administrators may also participate in incentive and other programs, under which such providers and administrators may be entitled to additional payments for effectively managing care and/or member/provider satisfaction.

In addition, the Company's contract with Medco may provide for the sharing in manufacturers' rebates. However, the co-payments, deductibles and/or coinsurance which are your responsibility will be calculated without regard to such rebates.

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Appealing A Claim

If your claim for a benefit is denied in whole or in part, you will be notified in writing via an Explanation of Benefits or "EOB." If any part of a claim is not paid, or if you do not understand or agree with the handling of a claim, there are several things you can do to appeal the decision. Most of your questions can be answered by calling the Claims Administrator at the telephone number shown on your Medical Plan identification card. Formal claims review procedures are discussed in the *ERISA Rights* section.

Right To Recovery/Subrogation different wording from original

Conditional Payments

If you or one of your family members becomes eligible for benefits under the Plan as a result of an injury for which expenses are paid or payable by a third party, the Company may make advance expenses reimbursements to, or on behalf of you or your family member pursuant to this Plan.

Such reimbursements or payments shall be subject to the Plan's reimbursement and/or subrogation rights. However, before any such reimbursements or payments will be conditionally made, the Company may require that you or your family member execute an agreement that acknowledges and affirms (1) the conditional nature of the reimbursements or payments; and (2) the Plan's rights of reimbursement and/or subrogation.

Reimbursement

Any benefits under the Plan paid to you or your family member shall be treated as an advance expense reimbursement for any such expenses which are paid by or are payable by a third party, including, but not limited to, an award of insurance benefits, such as benefits provided by the Social Security Administration (SSA).

You agree or your family member agrees to identify potential sources of benefits or recoveries to the Plan, to apply for and notify the Plan when he or she applies for insurance benefits or any other benefits which may be available to them from a third party, and to notify the Plan when he or she receives an award of benefits or recovery as a condition to receiving any advance payments from the Plan.

Any such benefits which are awarded retroactively shall be treated as having been received by you or your family member during the entire period for which such benefits are payable and any overpayments of advance payments shall be repaid to the Plan within thirty (30) days of receiving such benefits or recoveries. If you or your family member does not repay such overpayments made by the Plan, then the Plan may suspend or reduce Plan benefits until the total amount suspended equals the total amount of the overpayment.

Subrogation

Any expenses that are paid or that are payable by third parties are excluded from coverage under the Plan. If you or your family member receives any benefits arising from an injury or illness for which you or a family member have, may have, or assert or may assert any claim or right to recovery against a third party or parties, then any advance payment or payments under this Plan for such benefits shall be made on the condition and with the understanding that this Plan is temporarily assisting the Participant until the third party pays such expenses and that the Plan will be reimbursed for such payment(s). Such reimbursement will be made by you or your family member to the extent of, but not exceeding, the total amount payable to or on behalf of you or your family member from: (1) any

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policy or contract from any insurance company or carrier (including your insurer or your family member's insurer); and/or (2) any third party, plan, or fund as a result of a judgment or settlement; and/or (3) any third party that may award such benefits, including SSA disability or old age benefits. You acknowledge and agree that this Plan will be reimbursed in full, from any partial or full recovery payable to or on behalf of you or your family member before any amounts (including attorney fees incurred by you or a covered family member) are deducted from the policy, proceeds, award of benefits, judgment, or settlement. You agree and agree on behalf of your family member to recognize the Plan's right of subrogation and reimbursement. Your or your family member's right to be made whole is superseded by the Plan's subrogation rights. These rights provide the Plan with a priority over any partial or full recovery paid by a third party or insurer to you or a covered family member relative to the injury or illness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

This Plan will be subrogated to all claims, demands, actions, and rights of recovery against any entity, including, but not limited to, third parties and insurance companies and carriers (including your insurer or your covered family member's insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation will equal the total amount paid under this Plan arising out of the injury or illness for which you or a covered family member has, may have, or asserts a cause of action. In addition, this Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights. You or your family members are responsible for all attorney's fees and court costs. The Plan will not reimburse you or your family member for any portion of these expenses. You agree and agree on behalf of your covered family member to do nothing to prejudice this Plan's right to reimbursement or subrogation. In addition, you agree and agree on behalf of your family member to cooperate fully with the Company in asserting and protecting the Plan's subrogation rights. You agree and agree on behalf of your family member to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect this Plan's subrogation rights, including, but not limited to, holding any proceeds in trust for the benefit of the Plan; distributing the proceeds to the Plan upon demand by the Plan; and refraining from making any distribution of any settlement proceeds until the Plan approves the settlement.

