UMWA Health and Retirement Funds
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Summary Plan Description

UMWA Combined Benefit Fund

February 2019

United Mine Workers of America **Health and Retirement Funds**

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INTRODUCTION

In 1992, the Congress of the United States enacted the Coal Industry Retiree Health Benefit Act (the "Coal Act"). The Coal Act's purpose is to ensure that health care benefits will continue to be provided to retired miners and their families. Congress reiterated its promise with the passage of the Tax Relief and Health Care Act of 2006, which, among other things, provided additional sources of funding to the United Mine Workers of America ("UMWA") Combined Benefit Fund (the "UMWA Combined Benefit Fund," the "Combined Benefit Fund," or the "Combined Fund"), one of the UMWA health funds created by the Coal Act. This booklet describes the UMWA Combined Benefit Fund.

The Coal Act created two new health funds, the UMWA Combined Benefit Fund and the UMWA 1992 Benefit Plan. The UMWA Combined Benefit Fund replaced the collectively-bargained UMWA 1950 Benefit Plan and Trust and the UMWA 1974 Benefit Plan and Trust, which were merged into the Combined Fund effective February 1, 1993. The new plans changed the way in which the costs of the health benefits previously provided under the UMWA 1950 and 1974 Benefit Plans are paid. The Coal Act required the Combined Fund to enroll Plan participants into managed care arrangements in order to control health care costs. In addition, the Coal Act states that "to the maximum extent feasible," participants would receive "substantially the same" benefits as provided for previously under the UMWA 1950 and 1974 Benefit Plans.

About this Booklet

This booklet is the 2019 edition of the summary plan description of the UMWA Combined Benefit Fund. The purpose of this booklet is to explain the Plan in a way that can be more easily understood than the formal language of the Plan Document. In the event of a conflict or inconsistency between this booklet and the provisions of the Plan and trust documents for the Combined Benefit Fund, the provisions of the Plan and trust documents will control. To request a copy of the Plan Document, write to the UMWA Health and Retirement Funds in Washington, D.C. The address and phone numbers are listed at the end of this booklet on page 47.

Certain words and phrases used in this booklet have special meanings. Most of these are technical terms and are explained in the section entitled "Terms You Should Know." However, the words *Plan*, *Participant,* and *Beneficiary* often appear without qualifying words or phrases. When the word *Plan* appears by itself, it means the UMWA Combined Benefit Fund. When the words *Participant* or *Beneficiary* appear by themselves, it means a participant in the UMWA Combined Benefit Fund, that is a person who is eligible to be a participant in the Combined Fund under the provisions of the Coal Act.

References in this booklet to the United Mine Workers of America use the union's initials, *UMWA,* as its name, and references to the UMWA Health and

Retirement Funds generally use the abbreviated form, the *Funds.* Also, the pronouns *he*, *his*, and *him* refer to persons without regard to gender.

The text of this booklet often advises the reader to contact the Funds' Call Center for answers to questions about the Plan and Plan coverage. The telephone number for the Funds' Call Center appears at the end of this booklet on page 47.

Additional Information

If you have questions about the UMWA Combined Benefit Fund, you may call the Funds' Call Center, or write, or visit the Funds' main office in Washington, D.C. The Plan is governed by the provisions of the Coal Act, the Employee Retirement Income Security Act of 1974 ("ERISA"), and by regulations issued by the U.S. Departments of Labor and Treasury under ERISA, which are subject to change. In addition, the provisions of the Plan may be changed by action of the Board of Trustees.

General Information

UMWA Combined Benefit Fund

The Combined Fund was established in 1992 by Federal law under the Coal Act. Effective February 1, 1993, the UMWA 1950 Benefit Plan and Trust and the UMWA 1974 Benefit Plan and Trust were merged into the Combined Fund. In accordance with the Coal Act, the Combined Fund provides health and death benefits to individuals who were eligible to receive and receiving benefits from the 1950 Benefit Plan or the 1974 Benefit Plan on July 20, 1992.

The Combined Fund's day-to-day operations are administered by the UMWA Health and Retirement Funds (the "Funds"), which administered the UMWA 1950 Benefit Plan and Trust and the UMWA 1974 Benefit Plan and Trust, and which continues to administer the UMWA 1974 Pension Plan, the UMWA 1992 Benefit Plan, the UMWA 1993 Benefit Plan, the UMWA Prefunded Benefit Plan, and the UMWA Cash Deferred Savings Plan of 1988. (The UMWA 1974 Pension Plan is the trust that acts as the Master Administrative Entity and actually employs the staff of the Funds; the Combined Fund contracts with the UMWA 1974 Pension Trust for administrative services, as do the other pension and benefit plans that the Funds administers.) The Funds provides pensions to classified employees in the bituminous coal industry and provides health benefits to certain active, retired or disabled mine workers and their families.

Plan Name:	United Mine Workers of America Combined Benefit Fund
Plan Administrator:	Board of Trustees Combined Benefit Fund 2121 K Street, N.W., Suite 350 Washington, D.C. 20037 (202) 521-2200
EIN:	52-1805433
Plan Number:	501
Plan Type:	An ERISA-governed welfare benefit plan
Agent for Service of Legal Process:	Board of Trustees Combined Benefit Fund and/or Glenda Finch, General Counsel of the Funds 2121 K Street, N.W., Suite 350 Washington, D.C. 20037 (202) 521-2200
Plan Year:	Fiscal Year *October 1st through September 30th*

Funding

The method of funding the Combined Fund was established by the Coal Act. The money to pay health benefits comes from the following sources:

- one-time transfer of a portion of assets from the former UMWA 1950 Pension Trust;
- certain annual transfers from the Abandoned Mine Reclamation Fund; and
- premiums assessed from and paid by "assigned operators" as defined by the Coal Act.

These funds are used to pay health and death benefits and to pay the cost of administering the Plan. All money in excess of that which is required for these purposes may be invested in stocks, bonds, treasury notes or otherwise invested.

A complete list of the employers, assigned operators, and related entities that pay premiums to the Plan is available for inspection at the Funds' offices in Washington, D.C. The Funds will also respond to written inquiries asking whether a particular employer, operator or related entity is paying premiums to the Plan and will furnish the names and addresses of these upon request.

Plan Administration

Major policy decisions for the Combined Fund are made by the Board of seven Trustees who are the Plan Administrator; this type of administration is known as "trustee administration." The duties of the Trustees include collecting premiums and other funds owed to the Combined Fund, interpreting the provisions of the Plan to pay benefits, and investing the assets of the trust.

As required by the Coal Act, the UMWA appoints two trustees and the Bituminous Coal Operators' Association (BCOA) appoints two trustees. The remaining three trustees are selected by these four appointed individuals. Michael H. Holland and Marty Hudson have been appointed by the UMWA, and Michael O. McKown and Joseph R. Reschini have been appointed by the BCOA. Those four Trustees have selected William P. Hobgood, Gail R. Wilensky, and Carl E. Van Horn as Trustees. "Trustees" means these seven individuals collectively. Messrs. Holland and McKown are co-chairmen of the Board of Trustees, at the time of this booklet.

The Trustees have appointed Lorraine Lewis as Executive Director of the Funds. The Trustees have appointed Glenda Finch, General Counsel of the Funds, as agent for the service of legal process. Official court papers can be served on Ms. Finch or sent to her by mail to the extent permitted by court rules. Legal process can also be served on the Trustees. Letters to Ms. Finch and the Trustees should be addressed to the Funds' office in Washington, D.C. The address and phone numbers are listed on page 47.

The Combined Fund is independent and separate from the UMWA and bituminous coal industry employers. Created by the Coal Act, the Combined

Fund serves eligible mine workers who are retired or disabled and the families of those workers.

The Trustees reserve the right at any time and from time to time to modify or amend in whole or in part any or all of the provisions of the Plan, or to terminate the Plan as permitted by law. The Trustees are authorized to promulgate rules and regulations to implement the Plan, and those rules and regulations are binding on the Plan and its beneficiaries.

Subrogation and Non-Duplication

The Plan does not assume primary responsibility for participants' and beneficiaries' covered medical expenses which another party is obligated to pay or which an insurance policy or other medical plan covers. Where there is a dispute between the Plan and such other party, the Plan shall, subject to provisions (1) and (2) immediately below, pay for such covered expenses only as a convenience to the participant or beneficiary and only upon receipt of an appropriate indemnification or subrogation agreement; but the primary and ultimate responsibility for payment shall remain with the other party.

The Plan's obligations to pay benefits on behalf of any participant shall be conditioned:

(1) upon such individual taking all steps necessary or desirable to recover the costs thereof from any third party who may be obligated therefore, and

(2) upon such individual executing such documents as are reasonably required by the Plan Administrator, including, but not limited to, an equitable lien and subrogation agreement granting a constructive trust, lien and/or an equitable lien in favor of the Plan, or an assignment of rights to receive such third-party payments, in order to protect and perfect the Plan's right to reimbursement from any such third party.

Non-Duplication

Health benefits will be reduced by benefits provided under any other group plan, including a plan of another Employer signatory to the Wage Agreement, if the other plan does not include a coordination of benefits or non-duplication provision, or includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.

In determining whether this Plan or another group plan is primary, the following criteria will be applied:

(a) The plan covering the patient other than as a spouse or dependent will be the primary plan.

(b) Where both plans cover the patient as a dependent child, the plan covering the patient as a dependent child of a male will be the primary plan.

(c) Where the determination cannot be made in accordance with (a) or (b) above, the plan which has covered the patient the longer period of time will be the primary plan.

(d) In the event an eligible beneficiary is covered under another group plan by reason of his or her employment, the other group plan shall be the primary plan for such individual, and in the case of an eligible beneficiary covered under this Plan as a retiree, for his or her dependents.

As used herein, "group plan" means (i) any plan covering the individuals as members of a group and providing hospital or medical care benefits or services through group insurance or a group prepayment arrangement, or (ii) any plan covering individuals as employees (present or former) of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

If it is determined that benefits under this Plan should have been reduced because of benefits provided under another group plan, the Plan Administrator shall have the right to recover any payment already made which is in excess of the Plan's liability. Similarly, whenever benefits which are payable under the Plan have been provided under another group plan, the Plan Administrator may make reimbursement directly to the insurance company or other organization providing benefits under the other plan.

For the purpose of this provision the Plan Administrator may, without consent or notice to any eligible beneficiary, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expenses and benefits. Any individual claiming benefits under this Plan must furnish the Plan Administrator such information as may be necessary for the purpose of administering this provision.

Services Rendered Outside the U.S.

Benefits are provided for health care rendered outside the U.S. on the same basis as if the health care had been rendered to the beneficiary in the U.S. The beneficiary in such a case may be required to make payment of the expenses incurred outside the United States and file a claim with the Plan Administrator for reimbursement.

