

1993 UMWA BENEFIT PLAN

PLAN DOCUMENT

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1993 BENEFIT PLAN PROGRAMS OF BENEFITS

This Plan (“1993 Benefit Plan” or “1993 Plan” or “Plan”) is established in accordance with the requirements of the United Mine Workers of America 1993 Benefit Plan Agreement and Declaration of Trust. The 1993 Plan consists of five separate programs of benefits: (1) the “1993 Plan Traditional Program of Benefits;” (2) the “1993 Plan Post-Legislative Program of Benefits;” (3) the “1993 Plan Individual Employer Program of Benefits;” (4) the “1993 Plan UMWA Program of Benefits;” and (5) the “1993 Plan Crimson Oak Grove Individual Employer Program of Benefits.” Part I of this document describes the 1993 Plan Traditional Program of Benefits. Part II describes the 1993 Plan Post-Legislative Program of Benefits. Part III describes the 1993 Plan Individual Employer Program of Benefits. Part IV describes the 1993 Plan UMWA Program of Benefits. Part V describes the 1993 Plan Crimson Oak Grove Individual Employer Program of Benefits.

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PART I--1993 PLAN TRADITIONAL PROGRAM OF BENEFITS

ARTICLE I INTRODUCTION TO TRADITIONAL PROGRAM OF BENEFITS

This Plan is established in accordance with the requirements of Article IX of the United Mine Workers of America 1993 Benefit Plan Agreement and Declaration of Trust. The purpose of the 1993 Plan Traditional Program of Benefits is to provide eligible retired miners and dependents the benefits described herein. Notwithstanding any other provision in this Plan Document, the benefits provided under the Traditional Program of Benefits are available only to those eligible beneficiaries whose benefits are funded by federal transfers authorized under Section 402(h)(2)C, 402(i)(1)(B), and 402(i)(3) of the Surface Mining Control and Reclamation Act of 1977, as amended, (“SMCRA”), 30 U.S.C. § 1232(h)(2)(C), 1232(i)(1)(B), and 1232(i)(3), or by transfers from the voluntary employees’ beneficiary association (“VEBA”) described in Section 402(h)(2)C(iv) and (v) of SMCRA, 30 U.S.C. § 1232(h)(2)C(iv) and (v).

ARTICLE II DEFINITIONS UNDER TRADITIONAL PROGRAM OF BENEFITS

The following terms shall have the meanings hereinafter set forth:

(1) “BCOA” means the Bituminous Coal Operators’ Association, Inc. For purposes of any action required or permitted under this Plan, any action of the Employers which may, or must, be taken hereunder may be taken only by BCOA. Any action which must be taken in writing shall be signed by the President of BCOA. In the event that BCOA ceases to exist then such action may be taken by a majority vote, based on tonnage, of those employers who are operating, at the time of such action, the signatory mines of BCOA members that were covered by the 2016 National Bituminous Coal Wage Agreement.

(2) “Beneficiary” shall mean any person who is eligible pursuant to the Plan to receive health benefits as set forth in Article III hereof.

(3) “Dependent” shall mean any individual described in Article III.C hereof, but shall not mean an individual entitled to benefits under section 9711(f) of the Internal Revenue Code of 1986, as amended by the Coal Industry Retiree Health Benefit Act of 1992.

(4) “Effective Date” has the same meaning as set forth in Article XXIX of the National Bituminous Coal Wage Agreement of 2016.

(5) “Employer” means an employer that is signatory to the Wage Agreement.

(6) “ERISA” means the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001 et seq.

(7) “IRC” means the Internal Revenue Code of 1986, as amended.

(8) “Plan” and “1993 UMWA Benefit Plan” mean the United Mine Workers of America 1993 Benefit Plan established by the Trustees pursuant to the UMWA 1993 Benefit Plan Agreement and Declaration of Trust.

(9) “SMCRA” means the Surface Mining Control and Reclamation Act of 1977, as amended, 30 U.S.C. §§ 1201 et seq.

(10) “Trustees” means the Trustees designated in accordance with the Provisions of Article III of the UMWA 1993 Benefit Plan Agreement and Declaration of Trust, who shall be named fiduciaries and the Plan Administrator, as those terms are defined in ERISA.

(11) “Trust” means the UMWA 1993 Benefit Plan Agreement and Declaration of Trust.

(12) “UMWA” or “Union” means the United Mine Workers of America.

(13) “Wage Agreement” means (A) the National Bituminous Coal Wage Agreement of 2016; and (B) any other collective bargaining contract entered into between the United Mine Workers of America and any employer in the bituminous coal industry that provides for contributions to be made to this Plan at rates identical to those set forth in Article XX of the National Bituminous Coal Wage Agreement of 2016.

ARTICLE III ELIGIBILITY UNDER TRADITIONAL PROGRAM OF BENEFITS

The benefits provided under the Traditional Program of Benefits are available only to those eligible beneficiaries whose benefits are funded by federal transfers authorized under Section 402(h)(2)C, 402(i)(1)(B), and 402(i)(3) of the Surface Mining Control and Reclamation Act of 1977, as amended, (“SMCRA”), 30 U.S.C. § 1232(h)(2)C, 1232(i)(1)(B), and 1232(i)(3), or by transfers from the voluntary employees’ beneficiary association (“VEBA”) described in Section 402(h)(2)C(iv) and (v) of SMCRA, 30 U.S.C. § 1232(h)(2)C(iv) and (v) (hereinafter referred to collectively as the “funded group”). Beneficiaries in the funded group include the following:

A. Retired Miners

A Retired Miner in the funded group will be eligible for benefits under this Traditional Program of Benefits if (1) he was actually enrolled in the Plan as of December 27, 2020, as set forth in the Bipartisan American Miners Act of 2019, as amended by the American Miner Benefits Improvement Act of 2020, or (2) his health benefits, defined as those benefits payable, following death or retirement or upon a finding of disability, directly by an employer in the bituminous coal industry under a coal wage agreement (as defined in section 9701(b)(1) of title 26) or a related coal wage agreement (as defined in section 1232(h)(2)(C)(vi) of title 30), would be denied or reduced as a result of a bankruptcy proceeding commenced in 2012, 2015, 2018, 2019, or any year thereafter, as set forth in the Bipartisan American Miners Act of 2019 as amended by the American Miner Benefits Improvement Act of 2020. No individual (1) who is entitled to benefits under section 9711 of the Internal Revenue Code of 1986, as amended by the Coal Industry Retiree Health Benefit Act of 1992, or (2) who is a New Inexperienced Miner as

defined in Article XXB(d)(4) of the Wage Agreement other than a New Inexperienced Miner who becomes permanently and totally disabled as a result of a mine accident as set forth in Article XX(5)(d) of the Wage Agreement, shall be eligible for benefits under the Traditional Program of Benefits.

B. Disabled Employees

The funded group includes (1) disabled Retired Miners who are receiving health benefits under section A of this Article III, (2) a disabled Employee who was actually enrolled in the Plan as of December 27, 2020, as set forth in the Bipartisan American Miners Act of 2019, as amended by the American Miner Benefits Improvement Act of 2020, and (3) a disabled Employee whose health benefits, defined as those benefits payable, following a finding of disability, directly by an employer in the bituminous coal industry under a coal wage agreement (as defined in section 9701(b)(1) of title 26) or a related coal wage agreement (as defined in section 1232(h)(2)(C)(vi) of title 30), would be denied or reduced as a result of a bankruptcy proceeding commenced in 2012, 2015, 2018, 2019, or any year thereafter, as set forth in the Bipartisan American Miners Act of 2019, as amended by the American Miner Benefits Improvement Act of 2020, provided that the Employee:

1. Has completed 20 years of credited service, including the required number of years of signatory service pursuant to Article IV.C(6) of the 1974 Pension Plan or any corresponding paragraph of any successor thereto, or is a New Inexperienced Miner or Electing Miner as provided in Article XX(10)(l) of the Wage Agreement and has obtained more than 20 years of service as provided in Article XX (10)(l) of the Wage Agreement and as determined pursuant to Article XX (9)(e) of the Wage Agreement, and

b. has not attained age 55 (except for a New Inexperienced Miner or Electing Miner as provided in Article XX (10)(l) of the Wage Agreement), and

c. became disabled after December 6, 1974 while in classified employment with the Employer, and

d. is eligible for Social Security Disability Insurance Benefits under Title II of the Social Security Act or its successor; or

2. Becomes totally disabled due to a compensable disability within four years of the date the Employee would be eligible to receive a pension under the 1974 Pension Plan or any successor thereto, or is a New Inexperienced Miner or Electing Miner as provided in Article XX(10)(l) of the Wage Agreement and has obtained more than 20 years of service as provided in Article XX (10)(l) of the Wage Agreement and as determined pursuant to Article XX (9)(e) of the Wage Agreement, as long as the Employee continues to be so disabled during the period for which the Workers' Compensation payments are applicable (Workers' Compensation does not include Federal Black Lung Benefits).

C. Dependents

Dependents of beneficiaries who are in the funded group will be eligible for benefits under the Traditional Program of Benefits if they are the following members of the family of any

Retired Miner or Disabled Employee receiving health benefits pursuant to Section A or B of this Article III:

1. A spouse who is living with or being supported by an eligible Retired Miner or Disabled Employee;
2. Children of a Disabled Employee or an eligible Retired Miner who have not attained age 26;
3. A parent of an eligible Disabled Employee, Retired Miner, or spouse, if the parent has been dependent upon and living in the same household (residence) with the eligible Retired Miner or Disabled Employee for a continuous period of at least one year;
4. Unmarried dependent grandchildren of an eligible Disabled Employee, Retired Miner or spouse who have not attained age 22 and are living in the same household (residence) with such Retired Miner or Disabled Employee;
5. Dependent children (age 26 or older), of an eligible Disabled Employee, Retired Miner, or spouse, who are intellectually disabled or who become disabled prior to attaining age 26 and such disability is continuous and are either living in same household with such Disabled Employee or Retired Miner, or are confined to an institution for care or treatment. Health benefits for such children will continue as long as a surviving parent is eligible for health benefits.

For purposes of this Section C, a grandchild or parent shall be considered dependent upon an eligible Retired Miner, Disabled Employee or spouse if such Retired Miner, Disabled Employee or spouse provides over one half of the support to such person.

D. Surviving Spouse and Dependents of Deceased Employees or Retired Miners

Surviving Spouses and dependents of deceased Employees or Retired Miners who are in the funded group will be eligible for benefits under the Traditional Program of Benefits if they are (i) any unmarried surviving spouse (who was living with or being supported by such Employee or Retired Miner in the funded group immediately prior to the Employee's or Retired Miner's death) and (ii) such spouse's surviving dependent children as defined in subsections 2 and 5 of section C, of an Employee or Retired Miner in the funded group who died:

1. As a result of a mine accident occurring while the Employee was working in a classified job for the Employer;
2. Under conditions which qualify such spouse for a Surviving Spouse benefit under the 1974 Pension Plan or any successor thereto or would have so qualified such spouse had the Employee not been an Electing Miner as set forth in Article XX(10)(m) of the Wage Agreement;
3. At a time when such Employee or Retired Miner is entitled to receive health benefits pursuant to section A or B of this Article III, or benefits pursuant to the Employer Plan incorporated by reference in the Employer's Wage Agreement (provided such individuals would not be excluded from coverage under this Plan by the exclusions in Section A above). However,

(i) if such Employee or Retired Miner died prior to the Effective Date of the Wage Agreement and the spouse is not eligible for a Surviving Spouse's benefit, then health benefits are payable only for the period that the spouse is eligible to receive death benefits in installment payments pursuant to section C of Article III of the Employer Plan, or (ii) if such Employee or Retired Miner died on or after the Effective Date of the Wage Agreement and the spouse is not eligible for a Surviving Spouse's benefit and life insurance benefits or death benefits under any plan maintained pursuant to Article XX of the National Bituminous Coal Wage Agreement that are payable in a lump sum, then health benefits are payable only for 60 months following the month of the death of such Employee or only for 22 months following the month of the death of such Retired Miner. If life insurance benefits are not payable, health benefits shall be provided only to the end of the month in which the Employee or Retired Miner died.

4. Surviving spouses of Employees described in section B.1 of this Article III, who died prior to receiving a pension and after receiving all Sickness & Accident Benefits, shall, if they are not entitled to Surviving Spouse benefits under the 1974 Pension Plan, receive health benefits under Article IV until remarriage or for 36 months, whichever occurs first.

5. The surviving spouse of a New Inexperienced Miner or Electing Miner who is a Disabled Employee under section B.1 of this Article III and who died prior to reaching age 55, shall receive health benefits under Article IV until remarriage or for 36 months, whichever occurs first. If such New Inexperienced Miner or Electing Miner died upon or after reaching age 55, his surviving spouse will receive health benefits for life or until remarriage.

Health benefits shall continue for a surviving spouse until remarriage of such spouse, but if such spouse is entitled to such benefits under subsections 3, 4 or 5 above, such health benefits will continue not longer than for the period specified in those subsections.

At the death of an Employee described in subsection 1 above, health benefits will be continued for the children until they attain age 26, even if there is no surviving spouse or if the surviving spouse dies before they attain age 26.

The children of a Surviving Spouse eligible under subsection 2 above shall be eligible for health benefits until they attain age 26, so long as the Surviving Spouse is eligible for benefits.

If at the death of an Employee or Retired Miner described in subsection 3 above, there is no surviving spouse, or if the surviving spouse dies during any period in which health benefits are being continued, such health benefits will be continued for the children during the period in which such spouse would have been eligible for health benefits but in no event beyond their attaining age 26. Notwithstanding the above or any other provision of this Plan, if any Employee or Retired Miner had more than one spouse prior to the Employee's or Retired Miner's death, only one surviving spouse shall be eligible for health benefits from the Plan as a surviving spouse, and only the eligible children of such a surviving spouse shall be eligible for health benefits from the Plan if they otherwise satisfy the Plan's eligibility requirements.

ARTICLE IV
BENEFITS UNDER TRADITIONAL PROGRAM OF BENEFITS

The benefits provided under this Traditional Program of Benefits are as set forth in this Article IV. Benefits shall not be provided for any period prior to February 1, 1993. Benefit payments are based on negotiated rates applicable to services provided by hospitals, physicians, pharmacies and other providers on Participating Provider Lists (PPL's) adopted under Article V, or under other arrangements entered into by the Trustees. During any period when PPL's or other arrangements are not in effect, and for covered services and supplies not offered under a PPL or other arrangement (or otherwise not subject to a PPL-related benefit limit), benefit payments shall not exceed reasonable and customary charges* for covered services and supplies. Covered services shall be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at the appropriate level of care, or are otherwise provided for in the Plan.