You agree and agree on behalf of your family member, to notify the Company, in writing, of whatever benefits are paid under this Plan that arise out of injury or illness that provides or may provide the Plan subrogation rights.

Failure to comply with these requirements by you or your family member(s) may, at the Company's discretion, result in reduction, suspension or forfeiture of benefits under this Plan.

> If you or your dependent (s) do not comply with these provisions, or fail or refuse to complete or sign any document requested by the Plan, the Plan will no longer have any obligation to pay benefits for the injury or condition. However, the Plan's subrogation and reimbursement rights apply whether or not a repayment agreement is signed. In addition, the Plan may reduce future benefits paid for any other medical expenses in order to recover the amount it is entitled to under this provision.

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Coordination Of Benefits (COB)

Like most group health plans, the Plan includes a "Coordination of Benefits" (COB) provision. This provision applies if you or your dependents are covered by more than one group plan, Medicare, or by no-fault automobile insurance. No-fault benefits are always considered primary to the Company Plan. A Healthcare Reimbursement Account (HRA) feature or consumer directed health plan (CDHP) are also considered a group health plan.

Under COB, one plan is considered primary and the other secondary. The plan that is primary pays first and the secondary plan adjusts its benefits accordingly.

When the Company Plan is the secondary plan, the amount our Plan pays equals what the Plan would have paid if it were primary, *minus* what the primary plan pays. If the primary plan provides the same or higher level of benefits as the Company Plan, our Plan does not pay any benefit for that service. If the primary plan provides a lower level of benefits than the Company Plan, then our Plan will pay the difference for any eligible expenses.

COB information is requested from new hires and then on an annual basis. If your spouse and/or dependents have other coverage, it is your responsibility to inform your local HR Representative. If other coverage exists and you do not provide this information, it is considered fraud under the Plan. Furthermore, failure to return the COB request form may result in the denial or delay in claims payment.

A plan without a COB provision similar to ours is always the primary plan. If all plans have such a provision, the primary plan is determined as follows:

- The plan covering the patient as an employee, rather than as a dependent, is primary and the other plan is secondary.
- If the patient is a dependent child whose parents are not divorced or separated, the plan of the parent whose birthday is earlier in the calendar year is primary.
- When parents are separated or divorced, plans pay in this order:

  ① The plan of the parent with custody of the child.

  ② The plan of the spouse of the parent with custody of the child.

  ③ The plan of the parent not having custody of the child.

However, if the terms of a court decree have established financial responsibility for the child's health care expenses and the entity paying or providing the benefits of the plan has knowledge of those terms, the benefits of that plan are determined first. In any event, this paragraph does not apply when payment has been made or provided before the entity has that knowledge.

- If a plan covers a person as an active employee, that plan is primary and any plan that covers the 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 the plan that covers the 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.

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- If none of the above provisions determine the order of benefits, the plan that covered a person longer is primary.

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 receive payment from that plan, then you can submit your claim for payment to our Plan. When you submit a claim to the second plan, be sure to include the Explanation of Benefits (EOB) from the primary plan, as well as another copy of the itemized bill.

These rules for coordination of benefits will also apply if you and your spouse are both covered employees under the Company's Plan and one or both of you elect family coverage.

Coordination With Medicare

Effect Of Medicare On Benefits For Active Employees

If you are an active employee and you and/or your covered dependent becomes eligible for Medicare, you must choose whether you want coverage under either Medicare or the Company Plan. If you and/or your spouse choose to be covered under the Company Plan, the Company will be the primary payer and Medicare will pay secondary benefits (if you enroll for Medicare). If Medicare is chosen as your primary coverage, you and/or your spouse will not be eligible for any additional benefits under the Company Plan to supplement coverage that is provided by Medicare. PPOs will not be applicable for individuals who are Medicare primary.