HMO Election

All eligible beneficiaries may elect coverage by a certified health maintenance organization (HMO) in lieu of the health benefits provided under this Plan, in accordance with Federal or State laws governing HMOs; provided, however, that all beneficiaries in a family shall be governed by an HMO election. All elections must be approved by the Plan Administrator.

The Plan Administrator will pay the HMO, but if the monthly charge made by the HMO exceeds the monthly cost of this Plan to the Employer, the excess charges shall be paid by the Beneficiary.

Rights Guaranteed By ERISA

The Employee Retirement Income Security Act of 1974 ("ERISA") is a Federal law which provides certain rights and protections to participants and requires the Plan and its Trustees to perform certain duties. This section describes some of the rights and responsibilities established by that law.

As a participant in the Combined Benefit Fund, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits
    - Examine, without charge, at the Plan Administrator's office and at other specified locations, such as Funds' field offices, all documents governing the Plan 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 and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator's office 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
    - 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 on the rules governing your COBRA continuation coverage rights.
- Prudent Action 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 welfare benefit or exercising your rights under ERISA.

- Enforce Your Rights

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

  - Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request material from the Plan and do not receive it 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 material and pay you up to $110 per day until you receive the materials, unless 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 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 Administration, 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 Employee Benefits Security Administration.

TERMS YOU SHOULD KNOW

assigned operator

A signatory operator to which responsibility for payment of premiums with respect to certain eligible beneficiaries has been assigned under the Coal Act.

attains the age

An individual attains an age on or after 12:01 A.M. of the anniversary date of the individual's birth.

copayment

The part of a bill for visits to physicians and for prescription drugs which the patient is required to pay. There is a $5.00 copayment for each visit to a physician for medical care, up to a maximum of $100.00 per family per copayment year. For visits conducted by physicians within the primary care provider network copayments are waived. There is a $5.00 copayment for each prescription filled by a pharmacy, whether the prescription is for a 30, 60 or 90-day (or fraction thereof) supply, up to a maximum of $50.00 per family per copayment year. There is no copayment for a prescription filled through mail order service.

In the absence of demonstrated medical necessity, if a brand name drug is prescribed where a generic equivalent is available, the participant (or dependent) is responsible, in addition to any required copayment, for the additional cost of the brand name drug over the cost of the generic substitute. For further details about the Generic Drug Substitution program, refer to page 24. You may also be responsible, in addition to the required copayment, for the additional cost of certain drugs that are not "preferred" drugs. For further details about the Plan's Preferred Product Program, refer to pages 24-25 of this booklet.

copayment year

The twelve-month period used for calculating copayment maximums. The copayment year begins on March 27 of the calendar year and ends March 26 of the following year for the UMWA Combined Benefit Fund.

covered service

A service that is covered under the terms of the Plan, is reasonable and necessary for the diagnosis or treatment of an illness or injury and which is provided at the appropriate level of care.

earnings limitation

Health benefits will not be provided during any month in which a beneficiary is regularly employed with employment earnings of $1,000 or more, except for a beneficiary who is a dependent child and also a full-time student. This amount is set by the Trustees and is subject to change.

inpatient care

The care received when a Plan participant stays overnight in a hospital or other health care institution such as a skilled nursing care facility.

outpatient care — The care received when a Plan participant is not confined overnight to a hospital or other health care institution, even if it is furnished by a facility which also provides inpatient care. Also referred to as *ambulatory* care.

signatory operator — A person or company who is or was a signatory to a National Bituminous Coal Wage Agreement or an agreement containing similar pension and health care contribution and benefit provisions.

surgery — Any operative or cutting procedure.

surviving spouse — A widow or widower of a former mine worker who was eligible for health benefits at the time of the mine worker's death.

Eligibility for Health Benefits

Eligible Beneficiaries

Under the provisions of the Coal Act, an **eligible beneficiary** is any individual who was eligible to receive, and receiving, benefits from either the UMWA 1950 Benefit Plan and Trust or the UMWA 1974 Benefit Plan and Trust on July 20, 1992. Individuals who first met the eligibility rules for coverage as dependents of primary beneficiaries after July 20, 1992 shall be included as eligible beneficiaries **(eligible dependents)** of the UMWA Combined Benefit Fund. Health benefits shall not be provided to an eligible beneficiary during any month in which he would be disqualified from receiving benefits under the earnings limitation. The earnings limitation also applies to the surviving spouse and dependent children, but does not apply to a dependent child who is a full-time student.

An **eligible dependent** may be any of the following persons:

- A spouse living with or supported by the mine worker.
- An unmarried, dependent, natural or adopted child or stepchild under the age of twenty-two. Effective August 10, 1993, the Plan covers adopted children effective at the time of placement for adoption irrespective of whether the adoption becomes "final." "Placement for Adoption" means the assumption and retention by a Plan participant or beneficiary of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.
- A parent of the mine worker or his spouse if that parent depends upon and has lived with the mine worker for at least one year.
- An unmarried, dependent grandchild under the age of twenty-two if that grandchild lives with the retired or disabled mine worker.
- A dependent child of any age who is intellectually disabled or who was disabled before the age of twenty-two if his disability is continuous and he lives with the mine worker or is confined to an institution for care and treatment.
- Surviving spouse or dependent child of a mine worker who died under certain circumstances. The following general rules apply:
  - When a retired or disabled mine worker dies while he is receiving or eligible to receive a pension from the 1974 Pension Plan, his surviving spouse will remain eligible for health benefits until remarriage; surviving dependent children will remain eligible for health benefits until the age of twenty-two.

– When a mine worker in a classified signatory job dies as the result of a mine accident that occurs after December 5, 1974, his surviving spouse will remain eligible for health benefits until remarriage; surviving dependent children will remain eligible for health benefits until the age of twenty-two.

– When a disabled mine worker dies while receiving or eligible to receive sickness and accident benefits, his surviving spouse and dependent children will remain eligible for health benefits for sixty (60) months after his death.

Applying for Benefits

Eligibility to receive benefits under the Combined Benefit Fund as a "plan participant" is defined and limited by the terms of the Coal Act. The Coal Act does not allow for any new or additional participants outside of those terms. This is known as a "closed pool." However, if you believe you or a dependent should be receiving benefits based on the previous section entitled "Eligible Beneficiaries," or if you have acquired dependents or a spouse after July 20, 1992, you may submit an application for benefits to the Funds to determine eligibility under the Combined Benefit Fund or any other benefit plan which the Funds administers. Contact the Funds' Call Center at 1-800-291-1425 for forms and more information on how to apply.

Right to Appeal Denial of Health and Death Benefits Eligibility

If the Funds denies your application for health or death benefits from the Combined Fund, you may ask the Funds to review its decision. The Funds will provide a detailed explanation of the reasons for the Funds' decision. If you do not fully understand the decision, you may discuss your case with a Funds' representative. You may call the Funds' Call Center at 1-800-291-1425 where a representative will answer your questions and explain how the decision was reached.

Review may also include a request for a hearing. If a hearing is permitted, you will receive only one hearing and it will be the Funds' final action on your case. You have 90 days to request a hearing from the date of the Funds' letter of denial or termination of benefits. To request a form for a hearing and obtain more information about the hearing process, please call the Funds' Call Center at 1-800-291-1425.

Health Services ID and Pharmacy Card

If you are eligible for health benefits, you will receive one ID card – a combined health services and pharmacy identification card – which will identify you and your dependents as beneficiaries of the Plan. When you go to your physician, pharmacist, or hospital, show them the card so they can bill the Funds directly.

It is important to report any changes in information contained on the ID card to the Funds. To report a change of address, or to replace a missing ID card, call the Funds' Call Center at 1-800-291-1425. If you lose the card, notify the Funds' Call Center immediately.

If you have any questions, contact the Funds' Call Center for assistance.

The Funds and Medicare

Under a special arrangement with the Centers for Medicare & Medicaid Services, the Funds administers Medicare benefits for Medicare Part B (physician, Durable Medical Equipment and outpatient x-ray and laboratory services) for Combined Fund beneficiaries who are eligible for Medicare. This means that the Funds will pay for the portion of medical services covered by Medicare Part B and that the Centers for Medicare & Medicaid Services will reimburse the Funds for these types of claims and for administrative expenses. Medicare coinsurance, hospital deductibles, and other charges covered by the Plan but not covered by Medicare will be paid by the Funds under provisions of the Combined Fund, including the application of copayments.

According to the terms of the arrangement between the Funds and the Centers for Medicare & Medicaid Services, the Funds is the only organization that can process and pay Medicare Part B benefits for Combined Fund beneficiaries who are enrolled in Medicare and the Funds' Medicare Plan. Your Part A Medicare benefits will continue to be processed through the Medicare Administrative Contractors ("MACs"), as they have been in the past.

Under the terms of the Plan, beneficiaries who are eligible for Medicare Part A coverage without a premium and/or Medicare Part B coverage **must be** enrolled in Medicare Part A and Medicare Part B to retain their eligibility for health benefits from the Plan.

Beneficiaries of the Plan are not required to enroll in Medicare Part D (prescription drug coverage). Beneficiaries who are eligible for Medicare Part D will receive a "Notice of Creditable Coverage" each year. The Notice of Creditable Coverage is proof that a beneficiary's Combined Benefit Fund drug coverage meets the standard set by Medicare and that the beneficiary does not need to enroll in a Medicare Part D prescription drug plan.

Medical Care or Treatment

Appeals Procedures

The Combined Fund provides health benefits to Eligible Beneficiaries (see page 11) who may also be eligible for Medicare. If your claim for health benefits is denied, in whole or in part, you will receive a written explanation of the denial. If you think the decision to deny your claim is incorrect, you have the right to appeal that decision. As explained below, the timeframes for appealing a denial decision will be different depending on whether you are a Medicare-eligible beneficiary and/or whether the benefit is or is not covered by Medicare or by the Combined Fund.

If you have any questions concerning your right of appeal, you should contact the Funds' Call Center for more information. Remember, if a health service is denied as medically unnecessary or because it is an excessive charge, you may be held harmless by the Funds. See the section below entitled "**Hold Harmless Program**" on pages 26-27.

Rights of beneficiaries who are not eligible for Medicare

If you are **not** a Medicare-eligible beneficiary, the Funds will normally have up to 30 days to act on your claims for medical care or treatment. As explained below, in some cases you may have a right to a decision within 72 hours of your request for medical care or treatment. When the Funds receives a request for medical care or treatment from you, the Funds will determine if it is an urgent, pre-service, or post-service claim, or a request for a concurrent care decision.