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 this 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. Services which are not reasonable and necessary shall include, but are not limited to the following: 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 timely fashion in the patient's medical records; procedures which can be performed with equal efficiency at a lower level of care. The benefits described in this Article are subject to any precertification and other utilization review requirements implemented pursuant to Article V. 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 as described in this Article IV.

Coverage and benefit levels shall conform to each requirement of Article XX of the 2016 Wage Agreement relating to the UMWA 1993 Benefit Plan, including all restrictions set forth in the General Description of the Health and Retirement Benefits of such Article, and shall not exceed the level of benefits provided as of December 31, 2006. The Alternate Program of Benefits (under the Traditional Program of Benefits) will provide limited coverage to eligible retired miners and their dependents (1) from an otherwise qualifying last signatory Employer that first became obligated to contribute to the 1993 Trust after December 31, 2001, within the

* 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 some home health and hospice services.

meaning of Article XX(c)(3)(ii) of the 2016 NBCWA, and that did not contribute to the 1993 Benefit Trust substantially all amounts owed and at the rates specified in such Article, or (2) who are entitled to limited benefits pursuant to an agreement of the settlors or the Trustees of the Plan.

The benefits provided under this Plan shall be only such benefits as can be provided by the assets of the Trust. Accordingly, the benefits are subject to termination, suspension, revision or amendment by the Trustees in their discretion at any time.

A. Health Benefits Under Traditional Program of Benefits

1. Inpatient Hospital Benefits

a. Semi-private room

When a Beneficiary is admitted by a licensed physician (hereinafter “physician”) for treatment as an inpatient to an Accredited Hospital (hereinafter “hospital”), benefits will be provided for semi-private room accommodations (including special diets and general nursing care) and all medically necessary services provided by the hospital as set out below for the diagnosis and treatment of the Beneficiary’s condition.

Medically necessary services provided in a hospital include the following:

- Operating, recovery, and other treatment rooms
- Laboratory tests and x rays
- Diagnostic or therapy items and services
- Drugs and medication (including take home drugs which are limited to a 30-day supply)
- Radiation therapy
- Chemotherapy
- Physical therapy
- Anesthesia services
- Oxygen and its administration
- Intravenous injections and solutions
- Administration of blood and blood plasma
- Blood, if it cannot be replaced by or on behalf of the Beneficiary

b. Intensive Care Unit Coronary Care Unit

Benefits will also be provided for treatment rendered in an Intensive Care or Coronary Care Unit of the hospital, if such treatment is certified as medically necessary by the attending physician.

c. Private Room

For confinement in a private room, benefits will be provided for the hospital’s most common charge for semi private room accommodations and the Beneficiary shall be responsible for any excess over such charge except that private room rates will be paid when (i) the

Beneficiary's condition requires him to be isolated for his own health or that of others, or (ii) the hospital has semi private or less expensive accommodations but they are occupied and the Beneficiary's condition requires immediate hospitalization. Semi-private room rates, not private room rates, will be paid beyond the date a semi-private room first becomes available and the Beneficiary's condition permits transfer to those accommodations.

d. Renal Dialysis

Benefits will be provided for renal dialysis provided that the renal dialysis therapy is administered in accordance with Federal Medicare regulations as in effect from time to time.

e. Mental Illness

Benefits are provided for a Beneficiary who is confined for mental illness in a hospital by a licensed psychiatrist on the same basis as any medically necessary hospitalization.

f. Alcoholism and Drug Abuse

Benefits are provided for a Beneficiary who requires emergency detoxification hospital care for the treatment of alcoholism or emergency treatment for drug abuse. If treatment of a medical or mental condition is necessary following detoxification or emergency treatment for drug abuse, benefits may be provided under other provisions of this Plan and are subject to any requirements or limitations in such provisions.

See subsection 7.f. for information concerning other services related to treatment of alcoholism and drug abuse.

g. Oral Surgical/Dental Procedures

Benefits are provided for a Beneficiary who is admitted to a hospital for the oral surgical procedures described in subsection 3.e. provided hospitalization is medically necessary.

Benefits are also provided for a Beneficiary admitted to a hospital for dental procedures only if hospitalization is necessary due to a preexisting medical condition and prior approval is received from the Trustees.

h. Maternity Benefits

Benefits are provided for a female Beneficiary who is confined in a hospital for pregnancy. Such benefits will also be available for services pertaining to termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

i. General

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 United Mine Workers of America Combined Benefit Fund.

2. Outpatient Hospital Benefits

a. Emergency Medical and Accident Cases

Benefits are provided for a Beneficiary who receives emergency medical treatment or medical treatment of an injury as the result of an accident, provided that the beneficiary has acute medical symptoms and the absence of immediate medical attention could result in serious jeopardy of the individual's health or body.

b. Surgical Cases

Benefits are provided for a Beneficiary who receives surgical treatment in the outpatient department of a hospital.

c. Laboratory Tests and X rays

Benefits are provided for laboratory tests and x ray services performed in the outpatient department of a hospital which provides such services and when they have been ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

d. Chemotherapy and Radiation Therapy

Benefits are provided for chemotherapy treatments of a malignant disease or radiation treatments performed in the outpatient department of a hospital.

e. Physiotherapy

Benefits are provided for physiotherapy treatments performed in the outpatient department of a hospital. Such therapy must be prescribed and supervised by a physician.

f. Renal Dialysis

Benefits are provided for outpatient renal dialysis treatments rendered in accordance with Federal Medicare regulations as in effect from time to time.

3. Physicians' Services and Other Primary Care

a. Surgical Benefits

Benefits are provided for surgical services essential to a Beneficiary's care consisting of operative and cutting procedure (including the usual and necessary post-operative care) for the treatment of illnesses, injuries, fractures or dislocations, which are performed either in or out of a hospital by a physician.

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.

b. Assistant Surgeons

If the Beneficiary is an inpatient in a hospital, benefits will also be provided for the services of a physician who actively assists the operating physician in the performance of such surgical services when the condition of the Beneficiary and type of surgical service require such assistance.

c. Obstetrical Delivery Services

Benefits are provided for a female Beneficiary for obstetrical delivery services (including pre and post-natal care) performed by a physician. Benefits will also be provided if such delivery is performed by a midwife certified by the American College of Nurse Midwifery and licensed where such licensure is required.

Such benefits will also be provided for termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

d. Anesthesia Services

Benefits are provided for the administration of anesthetics provided either in or out of the hospital in surgical or obstetrical cases, when administered and billed by a physician, other than the operating surgeon or his assistant, who is not an employee of, nor compensated by, a hospital, laboratory or other institution; or by a nurse anesthetist.

e. Oral Surgery

Benefits are not provided for dental services. However, benefits are provided for 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
- Dental services required as the direct result of an accident

f. Surgical Services Limitations

Benefits are not provided for certain surgical services without prior approval of the Trustees. Such surgical procedures include, but are not limited to, the following:

- 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 government programs
Organ transplants

g. In-hospital Physicians' Visits

If a Beneficiary is confined as an inpatient in a hospital because of an illness or injury, benefits are provided for in-hospital visits by the physician in charge of the case. Such benefits will also be provided concurrently with benefits for surgical, obstetrical and radiation therapy services when the Beneficiary has 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.

h. Home, Clinic, and Office Visits

Benefits are provided for services rendered to a Beneficiary at home, in a clinic (including the outpatient department of a hospital) or in the physician's office for the treatment of illnesses or injuries, if provided by a physician.

i. Emergency Treatment

When provided by a physician, benefits are provided for a Beneficiary who receives outpatient emergency medical treatment or treatment of an injury as the result of an accident, provided that the individual has acute medical symptoms and the absence of immediate medical attention could result in serious jeopardy of the individual's health or body.

j. Laboratory Tests and X rays

Benefits will be provided for laboratory tests and x rays performed in a licensed laboratory when ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

Such benefits 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.

k. Radiation and Chemotherapy Benefits

Benefits are provided for treatment by x ray, radium external radiation or radioactive isotope (including the cost of materials unless supplied by a hospital), provided in or out of a hospital, when performed and billed by a physician.

When a Beneficiary's condition requires radiation therapy services in conjunction with medical, surgical or obstetrical services, benefits will be provided for such radiation therapy in

addition to the payment for such other types of covered services if the physician performing the radiation therapy services is not the same physician who performs the medical, surgical or obstetrical services.

Benefits are provided for treatment of malignant diseases by chemotherapy provided in or out of the hospital when prescribed and billed by a physician.

l. Medical Consultation

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 by a Beneficiary.

m. Specialist Care

Benefits will be provided for treatment prescribed or administered by a specialist if the treatment is for illness or injury which falls within the specialist's area of medical competence.

n. Primary Care Podiatrists' Services

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.

o. Primary Medical Care Miscellaneous

(1) Benefits are provided for care of newborn babies and routine medical care of children prior to attaining age 6.

(2) Benefits are provided for immunizations, allergy desensitization injections, pap smears, screening for hypertension and diabetes, and examinations for cancer, blindness, deafness, and other screening and diagnostic procedures when medically necessary.

(3) Benefits are provided for physical examinations when certified as medically necessary by a physician. Medically necessary will mean that a Beneficiary (i) has an existing medical condition under treatment by a physician, (ii) has attained age 55, (iii) is undergoing an annual or semi-annual routine examination by a gynecologist or (iv) is undergoing a routine examination prescribed by a specialist as part of such specialist's care of a medical condition.

(4) Benefits are provided for “physician extender” care or medical treatment administered by nurse practitioners, physician’s assistants or other certified or licensed health personnel when such service is rendered under the supervision of a physician.

(5) Benefits are provided for a nominal fee covering instruction in preparation for natural childbirth, if rendered in a hospital or clinic.

(6) Benefits are provided for family planning counseling when rendered by a physician or by other appropriately trained and supervised health care professionals.

(7) Benefits are provided covering artificial insemination if the service is provided by a licensed gynecologist.

(8) Benefits are provided for sterilization procedures if such procedures are performed by a physician.

(9) Birth control services and medications are not covered under the Plan, except that benefits are provided for physician services rendered in connection with the prescription of oral contraceptives, the fitting of a diaphragm or the insertion or removal of an IUD.

p. **Services Not Covered**

(1) Services rendered by a chiropractor or naturopathic services.

(2) Acupuncture therapy.

(3) Home obstetrical delivery.

(4) Telephone conversations with a physician in lieu of an office visit.

(5) Charges for writing a prescription.

(6) Medications dispensed by other than a licensed pharmacist.

(7) Charges for medical summaries and medical invoice preparations.

(8) Services of any practitioner who is not legally licensed to practice medicine, surgery, or counseling except as specifically provided herein.

(9) Cosmetic surgery, unless pertaining to surgical scars or to correct results of an accidental injury or birth defects.

(10) Physical examinations, except as specifically provided herein.

(11) Removal of tonsils or adenoids, unless medically necessary.

4. **Prescription Drugs**

a. **Benefits Provided**

Benefits are provided for insulin and prescription drugs (only those drugs which by Federal or State law require a prescription) dispensed by a licensed pharmacist and prescribed by a (i) physician for treatment or control of an illness or a non-occupational accident or (ii) licensed dentist for treatment following the performance of those oral surgical services set forth in 3.e.

The initial amount dispensed shall not exceed a 90-day supply. Any original prescription may be refilled for up to one year as directed by the attending physician. Each such refill may be for an amount up to, but no more than, a 90-day supply. Benefits for refills beyond the initial twelve months require a new prescription by the attending physician. Prescriptions filled by the Plan's mail order provider, if any, are not subject to the limits on quantity set forth in this paragraph.

Reasonable charges for prescription drugs or insulin are covered benefits. Reasonable charges will consist of the lesser of:

- (1) The amount actually billed per prescription or refill;
- (2) The price of the applicable generic substitution drug, if AB or better-rated, approved by the federal Food and Drug Administration; or, in the event the prescribing physician determines that use of a brand name drug is medically necessary, the price of such brand name drug; or
- (3) The current price paid to participating pharmacies in any prescription drug program established by the Plan.

However, in no event will a Beneficiary be responsible to pay more for a single prescription than the appropriate co-payment set forth in this Plan, plus any difference between the price of the generic and the brand name drug, where applicable.

b. **Benefits Excluded**

Benefits shall not be provided under subsection 4.a. for the following:

- (1) Medications dispensed in a hospital (including take home drugs), skilled nursing facility or physician's office. (See Article IV.A.1.a. and 5.a. for benefits provided for drugs and medications during inpatient confinement in a hospital skilled nursing facility.)
- (2) Birth control prescriptions.
- (3) Prescriptions dispensed by other than a licensed pharmacist.
- (4) Any medication not specifically provided for in a. above.

5. Skilled Nursing Care and Extended Care Units

a. Skilled Nursing Care Facility

Upon determination by the attending physician that confinement in a licensed skilled nursing care facility* is medically necessary, to the extent that benefits are not available from Medicare or other State or Federal programs, benefits will be provided for:

- (1) skilled nursing care provided by or under the supervision of a registered nurse;
- (2) room and board;
- (3) physical, occupational, inhalation and speech therapy, either provided or arranged for by the facility;
- (4) medical social services;
- (5) drugs, immunizations, supplies, appliances, and equipment ordinarily furnished by the facility for the care and treatment of inpatients;
- (6) 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
- (7) other health services usually provided by skilled nursing care facilities.

Benefits will be provided for up to a maximum of 100 days for a Beneficiary who is receiving benefits under the Alternate Program of Benefits.

The Plan will not pay for services in a nursing care facility that is not licensed or approved in accordance with Federal Medicare and state laws or regulations, unless the service is provided by or under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results.

Exclusions: Telephone, TV, radio, visitor's meals, private room or private nursing (unless necessary to preserve life), custodial care, and services not usually provided in a skilled nursing facility are not covered under the Plan.

* Skilled nursing care facility is limited to a skilled nursing care facility which is licensed and approved by Federal Medicare and by any appropriate state law, regulation or agency.

b. Extended Care Units

Benefits are provided for up to two weeks of specialized medical services and daily treatments by licensed personnel in extended care units. When medically necessary, benefit may be provided for a longer period of time, subject to approval from the Trustees.

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.

Exclusions:

Services, drugs or other items which are not covered for hospital inpatients; and custodial care.

6. Home Health Services & Equipment

a. General Provisions

Benefits are provided for home health services, including nursing visits by registered nurses and home health aides, and various kinds of rehabilitation therapy, subject to the following conditions and approval of the Trustees.

(1) The Beneficiary must be under the care of a physician.

(2) The Beneficiary's medical condition must require skilled nursing care, physical therapy, or speech therapy at least once in a 60-day period.