Medicare Coverage for Individuals with End-Stage Renal Disease

In all situations involving end-stage renal disease (ESRD), regardless of age or Medicare status, the Company Plan is the primary payor of medical expenses for the first 30 months of entitlement to Medicare because of ESRD. After the first 30 months, Medicare is the primary payor and the Company Plan is the secondary payor.

Medicare Coverage For Retired And Disabled Employees

If you are eligible for coverage after retirement, this Plan will coordinate benefits with Medicare as described in the *Coordination of Benefits* section. For eligible retired employees who are eligible for Medicare, as well as their dependents covered by the Plan, Medicare is the primary plan and this Plan is secondary. Medicare is also the primary plan for disabled employees who are covered by both Medicare and this Plan. PPOs will not be applicable for individuals who are Medicare primary.

When you receive the Medicare statement showing what Medicare has paid, you should submit a copy of the statement, along with copies of your bills and a properly completed claim form. Benefits from this Plan will be reduced so that the Plan will not pay any amount which would be reimbursable under Medicare and the total amount paid by both plans does not exceed 100% of your covered expenses.

For retirees and their eligible spouses/dependents, all Medicare-eligible participants must enroll in all forms of Medicare (Parts A, B and D) in order to continue coverage under the Medical and Prescription Drug Plan. Coverage for the retiree and all eligible family members will cease under the Plan if Medicare is not elected when eligible. Once coverage has ceased, it cannot be reinstated. For this reason, employees who are retired or on long-term disability should enroll for Medicare as soon as they are eligible. Medicare provides a special enrollment period for employees who are covered by an employer-sponsored group health when they stop working. Contact your Social Security office for more information. You and your covered dependents are responsible for all Medicare premiums.

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Your HIPAA Privacy & Security Rights

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. This information, known as protected health information, includes individually identifiable health information held by the health plan in oral, written, and electronic form.

The Plan has implemented policies and practices to appropriately protect the privacy of your protected health information. Protected health information will be handled in accordance with the Plan's HIPAA Privacy Policy. This Plan will not use or further disclose information that is protected by HIPAA except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

HIPAA Security requires, that in addition to protecting the confidentiality of your individually identifiable health information, health plans also take steps to protect the integrity, availability and confidentiality of any electronic protected health information that it collects, maintains, uses or transmits. The Plan has implemented policies and practices to appropriately protect the integrity, availability and confidentiality of electronic protected health information. Electronic protected health information will be handled in accordance with such policies and with the Plan's HIPAA Privacy Policy.

A complete description of your HIPAA privacy rights may be found in the Plan's Privacy Notice which was distributed to you and is also available from your local Human Resources Representative or the Plan's Privacy Officer. If you have questions about the privacy of your health information and/or wish to file a complaint under HIPAA, contact the Privacy Officer.

Your HIPAA Portability Rights

The Plan is required to provide a certificate of creditable coverage to each individual when the individual loses coverage under the Plan or when an individual's COBRA continuation coverage ceases, within a reasonable time after the individual's grace period for the payment of COBRA premium ends (where applicable) or, if requested, within 24 months after the individual's coverage under the Plan ends. The individual or a person or entity authorized by individual, (such as a new plan under the individual has enrolled) may make a request for a certificate. An individual is entitled to receive a certificate upon request even if the Plan has previously issued a certificate to that individual. In addition, a certificate of coverage will be issued when an employee or covered dependent meets the Plan's lifetime limit.

The Plan is required to provide special enrollment rights. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' coverage). You must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing towards the coverage).

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When Coverage Ends

Your Medical Plan coverage ends on the day:

- You leave the Company, voluntarily or involuntarily, for any reason including termination or layoff unless otherwise provided under a Company Severance Plan.
- You are no longer an eligible employee.
- You fail to pay any required contribution.
- Your employer ceases to be a participating employer under the Plan. Your employer will cease to be a participating employer if, among other things, it no longer falls within the definition of "Company"
- The Plan ends.

Coverage for your covered family members ends on the day:

- Your coverage ends.
- They no longer qualify as eligible dependents.
- You fail to pay any required contribution.
- The Plan ends.