An **urgent** care claim is any claim for medical care or treatment that the Funds determines could jeopardize your life or health or ability to regain maximum function if you were required to wait for the Funds to make a non-urgent care claims decision. It is also a claim for medical care or treatment that a doctor with knowledge of your medical condition determines would subject you to severe pain that cannot be adequately managed without the care or treatment that is the basis of your claim. If the Funds determines that your claim is urgent, or if a doctor informs the Funds that your claim is urgent, we must decide your claim as soon as possible but no later than 72 hours after we receive your claim. If your urgent claim is incomplete or not properly filed, the Funds must notify you within 24 hours. You will have 48 hours to provide the necessary information, and we must then notify you of our decision within 48 hours after we receive the additional information or from the time the information was due.

A **pre-service** care claim is any claim for a health benefit under the Plan for which you must first obtain approval from the Funds before receiving the medical care or treatment. The Funds has two levels of appeal, and must notify you of its decision to approve or deny your claim within a reasonable period, but no longer than 15 days from the date we receive your claim. The Funds may extend this time period for up to an additional 15 days if it determines that an extension is necessary for reasons beyond the Funds' control and the Funds notifies you, within 15 days from the date that it receives your claim, of the circumstances requiring the extension and the date by which the Funds expects to make its decision. If the Funds needs an extension because we did not receive sufficient information to make a decision regarding your claim, you must submit the additional information to us within 45 days. If your claim is improperly filed, the Funds must notify you of this failure within 5 days.

A **post-service** care claim is any claim for a health benefit under the Plan for which you are not required to obtain the approval of the Funds before receiving the medical care or treatment. The Funds has two levels of appeal. If the Funds denies your claim, in whole or in part, we must notify you within a reasonable time period, but normally no later than 30 days after we receive your claim. We may extend the time to decide your claim for up to an additional 15 days if, for reasons beyond our control, we are unable to reach a decision regarding your claim and we notify you that we need additional time within 30 days from the date that we receive your claim of the circumstances requiring the extension and the date by which the Funds expects to make our decision. If the Funds needs an extension because we did not receive sufficient information to make a decision regarding your claim, you must submit the additional information to us within 45 days.

The Funds must notify you of its **concurrent care decision** to reduce or terminate (other than by amending or terminating the Plan) any previously approved ongoing course of treatment that you are receiving over a period of time or number of treatments sufficiently in advance of the reduction or termination to allow you to appeal the concurrent care decision before the benefit is reduced or terminated. If you request the Funds to extend the course of treatment beyond the period of time or number of treatments and your claim involves urgent care (see definition above), the Funds must decide your claim as soon as possible but no later than 24 hours after the Funds receives your claim, provided that you file your claim at least 24 hours before the period of time or number of treatments would otherwise expire.

Appeals Procedures

If your request for a health benefit is denied, in whole or in part, you will receive a written explanation of the denial. If you believe that your claim was denied incorrectly, you have a right to appeal the denial decision. You must file your appeal within 180 days of the date that you receive notice that your claim has been denied. On appeal, a reviewer who was not involved in the initial determination and who is not his subordinate will review your claim. If your claim was denied because the treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Funds will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination, nor his subordinate.

If you are appealing a claim involving **urgent** care, you have a right to request orally or in writing, an expedited appeal. You may submit all necessary information to the Funds by telephone, facsimile (FAX) or other available similarly expeditious method.

To file a request by telephone, call 1-800-292-2288. The Plan will document the oral request for a fast appeal in writing.

To hand-deliver your request for appeal, the address is KEPRO, UMWA Funds, 2051 Killebrew Drive, Suite 210, Bloomington, MN 55425-1875.

To FAX your request for appeal, the number is 1-800-382-7792. If you are in a hospital or a nursing facility, you may request assistance in having your written request for a service transmitted to the Plan by use of a FAX machine.

To mail a written request for appeal, the mailing address is: KEPRO, UMWA Funds, P.O. Box 11897, St. Paul, MN 55111-0897. The 72-hour review time will not begin until your request for appeal is received.

If it is determined that you are entitled to an expedited appeal, a decision on an expedited appeal must be made within 72 hours. No extensions are permitted.

If you are appealing a claim for **pre-service** care, the Funds must make a decision on your appeal within 15 days. If you are appealing a claim for **post-service** care, the Funds must decide your appeal within 30 days. In either case, no extensions are permitted.

The Funds will, upon request and free of charge, provide access to all documents, records and other information relevant to the benefits determination, without regard to whether the Funds relied on the material in reaching its decision. We will also disclose the name of medical professionals or vocational experts whose advice we obtained, whether or not we relied on that advice in reaching our benefits determination.

Rights of Beneficiaries who are eligible for Medicare

If you are a Medicare-eligible beneficiary, you have a right to a Medicare Appeal. Your appeal rights include a standard 30 calendar day appeal for a denial of a health service and a standard 60 calendar day appeal for a denial of payment. In some cases, you have a right to an expedited 72-hour appeal when a health service is involved. You can receive a 72-hour appeal if your health or ability to regain maximum function could be seriously jeopardized by waiting 30 calendar days for a standard appeal. If you ask for an expedited appeal, the Funds will decide if you get a 72-hour appeal. If not, your appeal will be processed in 30 calendar days. If any doctor asks the Funds to give you an expedited appeal, or supports your request for an expedited appeal, and indicates that waiting up to 30 days could seriously jeopardize your health or ability to regain maximum function, the Funds must give you an expedited appeal.

Appeal of a Denial of Health Service

The Funds is responsible for processing your appeal request for a denial of a health service within 30 calendar days from the date the Funds receives your request or no later than the last day of the extension, which may be up to 14 calendar days.

As described above, you can request a 72-hour appeal orally or in writing. Your request needs to specifically state that "I want an expedited appeal, fast appeal, or 72-hour appeal," or "I believe that my health could be seriously harmed by waiting 30 calendar days for a standard 30 day appeal." If the Funds denies your request for an expedited appeal, your appeal will be processed within 30 calendar days from the date the Funds received your request for an expedited appeal or by no later than the last day of the extension (up to 14 additional calendar days). You have the right to file an expedited grievance with the Funds at 1-800-291-1425 if the Funds denies your request for an expedited appeal. If the Funds approves your request for a fast appeal, it will notify you of its decision within 72 hours of receipt of your request. If the Funds' decision on the expedited appeal is not fully in your favor, the Funds will automatically forward your appeal request to the Centers for Medicare & Medicaid Services Independent Review Entity for an independent review within 24 hours of the Funds' decision.

An extension of up to 14 calendar days is permitted for a 30 calendar day appeal or an expedited 72-hour appeal, if the Funds needs additional information and the extension of time benefits you; for example, if the Funds needs additional information from a health care provider that could change the Plan's denial decision. You will be notified in writing if the Funds needs an extension of 14 calendar days to process your request. You have the right to file an expedited grievance if you disagree with the Funds' decision to grant itself an extension.

You may file your request for a 30 calendar day appeal or a 72-hour appeal in writing, in person or by mail, or by telephone with the Funds or with an office of the Social Security Administration. You can appeal to the Plan in the following ways:

To request an appeal orally, call 1-800-292-2288. The Funds will document the oral appeal request in writing.

To hand-deliver your appeal request, the address is KEPRO, UMWA Funds, 2051 Killebrew Drive, Suite 210, Bloomington, MN 55425-1875.

To FAX your appeal request, the number is 1-800-382-7792. If you are in a hospital or a nursing facility, you may request assistance in having your written appeal request for a service transmitted to the Funds by use of a FAX machine.

To mail a written appeal request, the mailing address is: KEPRO, UMWA Funds, P.O. Box 11897, St. Paul, MN 55111-0897. If it is a 72-hour appeal, the 72-hour review time will not begin until your appeal request is received.

If the Funds does not rule in your favor, the Funds will forward your appeal request to the Centers for Medicare & Medicaid Services Independent Review Entity within 30 calendar days of the date the Funds received your request or by no later than the last day of the extension.

Appeal of a Denial of Payment

The Funds is responsible for processing your appeal request for a payment denial within 60 calendar days from the date the Funds receives your request. You may file your request for a 60 calendar day appeal in writing, in person or by mail, or by telephone with the Funds or with an office of the Social Security Administration. You can appeal to the Funds in the following ways:

To request an appeal orally, call 1-800-292-2288. The Funds will document the oral appeal request in writing.

To hand-deliver your appeal request, the address is: KEPRO, UMWA Funds, 2051 Killebrew Drive, Suite 210, Bloomington, MN 55425-1875.

To FAX your appeal request, the number is 1-800-382-7792. If you are in a hospital or a nursing facility, you may request assistance in having your written request transmitted to the Funds by use of a FAX machine.

To mail a written appeal request, the mailing address is: KEPRO, UMWA Funds, P.O. Box 11897, St. Paul, MN 55111-0897.

If the Funds does not rule in your favor, the Funds will forward your appeal request to the Centers for Medicare & Medicaid Services Independent Review Entity within 60 calendar days of the date the Plan received your request.

Right to File Grievance

As a beneficiary of the UMWA Combined Benefit Fund, you have the right to file a grievance or complaint with the Funds. A "grievance" is a complaint or dispute expressing dissatisfaction with the manner in which the Funds or certain other entities provide health care services and that may require further action on the part of the Funds. Some examples include dissatisfaction with physicians, facilities, providers, Funds' staff or operations, or quality of care, as well as the timeliness, access, or appropriateness or setting of a covered health care service or item. Grievances include complaints about an interpersonal aspect of care such as rudeness by a provider, failure to respect the rights of the beneficiary, or involuntary disenrollment of a beneficiary initiated by the Plan. If you have been denied coverage for a health claim or service, please see the Appeals Procedures set forth above.

How to File a Grievance

The Funds has a grievance procedure to address complaints about quality of service or any other issue that is not about denial of a service or claim. You may submit an informal grievance to the Funds either by telephone or in writing. To discuss a concern, you can call the Funds' Call Center at 1-800-291-1425.

Written complaints should be mailed to:

UMWA Health and Retirement Funds
160 Heartland Drive
Beckley, West Virginia 25801

All written grievances should include your name, address and a full explanation of your complaint, including specific dates, persons, places and events. In a clear statement, please tell us how you believe the problem should be resolved.

Often complaints result from simple misunderstandings that can be resolved informally through discussions among the parties involved. The Funds' Call Center representative will log your call or letter and the nature of the issue and attempt to resolve the problem. If we cannot immediately resolve your concern, we will investigate it and respond to you by phone or letter within 30 days unless it is necessary to take an extension of up to 14 calendar days to gather additional information/medical records and the extension of time benefits you.

You will be notified in writing if the Funds needs additional time (up to 14 calendar days) to consider a grievance case.

We are committed to making every effort to informally resolve your grievance. If, however, the Funds' representative cannot resolve your complaint or inquiry to your satisfaction, you or your authorized representative may file a second level grievance. This must be done in writing and sent to the address listed above. Funds' staff will review your grievance for completeness and may ask for additional information. Once the grievance is complete, it will be referred to an Internal Grievance Committee for review. This committee is made up of one or more internal Funds' management staff who has not previously been involved in your dispute.