(3) The physician must initiate a treatment plan and specify a diagnosis, the Beneficiary's functional limitations and the type and frequency of skilled services to be rendered.

(4) The Beneficiary must be confined to his home. The services must be provided by a certified home health agency.

Benefits will be provided for up to a maximum of 60 visits per year for a Beneficiary who is receiving benefits under the Alternate Program of Benefits.

b. Physical and Speech Therapy

Benefits are provided for physical and speech therapy services at home when prescribed by a physician to restore functions lost or reduced by illness or injury. Such services must be performed by qualified personnel. When the Beneficiary has reached his or her restoration potential, the services required to maintain this level do not constitute covered care.

c. Skilled Nursing

Benefits are provided for skilled nursing care rendered by a registered nurse as a home health service when a Beneficiary's condition has not stabilized and a physician concludes that

the Beneficiary must be carefully evaluated and observed by a registered nurse. The Trustees may request an evaluation visit to the Beneficiary's home.

d. Medical Equipment

Benefits are provided for rental or, where appropriate, purchase of medical equipment suitable for home use when determined to be medically necessary by a physician.

e. Oxygen

Benefits are provided for oxygen supplied to a Beneficiary subject to the following conditions when ordered by the attending physician:

- (1) The patient is referred to a designated pulmonary consultant for testing.
- (2) Such consultant's report is submitted to the Trustees with the order for oxygen.

Benefits are also provided for services of inhalation therapists in the home with the attending physician's order.

f. Coal Miners Respiratory Disease Program

Benefits are provided for services or treatments administered by personnel employed by the Coal Miners Respiratory Disease Program to a Beneficiary in such Beneficiary's home when ordered or requested by a physician, except where such benefits are available under a governmental program and such Beneficiary is eligible, or upon application would be eligible, under such programs.

7. Other Benefits

a. Orthopedic and Prosthetic Devices

Benefits are provided for orthopedic and prosthetic devices prescribed by a physician when medically necessary.

The following types of equipment are covered:

- (1) Prosthetic devices which serve as replacement for internal or external body parts, other than dental.

These include artificial eyes, noses, hands (or hooks), feet, arms, legs and ostomy bags and supplies.

- (2) Prosthesis following breast removal.
- (3) Leg, arm, back, and neck braces.

(4) Trusses.

(5) Stump stockings and harnesses when these devices are essential for the effective use of an artificial limb. An examination and recommendations by an orthopedic physician is required.

Note: Benefits are provided for repairs and adjustments for braces, trusses, stump stockings and harnesses as well as replacement of any of those devices which have been worn out and can no longer be repaired. Benefits will be provided for replacements for usable appliances and artificial limbs if they are needed because of a change in the Beneficiary's condition. Benefits will also be provided to cover repair and adjustment cost for appliances and artificial limbs.

If replacement of a prosthesis is required, the Beneficiary should in all cases be reevaluated by an orthopedic physician.

(6) Surgical stocking (up to two pairs per prescription with no refills) when prescribed by a physician for surgical or medical conditions. The Plan will not pay Beneficiaries for support hose, garter belts, etc.

(7) Orthopedic shoes when specifically prescribed by a physician or licensed podiatrist for a Beneficiary according to orthopedist specifications, including orthopedic shoes attached to a brace that have to be modified to accommodate the brace. Benefits will not be provided for stock orthopedic shoes.

(8) Orthopedic corrections added to ordinary shoes by a physician or licensed podiatrist. Benefits are provided for only the correction to the shoe.

b. Physical Therapy

Benefits are provided for physical therapy in a hospital, skilled nursing facility, treatment center, or in the Beneficiary's home. Such therapy must be prescribed and supervised by a physician and administered by a licensed therapist. The physical therapy treatment must be justified on the basis of diagnosis, medical recommendation and attainment of maximum restoration.

c. Speech Therapy

Benefits are provided for speech therapy rendered by a qualified licensed speech therapist if the Beneficiary is a stroke patient or has had conditions including ruptured aneurysm, brain tumors or autism and needs special instruction to restore technique of sound and to phonate, and needs direction in letter and word exercises in order to express basic needs. Benefits are also provided for speech therapy for child Beneficiaries with a speech impediment from a qualified speech therapist provided that the child cannot receive speech therapy through the public schools.

d. Hearing Aids

Benefits are provided for hearing aids recommended by a licensed otologist or otolaryngologist and a certified clinical audiologist. Such hearing aids must be purchased from a participating vendor. Benefits for necessary repairs and maintenance, except the replacement of batteries, will be provided after the expiration of the warranty period. Benefits will be provided for replacement hearing aids only if a new aid is needed because of a change in the Beneficiary's condition, or if the aid no longer functions properly. Benefits will not be provided for any fees for incorporating hearing aids into eyeglasses.

e. Ambulance and Other Transportation

Benefits are provided for ambulance transportation to or from a hospital, clinic, medical center, physician's office, or skilled nursing care facility, when considered medically necessary by a physician.

With prior approval from the Trustees benefits will also be provided for other transportation subject to the following conditions:

(1) If the needed medical care is not available near the Beneficiary's home and the Beneficiary must be taken to an out of area medical center.

(2) If the Beneficiary requires frequent transportation between the Beneficiary's home and a hospital or clinic for such types of treatment as radiation or physical therapy or other special treatment which would otherwise require hospitalization, benefits will be provided for such transportation only when the Beneficiary cannot receive the needed care without such transportation.

(3) If the Beneficiary requires an escort during transportation, the attending physician must submit satisfactory evidence as to why the Beneficiary needs an escort.

f. Outpatient Mental Health, Alcoholism and Drug Addiction

Benefits are provided for: Psychotherapy, psychological testing, counseling, group therapy and alcoholism or drug rehabilitative programs.

Benefits are not provided for:

- (1) Encounter and self-improvement group therapy.
- (2) Custodial care related to intellectual disability and other intellectual deficiencies.
- (3) School related behavioral problems.
- (4) Services by private teachers.

(5) Alcoholism and drug rehabilitation if an advance determination has not been made that the Beneficiary is a good candidate for rehabilitation.

(6) Alcoholism and drug rehabilitation programs not approved by Medicare, certified or licensed by the applicable state, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or otherwise authorized by law.

8. Co-Payments Under Traditional Program of Benefits

(Beneficiaries who are receiving benefits under the Alternate Program of Benefits should refer to subsection b. of this Section 8).

Effective January 1, 2017, the benefits provided in this Plan shall be subject to the copayments set forth below and such co-payments shall be the responsibility of the Beneficiary. The Trustees shall implement such procedures as deemed appropriate to achieve the intent of these co-payments. Beneficiaries and providers shall provide such information as the Trustees may require to effectively administer these co-payments, or such Beneficiaries or providers shall not be eligible for benefits or payments under this Plan. Any overpayments made to a provider who overcharges the Plan in lieu of collecting the applicable co-payment from a participant or Beneficiary shall be repaid to the Trustees by such provider.

a. Co-payments for covered Health Benefits are established below.

Participating Provider Lists (PPL's) implemented by the Plan pursuant to Article V may include participating hospitals, physicians, pharmacies and other providers. The Plan payment for non-emergency hospital and related benefits provided from a non-PPL source will be limited to 90% of the amount that would have been paid by the Plan if the benefit had been provided by a provider on a PPL (or actual charges, if less). If a provider then bills the Beneficiary for any remaining amount, the protections of subsection 10.f.(2) (Hold Harmless) will not apply until the non-PPL out-of-pocket maximum is reached. In any case where a non-PPL provider is treated as being within the PPL, pursuant to the provisions of Article V.C, the Beneficiary will be responsible for the co-payment that would apply to a PPL service. The Plan will pay the provider at no greater than the PPL rate, and the protections of subsection 10.f.(2) (Hold Harmless) will apply.

If a Retired Miner is covered under this Plan and an Employer Plan (established pursuant to the NBCWA of 2011 or 2016) by one or more signatory Employers during a calendar year, the total co-payments made and documented by the Employee or Pensioner during such calendar year shall be counted toward the out-of-pocket maximum in the same manner as if they had been made under a single plan.

Physician Office Visits:

In PPL:	\$20.00 per office visit (up to an annual maximum of \$400 per family)
Non-PPL:	\$30.00 per office visit (up to an annual maximum of \$400 per family)

Hospital and Related Charges:

In PPL:	No co-payment
Non-PPL:	Balance of charges after Plan pays 90% of the PPL rate for covered services from a non-PPL source. No co-payment for hospitalization resulting from a medical emergency.

Prescription Drugs (Co-pays do not apply to out-of-pocket maximum):

In PPL:	\$15.00 per prescription*
Non-PPL:	\$30.00 per prescription*
Mail Order:	\$5.00 per prescription**

Brand name where a generic equivalent is available:

In addition to the co-payment, the Beneficiary is responsible for the additional cost of the brand name drug over the cost of the generic substitute. A generic drug will not be considered “available” unless it has been approved by the federal Food and Drug Administration. In addition, if the prescribing physician determines that use of a brand name drug is medically necessary, the generic drug will not be considered “available,” and there will be no additional payment by the Beneficiary for the use of the brand name drug.

Annual Out-of-Pocket Maximum:

The requirement that co-payments be paid (other than all co-payments relating to prescription drugs) will be suspended for the remainder of any calendar year during which the following out-of-pocket maximum amounts have been paid:

Benefit	Annual Out-of-Pocket Maximum
Prescription drugs from a PPL provider	\$600.00 per year per family
PPL physician office visits	\$400.00 per year per family
Prescription drugs from a non-PPL provider	\$600.00 per year per family
Non-PPL physician office visits	\$400.00 per year per family
Non-PPL hospital and related charges	\$600.00 per year per family

No family will have to pay more than \$1,600 in combined non-PPL co-payments in any year.

When the non-PPL out-of-pocket maximum has been reached, the Plan will pay at no greater than the PPL rate for a covered benefit provided from a non-PPL source, but Hold Harmless protections will apply.

* **Note:** For purposes of this co-payment provision, a prescription or refill shall be deemed to be each 30 days’ (or fraction thereof) supply.

** **Note:** For purposes of this mail order co-payment provision, a prescription refill shall be deemed to be each 90 days’ (or fraction thereof) supply.

b. Co-payments under the Alternate Program of Benefits

The Alternate Program of Benefits shall be subject to the co-payments set forth below and such co-payments shall be the responsibility of the Beneficiary. The Trustees shall implement such procedures as deemed appropriate to achieve the intent of these co-payments. Beneficiaries and providers shall provide such information as the Trustees may require to effectively administer these co-payments, or such Beneficiaries or providers shall not be eligible for benefits or payments under this Plan. Any overpayments made to a provider who overcharges the Plan in lieu of collecting the applicable co-payments from a participant or Beneficiary shall be repaid to the Trustees by such provider.

Co-payments for covered Health Benefits under the Alternate Program of Benefits are established below.

Participating Provider Lists (PPL’s) implemented by the Plan pursuant to Article V may include participating hospitals, physicians, pharmacies and other providers. Under the Alternate Program of Benefits, there is a \$750.00 copayment (up to an annual maximum of \$750 per family) for hospital and related benefits. The Plan payment for non-emergency hospital and related benefits provided from a non-PPL source will be limited to 90% of the amount that would have been paid by the Plan if the benefit had been provided by a provider on a PPL (or actual charges, if less). The Beneficiary will be responsible for the balance of charges after the Plan’s payment. If a provider then bills the Beneficiary for any remaining amount, the protections of subsection 10.f.(2) (Hold Harmless) will not apply until the non-PPL out-of-pocket maximum is reached. In any case where a non-PPL provider is treated as being within the PPL, pursuant to the provisions of Article V.C, the Beneficiary will be responsible for the co-payment that would apply to a PPL service. The Plan will pay the provider at no greater than the PPL rate, and the protections of subsection 10.f.(2) (Hold Harmless) will apply.

If a Retired Miner is covered under this Plan and an employer Plan (established pursuant to the NBCWA of 2011) by one or more signatory employers during a calendar year, the total co-payments made and documented by the employee during such calendar year shall be counted toward the out-of-pocket maximum in the same manner as if they had been made under a single plan.

Physician Office Visits under Alternate Program of Benefits:

In PPL:	\$30.00 per office visit (up to an annual maximum of \$500 per family)
Non-PPL:	\$40.00 per office visit (up to an annual maximum of \$500 per family)

Hospital and Related Charges under Alternate Program of Benefits:

In PPL:	\$750.00 per inpatient hospital stay (up to an annual maximum of \$750 per family)
Non-PPL:	\$750.00 (up to a maximum of \$750 per family) then balance of charges after Plan pays 90% of the PPL rate for covered services from a non-PPL source. \$750.00 per inpatient hospital stay resulting from a medical emergency (up to an annual maximum of \$750 per family).

Emergency Room Visits under Alternate Program of Benefits:

In PPL:	\$30 per emergency room visit (up to an annual maximum of \$1250 per family)
Non-PPL:	\$30 per emergency room visit (up to an annual maximum of \$1250 per family)

Prescription Drugs under Alternate Program of Benefits (Co-pays do not apply to out-of-pocket maximum):

In PPL:	\$25.00 per prescription*
Non-PPL:	\$40.00 per prescription*
Mail Order:	\$10.00 per prescription**

Under the Alternate Program of Benefits, brand name where a generic equivalent is available:

In addition to the co-payment, the Beneficiary is responsible for the additional cost of the brand name drug over the cost of the generic substitute. A generic drug will not be considered “available” unless it has been approved by the federal Food and Drug Administration. In addition, if the prescribing physician determines that use of a brand name drug is medically necessary, the generic drug will not be considered “available,” and there will be no additional payment by the Beneficiary for the use of the brand name drug.

Annual Out-of-Pocket Maximum under Alternate Program of Benefits:

The requirement that co-payments be paid (other than all co-payments relating to prescription drugs) will be suspended for the remainder of any calendar year during which the following out-of-pocket maximum amounts have been paid:

Benefit	Annual Out-of-Pocket Maximum
Prescription drugs from a PPL provider	\$1,000.00 per year per family
PPL physician office visits	\$500.00 per year per family
Prescription drugs from a non-PPL provider	\$1,000.00 per year per family
Non-PPL physician office visits	\$500.00 per year per family
Non-PPL hospital and related charges	\$750.00 per year per family

Under the Alternate Program of Benefits, no family will have to pay more than \$2,250 in combined non-PPL co-payments in any year.

* **Note:** For purposes of this co-payment provision, a prescription or refill shall be deemed to be each 30 days’ (or fraction thereof) supply.

** **Note:** For purposes of this mail order co-payment provision, a prescription refill shall be deemed to be each 90 days’ (or fraction thereof) supply.