However, you and your dependents may be able to continue your coverage in the following situations:

- You are on a leave of absence protected by the Family and Medical Leave Act of 1993 (FMLA), provided you continue to pay any required contributions. If your contributions are more than 30 days late, your coverage under the Plan will end; however, upon your return to work from a leave approved under the FMLA, you will be eligible to have your coverage reinstated as if you had never been on leave. If you fail to return to work following the leave, you may be required to pay back the Company for its cost of providing coverage during your leave. However, you will not be required to repay the Company if the reason you don't return is due to a serious health condition or other circumstances beyond your control, as provided by law.
- You are on a military leave of absence protected by the Uniformed Services Employment and Reemployment Rights Act, provided you pay any required contributions as permitted by law (for up to 24 months). Upon return to work from a protected leave, you will be eligible to have your coverage reinstated as if you had never been on leave.
- You are a non-union hourly employee on a leave of absence because of a work-related accident or injury that has been approved by the Company, provided that health contributions continue monthly. Coverage will not continue past 52 weeks from date of accident/injury.
- You stop working because of a disability. Coverage may be continued while you are receiving benefits from the Company's Short-Term Disability Plan or the Company's Sickness and Accident Plan. If your location provides Long-Term Disability coverage, you and your dependents may qualify for continuation of health coverage. See the Disability Benefits section of this binder for more information.

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- You qualify for coverage as an eligible retiree. If you are eligible and your location provides retiree health coverage, your binder will include a section called Benefits After Retirement that explains rules for eligibility and the cost of this coverage. If it applies to you, this section will also explain coverage for a surviving spouse and dependent children if your death occurs when you are eligible for or receiving retirement benefits from the Company.
- If you die while an active employee from injuries sustained on the job and your location offers retiree health coverage, your eligible dependent(s) may continue health coverage according to the Plan's provisions for a retiree's surviving spouse. Please refer to the section of this binder called Benefits After Retirement. For locations without retiree health coverage, COBRA coverage, if elected, is available at no cost to the surviving dependent(s).
- If you die while an active employee from a non-work related accident, injury, or illness, your eligible dependent(s) may continue coverage under COBRA as described in the next section. COBRA coverage, if elected, is available at no cost to your surviving dependent(s) per the schedule below:
  1) Less than two years of service – 30 days COBRA, if elected, paid by the company
  2) 2 years but less than 5 years – 90 days COBRA, if elected, paid by the company
  3) 5 years but less than 15 years – 6 months COBRA, if elected, paid by the company
  4) 15 years or longer – 18 months COBRA, if elected, paid by the company.
- All benefits end if the Plan is terminated.

Continuation Of Coverage (COBRA)

The Plan offers covered employees and dependents the opportunity to continue group health coverage when it ends for certain reasons. The following provisions outline the requirements for continued coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These provisions apply only to the extent that the minimum period of continued coverage required by law has not already been received under another provision of the Plan.

Eligibility For Continued Coverage

An employee or covered dependent may continue health coverage for up to 18 months if coverage ends because of either a reduction in the number of hours worked or termination of employment for any reason other than gross misconduct. However, if you do not return to work following a leave of absence protected by the Family and Medical Leave Act, the 18-month maximum period will be measured from the date the protected leave expires.

In addition, spouses and dependent children may continue their health coverage under the group plan for up to 36 months if their coverage ends for any of the following reasons:

- Divorce or legal separation from the employee.
- The dependent child reaches the limiting age or otherwise ceases to qualify as a dependent under the Plan.
- The death of the employee.

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These periods of continued coverage begin on the date of the event that caused loss of coverage, for instance, the date you leave the Company or the date a dependent becomes ineligible. In no event will more than a total of 36 months of continued coverage be provided to any individual, even if more than one of the above events occurs.

You or your qualified beneficiary must provide your local Human Resources Representative documentation supporting the occurrence of a COBRA qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the Plan:

- Divorce- A copy of the divorce decree.
- Legal Separation- A copy of the separation agreement.
- Child no longer qualifying as a dependent- A copy of a driver's license or birth certificate showing the child's age (in the case of a child becoming too old for coverage), a copy of the child's marriage certificate (in the case of the marriage of a child), a letter from a school, college, or university indicating that the child is no longer a full-time student with the institution (in the case of a child no longer qualifying as a full-time student).