The Internal Committee will review your complaint and make a decision within 30 days of the referral of your grievance, unless special circumstances (such as the need to schedule a meeting with you and/or other involved parties) require an extension. If an extension is necessary, you will be notified and will receive a decision in writing from the Committee no later than 90 days after the referral of your grievance. This decision will be final for the Funds.

If you are a Medicare-eligible beneficiary, you may also file a complaint about the quality of your care with the Medicare Beneficiary and Family-Centered Care Quality Improvement Organization ("BFCC-QIO"). You may contact the Funds' Call Center, toll-free, at 1-800-291-1425 for the phone number of your regional BFCC-QIO.

The Funds' Call Center provides prompt responses to your questions and concerns. We encourage you to contact us at 1-800-291-1425 whenever you have a question or concern about your plan or physician. We will work with you to get your questions answered and your issues resolved quickly.

Continuation of Health Benefits Coverage (COBRA)

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1985, you may be able to continue your health benefits coverage even if you are no longer eligible for these benefits under the Combined Fund. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This information is intended to inform you of rights and obligations under COBRA, as amended and reflected in the final and proposed regulations published by the Department of the Treasury. It reflects the law and does not grant or take away any rights under the law.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Each person who is a qualified beneficiary with respect to the qualifying event has an independent right to elect COBRA continuation coverage. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay premiums for such coverage.

If you are the primary participant, you will become a qualified beneficiary if you lose your coverage under the Combined Fund because the following qualifying event happens:

- You exceed the earnings limitation in a month

If you are the spouse of the primary participant, you will become a qualified beneficiary if you lose your coverage under the Plan due to any of the following qualifying events:

- Your spouse dies and you remarry
- You become divorced or legally separated from your spouse
- Your spouse dies and you exceed the earnings limitation in a month

A primary participant's dependent children (not grandchildren) will become qualified beneficiaries if they lose coverage under the Combined Fund because any of the following qualifying events happens:

- The parents die
- The primary participant-parent dies and the surviving spouse-parent remarries
- The parents become divorced or legally separated
- The child loses "dependent child" status coverage under the Plan, or the dependent child exceeds the earnings limitation in a month (unless the dependent child is a full-time student).

Notice Requirements

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. A qualified beneficiary is required to provide the following notices to the Plan Administrator:

(1) Notice of the occurrence of a qualifying event that is a divorce or legal separation of the primary participant from his or her spouse;

(2) Notice of the occurrence of a qualifying event that is a qualified beneficiary's ceasing to be covered under the Plan as a dependent child;

(3) Notice that the primary participant, surviving spouse, or a dependent child who is not a full-time student exceeded the monthly earnings limitation.

Any notice required by (1), (2) and (3) above must be furnished to the Plan Administrator no later than 60 days after the latest of: (i) the date of the occurrence of the qualifying event; (ii) the date on which the qualified beneficiary loses or would lose coverage under this Plan as a result of the qualifying event; or (iii) the date that the qualified beneficiary is informed,

through the furnishing of the Plan's summary plan description or the general COBRA notice, of both the responsibility to provide the notice and the Plan's procedure for providing such notice to the Plan Administrator.

To notify the Plan Administrator of the occurrence of a qualifying event, participants and qualified beneficiaries must request a Notice of Qualifying Event form by contacting the Plan Administrator in writing at: UMWA CBF, 2121 K Street N.W., Suite 350, Washington, D.C. 20037; or by telephoning the Special Payments Analyst at 1-800-291-1425. The form will be provided to you and/or your qualified beneficiaries at no cost and will request information about the qualifying event for the Plan to provide continuation rights to you. The Notice of Qualifying Event form must be completed in full and returned within the periods set forth in this summary plan description. Within 14 days of receipt of the Notice of Qualifying Event form, the Plan Administrator will send you a Notice of Right to Elect Continuation Coverage form. If continuation coverage is not elected within 60 days of the date printed on the Notice of Right to Elect Continuation Coverage Form, then your right to elect COBRA continuation coverage ceases. All questions should be directed to the Plan Administrator at the above contact information.

Benefits That May Be Continued Under COBRA

COBRA coverage must be identical to coverage that is provided to other beneficiaries under this Plan. The qualified beneficiary may, but is not required to, continue these benefits under COBRA. A child born to or placed for adoption with the covered mineworker during the period of COBRA coverage must also be offered these benefits.

Maximum Time Periods

Continuation will be available for a qualified beneficiary up to the maximum time period as shown below. Combined or second qualifying events will not continue a qualified beneficiary's coverage for more than the 36 month limit.

Qualifying Event	Maximum Continuation Period
Divorce or legal separation	36 months
Death of a participant and spouse remarries	36 months
Dependent child loses eligibility	36 months
Death of participant and surviving spouse	36 months
Participant, surviving spouse, or dependent child who is not a full-time student exceeds monthly earnings limitation	36 months

When COBRA Continuation Coverage Ends

Continued coverage will cease on the earliest of:

(1) The last day of the 36 month period.

(2) The date for which timely payment is not made to this Plan with respect to the qualified beneficiary.

(3) The date upon which the Plan Administrator ceases to provide any group health plan (including successor plans) to any participant.

(4) The date, after the election, that the qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion of limitation with respect to any pre-existing condition, if any, other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified beneficiary.

Medical Child Support Orders

Under the provisions of the Omnibus Budget Reconciliation Act of 1993, and Section 609 of ERISA, and consistent with the terms of the Coal Act, effective August 10, 1993, the Plan will provide benefits pursuant to the terms of "qualified medical child support orders."

A "medical child support order" ("MCSO") is any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction (typically, a state court which handles domestic relations matters) which (1) provides for child support with respect to a child of a participant under the Plan or provides for health benefits coverage to such a child, is made pursuant to a state domestic relations law, and relates to benefits under the Plan, or (2) is made pursuant to a law relating to medical child support described in the Social Security Act.

A "qualified" medical child support order ("QMCSO") is an order that (A) either creates or recognizes the right of an "alternate recipient" (a participant's child who is recognized under a MCSO as having a right to be enrolled under the Plan) or assigns to the alternate recipient the right to receive benefits for which a participant or other beneficiary is entitled under the Plan, and (B) includes (i) the name and last known mailing address of the participant and the name and address of each alternate recipient, (ii) a reasonable description of the type of coverage to be provided to each alternate recipient by the group health plan or the manner in which such coverage is to be determined, (iii) the period for which coverage must be provided, and (C) does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan (except to the extent necessary to meet requirements of certain laws).

The procedures governing QMCSO determinations can be obtained, without charge, by participants and beneficiaries from the Plan Administrator.

Once the Funds has determined that a MCSO is or is not "qualified," the Plan will pay benefits to the participant and to each alternate recipient child in line with the determination. Alternate recipients are considered "plan beneficiaries" for all purposes under ERISA and are considered "plan participants" with respect to reporting and disclosure requirements under ERISA. Any payment for benefits made by the Plan under a QMCSO to reimburse the child's out-of-pocket medical expenses paid by the child, by his custodial parent, or his legal guardian shall be made to the child, custodial parent or legal guardian.

Health Benefit Payments

Billing the Funds for Medical Services

When you or an eligible member of your family receives medical treatment, prescription drugs, or other services covered by the Plan, the Funds will pay for those services. Ask your health care provider (physician, hospital, clinic, pharmacy, etc.) to bill the Funds directly. Show him your Funds' combined health services/pharmacy identification card and, if you are also covered by Medicare or the Federal Black Lung Program, show those cards too. It is important to do this because the cards contain information needed for correct billing.

If your provider bills the Funds, you need to pay only the copayments for prescription drugs and visits to a physician. For physician visits, copayments are $5.00 for each visit up to a yearly maximum of $100.00 per family. For prescription drugs filled by a pharmacy, copayments are $5.00 for each prescription, whether the prescription is for a 30, 60 or 90-day (or fraction thereof) supply, up to a yearly maximum of $50.00 per family. **There is no copayment for prescriptions filled through mail order service.**

If your provider will not bill the Funds, you must submit an itemized bill and a completed claim form. Contact the Funds' Call Center for more information about submitting such claims and for copies of the appropriate forms. A list of the addresses to which to send the forms appears at the end of this booklet on page 48.

Generic Drug Substitution Program

The Plan provides that, in the absence of medical necessity, if a brand name drug is prescribed where a generic equivalent is available, you are responsible, in addition to any required copayment, for the additional cost of the brand name drug over the cost of the generic substitute. You will not have to pay the additional cost for the brand name drug if your physician demonstrates to the Plan that it is medically necessary for you to take the brand name drug. To obtain a waiver of the additional charges, your physician must complete a special form, which should be obtained from and returned to CVS/caremark, the Plan's pharmacy benefit manager, indicating the medical reason(s) why it is necessary for you to take the brand name drug. The address and telephone number of CVS/caremark appear at the end of this booklet on page 48.

Preferred Product Program

The Preferred Product Program requires you to obtain "preferred" medication products in seven selected drug categories for the standard copayment. Certain cholesterol drugs, blood pressure drugs, nasal steroid inhalations, drugs to treat diabetes, sleep aids, bladder control drugs, and drugs for opioid-induced constipation are on the "preferred" drug list. "Non-preferred" medications from the seven selected drug categories may still be obtained; however, in addition to the standard copayment, you will also have to pay an additional charge, depending on the dosage and the quantity prescribed. Categories in this program are reviewed each year and are subject to change.

In addition, the Plan has developed a **Specialty Preferred Product Program** for certain classes of medications called "specialty medications." These are medications used to treat chronic conditions such as rheumatoid arthritis and multiple sclerosis. There are four designated categories of specialty medications in this program currently. The categories are autoimmune drugs (used to treat rheumatoid arthritis and other inflammatory conditions), drugs to treat multiple sclerosis, drugs to treat hepatitis C infection, and growth hormone drugs. Because they require significant monitoring, specialty medications in these categories must be obtained through the Plan's Specialty Pharmacy Provider. In addition, the preferred product(s) within one of these four specialty medication categories must be prescribed before a non-preferred drug in the same category will be covered by the Plan. Categories in this program are reviewed each year and are subject to change.

If your physician believes that you cannot take the "preferred" or "preferred specialty" drug because of medical reasons, he must complete a special form, which should be obtained from and returned to CVS/caremark, the Plan's pharmacy benefit manager, detailing the medical reason(s) why a "non-preferred" drug is medically necessary for you.