When the non-PPL out-of-pocket maximum has been reached, the Alternate Program of Benefits will pay at no greater than the PPL rate for a covered benefit provided from a non-PPL source, but Hold Harmless protections will apply.

9. Vision Care Program

a. Benefits Provided.

Benefits	Actual Charge Up To Maximum Amount	Frequency Limits
Vision Examination	\$46.77	Once every 24 months
Per Lens (Maximum = 2)		
Single vision	\$23.39	Once every 24 months
-- Bifocal	\$35.09	Once every 24 months
-- Trifocal	\$46.77	Once every 24 months
-- Lenticular	\$58.47	Once every 24 months
-- Contact	\$35.09	Once every 24 months
-- Frames	\$33.13	Once every 24 months

Note: The 24-month period shall be measured from the date the examination is performed or from the date the lenses or frames are ordered, respectively, even if the last examination occurred during a prior Wage Agreement.

b. **Lenses** will not be covered unless the new prescription differs from the most recent one by an axis change of 20 degrees or .50 diopter sphere or cylinder change and the lenses must improve visual acuity by at least one line on the standard chart.

c. Exclusions include:

- (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), 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 worker's 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.

d. The exclusions in c. above shall not be read to limit or exclude coverage that may be contained elsewhere in the Plan.

10. **General Provisions**

a. **Administration**

The Trustees are authorized to promulgate rules and regulations to implement the Plan, and such rules and regulations shall be binding upon all persons dealing with and Beneficiaries claiming benefits under this Plan.

b. **Services Rendered Outside the United States**

Benefits are provided for health care rendered outside of the United States on the same basis as if such care had been rendered in the United States. (The Eligible Beneficiary in such a case may be required to make payment of the expenses and file a claim with the Trustees for reimbursement.)

c. **Medicare**

The benefits provided under Article IV will not be paid to a Beneficiary otherwise eligible if such Beneficiary is eligible for Hospital Insurance coverage (Part A) of Medicare where a premium is not required and/or Medical Insurance coverage (Part B) of Medicare unless such Beneficiary is enrolled for each part of Medicare for which such Beneficiary is eligible. Any such Beneficiary who is enrolled in a Medicare program shall receive the benefits provided under the Plan only to the extent such benefits are not provided for under Medicare.

The Trustees shall give written notification of the obligation to enroll in Medicare. Failure to provide such notification shall not remove any obligation to enroll.

d. Subrogation

The Plan does not assume primary responsibility for covered medical expenses which another party is obligated to pay or which another insurance policy or other medical plan covers. Where there is a dispute between the carriers, the Plan shall, subject to provisions (1) and (2) immediately below, pay for such covered expenses but only as a convenience to the Beneficiary eligible for benefits under the Plan 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 or carrier.

Obligations to pay benefits on behalf of any Beneficiary shall be conditioned:

- (1) upon such Beneficiary taking all steps necessary or desirable to recover the costs thereof from any third party who may be obligated therefore, and
- (2) upon such Beneficiary executing such documents as are reasonably required by the Trustees, 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.

e. Non-Duplication

The health benefits provided under this Plan are subject to a non-duplication provision as follows:

- (1) 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:
 - (i) does not include a coordination of benefits or non-duplication provision, or
 - (ii) includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.
- (2) In determining whether this Plan or another group plan is primary, the following criteria will be applied:
 - (i) The plan covering the patient other than as a spouse or dependent will be the primary plan.
 - (ii) Where both plans cover the patient as a dependent, the plan of the parent or step-parent whose birthday occurs earlier in the calendar year will be the primary plan.

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

(iv) In the event a Retired Miner or surviving spouse is covered under another group plan by reason of his or her employment, the other group plan shall be the primary plan for such Retired Miner or surviving spouse and their eligible dependents.

(3) 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 of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

(4) If it is determined that benefits under this Plan should have been reduced because of benefits provided under another group plan, the Trustees 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 Trustees may make reimbursement directly to the insurance company or other organization providing benefits under the other plan.

(5) For the purpose of this provision the Trustees may, without consent or notice to any Beneficiary, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expense and benefits.

(6) Any Beneficiary claiming benefits under this Plan must furnish the Trustees such information as may be necessary for the purpose of administering this provision.

f. Explanation of Benefits (EOB) and Hold Harmless

(1) Each Beneficiary shall receive an explanation of billing and payment rendered on behalf of such Beneficiary. Should full payment for a service be denied because of a charge that has been determined by the Trustees to be in excess of the reasonable and customary charge, the UMWA may request that a copy of such EOB shall be forwarded to the UMWA (International Headquarters, Attention: Benefits Department).

(2) The Plan and the UMWA agree that excessive charges and escalating health costs are a joint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, the Trustees 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 commenced by the provider. Whether the Trustees 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 Trustees 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. The “hold harmless” protections available under this subparagraph do not apply in the case of any service or supply obtained from a non-PPL source until the non-PPL out-of-pocket maximum is reached.

11. General Exclusions

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

(1) 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.

(2) 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 as set forth in Article IV.A.2.a. and IV.A.3.i.

(3) 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.

(4) Services furnished by tax supported or voluntary agencies.

(5) Immunizations provided by local health agencies.

(6) 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.

(7) Private duty nursing. If necessary to preserve life and certified as medically necessary by the attending physician and an Intensive Care Unit is unavailable, benefits are provided for private duty nursing services 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.

(8) Custodial care, convalescent or rest cures.

(9) 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.

- (10) Charges for private room confinement, except as specifically described in the Plan.
- (11) Services for which a Beneficiary is not required to make payment.
- (12) Excessive charges.
- (13) Charges related to gender transformation services unless required by law.
- (14) Charges for reversal of sterilization procedures.
- (15) Charges in connection with a general physical examination, other than as specified in this Plan.
- (16) Inpatient confinements solely for diagnostic evaluations which can be provided on an outpatient basis.
- (17) Charges for medical services for inpatient or outpatient treatment for intellectual disability and other intellectual deficiencies.
- (18) Finance charges in connection with a medical bill.
- (19) Dental services.
- (20) Birth control devices and medications.
- (21) Abortion, except as specifically described in the Plan.
- (22) Eyeglasses or lenses, except when medically required because of surgically caused refractive errors or as otherwise provided in section A.9.
- (23) Exercise equipment.
- (24) Charges for treatment with new technological medical devices, therapy which are experimental in nature.
- (25) 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 Trustees.
- (26) Charges for an autopsy or post mortem surgery.
- (27) Any types of services, supplies or treatments not specifically provided by the Plan.
- (28) Any claim that is submitted for payment under the Plan after twelve (12) months or more from the date of service.

12. **Health Benefit Provisions**

a. **Newborns' and Mothers' Health Protection Act**

The Plan shall provide maternity care benefits in accordance with the Newborns' and Mothers' Health Protection Act (the "Newborn's Act"). The Plan 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 from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours.)

b. **Mental Health Parity and Addiction Equity Act**

The Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Internal Revenue Code Section 9812 and ERISA Section 712, and the regulations thereunder.

(1) **Lifetime or Annual Dollar Limits.** The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(2) **Financial Requirement or Treatment Limitations.** The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

(3) **Criteria for medical necessity determinations.** The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

c. **Women's Health and Cancer Rights Act**

Medical and surgical benefits provided for mastectomies under the Plan will be provided in accordance with the Women's Health and Cancer Rights Act of 1998 (the "Women's Health Act"). In accordance with the Women's Health Act, coverage will be provided for the following: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and coverage for any complications in all stages of mastectomy, including lymphedema.

d. Compliance with GINA

The Plan shall be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act of 2008.

e. No Lifetime or Annual Limits

The Plan shall not impose a lifetime or annual limit on the dollar value of Essential Health Benefits under any medical benefits available under the Plan unless the medical benefit is an Excepted Benefit (as defined under the Affordable Care Act) to which the Affordable Care Act does not apply.

“Essential Health Benefits” are health-related items and services that fall into the following categories, as defined in §1302 of the Affordable Care Act, and further determined by the Secretary of Health and Human Services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits under the Affordable Care Act, the Plan has chosen Ohio as its benchmark state.

f. No Preexisting Condition Exclusions

The Plan shall not impose a preexisting condition exclusion on any medical benefits available under the Plan.

g. No Rescission of Coverage

The Plan shall not cancel nor discontinue medical benefits under the Plan with a retroactive effect with respect to a Beneficiary except in the event of fraud or intentional misrepresentation.

h. Claims and Appeals Procedures

Beneficiaries shall be provided benefits as set forth in the Plan. Beneficiaries seeking benefits under the Plan shall follow and comply with the procedures established herein. In general, for in-PPL services, no claim forms will be required. The in-PPL provider generally

will be responsible for the submission of claims and other paperwork. For out-of-PPL services, claim forms generally will be available at most hospitals, clinics, and physician offices. For both in-PPL and out-of-PPL services, the hospital, clinic, or physicians' office will bill the Beneficiary for the co-payment and deductible until the maximum is reached.

If a Beneficiary is requesting reimbursement for a covered expense paid by the Beneficiary, the Beneficiary must first seek to resolve the matter with the applicable Provider. All other claims for covered benefits must also be submitted first to the Provider. If the matter is not resolved by the Provider, the Beneficiary must file a claim with the Plan Administrator. All claims must be filed with the Plan Administrator within twelve (12) months of the date of service. Any claim that is submitted for payment under the Plan after twelve (12) months or more from the date of service is untimely and shall be denied.

Beneficiaries shall be reimbursed for benefits as set forth in the Plan or Summary Plan Description ("SPD"), as applicable. Beneficiaries seeking benefits under this Plan shall follow the claims procedures established for that particular benefit by the SPD. Such claims and appeals procedures shall comply with the requirements of ERISA Section 503 and the Affordable Care Act and shall be performed by an appeals administrator named in the SPD.

B. COBRA Continuation Coverage

To the extent applicable, this Plan shall comply with the health care continuation coverage provisions of Sections 601-608 of ERISA and Section 4980B of the Internal Revenue Code.

C. Qualified Medical Child Support Orders

The Plan shall comply with the provisions of Section 609 of ERISA as amended by the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993").

**ARTICLE V
MANAGED CARE, COST CONTAINMENT UNDER TRADITIONAL
PROGRAM OF BENEFITS**

A. 1. The Trustees may adopt Participating Provider Lists (PPL's) of physicians, hospitals, pharmacies and other providers.

2. In addition or in the alternative, the Trustees may implement other managed care and cost containment rules, as well as preferred drug or formulary programs for dispensing prescription drugs, which may apply to benefits provided both by PPL providers and by non-PPL sources.

B. The Plan shall not in any way be responsible for the failure of a physician, health care facility, or other provider to satisfy any criteria set forth in C, below. Further, notwithstanding the implementation of any PPL or other managed care or cost containment rule or procedure, the Plan shall not in any way be responsible for the outcome of any medical treatment or health care (or lack of such treatment or care).

C. The Trustees may consider the following guidelines in deciding upon a PPL to be implemented under this Plan:

1. **Criteria**--A PPL may be considered on the basis of the following elements:

a. **Choice**--Each covered individual would have the freedom to select any provider within the PPL, regardless of whether that provider is a generalist or specialist.

b. **Reduction of Paperwork and Prohibition on Prepayment**--Eligible individuals utilizing PPL providers would, to the extent possible, not be required to fill out or submit claims forms.

c. **Quality Certification**--All providers should meet quality standards.

d. **Accessibility**

(1) Providers would be available within a reasonable distance. Where possible, this would mean that a covered individual would not have to travel more than 20 to 30 minutes to receive general medical care.

(2) There would be adequate numbers of providers in the different specialties to ensure that each member has a sufficient choice.

(3) Providers would be available to see covered individuals within a reasonable period, depending upon the nature of the problem.

e. **Breadth of Scope**--The PPL should include adequate diversification of specialties and facilities.

f. **Additional Specialties**--The program would have provision for going outside the PPL for necessary specialties and/or facilities that are not contained within the PPL, at no additional cost to the covered individual.

g. **Other Outside Referrals**--The program would have provision for referral outside the PPL where particular medical services can be better provided elsewhere in the opinion of the referring PPL provider, at no additional cost to the covered individual.

2. **Emergencies**--Emergency treatment would be covered in full (subject to applicable copayments) whether or not provided within the PPL.

3. **Beneficiaries Outside PPL Area**--A Beneficiary who lives outside an area served by the PPL would be permitted to utilize non-PPL providers without incurring additional copayments. For purposes of determining the Beneficiary's copayments, utilization of such non-PPL providers would be considered to be within the PPL.

4. **Transition--Out of PPL**--If a Beneficiary has begun to undergo a course of treatment with a non-PPL provider prior to the establishment of the PPL (or with a PPL

provider that leaves the PPL), completion of that course of treatment would not be considered “out of PPL” as follows:

a. for an acute condition (including pregnancy, treatment for cancer, etc.), for the duration of the specific course of treatment.

b. for a chronic condition, for up to six months.

5. **Viability**--A PPL should be viable, both financially and otherwise, in order to ensure that it will continue to be able to appropriately serve the participant population.

6. **Internal Review**--Each PPL should have internal mechanisms (including physician peer review) to resolve member complaints and to ensure that the highest quality standards are maintained.

7. **Precertification**--Precertification for services (including hospitalization) performed by PPL providers would be the responsibility of the provider, and not the covered individual. In addition, precertification in the event a covered individual is referred to a provider outside the PPL would be the responsibility of the PPL provider making the referral.

ARTICLE VI AMENDMENT AND TERMINATION UNDER TRADITIONAL PROGRAM OF BENEFITS

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 this Plan, including but not limited to the Alternate Program of Benefits, or to terminate this Plan as permitted by law, provided that the benefits provided shall not exceed the level of benefits provided as of December 31, 2006. Among other things, the Trustees reserve the right to modify or amend the provisions of this Plan and Program of Benefits to the extent provisions of the Affordable Care Act are repealed, replaced or modified, or otherwise to comply with law. For those beneficiaries who (a) become eligible for benefits from the 1993 Benefit Plan after December 27, 2020, (b) are not covered by transfers authorized under Sections 402(h)(2)(C), 402(i)(1)(B), and 402(i)(3) of SMCRA, 30 U.S.C. §§1232(h)(2)(C), 1232(i)(1)(B), and 1232(i)(3), and (c) are not enrolled in the Plan under the terms of a participation agreement between the Employer or the UMWA and the 1993 Benefit Plan, the benefits provided are addressed in Part II of this Plan Document under “1993 Plan Post-Legislative Program of Benefits.”