Similar rights may apply to retirees and their dependents who lose coverage because the Company files for bankruptcy.

Separate Elections

Each qualified dependent has an independent election right for COBRA coverage. For example, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect different coverage than what the employee elects.

Disabled Individuals

If coverage ends because of a reduction in hours worked or termination of employment and a covered person becomes disabled at any time during the first 60 days of continued coverage, the maximum coverage period for the disabled individual and other covered family members will be 29 months, rather than 18, provided the disability is continuous.

To be eligible for the extended period, the disabled individual must be determined to be disabled by the Social Security Administration at any time during the first 60 days of continued coverage, and must notify a Human Resources Representative during the first 18 months of continued coverage and within 60 days after the date the determination of disability has been made by Social Security. Extended coverage will end before 29 months if the individual is no longer disabled.

Application For Continued Coverage

When your Human Resources Representative is notified that one of these events has happened, you will be sent an election form notifying you and/or your qualified beneficiaries of the conditions that apply to continued coverage.

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However, in the event you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under the Plan, you, your covered spouse or your covered dependent must notify your Human Resources Representative within 60 days. If you fail to do this, your dependent's rights to continued coverage will be forfeited.

Continued coverage is not automatic. You or your qualified beneficiaries must submit the completed election form within 60 days from the later of the following dates:

- The date you are no longer eligible under the group Plan.
- The date you receive the election form.

Cost Of Continued Coverage

Any person who elects to continue coverage under the Plan must pay the total cost of that coverage on a monthly basis, plus any administrative or other costs as permitted by law. Your first payment for continued coverage must be made within 45 days of the date you sign the election form. The COBRA rates will be periodically reviewed by the Plan Administrator.

When Continued Coverage Ends

Continued coverage, including coverage for disabled individuals, ends automatically if:

- The cost of continued coverage is not paid on or before the date it is due.
- After the date of the COBRA election, an individual first becomes entitled to Medicare.
- After the date of the COBRA election, an individual first becomes covered by another group health plan, unless coverage with the other plan is limited due to the individual's pre-existing condition.
- The Plan terminates for all employees.
- The applicable maximum coverage period expires.

Benefits Under Continued Coverage

Continued coverage will be exactly the same health coverage you or your dependent would have been eligible for if your employment or his or her dependent status had not changed. Any future changes in the benefits or cost of coverage for the Plan also will apply. Qualified beneficiaries who elect COBRA coverage will have the right to enroll eligible dependents and/or change coverage under the same rules that apply to active employees covered by the Plan. If you acquire a newborn or adopted child while you are covered under COBRA, the child will also be considered a qualified beneficiary and eligible for coverage, provided he or she is enrolled within 30 days of the date the child becomes an eligible dependent.

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Glossary

The following are definitions of terms used in this summary plan description:

Ambulatory Surgical Center - A specialized facility that allows patients to have minor surgery without having to be confined overnight at a hospital. 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.

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.

Claims Administrator - The agent designated by the Plan Administrator to administer benefits under the Plan. The address and telephone number of the Claims Administrators are shown on your Medical Plan ID and Prescription Plan ID cards and in the section called Helpful Information. Currently, the Claims Administrator is Fiserv Health - Harrington Benefit Services, Inc., P.O. Box 700, Pueblo, CO 81002-0700. Telephone toll-free 1-800-972-3023. Website http://benefits.fiservhealth.com.

Company - Magnum Coal Company, or one of its subsidiaries/affiliates covered by the Plan.

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

- Is supervised by a resident physician or a resident registered graduate nurse.
- Requires that the health care of each patient be under the supervision of a physician.
- Requires that a physician be available to furnish necessary medical care in emergencies.
- Provides 24 hour-a-day nursing service.
- Is approved or is qualified to receive approval for payment of Medicare benefits.
- Keeps clinical records on all patients.

Custodial Care - Care given primarily to assist a person in the activities of daily living, routine maintenance, or supportive care, which need not be provided in an institutional-type setting by skilled professional medical personnel.