The Plan also has a **Generics First Specialty Preferred Product Program** for certain specialty medications used to treat some cardiac disorders, cystic fibrosis, hepatitis C infection, pulmonary arterial hypertension, and some cancers, as well as some movement and seizure disorders. The preferred generic specialty drug in these designated categories must be prescribed before a non-preferred drug in the same category will be covered by the Plan. If your physician believes that you cannot take the "preferred generics first specialty" drug because of medical reasons, he must complete a special form, which should be obtained from and returned to CVS/caremark, the Plan's pharmacy benefit manager, detailing the medical reason(s) why a "non-preferred" brand drug is medically necessary for you. Categories in this program are reviewed each year and are subject to change.

For a complete list of "preferred," "preferred specialty," and "preferred generics first specialty" drugs, you should contact the Funds' Call Center or CVS/caremark. Appropriate addresses and telephone numbers appear at the end of this booklet on pages 47-48. You may also view the list of these drugs online at www.umwafunds.org.

Multi-ingredient compound prescriptions with a charge equal to or greater than $300 may be subject to prior authorization requirements.

Vision Care Program

In addition to coverage of medical services, the Plan includes a vision care program. All participants who are eligible for health benefits, including dependents, are covered by this program, which provides benefits for routine eye examinations, eyeglass frames and lenses, and contact lenses. For details, please refer to the "Summary of Health Benefits" section of this booklet under the heading "Routine Vision Care."

Claims for payment of vision care benefits may be submitted by you or your provider (ophthalmologist, optometrist, etc.). Contact the Funds' Call Center for more information about submitting such claims and for copies of the appropriate forms. The address to which to send the forms appears at the end of this booklet on page 48.

Payment of Claims; Explanation of Medical Benefits

In general, for covered services, the Funds will pay the Medicare level of reimbursement established by the Federal Medicare program, less any copayments that you must pay to the provider. If your provider charges more than the amount usually charged for a service, the Funds will pay only the maximum amount that it allows for that service. Excess charges will be subject to the Funds' "hold harmless" program (see below). Payment will be made to you or to your provider, depending upon who submits the claim. For some covered services, the Funds will not pay a claim without documentation that the service is medically necessary.

The Funds will send an Explanation of Benefits ("EOB") form to each beneficiary for whom a medical or vision claim has been processed. The EOB will list the health care services for which the Funds paid and will indicate whether the payment was sent to you or to your provider; it will show the amount that the Funds paid and the copayments that you made. If you submit a claim for reimbursement for prescription drugs yourself, you will receive an "Explanation of Payments" ("EOP") form which will list the prescriptions and amounts for which the Funds paid.

When you have met the yearly copayment maximum for medical care, the EOB will state that your copay for physician visits paid for the year has reached the maximum amount allowed. After you have met a maximum, show the EOB to your provider as proof that you are not required to make further copayments during the current copayment year. When you have met the yearly copayment maximum for prescription drugs, CVS/caremark will inform your pharmacy automatically through its computerized network each time you fill a prescription at a participating pharmacy for the rest of the year. Remember that a **copayment year begins March 27 of one calendar year and ends March 26 of the following calendar year.**

The EOB and EOP are also designed to ensure accurate payments. If any service or prescription listed on one of the EOBs or EOPs is for care or prescriptions that you or another member of your family did not receive, please promptly notify the Funds of that fact by contacting the Funds' Call Center.

Hold Harmless Program

When a provider attempts to collect excessive charges or charges for services not medically necessary, as defined by the Plan, the Plan Administrator or their agent shall, with the written consent of the beneficiary, attempt to resolve the matter either by negotiating a resolution or defending any legal action brought by the provider. Whether the Plan Administrator or their agent negotiates a resolution of a matter or defends a legal action on a beneficiary's behalf, the beneficiary shall not be responsible for any legal fees, settlements, judgments or

other expenses in connection with the case, but may be liable for any services of the provider which are not provided under the Plan. The Plan Administrator or their agent shall have sole control over the conduct of the defense, including the determination of whether the claim should be settled or an adverse determination should be appealed.

You need to use the program only if a provider, a collection agency, or a lawyer tries to collect from you amounts denied by the Funds. If such an attempt to collect from you is made, you should promptly contact the Funds' Call Center.

Care Management

The UMWA Combined Benefit Fund includes provisions to control health care costs and to improve the quality of care without reducing benefits covered by the Plan. Such cost containment programs may include pre-admission approval of inpatient hospital care and review of the length of stay, pre-certification of certain outpatient and surgical procedures, second surgical opinions, case management, and other quality of care programs. Programs to contain prescription drug costs include agreements with networks of pharmacies to accept certain levels of payment for drugs, encouraging the use of generic drugs when medically appropriate, and supplying drugs by mail when advantageous to the beneficiary.

1. Cooperating Provider Networks

The Combined Benefit Fund has established Cooperating Provider Networks as part of its overall cost management strategy. The Combined Benefit Fund has been successful in recruiting providers in all areas where beneficiaries reside, including rural coal field communities. Cooperating providers agree to accept the Combined Benefit Fund's Medicare-based fee schedules as payment in full for all covered services provided to you, regardless of your Medicare status. You can call the Funds' Call Center to find out if the Coopering Provider Network is available in your area.

The Combined Benefit Fund has initiated a program to help ensure that you have access to transportation to medically necessary care in non-emergency situations through a Non-emergency Medical Transportation Network. In exchange for referral of beneficiaries who require transportation, providers in this network accept the Combined Benefit Fund's reimbursement rates.

2. Primary Care Provider (PCP) Networks

In addition to the Cooperating Provider Networks, the Combined Benefit Fund has also established Primary Care Provider networks in a five county area around Birmingham, Alabama and in an eleven county area in southwestern Pennsylvania/northern West Virginia. Beneficiaries living in these areas may select a participating PCP, who may be a general practitioner, family practitioner, general internist, geriatrician or pediatrician to be their Funds network PCP. The $5 copayment for each visit to your physician is waived when you obtain medical care from a physician you

select as your Funds network PCP. If you do not live in a Funds PCP network area, then please refer to the Summary of Health Benefits section below.

Participating PCPs coordinate the care of those beneficiaries who select the practitioner as their PCP, and they agree to obtain prior authorizations and pre-certifications for their panel of beneficiaries, as appropriate. You still retain the freedom to see physicians of your choice. However, you will be required to pay the copayment for each visit to a physician (until your family reaches the annual maximum for the copayment year) for medical care you obtain from a physician who is not a Funds' network PCP. Refer to the General Scope of Benefits section below for more details.

The Combined Fund maintains a fully operational on-line provider directory at "http://www.umwafunds.org". It is also available by mail at no cost. This directory lists all providers who participate as Combined Fund cooperating providers, and is updated and enhanced on a regular basis.

3. Durable Medical Equipment (DME) Network

The Combined Benefit Fund has established a network of seven preferred DME vendors to meet your equipment needs. The DME network offers beneficiaries access to local and national service through the preferred vendors and their subcontractors. Some of the preferred providers have national distribution networks, while others have subcontracts with locally based vendors. Beneficiaries are required to obtain their durable medical equipment from one of the preferred network vendors. Network providers are also the recommended, but not required source for all medical supplies. Beneficiaries are required to utilize network vendors for all incontinence and diabetic supplies. You can call the Funds' Call Center to help you locate a network provider or answer any DME questions you may have.

CARE COORDINATION CONTINUUM

A. Care Coordination (Case Management and Disease Management)

Keystone Peer Review Organization, Inc. ("KEPRO") is the Combined Fund's principal provider of care coordination – case management and disease management – services. Case management is a process designed to meet individual beneficiary needs by mobilizing and integrating appropriate resources and services offered by a variety of health care providers. The process entails identifying, discussing and adopting treatment alternatives in consultation with you, your doctor, your family and other providers. Your doctor remains in control of your care.

Care Coordinators at KEPRO coordinate the provision of agreed-upon care alternatives by the appropriate providers to patients with acute or chronic conditions. Case management uses data resources, assessment and implementation tools and oversight methods to achieve outcomes

that meet the beneficiary's needs in a cost-effective manner. The core functions of case management include assessment of beneficiary needs, development of a plan to meet those needs, coordination of services specified in the plan and oversight of plan implementation and progress. Continual close contact is maintained with the beneficiary's physician, who remains in control of the patient's care.

Candidates for case management are identified through a variety of methods including primary care and other physician referrals, and referrals (by beneficiaries or their families/caregivers) to the Funds' Call Center.

B. Geriatric Care Management

Geriatric Care Management ("GCM") is a care coordination program designed to improve the quality of life of frail elderly beneficiaries and their families. The program seeks to enable enrolled beneficiaries to achieve maximal functional health status, increase access to primary and preventive care as a means to improve quality and control health expense trends, and change patterns of care in order to better meet the health and social needs of beneficiaries and their families.

Enrollment in the GCM program is based on the beneficiary's specific diagnoses or conditions and an assessment by experienced clinicians that enrollment in the program can affect the beneficiary's quality of life and avert or moderate catastrophic developments.

Candidates for GCM are identified through a variety of sources including primary care and other physician referrals, telephonic case management, medical and prescription drug claims data review, field health staff referrals, and referrals from the Funds' Call Center. Geriatric Care Managers, nurses with extensive skills and experience in providing home health and related services to elderly and frail individuals, work directly with beneficiaries, their families, and their providers to facilitate access to health system resources and coordinate the delivery of care and other services. The program involves frequent on-site visits by the GCM nurses to the participants and their families. Depending on developments in their health status, beneficiaries may be transferred from the GCM program to telephonic case management and eventually discharged, as appropriate. Beneficiaries with conditions not suited for the GCM program – conditions for which GCM interventions are not likely to yield the desired results – are referred to KEPRO for other forms of care coordination/management.

GCM services are currently provided to beneficiaries in four areas, southern West Virginia, Eastern Kentucky, parts of Alabama, and Utah.

The GCM site in southern West Virginia serves beneficiaries residing in Mercer, McDowell, Wyoming, Raleigh, Boone, Logan and Mingo counties.

SUMMARY OF HEALTH BENEFITS

This section describes the medical, hospital, and other health care services covered by the UMWA Combined Benefit Fund. Hospital care may be provided by any hospital accredited by The Joint Commission, or by non-accredited hospitals, which have been approved by the Funds. Medical care may be provided by physicians and, in certain instances, by other appropriately trained and licensed health care professionals. Prescription drugs and medications may be provided by pharmacies, hospital outpatient clinics, and facilities such as hospitals and skilled nursing care facilities that provide health care services on an inpatient basis. Some services require prior approval; to obtain such approval, write to the address that appears at the end of this booklet.

This section is a simplified and condensed version of the Plan Document for the UMWA Combined Benefit Fund's provisions for covered services. All final determinations concerning coverage of a particular service are subject to the specific provisions of the Plan Document. If you cannot find the information that you want about a particular service, contact the Funds' Call Center or write to the address that appears at the end of this booklet and request a copy of the Plan Document.