ARTICLE VII DENIAL NOTIFICATION/REVIEW UNDER TRADITIONAL PROGRAM OF BENEFITS

Any participant or Beneficiary whose claim for benefits under this program of benefits has been denied shall be: (i) provided with adequate notice in writing setting forth the specific reasons for such denial, such notice to be written in a manner calculated to be understood by the participant, and (ii) afforded a reasonable opportunity for a full and fair review of the decision denying the claim by an appropriate named fiduciary or a person properly designated to carry out such responsibility. The decision on review will be in writing and will include the specific

reasons for the decision. All decisions of the Board of Trustees are final and binding on all parties. The Trustees shall develop such procedures for claims and appeals as are required under applicable law.

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PART II--1993 PLAN POST-LEGISLATIVE PROGRAM OF BENEFITS

ARTICLE I

INTRODUCTION TO POST-LEGISLATIVE PROGRAM OF BENEFITS

Part II of this Plan Document for the 1993 Benefit Plan describes the 1993 Plan Post-Legislative Program of Benefits. This is a limited program of benefits that applies to eligible beneficiaries of the 1993 Benefit Plan whose benefits are not funded by the transfers described in Part I of this Plan Document or by an Employer or the UMWA that is party to a participation agreement with the 1993 Benefit Plan.

ARTICLE II

DEFINITIONS UNDER POST-LEGISLATIVE PROGRAM OF BENEFITS

Definitions under the Post-Legislative Program of Benefits shall be the same as the Definitions under Part I of this Plan Document pertaining to the Traditional Program of Benefits.

ARTICLE III

ELIGIBILITY UNDER POST-LEGISLATIVE PROGRAM OF BENEFITS

In general, those eligible for benefits under the Post-Legislative Program of Benefits will consist of those retired miners and their dependents who meet the eligibility requirements of the Plan as set forth below and a) became enrolled in the Plan after December 27, 2020, (b) whose benefits are not funded by federal transfers under Section 402(h)(2)(C), 402(i)(1)(B), or 402(i)(3) of the Surface Mining Control and Reclamation Act of 1977, as amended, (“SMCRA”), 30 U.S.C. § 1232(h)(2)(C), 1232(i)(1)(B), and 1232(i)(3), (c) whose benefits are not funded by transfers from the voluntary employees’ beneficiary association (“VEBA”) described in Section 402(h)(2)(C)(iv) and (v) of SMCRA, 30 U.S.C. §§ 1232(h)(2)(C)(iv) and (v), and (d) are not enrolled in the Plan under the terms of a participation agreement between the Employer or the UMWA and the 1993 Benefit Plan. In addition to the foregoing, Retired Miners, Disabled Employees, Dependents, and Surviving Spouses and Dependents of Deceased Employees or Retired Miners must satisfy the applicable eligibility provisions set forth below.

A. Retired Miners

A Retired Miner will be eligible for benefits under this Post-Legislative Program of Benefits if he satisfies the conditions set forth in the introductory paragraph above and meets the conditions set forth in Article IX-B of the Trust and Article XX(c)(3)(ii) of the Wage Agreement. No individual (1) who is entitled to benefits under section 9711 of the Internal Revenue Code of 1986, as amended by the Coal Industry Retiree Health Benefit Act of 1992, or (2) who is a New Inexperienced Miner as defined in Article XXB(d)(4) of the Wage Agreement other than a New Inexperienced Miner who becomes permanently and totally disabled as a result of a mine accident as set forth in Article XX(5)(d) of the Wage Agreement, shall be eligible for benefits under the Post-Legislative Program of Benefits.

B. Disabled Employees

In addition to disabled Retired Miners who are receiving pension benefits and are therefore entitled to receive health benefits under section A of this Article III, a disabled Employee will be eligible for benefits under the Post-Legislative Program of Benefits if, in addition to the general eligibility conditions set forth in the introductory paragraph above, the Employee of the Employer:

1. Has completed 20 years of credited service, including the required number of years of signatory service pursuant to Article IV.C(6) of the 1974 Pension Plan or any corresponding paragraph of any successor thereto, or is a New Inexperienced Miner or Electing Miner as provided in Article XX(10)(l) of the Wage Agreement and has obtained more than 20 years of service as provided in Article XX (10)(l) of the Wage Agreement and as determined pursuant to Article XX (9)(e) of the Wage Agreement, and

a. has not attained age 55 (except for a New Inexperienced Miner or Electing Miner as provided in Article XX (10)(l) of the Wage Agreement), and

b. became disabled after December 6, 1974 while in classified employment with the Employer, and

c. is eligible for Social Security Disability Insurance Benefits under Title II of the Social Security Act or its successor; or

2. Becomes totally disabled due to a compensable disability within four years of the date the Employee would be eligible to receive a pension under the 1974 Pension Plan or any successor thereto, or is a New Inexperienced Miner or Electing Miner as provided in Article XX(10)(l) of the Wage Agreement and has obtained more than 20 years of service as provided in Article XX (10)(l) of the Wage Agreement and as determined pursuant to Article XX (9)(e) of the Wage Agreement, as long as the Employee continues to be so disabled during the period for which the Workers' Compensation payments are applicable (Workers' Compensation does not include Federal Black Lung Benefits).

C. Dependents

In addition to the general eligibility conditions set forth in the introductory paragraph above, Dependents will be eligible for benefits under the Post-Legislative Program of Benefits if they are the following members of the family of any Retired Miner or Disabled Employee receiving health benefits pursuant to Section A or B of this Article III:

1. A spouse who is living with or being supported by an eligible Retired Miner or Disabled Employee;

2. Dependent children of a Disabled Employee or an eligible Retired Miner who have not attained age 26;

3. A parent of an eligible Disabled Employee, Retired Miner, or spouse, if the parent has been dependent upon and living in the same household (residence) with the eligible Retired Miner or Disabled Employee for a continuous period of at least one year;

4. Unmarried dependent grandchildren of an eligible Disabled Employee, Retired Miner or spouse who have not attained age 22 and are living in the same household (residence) with such Retired Miner or Disabled Employee;

5. Dependent children (age 26 or older), of an eligible Disabled Employee, Retired Miner, or spouse, who are intellectually disabled or who become disabled prior to attaining age 26 and such disability is continuous and are either living in same household with such Disabled Employee or Retired Miner, or are confined to an institution for care or treatment. Health benefits for such children will continue as long as a surviving parent is eligible for health benefits.

For purposes of this Section C, a grandchild or parent shall be considered dependent upon an eligible Retired Miner, Disabled Employee or spouse if such Retired Miner, Disabled Employee or spouse provides over one half of the support to such person.

D. Surviving Spouse and Dependents of Deceased Employees or Retired Miners

In addition to the general eligibility conditions set forth in the introductory paragraph above, Surviving Spouses and dependents of deceased Employees or Retired Miners will be eligible for benefits under the Post-Legislative Program of Benefits if they are (i) any unmarried surviving spouse (who was living with or being supported by the Employee or Retired Miner immediately prior to the Employee's or Retired Miner's death) and (ii) such spouse's surviving dependent children as defined in subsections 2 and 5 of section C, of an Employee or Retired Miner who died:

1. As a result of a mine accident occurring while the Employee was working in a classified job for the Employer;

2. Under conditions which qualify such spouse for a Surviving Spouse benefit under the 1974 Pension Plan or any successor thereto or would have so qualified such spouse had the Employee not been an Electing Miner as set forth in Article XX(10)(m) of the Wage Agreement;

3. At a time when such Employee or Retired Miner is entitled to receive health benefits pursuant to section A or B of this Article III, or benefits pursuant to the Employer Plan incorporated by reference in the Employer's Wage Agreement (provided such individuals would not be excluded from coverage under this Plan by the exclusions in Section A above). However, (i) if such Employee or Retired Miner died prior to the Effective Date of the Wage Agreement and the spouse is not eligible for a Surviving Spouse's benefit, then health benefits are payable only for the period that the spouse is eligible to receive death benefits in installment payments pursuant to section C of Article III of the Employer Plan, or (ii) if such Employee or Retired Miner died on or after the Effective Date of the Wage Agreement and the spouse is not eligible for a Surviving Spouse's benefit and life insurance benefits or death benefits under any plan maintained pursuant to Article XX of the National Bituminous Coal Wage Agreement that are payable in a lump sum, then health benefits are payable only for 60 months following the month

of the death of such Employee or only for 22 months following the month of the death of such Retired Miner. If life insurance benefits are not payable, health benefits shall be provided only to the end of the month in which the Employee or Retired Miner died.

4. Surviving spouses of Employees described in section B.1. of this Article III, who died prior to receiving a pension and after receiving all Sickness & Accident Benefits, shall, if they are not entitled to Surviving Spouse benefits under the 1974 Pension Plan, receive health benefits under Article IV until remarriage or for 36 months, whichever occurs first.

5. The surviving spouse of a New Inexperienced Miner or Electing Miner who is a Disabled Employee under section B.1. of this Article III and who died prior to reaching age 55, shall receive health benefits under Article IV until remarriage or for 36 months, whichever occurs first. If such New Inexperienced Miner or Electing Miner died upon or after reaching age 55, his surviving spouse will receive health benefits for life or until remarriage.

Health benefits shall continue for a surviving spouse until remarriage of such spouse, but if such spouse is entitled to such benefits under subsections 3, 4 or 5 above, such health benefits will continue not longer than for the period specified in those subsections.

At the death of an Employee described in subsection 1 above, health benefits will be continued for the children until they attain age 26, even if there is no surviving spouse or if the surviving spouse dies before they attain age 26.

The children of a Surviving Spouse eligible under subsection 2 above shall be eligible for health benefits until they attain age 26, so long as the Surviving Spouse is eligible for benefits.

If at the death of an Employee or Retired Miner described in subsection 3 above, there is no surviving spouse, or if the surviving spouse dies during any period in which health benefits are being continued, such health benefits will be continued for the children during the period in which such spouse would have been eligible for health benefits but in no event beyond their attaining age 26. Notwithstanding the above or any other provision of this Plan, if any Employee or Retired Miner had more than one spouse prior to the Employee's or Retired Miner's death, only one surviving spouse shall be eligible for health benefits from the Plan as a surviving spouse, and only the eligible children of such a surviving spouse shall be eligible for health benefits from the Plan if they otherwise satisfy the Plan's eligibility requirements.

ARTICLE IV BENEFITS UNDER POST-LEGISLATIVE PROGRAM OF BENEFITS

Benefits under the Post-Legislative Program of Benefits are limited to those benefits that can be provided by the assets of the Trust that are available for such benefits. For those Beneficiaries who are enrolled in the 1993 Benefit Plan and eligible for benefits under the Post-Legislative Program of Benefits, the Trustees must monitor the assets of the Trust in order to provide benefits and shall address the Plan's overall financial status, including the stream of benefit obligations as well as the projected income from all available resources, and take prudent and appropriate actions consistent with their duties and obligations under the Trust and Plan documents, including, if necessary, reducing benefits. If the Trustees do not act to reduce Plan benefits when and as required, then the Executive Director of the UMWA Health & Retirement

Funds (or if such position is vacant, the highest ranking staff member working exclusively on health benefit plan matters) shall adopt such benefit reductions effective immediately.

The initial benefits provided under the Post-Legislative Program of Benefits are set forth in this Article IV. Benefit payments are based on negotiated rates applicable to services provided by hospitals, physicians, pharmacies and other providers on Participating Provider Lists (PPL's) adopted under Article V, or under other arrangements entered into by the Trustees. During any period when PPL's or other arrangements are not in effect, and for covered services and supplies not offered under a PPL or other arrangement (or otherwise not subject to a PPL-related benefit limit), benefit payments shall not exceed reasonable and customary charges* for covered services and supplies. Covered services shall be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at the appropriate level of care, or are otherwise provided for in the Plan. 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 this 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.

Services which are not reasonable and necessary shall include, but are not limited to the following: 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 timely fashion in the patient's medical records; procedures which can be performed with equal efficiency at a lower level of care.

The benefits described in this Article are subject to any precertification, prescription drug formulary, and other utilization review requirements implemented pursuant to Article V. 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 as described in this Article IV.

Coverage and benefit levels shall conform to each requirement of Article XX of the 2016 Wage Agreement relating to the UMWA 1993 Benefit Plan, including all restrictions set forth in the General Description of the Health and Retirement Benefits of such Article, and shall not exceed the level of benefits provided as of December 31, 2006.

* 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 some home health and hospice services.

The benefits provided under this Plan shall be only such benefits as can be provided by the assets of the Trust. Accordingly, the benefits are subject to termination, suspension, revision or amendment by the Trustees in their discretion at any time.

A. Health Benefits Under Post-Legislative Program of Benefits

1. Inpatient Hospital Benefits

a. Semi-private room

When a Beneficiary is admitted by a licensed physician (hereinafter “physician”) for treatment as an inpatient to an Accredited Hospital (hereinafter “hospital”), benefits will be provided for semi-private room accommodations (including special diets and general nursing care) and all medically necessary services provided by the hospital as set out below for the diagnosis and treatment of the Beneficiary’s condition.

Medically necessary services provided in a hospital include the following:

- Operating, recovery, and other treatment rooms
- Laboratory tests and x rays
- Diagnostic or therapy items and services
- Drugs and medication (including take home drugs which are limited to a 30-day supply)
- Radiation therapy
- Chemotherapy
- Physical therapy
- Anesthesia services
- Oxygen and its administration
- Intravenous injections and solutions
- Administration of blood and blood plasma
- Blood, if it cannot be replaced by or on behalf of the Beneficiary

b. Intensive Care Unit Coronary Care Unit

Benefits will also be provided for treatment rendered in an Intensive Care or Coronary Care Unit of the hospital, if such treatment is certified as medically necessary by the attending physician.

c. Private Room

For confinement in a private room, benefits will be provided for the hospital’s most common charge for semi private room accommodations and the Beneficiary shall be responsible for any excess over such charge except that private room rates will be paid when (i) the Beneficiary’s condition requires him to be isolated for his own health or that of others, or (ii) the hospital has semi private or less expensive accommodations but they are occupied and the Beneficiary’s condition requires immediate hospitalization. Semi-private room rates, not private room rates, will be paid beyond the date a semi-private room first becomes available and the Beneficiary’s condition permits transfer to those accommodations.

d. Renal Dialysis

Benefits will be provided for renal dialysis provided that the renal dialysis therapy is administered in accordance with Federal Medicare regulations as in effect from time to time.

e. Mental Illness

Benefits are provided for a Beneficiary who is confined for mental illness in a hospital by a licensed psychiatrist on the same basis as any medically necessary hospitalization.

f. Alcoholism and Drug Abuse

Benefits are provided for a Beneficiary who requires emergency detoxification hospital care for the treatment of alcoholism or emergency treatment for drug abuse. If treatment of a medical or mental condition is necessary following detoxification or emergency treatment for drug abuse, benefits may be provided under other provisions of this Plan and are subject to any requirements or limitations in such provisions.