Durable medical equipment - Equipment that meets all of the following conditions:

- Can withstand repeated use.
- Is primarily and customarily used in the therapeutic treatment of sickness or injury.
- Is generally not useful to a person in the absence of a sickness or injury.
- Is appropriate for use in the home
- Is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature.
- Is not primarily for the convenience of the person caring for the patient.
- Is not used for exercise or training.

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Emergency - An accidental injury or medical condition that is life-threatening or may cause serious injury to bodily functions and requires you or a family member to seek immediate medical care. (A chronic condition in which symptoms have existed over a period of time will not qualify as a medical emergency unless symptoms become acute and require immediate medical attention to protect the life of the patient or to avoid serious physical impairment.) Some examples of an emergency include heart attacks, loss of consciousness or respiration and other similarly acute conditions. See your Human Resources Representative for a more detailed description.

Eligible Employee - An active, full-time salaried or non-union hourly employee of the Company who is scheduled to work at least 40 hours per week. You must be a citizen or legal resident of the United States, its territories or Canada. You are not eligible if you are a temporary or seasonal employee, or if you are a full-time member of the armed forces of any country.

Experimental and/or Investigational Services - Services which have not been clinically proven to be safe and effective based upon available professional assessments. In the event of a dispute, the Plan Administrator reserves the right to make the final determination.

Foster child - A child for whom you have assumed a legal obligation when all the following conditions are met:

- You are raising the child as your own and have assumed full parental responsibility for the child.
- The child lives in your home and depends on you for primary support.
- You may legally claim the child as a federal income tax deduction.

A foster child does not include a child:

- Temporarily living in your home.
- Placed with you in your home by a social service agency that retains control of the child.
- Whose natural parent may exercise or share parental responsibility and control.

Hospital - A licensed facility which provides inpatient diagnostic, therapeutic, and rehabilitative services for the diagnosis, treatment and care of injured and sick persons under the supervision of a physician. Such an institution must also meet the following requirements: a) must be accredited by the Joint Commission of Hospitals, or be approved by the federal government to participate in federal and state programs; b) must maintain clinical records on all patents; c) must have by-laws which govern its staff or Physicians; and d) must provide nursing care twenty-four (24) hours per day.

Injury - Medical treatment for accidental bodily injuries such as fractures, stab wounds, allergic reactions, severe head wounds or any acute injury. An accidental injury may or may not be considered a medical emergency.

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:

- The care is proven: It meets strict standards of care established by the medical community on a national basis, is published in recognized journals, is approved by the Food and Drug Administration (FDA) and other regulatory agencies, and is not experimental or investigational or provided for research purposes.

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- The care is effective: Its beneficial effects are expected to outweigh any harmful effects encountered while addressing the particular disease, injury or sickness.
- The care is appropriate: It provides the most appropriate supply, timing, setting and level of service that can be provided on a cost-effective basis. The fact that a physician prescribes services or supplies does not automatically mean such services or supplies are medically necessary.

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

Mental or Nervous Disorder - A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

Physician - A legally licensed physician, physician assistant (who works in a group practice), or surgeon, and, for purposes of mental health and chemical dependency benefits, a registered psychologist, licensed social worker, or licensed professional counselor who is under the supervision of a registered psychologist or psychiatrist.

Reasonable and Customary - Medical services, treatment, supplies or drugs essential to the care of the individual that are no more than the amount normally charged by the provider and by most providers in the locality as determined by the Claims Administrator based on past charges for the same care. Charges in excess of these amounts are not covered by the Plan and do not apply toward satisfying your out-of-pocket maximum. Reasonable and customary does not apply to network expenses.

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.

Sickness - A bodily illness or disease, including a mental disorder of any kind, which requires treatment by a physician and includes care for pregnancy, childbirth, abortion, miscarriage and complications of pregnancy unless otherwise limited by the Plan.

Spouse - Your legal partner in marriage by a civil or religious ceremony that is recognized in the state where you reside. Common-law marriage is not recognized by the Plan.

Temporomandibular Joint Dysfunction (TMJ) and Related Care - 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.