1. General Scope of Benefits

Physicians' Services and Other Primary Care

Primary care encompasses treatment of illnesses and injuries as well as preventive care. A primary care physician is a physician of first contact, often a general or family practitioner, pediatrician or internist.

In addition to primary care, the Plan covers treatment prescribed or administered by a specialist if the treatment is for an illness or injury that falls within the specialist's area of expertise. Consultations with specialists will be covered when the physician in charge of the case requests the consultation.

The Plan also covers care or medical treatment administered by physician extenders such as nurse practitioners, physician's assistants, and other certified or licensed health personnel. However, with the exception of Certified Registered Nurse Anesthetists ("CRNAs"), services of physician extenders will be covered only when provided under the supervision of a physician. The Plan will not cover services of any practitioner who is not legally licensed to practice medicine, surgery, or counseling unless specifically provided herein.

The Plan does **not** cover dental services, acupuncture therapy, naturopathic therapy, or chiropractic services. However, as a Medicare Health Care Prepayment Plan ("HCPP"), the Funds will pay Medicare-eligible

beneficiaries for chiropractic services that are covered by Medicare Part B. The Plan does not cover charges for writing prescriptions, preparing medical summaries and invoices, or telephone conversations with a physician in the place of an office visit.

Benefit payments shall not exceed reasonable and customary charges for covered services, as defined by the Plan, and supplies. The fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary or that it is covered under the Plan. In determining questions of reasonableness and necessity, due consideration will be given to the customary practices of physicians in the community where the service is provided.

The reasonable and customary charge for any service or supply is the Medicare allowable amount for a medical service in a geographic area, or as otherwise determined by the Trustees. In general, the Plan uses the Medicare Fee Schedules to determine amounts payable for physician, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies. The Plan uses the Medicare Prospective Payment Systems to pay for inpatient hospital services, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities, and other appropriate classification systems and methodologies to pay for other services including home health and hospice services.

Services which are not reasonable and necessary shall include, but are not limited to:

- Procedures which are of unproven value or of questionable current usefulness;
- Procedures which tend to be redundant when performed in combination with other procedures;
- Diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly;
- Procedures which are not ordered by a physician or which are not documented in a timely fashion in the patient's medical records;
- Procedures which can be performed with equal efficiency at a lower level of care.

Covered services that are medically necessary will continue to be provided, and accordingly, while benefit payments are subject to prescribed limits, this paragraph shall not be construed to detract from plan coverage or eligibility.

2. Preventive Care

The Plan covers physical examinations, and any laboratory tests and x-rays ordered in connection with such examinations, if they are medically necessary. Examinations that the Plan defines as medically necessary include

those performed when your age places you in a high-risk group (defined by the Plan as under age six or age fifty-five or older) or when you are being treated for a specific condition or chronic illness. Examinations prescribed by a specialist as part of the specialist's care of your medical condition are covered. Annual or semiannual routine examination by a gynecologist and pap smears are also considered medically necessary. The Plan also covers preventive health care services such as immunizations, allergy desensitization injections, screenings for hypertension, diabetes, tests to detect cancer, blindness, and deafness when medically necessary. Copayments are required for all examinations covered by the Plan, except for the following preventive care services:

- Abdominal aortic aneurysm screening
- Alcohol misuse screenings & counseling
- Bone mass measurements (bone density)
- Cardiovascular disease screenings
- Cardiovascular disease (behavioral therapy)
- Cervical & vaginal cancer screening
- Colorectal cancer screenings
- Depression screenings
- Diabetes screenings
- Diabetes self-management training
- Glaucoma tests
- Hepatitis C screening test
- HIV screening
- Lung cancer screening
- Mammograms (screening)
- Nutrition therapy services
- Obesity screenings & counseling
- One-time "Welcome to Medicare" preventive visit
- Prostate cancer screenings
- Sexually transmitted infections screening & counseling
- Shots:
  - Flu shots
  - Hepatitis B shots
  - Pneumococcal shots
- Tobacco use cessation counseling
- Yearly "Wellness" visit

For the most current list of preventive services, please contact the Funds' Call Center at 1-800-291-1425.

Routine checkups performed at your request such as those required to obtain a marriage license or to gain employment are not considered medically necessary, nor are examinations that are required for Federal Black Lung Benefit applications. If payment for an examination is denied, payment will also be denied for diagnostic procedures performed in connection with the examination.

3. Treatment of Illnesses and Injuries

The Plan covers visits to a physician in his office, by a physician in your home, in a clinic (including the outpatient department of a hospital), or in a hospital if you are being treated for an illness or injury. Telephone conversations with a physician in lieu of an office visit are not covered by the Plan. If you are an inpatient in a hospital, benefits treating your illness or injury will also be provided concurrently with benefits for surgical, obstetrical and radiation therapy services when you have a separate and complicated condition, the treatment of which requires skills not possessed by the physician who is rendering the surgical, obstetrical or radiation therapy services. Benefits are provided for services rendered, at the request of the attending physician in charge of the case, by a physician who is qualified in a medical specialty necessary in connection with medical treatment required for you. The Plan also covers x-rays and laboratory tests ordered for diagnostic purposes when they are performed by an appropriately licensed provider or facility. Emergency medical treatment rendered by a physician in an emergency room is covered if you receive care within 48 hours of the onset of acute medical symptoms or the occurrence of an accident.

If you are a non-Medicare-eligible beneficiary in an area in which Funds' Cooperating Hospitals are not located and you require emergency hospital services rendered in an Accredited Hospital, such services will be considered to have been rendered in a Funds' Cooperating Hospital. An Accredited Hospital is a hospital which is operated primarily for the purpose of rendering inpatient therapy for the several classifications of medical and surgical cases and which is approved by The Joint Commission or which has been approved by the Trustees of the UMWA Combined Benefit Fund. A Funds' Cooperating Hospital is an Accredited Hospital which has been designated by the Trustees as a hospital approved as a primary provider of hospital care and treatment.

Medicare-eligible beneficiaries can receive emergency services in any hospital, whether or not such hospital is an Accredited or a Funds Cooperating Hospital.

4. Treatment of Mental Illnesses

When a physician determines that treatment is medically necessary and, such treatment is not available at no cost from another source, the Plan provides benefits for individual psychotherapy, group therapy, psychological testing, and counseling. The cost of an alcoholism or drug rehabilitation program may also be covered, but such services are subject to prior approval based upon the patient's prospects for rehabilitation. The Plan will not cover alcoholism and drug rehabilitation if an advance determination has not been made by the rehabilitation team. It also will not approve alcoholism and drug rehabilitation programs that are not approved by the Plan Administrator. Copayments are required for all mental health services, including rehabilitation.

The Plan does not cover encounter and self-improvement group therapy, custodial care related to intellectual disability and other mental deficiencies, services rendered by private teachers, or treatment intended to correct school-related behavior problems.

5. Surgical Services

The Plan defines surgical services as operative and cutting procedures, as well as usual and necessary postoperative care required for treatment of illnesses, injuries, and dislocations of bones. The Plan will pay for surgical services whether you receive them in or out of a hospital. Copayments are not required for inpatient surgical services.

When surgical services consist of necessary major surgery (primary) and the physician performs surgery additional to the primary surgery (incidental surgery), benefits payment for the incidental surgery will be provided but at a rate 50% lower than the physician's normal charge had he performed only the incidental surgery. If your condition or the nature of the procedure necessitates admission to a hospital, the Plan will also provide for the services of a physician who actively assists the operating physician in the performance of such surgical services when your condition and type of surgical service require such assistance.

In addition to fees for surgical services, the Plan will cover the cost of anesthesia and charges for administering it when billed by a physician or Certified Registered Nurse Anesthetist ("CRNA") other than the operating surgeon or the assistant surgeon, who is not an employee of nor compensated by a hospital, laboratory or other institution.

The Plan requires **prior approval** for certain surgical services and limits payments for others:

Oral Surgery: The Plan covers the following limited oral surgical procedures if performed by a dental surgeon or general surgeon:

Tumors of the jaw (maxilla and mandible);

Fractures of the jaw, including reduction and wiring;

Fractures of the facial bones;

Frenulectomy when related only to ankyloglossia (tongue tie);

Temporomandibular Joint Dysfunction, only when medically necessary and related to an oral orthopedic problem;

Biopsy of the oral cavity; and

Dental services required as the direct result of an accident.

The Plan does not provide for dental services like orthodontia and orthodontic treatments.

Podiatrists: Benefits are provided for minor surgery rendered by a qualified licensed podiatrist. Routine care of the feet such as trimming of nails, the treatment of corns, bunions (except capsular or bone surgery therefor) and calluses is excluded. Covered minor surgery includes surgery for ingrown nails and surgery in connection with the treatment of flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. Benefits for major surgical procedures rendered by a licensed podiatrist are not provided, except if such surgery is rendered in a hospital and the Plan Administrator has given prior approval.

Other services that are subject to **prior approval** include but are not limited to:

Plastic surgery, including mammoplasty;

Reduction mammoplasty;

Intestinal bypass for obesity;

Gastric bypass for obesity;

Cerebellar implants;

Dorsal stimulator implants;

Prosthesis for cleft palate if not covered by any private charitable organization or government program; and

Organ transplants.

The Plan covers plastic surgery that is necessary to correct surgical scars, the effects of an accidental injury, or birth defects. The Plan does not cover tonsillectomies and adenoidectomies unless they are medically necessary.

6. Obstetrical and Family Planning Care

Annual or semiannual routine examination by a gynecologist and pap smears are covered by the Plan. The Plan covers prenatal and postnatal care, and classes in natural childbirth techniques rendered at hospitals and clinics. Benefits are provided for a beneficiary who is confined in a hospital for pregnancy. Hospital delivery, and administration of anesthesia during delivery are covered. Home delivery is not covered by the Plan. A covered delivery may be performed by a physician or by a midwife who is certified by the American Midwifery Certification Board and is licensed as required by law. Prenatal and postnatal care visits are subject to the copayment provisions of the Plan if they are not included in the delivery fee, that is, if the visits and the delivery are billed separately.

The Plan 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 vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting

with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Plan covers a termination of pregnancy performed by a licensed gynecologist or surgeon when a physician certifies that it is medically necessary. It also covers all sterilization procedures performed by physicians and family planning services furnished by physicians and other appropriately trained and licensed health care professionals who practice under the supervision of a physician. The Plan does not cover reversal of sterilization procedures. Fees for artificial insemination are covered when the procedure is performed by a licensed gynecologist.

Although the Plan does not cover birth control devices and medications, it does cover fees for services rendered in connection with the prescription of birth control medications or the fitting of birth control devices. For example, the Plan will pay a physician's fee for inserting or removing an IUD or fitting a diaphragm, but will not pay for the IUD or diaphragm itself.