See subsection 7.f. for information concerning other services related to treatment of alcoholism and drug abuse.

g. Oral Surgical/Dental Procedures

Benefits are provided for a Beneficiary who is admitted to a hospital for the oral surgical procedures described in subsection 3.e. provided hospitalization is medically necessary. Benefits are also provided for a Beneficiary admitted to a hospital for dental procedures only if hospitalization is necessary due to a preexisting medical condition and prior approval is received from the Trustees.

h. Maternity Benefits

Benefits are provided for a female Beneficiary who is confined in a hospital for pregnancy. Such benefits will also be available for services pertaining to termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

i. General

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 United Mine Workers of America Combined Benefit Fund.

2. **Outpatient Hospital Benefits**

a. **Emergency Medical and Accident Cases**

Benefits are provided for a Beneficiary who receives emergency medical treatment or medical treatment of an injury as the result of an accident, provided that the beneficiary has acute medical symptoms and the absence of immediate medical attention could result in serious jeopardy of the individual's health or body.

b. **Surgical Cases**

Benefits are provided for a Beneficiary who receives surgical treatment in the outpatient department of a hospital.

c. **Laboratory Tests and X rays**

Benefits are provided for laboratory tests and x ray services performed in the outpatient department of a hospital which provides such services and when they have been ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

c. **Chemotherapy and Radiation Therapy**

Benefits are provided for chemotherapy treatments of a malignant disease or radiation treatments performed in the outpatient department of a hospital.

d. **Physiotherapy**

Benefits are provided for physiotherapy treatments performed in the outpatient department of a hospital. Such therapy must be prescribed and supervised by a physician.

e. **Renal Dialysis**

Benefits are provided for outpatient renal dialysis treatments rendered in accordance with Federal Medicare regulations as in effect from time to time.

3. **Physicians' Services and Other Primary Care**

a. **Surgical Benefits**

Benefits are provided for surgical services essential to a Beneficiary's care consisting of operative and cutting procedure (including the usual and necessary post-operative care) for the treatment of illnesses, injuries, fractures or dislocations, which are performed either in or out of a hospital by a physician.

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.

b. Assistant Surgeons

If the Beneficiary is an inpatient in a hospital, benefits will also be provided for the services of a physician who actively assists the operating physician in the performance of such surgical services when the condition of the Beneficiary and type of surgical service require such assistance.

c. Obstetrical Delivery Services

Benefits are provided for a female Beneficiary for obstetrical delivery services (including pre and post-natal care) performed by a physician. Benefits will also be provided if such delivery is performed by a midwife certified by the American College of Nurse Midwifery and licensed where such licensure is required.

Such benefits will also be provided for termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

d. Anesthesia Services

Benefits are provided for the administration of anesthetics provided either in or out of the hospital in surgical or obstetrical cases, when administered and billed by a physician, other than the operating surgeon or his assistant, who is not an employee of, nor compensated by, a hospital, laboratory or other institution; or by a nurse anesthetist.

e. Oral Surgery

Benefits are not provided for dental services. However, benefits are provided for 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
- Dental services required as the direct result of an accident

f. Surgical Services Limitations

Benefits are not provided for certain surgical services without prior approval of the Trustees. Such surgical procedures include, but are not limited to, the following:

- 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 government programs
Organ transplants

g. In-hospital Physicians' Visits

If a Beneficiary is confined as an inpatient in a hospital because of an illness or injury, benefits are provided for in-hospital visits by the physician in charge of the case. Such benefits will also be provided concurrently with benefits for surgical, obstetrical and radiation therapy services when the Beneficiary has 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.

h. Home, Clinic, and Office Visits

Benefits are provided for services rendered to a Beneficiary at home, in a clinic (including the outpatient department of a hospital) or in the physician's office for the treatment of illnesses or injuries, if provided by a physician.

i. Emergency Treatment

When provided by a physician, benefits are provided for a Beneficiary who receives outpatient emergency medical treatment or treatment of an injury as the result of an accident, provided that the individual has acute medical symptoms, and the absence of immediate medical attention could result in serious jeopardy of the individual's health or body.

j. Laboratory Tests and X rays

Benefits will be provided for laboratory tests and x rays performed in a licensed laboratory when ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

Such benefits 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.

k. Radiation and Chemotherapy Benefits

Benefits are provided for treatment by x ray, radium external radiation or radioactive isotope (including the cost of materials unless supplied by a hospital), provided in or out of a hospital, when performed and billed by a physician.

When a Beneficiary's condition requires radiation therapy services in conjunction with medical, surgical or obstetrical services, benefits will be provided for such radiation therapy in addition to the payment for such other types of covered services if the physician performing the radiation therapy services is not the same physician who performs the medical, surgical or obstetrical services.

Benefits are provided for treatment of malignant diseases by chemotherapy provided in or out of the hospital when prescribed and billed by a physician.

l. Medical Consultation

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 by a Beneficiary.

m. Specialist Care

Benefits will be provided for treatment prescribed or administered by a specialist if the treatment is for illness or injury which falls within the specialist's area of medical competence.

n. Primary Care Podiatrists' Services

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.

o. Primary Medical Care Miscellaneous

(1) Benefits are provided for care of newborn babies and routine medical care of children prior to attaining age 6, subject to the requirements of subsection (9) below regarding preventive services.

(2) Benefits are provided for immunizations, allergy desensitization injections, pap smears, screening for hypertension and diabetes, and examinations for cancer, blindness, deafness, and other screening and diagnostic procedures when medically necessary.

(3) Subject to the requirements of subsection (9) below regarding preventive services, benefits are provided for physical examinations when certified as medically necessary by a physician. Medically necessary will mean that a Beneficiary (i) has an existing medical condition under treatment by a physician, (ii) has attained age 55, (iii) is undergoing an annual or semi-annual routine examination by a gynecologist or (iv) is undergoing a routine examination prescribed by a specialist as part of such specialist's care of a medical condition.

(4) Benefits are provided for "physician extender" care or medical treatment administered by nurse practitioners, physician's assistants or other certified or licensed health personnel when such service is rendered under the supervision of a physician.

(5) Benefits are provided for a nominal fee covering instruction in preparation for natural childbirth, if rendered in a hospital or clinic.

(6) Benefits are provided for family planning counseling when rendered by a physician or by other appropriately trained and supervised health care professionals.

(7) Benefits are provided covering artificial insemination if the service is provided by a licensed gynecologist.

(8) Benefits are provided for sterilization procedures if such procedures are performed by a physician.

(9) Preventive care and preventive services meeting one of the following requirements are covered benefits and will not be subject to any deductible or copayment when provided in-PPL:

(i) Evidenced-based items or preventive services, including various types of screenings (e.g., blood pressure screenings, cholesterol screenings, various STD screenings, diabetes screening, depression screenings, tobacco use counseling, breast cancer screenings, genetic counseling, and BRCA testing) with an “A” or “B” rating recommended by the United States Preventive Services Task Force (USPSTF), an independent panel of scientific experts;

(ii) Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, such as periodic tetanus shots or other vaccinations for diseases like polio, chickenpox, measles, whooping cough and hepatitis;

(iii) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents, such as regular pediatrician visits, vision and hearing screening, developmental assessments and screening and counseling to address obesity; and

(iv) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA for women, including FDA-approved contraceptives and contraceptive counseling, as well as well-woman visits, domestic violence screening and counseling, HIV and other sexually transmitted disease counseling and breastfeeding support, supplies and counseling.

p. Services Not Covered

(1) Services rendered by a chiropractor or naturopathic services.

(2) Acupuncture therapy.

(3) Home obstetrical delivery.

- (4) Telephone conversations with a physician in lieu of an office visit.
- (5) Charges for writing a prescription.
- (6) Medications dispensed by other than a licensed pharmacist.
- (7) Charges for medical summaries and medical invoice preparations.
- (8) Services of any practitioner who is not legally licensed to practice medicine, surgery, or counseling except as specifically provided herein.
- (9) Cosmetic surgery, unless pertaining to surgical scars or to correct results of an accidental injury or birth defects.
- (10) Physical examinations, except as specifically provided herein.
- (11) Removal of tonsils or adenoids, unless medically necessary.

4. **Prescription Drugs**

a. **Benefits Provided**

Benefits are provided for insulin and prescription drugs (only those drugs which by Federal or State law require a prescription) dispensed by a licensed pharmacist and prescribed by a (i) physician for treatment or control of an illness or a non-occupational accident or (ii) licensed dentist for treatment following the performance of those oral surgical services set forth in 3.e.

The initial amount dispensed shall not exceed a 90-day supply. Any original prescription may be refilled for up to one year as directed by the attending physician. Each such refill may be for an amount up to, but no more than, a 90-day supply. Benefits for refills beyond the initial twelve months require a new prescription by the attending physician. Prescriptions filled by the Plan's mail order provider, if any, are not subject to the limits on quantity set forth in this paragraph.

Reasonable charges for prescription drugs or insulin are covered benefits. Reasonable charges will consist of the lesser of:

- (1) The amount actually billed per prescription or refill;
- (2) The price of the applicable generic substitution drug, if AB or better-rated, approved by the federal Food and Drug Administration; or, in the event the prescribing physician determines that use of a brand name drug is medically necessary, the price of such brand name drug; or
- (3) The current price paid to participating pharmacies in any prescription drug program established by the Plan.

However, in no event will a Beneficiary be responsible to pay more for a single prescription than the appropriate co-payment set forth in this Plan, plus any difference between the price of the generic and the brand name drug, where applicable.

b. Benefits Excluded

Benefits shall not be provided under subsection 4.a. for the following:

- (1) Medications dispensed in a hospital (including take home drugs), skilled nursing facility or physician's office. (See Article IV.A.1.a. and 5.a. for benefits provided for drugs and medications during inpatient confinement in a hospital skilled nursing facility.)
- (2) Prescriptions dispensed by other than a licensed pharmacist.
- (3) Any medication not specifically provided for in a. above.

5. Skilled Nursing Care and Extended Care Units

a. Skilled Nursing Care Facility

Upon determination by the attending physician that confinement in a licensed skilled nursing care facility* is medically necessary, to the extent that benefits are not available from Medicare or other State or Federal programs, benefits will be provided for:

- (1) skilled nursing care provided by or under the supervision of a registered nurse;
- (2) room and board;
- (3) physical, occupational, inhalation and speech therapy, either provided or arranged for by the facility;
- (4) medical social services;
- (5) drugs, immunizations, supplies, appliances, and equipment ordinarily furnished by the facility for the care and treatment of inpatients;
- (6) 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
- (7) other health services usually provided by skilled nursing care facilities.

* Skilled nursing care facility is limited to a skilled nursing care facility which is licensed and approved by Federal Medicare and by any appropriate state law, regulation or agency.

The Plan will not pay for services in a nursing care facility that is not licensed or approved in accordance with Federal Medicare and state laws or regulations, unless the service is provided by or under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results.

Exclusions: Telephone, TV, radio, visitor's meals, private room or private nursing (unless necessary to preserve life), custodial care, and services not usually provided in a skilled nursing facility are not covered under the Plan.

b. Extended Care Units

Benefits are provided for up to two weeks of specialized medical services and daily treatments by licensed personnel in extended care units. When medically necessary, benefit may be provided for a longer period of time, subject to approval from the Trustees.

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.

Exclusions:

Services, drugs or other items which are not covered for hospital inpatients; and custodial care.

6. Home Health Services & Equipment

a. General Provisions

Benefits are provided for home health services, including nursing visits by registered nurses and home health aides, and various kinds of rehabilitation therapy, subject to the following conditions and approval of the Trustees.

(1) The Beneficiary must be under the care of a physician.

(2) The Beneficiary's medical condition must require skilled nursing care, physical therapy, or speech therapy at least once in a 60-day period.

(3) The physician must initiate a treatment plan and specify a diagnosis, the Beneficiary's functional limitations and the type and frequency of skilled services to be rendered.

(4) The Beneficiary must be confined to his home. The services must be provided by a certified home health agency.

Benefits will be provided for up to a maximum of 60 visits per year for a Beneficiary who is receiving benefits under the Post-Legislative Program of Benefits.

b. Physical and Speech Therapy

Benefits are provided for physical and speech therapy services at home when prescribed by a physician to restore functions lost or reduced by illness or injury. Such services must be

performed by qualified personnel. When the Beneficiary has reached his or her restoration potential, the services required to maintain this level do not constitute covered care.

c. Skilled Nursing

Benefits are provided for skilled nursing care rendered by a registered nurse as a home health service when a Beneficiary's condition has not stabilized and a physician concludes that the Beneficiary must be carefully evaluated and observed by a registered nurse. The Trustees may request an evaluation visit to the Beneficiary's home.

d. Medical Equipment

Benefits are provided for rental or, where appropriate, purchase of medical equipment suitable for home use when determined to be medically necessary by a physician.

e. Oxygen

Benefits are provided for oxygen supplied to a Beneficiary subject to the following conditions when ordered by the attending physician:

- (1) The patient is referred to a designated pulmonary consultant for testing.
- (2) Such consultant's report is submitted to the Trustees with the order for oxygen.

Benefits are also provided for services of inhalation therapists in the home with the attending physician's order.

f. Coal Miners Respiratory Disease Program

Benefits are provided for services or treatments administered by personnel employed by the Coal Miners Respiratory Disease Program to a Beneficiary in such Beneficiary's home when ordered or requested by a physician, except where such benefits are available under a governmental program and such Beneficiary is eligible, or upon application would be eligible, under such programs.

7. Other Benefits

a. Orthopedic and Prosthetic Devices

Benefits are provided for orthopedic and prosthetic devices prescribed by a physician when medically necessary.

The following types of equipment are covered:

- (1) Prosthetic devices which serve as replacement for internal or external body parts, other than dental. These include artificial eyes, noses, hands (or hooks), feet, arms, legs and ostomy bags and supplies.
- (2) Prosthesis following breast removal.
- (3) Leg, arm, back, and neck braces.
- (4) Trusses.
- (5) Stump stockings and harnesses when these devices are essential for the effective use of an artificial limb. An examination and recommendations by an orthopedic physician is required.

Note: Benefits are provided for repairs and adjustments for braces, trusses, stump stockings and harnesses as well as replacement of any of those devices which have been worn out and can no longer be repaired. Benefits will be provided for replacements for usable appliances and artificial limbs if they are needed because of a change in the Beneficiary's condition. Benefits will also be provided to cover repair and adjustment cost for appliances and artificial limbs.

If replacement of a prosthesis is required, the Beneficiary should in all cases be reevaluated by an orthopedic physician.