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Plan Administration

The following information is provided in accordance with the Employee Retirement Income Security Act of 1974 (ERISA):

Name of Plan:
Magnum Coal Company and Covered Subsidiaries/Affiliates Welfare Plan

Type of Plan:
Welfare Benefit Plan

Plan Sponsor: Magnum Coal Company
500 Lee Street East
Charleston, WV 25301
Telephone: (304) 380-0306

Plan Administrator:
Vice President - Human Resources
Magnum Coal Company
500 Lee Street East
Charleston, WV 25301
Telephone: (304) 380-0304

Plan Number: 501

Employer Identification Number:
20-3678373

Type of Plan Administration:
The Plan is administered by the Plan Administrator and the Claims Administrator.

Plan Year:
January 1–December 31

Plan Funding:
The Plan is funded by contributions from the general assets of the Plan Sponsor.

Agent for Service of Legal Process:
Vice President - Human Resources
Magnum Coal Company
500 Lee Street East
Charleston, WV 25301
Telephone: (304) 380-0304

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ERISA Rights

ERISA provides that all participants in the Plan shall be entitled to the following rights.

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as the Human Resources department's office at the mine where you are or were last employed before retirement, all documents governing the Plan, including the Plan document, insurance contracts, collective bargaining agreements, 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, collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

In addition, if you are a participant in a group health plan, you have the right to:

- 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 regarding your COBRA continuation coverage rights.
- Receive a copy of the Plan's qualified medical child support procedures without charge from the Plan Administrator.
- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under group health plans, 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, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Note that this right is available only if you are a participant in a group health plan that is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Prudent Actions by Plan Fiduciaries

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

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Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request 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 up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your 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 nearest office of the Employee Benefits Security Administrator, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Claim Review Procedures/Appeals For Health Care Claims

Time Frame for Initial Claim Determination

For urgent care claims (defined below) and pre-service claims (claims that require approval of the benefit before receiving medical care), the Claims Administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- 72 hours after receipt of a claim initiated for urgent care. A decision may be provided orally, as long as written or electronic notification is provided to you within 3 days after the oral notification.
- 15 days after receipt of a pre-service claim

For post-service claims (claims that are submitted for payment after receiving medical care), the Claims Administrator will notify you of adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For urgent care claims, if you fail to provide the Claims Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claims Administrator must notify you within 24 hours of receiving your claim of the specific information

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needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 72 hours after the earlier of:

- The Claims Administrator's receipt of the requested information
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For pre- and post-service claims, a 15-day extension may be allowed to make a determination provided that the Claims Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claims Administrator will notify you before the end of the first 15 or 30 day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to the failure to submit the information necessary to decide upon the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your failure to submit necessary information, the Plan's time frame for making a benefit determination is stopped from the date the Claims Administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fail to follow the Plan's procedures for filing a pre-service claim, you or your authorized representative will be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within 5 days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters
- Is a communication that names you, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

Urgent Care Claims

Urgent care claims are those which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to serve pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual action on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

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Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is an urgent care claim as previously defined, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for an extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames previously described. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

If You Receive an Adverse Benefit Determination

The Claims Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information needed to process the claim and an explanation of why such information is necessary
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol, or similar criterion relied upon in making the adverse determination, or a statement that such information will be provided free of charge upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination.

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You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
- Was relied upon in making the benefit determination
- Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
- Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination
- Constitutes a statement of policy or guidance with respect to the Plan concerning denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination.
- A review that takes into account all comments, documents, records, and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug, or item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for urgent care, an expedited review process in which:
- You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
- All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly prompt method.

Ordinarily, a decision regarding your appeal will be reached within:

- 72 hour after receipt of your request for review of an urgent care claim
- 30 days after receipt of your request for review of a pre-service claim
- 60 days after receipt of your request for review of a post-service claim

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The notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provision(s) on which the determination is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA such as "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- Any internal rule, guideline, protocol, or similar criterion relied upon in making the adverse determination, or a statement that such information will be provided free of charge upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request

Amending the Plan

The Company reserves the right to terminate the Plan, change required contributions, or modify the Plan in whole or in part at any time or for any reason, including changes to any and all of the benefits provided. This may cause employees and/or retired employees to lose all or a portion of their benefits under the Plan.

This means than an employee or retired employee does not have a lifetime right to any Plan benefit or to continuation of the Plan simply because this Plan or specific benefit is in existence at any time during the employee's employment or retirement.

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