The Plan covers care of newborn babies and routine medical care of children prior to attaining age 6.

7. Eye Care

The Plan covers fees for medical and surgical treatment of eye diseases and injuries and the cost of eyeglasses or contact lenses if they are medically required because of surgically caused refractive errors. These coverages are separate from the routine eye care provided by the vision care program.

Inpatient Hospital Services

If you are hospitalized by a licensed physician for treatment as an inpatient to an Accredited Hospital (hereinafter "hospital") for the diagnosis or medically necessary treatment of a covered illness, injury, or obstetrical condition, the Plan will cover the following:

- Semiprivate room and board including charges for special diets and general nursing care. Additional fees for a private room will be covered only if isolation is necessary for your health or the health of other patients or if a semiprivate room is not available and your condition requires immediate hospitalization. If you are put into a private room because no semiprivate room is available, the Plan will not cover the additional fee for the private room beyond the day on which a semiprivate room first becomes available and your condition permits transfer to the semiprivate room.

- Intensive and Coronary Care Unit services if your attending physician certifies that it is medically necessary for you to be in such a unit.

- Private duty nursing care if there is no space in the hospital's intensive care unit and your physician certifies that private duty nursing is necessary to preserve life. The Plan will cover this care for up to 72 hours per inpatient hospital admission. In no event will payment be made for private duty nursing during a period of confinement in the Intensive Care Unit of a hospital.

- Use of hospital facilities such as operating, delivery and recovery rooms.

- Diagnostic or therapeutic items and services such as laboratory tests, x-rays, chemotherapy, radiation therapy and physical therapy.

- Administration of blood and blood plasma, as well as the cost of the blood itself if it is not replaced by you or replaced by someone else on your behalf.

- Renal dialysis benefits will be provided so long as the renal dialysis therapy is administered in accordance with Federal Medicare regulations as in effect from time to time.

- Medically necessary services provided in a hospital also include the following:

  Anesthesia services;

  Oxygen and its administration; and,

  Intravenous injections and solutions.

- The Plan will only cover hospitalizations for acute (short-term) mental illnesses for up to a maximum of ninety (90) days of care over a two-year period, and will provide benefits only for a maximum of thirty (30) days of hospital care for each episode of acute mental illness. Benefits for an additional thirty (30) days of hospital care for a single episode of mental illness may be provided subject to prior approval.

- The Plan will cover emergency hospital stays for a maximum of seven (7) days when the reason for hospitalization is alcohol detoxification or treatment of drug abuse. If a separate medical condition or mental illness requires a longer hospital stay, the usual Plan coverages and limitations will apply.

- The Plan will not cover admission to a hospital for diagnostic procedures that could be performed on an outpatient basis, nor will the Plan cover personal services such as barber services, guest meals and cots, telephone or rental of radio or television and personal comfort items not necessary to the treatment of an illness or injury; and additional fees for a private room.

Outpatient Hospital Services

The Plan will cover the following Outpatient services:

- Surgical treatment in the outpatient department of a hospital or ambulatory surgical center.
- Chemotherapy for treatment of malignant diseases and radiation treatments performed in the outpatient department of a hospital are covered.
- Physical therapy furnished on an outpatient basis by a hospital that is prescribed and supervised by a physician is covered.
- Renal dialysis is also covered on an outpatient basis when the method of administration is such that benefits can be coordinated with Medicare.
- The Plan covers laboratory tests and x-rays performed on an outpatient basis in the outpatient department of a hospital when they are ordered by a physician as necessary for diagnosis or treatment of a definite illness, injury, or medical condition. The Plan will not cover laboratory tests and x-rays ordered in connection with a routine physical examination, unless the examination is considered medically necessary by a physician.
- Psychotherapy, psychological testing, counseling, group therapy and alcoholism or drug rehabilitative programs are covered outpatient services where free care services are not available and when they are determined to be medically required by a physician.
- Emergency room services will be covered by the Plan if you receive such emergency medical treatment within 48 hours of the onset of acute medical symptoms or the occurrence of an accident.

Skilled Nursing Care Facilities

Coverage for stays in skilled nursing care facilities are subject to **prior approval.** For the Plan to cover such stays, skilled nursing care services must be medically necessary. The Plan will not pay for confinement in a skilled nursing care facility for custodial care or for a rest cure. Only stays in nursing facilities which are licensed, Medicare-certified, and in accordance with state laws and regulations will be authorized, and the Plan will provide coverage only to the extent that it is not provided by state and Federal programs. If you are a Medicare beneficiary, coverage under the Plan will commence on the one hundredth one (101) day of your stay at a skilled nursing care facility and will end on the day that skilled care services are no longer medically necessary.

During approved stays in skilled nursing care facilities, the Plan will cover room and board; skilled nursing care provided by or under the supervision of a registered nurse and under the general direction of a physician; physical, occupational, inhalation or speech therapy provided by or arranged for by the

facility; drugs; immunizations; supplies; appliances; equipment; medical social services; medical services, including services provided by interns or residents in an approved, hospital run training program, as well as other diagnostic and therapeutic services provided by the hospital; and other health services ordinarily furnished by skilled nursing care facilities.

Among the services not covered by the Plan is private duty nursing (unless necessary to preserve life); personal items such as telephones, televisions, radio, barber services and meals for guests; additional fees for a private room or custodial care, and services not usually provided in a skilled nursing facility. The Plan also will not pay for services in a skilled nursing facility where the Trustees have deemed the quality of care unacceptable.

Extended Care Units

All stays in extended care units are subject to **prior approval** by the Plan Administrator. The Plan may cover an initial stay in an extended care unit for up to 2 weeks; an extension may be granted when requested by a physician and approved by the Plan Administrator. The Plan will not pay for services in an extended care unit unless, in the case of a Medicare patient, such extended care has prior approval of Medicare.

The same benefits will be provided during a stay in a hospital's extended care unit as during a stay in any other hospital unit. The Plan will not pay bills for services, drugs, or other items unless those items would be paid for a hospital patient, nor will the Plan pay for custodial care.

Home Health Services and Equipment

Home health services will be covered by the Plan if your condition is such that you are confined to your home and you require skilled nursing care, physical therapy or speech therapy at least once in a 60-day period. Bills will be paid only for services ordered by physicians and provided by licensed personnel employed by certified home health agencies.

Your physician must document the need for home health services by submitting a treatment plan which includes a diagnosis and specific information about your functional limitations. The treatment plan must specify the kinds and frequency of services that are needed. Home health services may be provided by qualified personnel, such as registered nurses, and home health aides, and include various kinds of rehabilitation therapy.

1. Home Health Services

The Plan will cover skilled nursing care services rendered in your home if your condition is unstable and a physician concludes that evaluation and observation by a registered nurse are necessary. The Plan Administrator may request an evaluation visit to your home.

The Plan will also cover physical and speech therapy provided in your home if it is prescribed by a physician to restore functions lost or reduced by illness or injury and is performed by qualified personnel. When you have reached

your restoration potential, the services required to maintain this level will no longer be covered.

2. Durable Medical Equipment and Supplies

The Plan will cover the cost of rental or purchase of durable medical equipment suitable for home use when a physician determines that the equipment is necessary. The equipment must be rented or purchased from an approved Funds' durable medical equipment vendor. Exercise equipment is not covered by the Plan.

The Plan will also cover the use of medical supplies. Certain supplies, however, must be purchased from an approved vendor. Contact the Funds' Call Center for more information. The Plan covers oxygen and related equipment if you have been referred by an attending physician to a pulmonary consultant for testing and the consultant's report is submitted with the bill for the oxygen. The Plan may also cover services of an inhalation therapist who visits your home if your physician orders such treatment.

3. Coal Miners Respiratory Disease Program

The Plan covers services or treatment provided in your home by the Coal Miners Respiratory Disease Program if ordered or requested by a physician. Such services are subject to prior approval and will be covered by the Plan only if similar services cannot be obtained under a government program for which you are or would be eligible.

Hospice Care

The Plan will cover hospice care in a certified hospice care facility or provided in your home by a certified home health agency provided that the care is administered in accordance with the Federal Medicare program.

Drugs and Medications

The Plan covers reasonable charges for insulin and drugs which by law require a prescription. Participating network pharmacies directly submit claims for prescription drug benefits and accept the Funds' reimbursement for prescription drugs as payment in full.

The Plan covers drugs prescribed by a physician for treatment or control of an illness or non-occupational injury when they are dispensed by a licensed pharmacist, or drugs prescribed by a licensed dentist for treatment following the performance of an oral surgical service covered by the Plan. The Plan does not cover medications prescribed for birth control.

During any twelve-month period, the initial fill and subsequent refills of your prescription may be dispensed in an amount up to, but no more than, a 90-day supply. Benefits beyond the initial twelve months require a new prescription.

If you are confined to a hospital, skilled nursing care facility, or extended care unit for treatment of a covered illness, injury, or obstetrical condition, the Plan

will cover the cost of all medications administered during your stay in the facility.

Copayments are not required for drugs and medications administered during your stay in an inpatient facility. However, you will be required to make a copayment for each 90-day supply or less of a drug or medication filled by a pharmacy on an outpatient basis as well as for take-home supplies of drugs following a hospital stay. These copayments will continue until your family reaches the maximum for the copayment year. There is no copayment for prescriptions filled through mail order service.

Routine Vision Care

The Plan provides benefits for eye examinations, eyeglasses, and contact lenses. There are no co-payments required for the vision care program, but payments are limited to the following amounts once every 24 months:

Benefit	*Actual Charge to Maximum Amount*
Vision examination	$20 per exam
Per lens (maximum of two) Single vision lens Bifocal lens Trifocals Lenticular lens Contact lens	 $10 per lens $15 per lens $20 per lens $25 per lens $15 per lens
Eyeglasses frames	$14 per set

The 24-month period begins the date the examination is performed or the date the lenses or frames are ordered. The vision care program does not cover the cost of new lenses unless there is an axis change of 20 degrees or a .50 diopter sphere or cylinder change in your prescription and, the new prescription improves your vision by at least one line on the standard eye chart. These prescription and frequency limitations described above apply even if you lose or break your eyeglasses or contact lenses. Unless coverage is provided for elsewhere in the Plan, the vision care program does not cover the following:

(1) sunglasses (other than Tints #1 or #2);

(2) extra charges for photosensitive or anti-reflective lenses;

(3) drugs or medication (other than for vision examination), and medical or surgical treatment of eyes;

(4) special procedures, such as orthoptics, vision training, subnormal vision aids, aniseikonia lenses and tonography;

(5) experimental services or supplies;

(6) replacement of lost or broken lenses and/or frames unless replacement is eligible under the frequency and prescription limitations;

(7) services or supplies not prescribed as necessary by a licensed physician, optometrist or optician;

(8) services or supplies for which the insured person is entitled to benefits under any other provision of the Plan or as provided under a mine safety glass program;

(9) any services which are covered by any workers' compensation laws or employer's liability laws, or services which the Employer is required by law to furnish in whole or in part;

(10) services or supplies which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any federal, state, municipal or other governmental body;

(11) charges for services or supplies for which no charge is made that the Beneficiary is legally obligated to pay or for which no charge would be made in the absence of vision care coverage.