(6) Surgical stocking (up to two pairs per prescription with no refills) when prescribed by a physician for surgical or medical conditions. The Plan will not pay Beneficiaries for support hose, garter belts, etc.

(7) Orthopedic shoes when specifically prescribed by a physician or licensed podiatrist for a Beneficiary according to orthopedist specifications, including orthopedic shoes attached to a brace that have to be modified to accommodate the brace. Benefits will not be provided for stock orthopedic shoes.

(8) Orthopedic corrections added to ordinary shoes by a physician or licensed podiatrist. Benefits are provided for only the correction to the shoe.

b. Physical Therapy

Benefits are provided for physical therapy in a hospital, skilled nursing facility, treatment center, or in the Beneficiary's home. Such therapy must be prescribed and supervised by a physician and administered by a licensed therapist. The physical therapy treatment must be justified on the basis of diagnosis, medical recommendation and attainment of maximum restoration.

c. Speech Therapy

Benefits are provided for speech therapy rendered by a qualified licensed speech therapist if the Beneficiary is a stroke patient or has had conditions including ruptured aneurysm, brain tumors or autism and needs special instruction to restore technique of sound and to phonate, and needs direction in letter and word exercises in order to express basic needs. Benefits are also provided for speech therapy for child Beneficiaries with a speech impediment from a qualified speech therapist provided that the child cannot receive speech therapy through the public schools.

d. Hearing Aids

Benefits are provided for hearing aids recommended by a licensed otologist or otolaryngologist and a certified clinical audiologist. Such hearing aids must be purchased from a participating vendor. Benefits for necessary repairs and maintenance, except the replacement of batteries, will be provided after the expiration of the warranty period. Benefits will be provided for replacement hearing aids only if a new aid is needed because of a change in the Beneficiary's condition, or if the aid no longer functions properly. Benefits will not be provided for any fees for incorporating hearing aids into eyeglasses.

e. Ambulance and Other Transportation

Benefits are provided for ambulance transportation to or from a hospital, clinic, medical center, physician's office, or skilled nursing care facility, when considered medically necessary by a physician.

With prior approval from the Trustees benefits will also be provided for other transportation subject to the following conditions:

(1) If the needed medical care is not available near the Beneficiary's home and the Beneficiary must be taken to an out of area medical center.

(2) If the Beneficiary requires frequent transportation between the Beneficiary's home and a hospital or clinic for such types of treatment as radiation or physical therapy or other special treatment which would otherwise require hospitalization, benefits will be provided for such transportation only when the Beneficiary cannot receive the needed care without such transportation.

(3) If the Beneficiary requires an escort during transportation, the attending physician must submit satisfactory evidence as to why the Beneficiary needs an escort.

f. Outpatient Mental Health, Alcoholism and Drug Addiction

Benefits are provided for: Psychotherapy, psychological testing, counseling, group therapy and alcoholism or drug rehabilitative programs.

Benefits are not provided for:

- (1) Encounter and self-improvement group therapy.
- (2) Custodial care related to intellectual disability and other intellectual deficiencies.
- (3) School related behavioral problems.
- (4) Services by private teachers.
- (5) Alcoholism and drug rehabilitation if an advance determination has not been made that the Beneficiary is a good candidate for rehabilitation.
- (6) Alcoholism and drug rehabilitation programs not approved by Medicare, certified or licensed by the applicable state, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or otherwise authorized by law.

8. Co-Payments and Deductibles Under Post-Legislation Program of Benefits

The benefits provided under the Post-Legislative Program of Benefits shall be subject to the copayments and deductibles set forth below and such co-payments and deductibles shall be the responsibility of the Beneficiary. The Trustees shall implement such procedures as deemed appropriate to achieve the intent of these co-payments. Beneficiaries and providers shall provide such information as the Trustees may require to effectively administer these co-payments, or such Beneficiaries or providers shall not be eligible for benefits or payments under this Plan. Any overpayments made to a provider who overcharges the Plan in lieu of collecting the applicable co-payment from a participant or Beneficiary shall be repaid to the Trustees by such provider.

Co-payments and deductibles for covered Health Benefits are established below.

Participating Provider Lists (PPL's) implemented by the Plan pursuant to Article V may include participating hospitals, physicians, pharmacies and other providers. The Plan payment for non-emergency hospital and related benefits provided from a non-PPL source will be limited to 90% of the amount that would have been paid by the Plan if the benefit had been provided by a provider on a PPL (or actual charges, if less). If a provider then bills the Beneficiary for any remaining amount, the protections of subsection 10.f.(2) (Hold Harmless) will not apply until the non-PPL out-of-pocket maximum is reached. In any case where a non-PPL provider is treated as being within the PPL, pursuant to the provisions of Article V.C, the Beneficiary will be responsible for the co-payment that would apply to a PPL service. The Plan will pay the provider at no greater than the PPL rate, and the protections of subsection 10.f.(2) (Hold Harmless) will apply.

If a Retired Miner is covered under this Plan and an Employer Plan (established pursuant to the NBCWA of 2011 or 2016) by one or more signatory Employers during a calendar year, the total co-payments and deductibles made and documented by the Employee or Pensioner during

such calendar year shall be counted toward the out-of-pocket maximum in the same manner as if they had been made under a single plan.

The following co-payments and deductibles are required under the Post-Legislative Program of Benefits. The deductibles that apply to prescription drugs and medical benefits must be paid first by the Beneficiary. After the applicable deductibles are paid, the co-payments set forth below apply and must be paid by the Beneficiary.

Out-of-PPL Costs

a. **Hospitalization**--Benefits for inpatient treatment by a non-PPL hospital are paid at 90% of the in-PPL rates. The Beneficiary is responsible for the remainder of the charges. Benefits for emergency care provided at a non-PPL hospital are paid at the PPL rate.

b. **Doctor Visits**--Each office visit to a non-PPL physician is subject to \$30.00 copayment.

Prescription Drugs--Prescription drugs will be provided through the PPL at a copayment of \$15.00 per 30-day supply. Prescriptions bought Out of PPL are subject to a \$30.00 copayment per 30-day supply. Mail order prescription drugs, where available in PPL, will be subject to a \$5.00 copayment per 30-day supply. (See chart below.) The co-payment for a 90-day supply shall be three times the 30-day supply co-payment.

The required co-payments are:

Physician Office Visits:

In PPL:	\$20.00 per office visit
Non-PPL:	\$30.00 per office visit

Hospital and Related Charges:

In PPL:	No co-payment
Non-PPL:	Balance of charges after Plan pays 90% of the PPL rate for covered services from a non-PPL source. No co-payment for hospitalization resulting from a medical emergency.

Prescription Drugs (Co-pays do not apply to out-of-pocket maximum):

In PPL:	\$15.00 per prescription
Non-PPL:	\$30.00 per prescription
Mail Order:	\$5.00 per prescription

The co-payments set forth above are for a 30-day supply. The co-payment for a 90-day supply is three times the 30-day supply co-payment. Brand name where a generic equivalent is available:

In addition to the co-payment, the Beneficiary is responsible for the additional cost of the brand name drug over the cost of the generic substitute. A generic drug will not be considered

“available” unless it has been approved by the federal Food and Drug Administration. In addition, if the prescribing physician determines that use of a brand name drug is medically necessary, the generic drug will not be considered “available,” and there will be no additional payment by the Beneficiary for the use of the brand name drug.

Deductibles -- In addition to these co-payments, each Beneficiary shall be responsible for a prescription drug deductible of \$200.00 per individual per year up to the annual out-of-pocket maximum of \$1,000.00 per family. Each Beneficiary shall also be responsible for a medical deductible of \$1,000 per year with no out-of-pocket maximum.

Annual Out-of-Pocket Maximum:

The requirement that co-payments be paid relating to prescription drugs will be suspended for the remainder of any calendar year during which the following out-of-pocket maximum amounts have been paid:

Benefit	Annual Out-of-Pocket Maximum
Prescription drugs from a PPL provider	\$1,000.00 per year per family
PPL physician office visits	There is no annual out-of-pocket maximum
Prescription drugs from a non-PPL provider	\$1,000.00 per year per family
Non-PPL physician office visits	There is no annual out-of-pocket maximum
Non-PPL hospital and related charges	There is no annual out-of-pocket maximum

No family will have to pay more than \$1,000.00 in combined prescription drug co-payments in any year.

When the non-PPL out-of-pocket maximum has been reached for prescription drugs, the Plan will pay at no greater than the PPL rate for a covered prescription drug benefit provided from a non-PPL source, but Hold Harmless protections will apply.

9. **Vision Care Program**

a. **Benefits Provided.**

Benefits	Actual Charge Up to Maximum Amount	Frequency Limits
Vision Examination	\$46.77	Once every 24 months
Per Lens (Maximum = 2)		
Single vision	\$23.39	Once every 24 months
--Bifocal	\$35.09	Once every 24 months
-- Trifocal	\$46.77	Once every 24 months
-- Lenticular	\$58.47	Once every 24 months
-- Contact	\$35.09	Once every 24 months
-- Frames	\$33.13	Once every 24 months

Note: The 24-month period shall be measured from the date the examination is performed or from the date the lenses or frames are ordered, respectively, even if the last examination occurred during a prior Wage Agreement.

b. **Lenses** will not be covered unless the new prescription differs from the most recent one by an axis change of 20 degrees or .50 diopter sphere or cylinder change and the lenses must improve visual acuity by at least one line on the standard chart.

c. **Exclusions include:**

- (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), 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 worker's 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.

d. The exclusions in c. above shall not be read to limit or exclude coverage that may be contained elsewhere in the Plan.

10. **General Provisions**

a. **Administration**

The Trustees are authorized to promulgate rules and regulations to implement the Plan, and such rules and regulations shall be binding upon all persons dealing with and Beneficiaries claiming benefits under this Plan.

b. **Services Rendered Outside the United States**

Benefits are provided for health care rendered outside of the United States on the same basis as if such care had been rendered in the United States. (The Eligible Beneficiary in such a case may be required to make payment of the expenses and file a claim with the Trustees for reimbursement.)

c. **Medicare**

The benefits provided under Article IV will not be paid to a Beneficiary otherwise eligible if such Beneficiary is eligible for Hospital Insurance coverage (Part A) of Medicare where a premium is not required and/or Medical Insurance coverage (Part B) of Medicare unless such Beneficiary is enrolled for each part of Medicare for which such Beneficiary is eligible. Any such Beneficiary who is enrolled in a Medicare program shall receive the benefits provided under the Plan only to the extent such benefits are not provided for under Medicare.

The Trustees shall give written notification of the obligation to enroll in Medicare. Failure to provide such notification shall not remove any obligation to enroll.

d. Subrogation

The Plan does not assume primary responsibility for covered medical expenses which another party is obligated to pay or which another insurance policy or other medical plan covers. Where there is a dispute between the carriers, the Plan shall, subject to provisions (1) and (2) immediately below, pay for such covered expenses but only as a convenience to the Beneficiary eligible for benefits under the Plan 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 or carrier.

Obligations to pay benefits on behalf of any Beneficiary shall be conditioned:

- (1) upon such Beneficiary taking all steps necessary or desirable to recover the costs thereof from any third party who may be obligated therefore, and
- (2) upon such Beneficiary executing such documents as are reasonably required by the Trustees, 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.

e. Non-Duplication

The health benefits provided under this Plan are subject to a non-duplication provision as follows:

(1) 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:

- (i) does not include a coordination of benefits or non-duplication provision, or
- (ii) includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.

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

- (i) The plan covering the patient other than as a spouse or dependent will be the primary plan.
- (ii) Where both plans cover the patient as a dependent, the plan of the parent or step-parent whose birthday occurs earlier in the calendar year will be the primary plan.

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

(iv) In the event a Retired Miner or surviving spouse is covered under another group plan by reason of his or her employment, the other group plan shall be the primary plan for such Retired Miner or surviving spouse and their eligible dependents.

(3) 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 of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

(4) If it is determined that benefits under this Plan should have been reduced because of benefits provided under another group plan, the Trustees 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 Trustees may make reimbursement directly to the insurance company or other organization providing benefits under the other plan.

(5) For the purpose of this provision the Trustees may, without consent or notice to any Beneficiary, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expense and benefits.

(6) Any Beneficiary claiming benefits under this Plan must furnish the Trustees such information as may be necessary for the purpose of administering this provision.

f. Explanation of Benefits (EOB) and Hold Harmless

(1) Each Beneficiary shall receive an explanation of billing and payment rendered on behalf of such Beneficiary. Should full payment for a service be denied because of a charge that has been determined by the Trustees to be in excess of the reasonable and customary charge, the UMWA may request that a copy of such EOB shall be forwarded to the UMWA (International Headquarters, Attention: Benefits Department).

(2) The Plan and the UMWA agree that excessive charges and escalating health costs are a joint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, the Trustees 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 commenced by the provider. Whether the Trustees 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 Trustees 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. The “hold harmless” protections available under this subparagraph do not apply in the case of any service or supply obtained from a non-PPL source until the non-PPL out-of-pocket maximum is reached.

11. General Exclusions

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

(1) 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.

(2) 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 as set forth in Article IV.A.2.a. and IV.A.3.i.

(3) 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.

(4) Services furnished by tax supported or voluntary agencies.

(5) Immunizations provided by local health agencies.

(6) 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.

(7) Private duty nursing. If necessary to preserve life and certified as medically necessary by the attending physician and an Intensive Care Unit is unavailable, benefits are provided for private duty nursing services 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.

(8) Custodial care, convalescent or rest cures.

(9) 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.

- (10) Charges for private room confinement, except as specifically described in the Plan.
- (11) Services for which a Beneficiary is not required to make payment.
- (12) Excessive charges
- (13) Charges related to gender transition services unless required by law.
- (14) Charges for reversal of sterilization procedures.
- (15) Charges in connection with a general physical examination, other than as specified in this Plan.
- (16) Inpatient confinements solely for diagnostic evaluations which can be provided on an outpatient basis.
- (17) Charges for medical services for inpatient or outpatient treatment for intellectual disability and other intellectual deficiencies.
- (18) Finance charges in connection with a medical bill.
- (19) Dental services.
- (20) Birth control devices and medications, except preventive care and preventive services meeting one of the requirements of subpart A.3.o.(9) of this Article IV.
- (21) Abortion, except as specifically described in the Plan.
- (22) Eyeglasses or lenses, except when medically required because of surgically caused refractive errors or as otherwise provided in section A.9.
- (23) Exercise equipment.
- (24) Charges for treatment with new technological medical devices, therapy which are experimental in nature.
- (25) 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 Trustees.
- (26) Charges for an autopsy or post mortem surgery.
- (27) Any types of services, supplies or treatments not specifically provided by the Plan.
- (28) Any claim that is submitted for payment under the Plan after twelve (12) months or more from the date of service.