Other Benefits

1. Prosthetic Devices

The Plan will cover the cost of prosthetic devices, which serve as replacements for internal and external body parts, if they are prescribed by a physician and deemed medically necessary. Types of prostheses which are covered include artificial eyes, noses, hands or hooks, feet, arms and legs, and breast prostheses for patients who have undergone mastectomies. Ostomy bags and supplies are also covered. Stump stockings and harnesses require prior approval from the Plan Administrator and are covered when these devices are essential for the effective use of an artificial limb; an examination and recommendations by an orthopedic physician are required. Up to two pairs per prescription (no refills) of surgical stockings are covered when prescribed by a physician for surgical or medical conditions. The Plan does not cover support hose, garter belts, etc. The Plan also does not cover any dental prostheses.

2. Orthopedic Appliances

Orthopedic appliances may be covered if they are prescribed by a physician. Among the appliances covered by the Plan are leg, arm, back and neck braces and trusses. In addition, the Plan will cover the cost of repair or adjustment of orthopedic appliances and replacement of appliances which have worn out and can no longer be repaired. Benefits will also be provided to cover repair and adjustment cost for appliances and artificial limbs. Replacements

of usable appliances will be covered only if they are needed due to a change in your condition. If replacement of a prosthesis is required, you should in all cases be reevaluated by an orthopedic physician.

3. Orthopedic Shoes

The Plan covers the cost of specially-built orthopedic shoes and shoes that must be modified to be attached to a brace, provided that the shoes are prescribed by a licensed physician. Benefits will not be provided for stock orthopedic shoes. When prescribed by a licensed orthopedist, podiatrist, family practitioner, or pediatrician, the cost of adding orthopedic modifications or corrections to ordinary shoes may also be covered; however, the cost of the shoes themselves will not be covered.

4. Physical Therapy

The Plan covers physical therapy provided in a hospital, skilled nursing care facility, treatment center, or your home when necessary to restore functions lost or reduced by illness or injury. Physical therapy must be prescribed and supervised by a licensed physician and must be administered by a licensed physical therapist approved by the Plan Administrator. In addition, the therapy must be justified by the physician's diagnosis and medical recommendation. Once maximum restoration of function has been obtained, the Plan will not continue to pay for physical therapy.

5. Speech Therapy

The same general limitations which apply to physical therapy also apply to speech therapy. The Plan covers speech therapy rendered by a licensed therapist for stroke patients, patients who have had a ruptured aneurism, brain tumor or autism, and need special instruction to restore technique of sound and to phonate, and need direction in letter and word exercises in order to express basic needs. Therapy by a qualified speech therapist may also be covered for children who have speech impediments if they are unable to obtain therapy through the public school system.

6. Hearing Aids

The Plan covers hearing aids only if they are recommended by an otologist or otolaryngologist and certified audiologist. To be covered, hearing aids must be purchased from approved, participating hearing aid vendors; a list of these vendors can be obtained by calling the Funds' Call Center or by visiting the Funds' on-line provider directory at www.umwafunds.org. It is also available by mail at no cost. The on-line directory lists all providers who participate in the Hearing Aid Network, and is updated and enhanced on a regular basis. Unless prior approval has been granted, the Plan will cover the cost of a hearing aid for only one ear.

After the expiration of the warranty period, the Plan will cover necessary maintenance and repairs except for the replacement of batteries. The Plan does not cover fees for incorporating hearing aids into eyeglass frames. The cost of a new hearing aid will be covered only if it is needed due to a change in your condition, or if the old hearing aid no longer functions properly.

7. Ambulance and Other Transportation

The Plan will pay for ambulance transportation to or from a hospital, clinic, physician's office, medical center, or skilled nursing care facility provided that the ambulance is considered medically necessary by a physician and approved by the Plan. With prior approval, the Plan provides coverage for the cost of frequent transportation to a hospital or clinic for essential treatment, such as radiation or physical therapy, if hospitalization would be the only feasible alternative to the transportation coverage in order for you to receive the needed treatment. With prior approval, if the needed medical care is not available near your home and you must be taken to an out of area medical center for treatment, transportation may be covered. Under certain, limited circumstances, the Plan may also cover the services of an escort; an attending physician must submit satisfactory evidence as to why you need an escort and you must receive prior approval.

For more complete information about the Plan's coverage of transportation for medical services, please contact the Funds' Call Center. You will be given details on the procedures you must follow to be reimbursed for transportation expenses and the level of reimbursement you will receive.

8. Chiropractic Care for Medicare-Eligible Beneficiaries

Chiropractic Care is a benefit covered only for Medicare-eligible beneficiaries. The Plan will reimburse the Medicare portion only and will not cover the Medicare copayment for these services. Prior approval must be obtained from the Plan Administrator before any treatments begin.

The Plan will not provide chiropractic care to non-Medicare-eligible beneficiaries. For more complete information about the Plan's coverage of chiropractic care, please contact the Funds' Call Center.

Other General Exclusions

In addition to the specific exclusions otherwise contained in the Plan, benefits are also not provided for the following:

- Charges for writing a prescription;
- Medications dispensed by other than a licensed pharmacist;
- Charges for medical summaries and medical invoice preparations;
- Cases covered by workers' compensation laws or employer's liability acts or services for which an employer is required by law to furnish in whole or in part;

- Services rendered (i) prior to the effective date of a Beneficiary's eligibility under the Plan, (ii) subsequent to the period after which a Beneficiary is no longer eligible for benefits under the Plan; or (iii) in a non-accredited hospital, other than for emergency services;
- Services furnished by any governmental agency, including benefits provided under Medicaid, Federal Medicare and Federal and State Black Lung Legislation for which a Beneficiary is eligible or upon proper application would be eligible;
- Services furnished by tax supported or voluntary agencies;
- Immunizations provided by local health agencies;
- Evaluation procedures such as x-rays and pulmonary function tests, in connection with applications for black lung benefits, or required by Federal or State Black Lung legislation;
- Custodial care, convalescent or rest cures;
- Services for which a Beneficiary is not required to make payment;
- Excessive charges;
- Charges related to sex transformation unless required by law;
- Charges in connection with a general physical examination, other than as specified in this Plan;
- Inpatient confinements solely for diagnostic evaluations which can be provided on an outpatient basis;
- Finance charges in connection with a medical bill;
- Charges for treatment with new technological medical devices, therapy which are experimental in nature;
- Charges for treatment of obesity, except for pathological, morbid forms of severe obesity (200% or more of desirable weight) when prior approval is obtained from the Plan Administrator;
- Charges for an autopsy or post mortem surgery;
- Any types of services, supplies or treatments not specifically provided by the Plan;
- Any claim which is submitted for payment under the Plan after twelve (12) months or more from the date of service.

DEATH BENEFITS

The Plan pays a lump-sum death benefit to the eligible survivors of a participant:

(1) who is receiving pension payments under the UMWA 1974 Pension Trust, or

(2) has made application for and is eligible to receive such payments, and whose death occurs on or after February 1, 1993.

The amount of the death benefit payment is $5,000 to the surviving spouse or other eligible dependent, or $4,000 to his estate or, for 1974 Plan pensioners, any other named beneficiary, if no eligible dependent survives him.

Funds' Address and Phone Numbers

Central Office

UMWA Health and Retirement Funds
2121 K Street, N.W., Suite 350
Washington, D.C. 20037
Telephone: (202) 521-2200

Funds' Call Center: 1-800-291-1425

CLAIMS SUBMISSIONS

Prescription Drugs

UMWA Health and Retirement Funds
c/o CVS/caremark
P.O. Box 52136
Phoenix, AZ 85072-2136
Toll Free: 1-800-294-4741

Medical Services, Supplies and Vision Care

UMWA Health and Retirement Funds
P.O. Box 99002
Lubbock, TX 79490-9002
Toll Free: 1-888-865-5290

Care Management

KEPRO
UMWA Funds
P.O. Box 11897
St. Paul, MN 55111-0897
Toll Free: 1-800-292-2288

Prior Approval and Managed Care Programs

*The Funds will not pay for some services unless you get approval from the Funds **before** you receive the services; the section titled "Summary of Health Benefits" identifies services that require prior approval. If your provider has any questions about prior approval or any other managed care programs, ask him to call 1-800-292-2288. If you have any questions, please call the Funds' Call Center at 1-800-291-1425.*

THE ACA, NON-DISCRIMINATION, AND LANGUAGE SERVICES

The Affordable Care Act

This Plan covers only retired employees, disabled employees, and their dependents and survivors, and it is therefore exempt from most of the requirements of the Affordable Care Act ("ACA").

Discrimination is Against the Law

Non-discrimination

The UMWA Health and Retirement Funds complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The UMWA Health and Retirement Funds does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The UMWA Health and Retirement Funds:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Funds' Call Center at 1-800-291-1425.

If you believe that the UMWA Health and Retirement Funds has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Compliance Manager
UMWA Health and Retirement Funds
160 Heartland Drive
Beckley, WV 25801
1-800-291-1425 (TTY: 711)

You can file a grievance in person or by mail. If you need help filing a grievance, the Compliance Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-800-291-1425 (TTY: 711).

Español (SPANISH)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-291-1425 (TTY: 711).

□□촵頂 (CHINESE)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-291-1425 (TTY: 711).

Polski (POLISH)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-291-1425 (TTY: 711).

한국어 (KOREAN)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-291-1425 (TTY: 711). 번으로 전화해 주십시오.

Tiếng Việt (VIETNAMESE)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-291-1425 (TTY: 711).

Deutsch (GERMAN)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-291-1425 (TTY: 711).

ية (ARABIC)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-291-1425 (رقم هاتف الصم والبكم: 711).

Русский (RUSSIAN)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-291-1425 (TTY: 711).

Tagalog (TAGALOG – FILIPINO)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-291-1425 (TTY: 711).

Français (FRENCH)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-291-1425 (ATS: 711).

Deitsch (PENNSYLVANIA DUTCH)
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-800-291-1425 (TTY: 711).

ગુજરાતી (GUJARATI)
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-291-1425 (TTY: 711).

Italiano (ITALIAN)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-291-1425 (TTY: 711).

اُردُو (URDU)
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-291-1425 (TTY: 711).

हिंदी (HINDI)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-291-1425 (TTY: 711). पर कॉल करें।

Diné Bizaad (Navajo)
Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-291-1425 (TTY: 711)