12. **Health Benefit Provisions**

a. **Newborns' and Mothers' Health Protection Act**

The Plan shall provide maternity care benefits in accordance with the Newborns' and Mothers' Health Protection Act (the "Newborn's Act"). The Plan 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 from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours.)

b. **Mental Health Parity and Addiction Equity Act**

The Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Internal Revenue Code Section 9812 and ERISA Section 712, and the regulations thereunder.

(1) **Lifetime or Annual Dollar Limits.** The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(2) **Financial Requirement or Treatment Limitations.** The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

(3) **Criteria for medical necessity determinations.** The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

c. **Women's Health and Cancer Rights Act**

Medical and surgical benefits provided for mastectomies under the Plan will be provided in accordance with the Women's Health and Cancer Rights Act of 1998 (the "Women's Health Act"). In accordance with the Women's Health Act, coverage will be provided for the following: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and coverage for any complications in all stages of mastectomy, including lymphedema.

d. Compliance with GINA

The Plan shall be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act of 2008.

e. Patient Protections

To the extent applicable, group health coverage under the Plan shall comply with the patient protections regarding your choice of health care professionals and emergency care services under the Public Health Services Act § 2719A.

f. No Lifetime or Annual Limits

The Plan shall not impose a lifetime or annual limit on the dollar value of Essential Health Benefits under any medical benefits available under the Plan unless the medical benefit is an Excepted Benefit (as defined under the Affordable Care Act) to which the Affordable Care Act does not apply.

“Essential Health Benefits” are health-related items and services that fall into the following categories, as defined in § 1302 of the Affordable Care Act, and further determined by the Secretary of Health and Human Services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits under the Affordable Care Act, the Plan has chosen Ohio as its benchmark state.

g. No Preexisting Condition Exclusions

The Plan shall not impose a preexisting condition exclusion on any medical benefits available under the Plan.

h. No Rescission of Coverage

The Plan shall not cancel nor discontinue medical benefits under the Plan with a retroactive effect with respect to a Beneficiary except in the event of fraud or intentional misrepresentation.

i. Coverage of Clinical Trials

The Plan shall not deny a Beneficiary the right to participate in an approved clinical trial for which such Beneficiary is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A Beneficiary who is participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial. For purposes of this provision, the terms “qualified individual,” “life threatening disease or condition,” “approved clinical trial” and “routine patient costs” shall have the same meaning as found in § 2709 of the Public Health Services Act.

j. Claims and Appeals Procedures

Beneficiaries shall be provided benefits as set forth in the Plan. Beneficiaries seeking benefits under the Plan shall follow and comply with the procedures established herein. In general, for in-PPL services, no claim forms will be required. The in-PPL provider generally will be responsible for the submission of claims and other paperwork. For out-of-PPL services, claim forms generally will be available at most hospitals, clinics, and physician offices. For both in-PPL and out-of-PPL services, the hospital, clinic, or physicians’ office will bill the Beneficiary for the co-payment and deductible until the maximum is reached.

If a Beneficiary is requesting reimbursement for a covered expense paid by the Beneficiary, the Beneficiary must first seek to resolve the matter with the applicable Provider. All other claims for covered benefits must also be submitted first to the Provider. If the matter is not resolved by the Provider, the Beneficiary must file a claim with the Plan Administrator. All claims must be filed with the Plan Administrator within twelve (12) months of the date of service. Any claim that is submitted for payment under the Plan after twelve (12) months or more from the date of service is untimely and shall be denied.

Beneficiaries shall be reimbursed for benefits as set forth in the Plan or Summary Plan Description (“SPD”), as applicable. Beneficiaries seeking benefits under this Plan shall follow the claims procedures established for that particular benefit by the SPD. Such claims and appeals procedures shall comply with the requirements of ERISA Section 503 and the Affordable Care Act (including external review rights) and shall be performed by an appeals administrator named in the SPD.

B. COBRA Continuation Coverage

To the extent applicable, this Plan shall comply with the health care continuation coverage provisions of Sections 601-608 of ERISA and Section 4980B of the Internal Revenue Code.

C. Qualified Medical Child Support Orders

The Plan shall comply with the provisions of Section 609 of ERISA as amended by the Omnibus Budget Reconciliation Act of 1993 (“OBRA 1993”).

**ARTICLE V
MANAGED CARE, COST CONTAINMENT UNDER POST-LEGISLATIVE
PROGRAM OF BENEFITS**

The provisions of Part I, Article V of this Plan Document, entitled “Managed Care, Cost Containment Under Traditional Program of Benefits,” shall apply to the Post-Legislative Program of Benefits and are incorporated by reference herein.

**ARTICLE VI
AMENDMENT AND TERMINATION UNDER POST-LEGISLATIVE PROGRAM OF
BENEFITS**

The benefits provided under this Post-Legislative Program of Benefits shall be only such benefits as can be provided by the assets of the Trust. Accordingly, the benefits are subject to termination, suspension, revision or amendment by the Trustees in their discretion at any time and, if necessary, the benefits are subject to reduction by the Executive Director of the UMWA Health and Retirement Funds, or highest ranking staff member, as set forth in Article IV herein. 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, including but not limited to the Post-Legislative Program of Benefits, or to terminate the Plan as permitted by law.

Among other things, the Trustees reserve the right to modify or amend the provisions of this Plan and Program of Benefits to the extent provisions of the Affordable Care Act are repealed, replaced or modified, or otherwise to comply with law. The Trustees shall fully cooperate to obtain all necessary rulings and do all other acts appropriate to ensure that any payments made in accordance with the financing requirements hereunder are deductible for Federal Income Tax purposes.

**ARTICLE VII
DENIAL NOTIFICATION/REVIEW UNDER POST-LEGISLATIVE PROGRAM OF
BENEFITS**

Any participant or Beneficiary whose claim for benefits under this Post-Legislative Program of Benefits has been denied shall be: (i) provided with adequate notice in writing setting forth the specific reasons for such denial, such notice to be written in a manner calculated to be understood by the participant, and (ii) afforded a reasonable opportunity for a full and fair review of the decision denying the claim by an appropriate named fiduciary or a person properly

designated to carry out such responsibility. The decision on review will be in writing and will include the specific reasons for the decision. All decisions of the Board of Trustees are final and binding on all parties. The Trustees shall develop such procedures for claims and appeals as are required under applicable law.

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PART III--1993 PLAN INDIVIDUAL EMPLOYER PROGRAM (IEP) OF BENEFITS

ARTICLE I INTRODUCTION OF IEP PROGRAM OF BENEFITS

Part III of this Plan Document for the 1993 Benefit Plan describes the 1993 Plan Individual Employer Program of Benefits. The purpose of this Individual Employer Program (“IEP”) of Benefits is to provide health, vision, and dental benefits to eligible active employees and their dependents of certain Employers, provided that the Employers exercise an option under the 2020 Coal Wage Agreement to have their health benefits administered by the UMWA Health and Retirement Funds and sign a participation agreement with the 1993 Benefit Plan. This program of benefits has been established pursuant to the provisions of Article XX of the 2020 Coal Wage Agreement and the Employer Benefit Plan incorporated therein.

ARTICLE II DEFINITIONS UNDER IEP PROGRAM OF BENEFITS

The following terms shall have the meanings herein set forth:

1. “Employer” means Harrison County Coal Resources, Inc., Marion County Coal Resources, Inc., Ohio County Coal Resources, Inc., Marshall County Coal Resources, Inc., Monongalia County Coal Resources, Inc., Franklin County Coal Resources, Inc., and Ohio Valley Coal Resources, Inc., which are members of the Bituminous Coal Operators’ Association, Inc. (“BCOA”), signatory to the Coal Wage Agreement of 2020, and signatory to a participation agreement with the 1993 Benefit Plan.
2. “Wage Agreement” means the 2020 Coal Wage Agreement.
3. “Plan Administrator” shall be the Trustees of the UMWA 1993 Benefit Plan.
4. “Employee” shall mean a person working in a classified job for the Employer, eligible to receive benefits hereunder.
5. “Beneficiary” shall mean any person who is eligible pursuant to the Plan to receive health benefits as set forth in Article III hereof.
6. “Dependent” shall mean any person described in Section C of Article III hereof.
7. “Attains the age” shall mean on or after 12:01 A.M. of the anniversary date of one’s birth.
8. “Signatory Service” shall have the meaning assigned to such term in the United Mine Workers of America 1974 Pension Plan (the “1974 Pension Plan”) under the National Bituminous Coal Wage Agreement of 2016 (“NBCWA of 2016”).

9. “Trustee” or “Trustees” shall mean the Trustees of the United Mine Workers of America Health and Retirement Funds or, as applicable, the Trustees of the UMWA 1993 Benefit Plan.

10. “UMWA” means the United Mine Workers of America.

11. “BCOA” means the Bituminous Coal Operators’ Association, Inc.

12. “Affordable Care Act” means the Patient Protection and Affordable Care Act of 2010.

13. “Effective Date” means the effective date of the Wage Agreement. Notwithstanding the forgoing, nothing herein shall require the Plan to duplicate any benefits provided by the Employer Plan maintained by the Employer pursuant to the Wage Agreement.

ARTICLE III ELIGIBILITY UNDER IEP PROGRAM OF BENEFITS

The persons eligible to receive the health benefits pursuant to Article IV are as follows:

A. Active Employees

Benefits under Article IV of the IEP shall be provided to any Employee who:

1. is actively at work* for the Employer on the Effective Date of the Wage Agreement; or

2. is on layoff or disabled from the Employer and had continuing eligibility as of the Effective Date of the Wage Agreement for coverage under the 2016 Employer’s Benefit Plan (“prior Plan”) as a laid off or disabled employee. Coverage for such laid off or disabled Employees shall not continue beyond the date when they would no longer have been eligible for coverage under the provisions of the prior Plan.

3. is on leave under section 102 of the Family and Medical Leave Act of 1993, subject to Article IV.A.10.g. herein.

4. Except as provided in subsections 2 and 3 above, any Employee of the Employer who is not actively at work* for the Employer on the Effective Date of the Wage Agreement will not be eligible for coverage under the Plan until he returns to active employment with the Employer.

Any Employee of the Employer who as of the Effective Date, was eligible for benefits under the prior Plan who is not scheduled to work within two weeks after the Effective Date of the Wage Agreement because of lack of work, will, if eligible under Article IV.C.1.a. of this IEP,

* Actively at work includes an Employee of the Employer who was actively at work on the Effective Date and who returns to active work with the Employer two weeks after the Effective Date of the Wage Agreement, which is September 16, 2020.

be considered eligible for coverage under this IEP as of the Effective Date of the Wage Agreement but as an Employee on layoff as of such date.

5. A new Employee will be eligible for health benefits from the first day worked with the Employer.

B. Disabled Employees

Health benefits under Article IV of this IEP shall also be provided to any Employee who:

1. Has completed 20 years of credited service including, for purposes of this Article II.B. and Article II.D. only, years of signatory service with the Employer, years of signatory service pursuant to Article IV.C.6 of the 1974 Pension Plan as provided under the NBCWA of 2016, and for New Inexperienced Miners and Electing Miners as defined in the NBCWA of 2016, the number of years before employment with the Employer in which the miner received Supplemental Pension Contributions to the UMWA Cash Deferred Savings Plan of 1988, and

a. has not attained age 55 (except for a New Inexperienced Miner as defined in the NBCWA of 2016 or a miner who became disabled after age 55 while working for the Employer), and

b. became disabled after December 6, 1974 while in classified employment with the Employer, and

c. is eligible for Social Security Disability Insurance Benefits under Title II of the Social Security Act or its successor;

2. Becomes totally disabled due to a compensable disability within four years of the date the Employee would be eligible to receive a pension under the 1974 Pension Plan or any successor thereto, or has obtained more than 20 years of service as provided in this section B, as long as the Employee continues to be so disabled during the period for which Workers' Compensation payments (Workers' Compensation does not include Federal Black Lung Benefits) are applicable; or

3. Is receiving or would, upon proper application, be eligible to receive Sickness and Accident Benefits pursuant to the Wage Agreement.

Life and accidental death and dismemberment benefits shall also be provided to Employees described in 3 above.

C. Eligible Dependents

Health benefits under Article IV of this IEP shall be provided to the following members of the family of any Employee or disabled Employee receiving health benefits pursuant to sections A or B of this Article III:

1. A spouse who is living with or being supported by an eligible Employee;

2. Children of an eligible Employee who have not attained age 26.
3. A parent of an eligible Employee or spouse, if the parent has been dependent upon and living in the same household (residence) with the eligible Employee for a continuous period of at least one year;
4. Unmarried dependent grandchildren of an eligible Employee or spouse who have not attained age 22 and are living in the same household (residence) with such Employee;
5. Dependent children (age 26 or older), of an eligible Employee or spouse, who are intellectually disabled or who become disabled prior to attaining age 26 and such disability is continuous and are either living in same household with such Employee or are confined to an institution for care or treatment. Health benefits for such children will continue as long as a surviving parent is eligible for health benefits.
6. For purposes of this section C, a grandchild or parent shall be considered dependent upon an eligible Employee or spouse if such Employee or spouse provides over one half of the support to such person.

D. Surviving Spouse And Dependents Of Deceased Employees

Health benefits under Article IV of this IEP shall be provided to (i) any unmarried surviving spouse (who was living with or being supported by the Employee immediately prior to the Employee's death) and (ii) such spouse's surviving children as defined in subsection 2 of section C herein and such spouse's dependent children as defined in subsection 5 of section C herein, of an Employee who died:

1. As a result of a mine accident occurring on or after the effective date of the Plan while the Employee was working in a classified job for the Employer;
2. Under conditions which qualify such spouse for a Surviving Spouse benefit under the 1974 Pension Plan or would have so qualified the spouse taking into account the Employee's credited service as defined in section B.1. of this Article III;
3. At a time when such Employee is entitled to receive health benefits pursuant to section A or B of this Article III, provided that (i) if such Employee died prior to the effective date of the Wage Agreement and the spouse is not eligible or would not have been eligible for a Surviving Spouse's benefit as described in subsection 2 above, then only for the period that the spouse is eligible to receive death benefits in installment payments, or (ii) if such Employee died on or after the Effective Date of the Wage Agreement as provided for in Article XXIX of the 2020 Wage Agreement and the spouse is not eligible or would not have been eligible for a Surviving Spouse's benefit as described in subsection 2 above and entitled to life insurance benefits or death benefits under the 1974 Pension Plan or any plan maintained pursuant to Article XX of the Wage Agreement that are payable in a lump sum, then only for 60 months following the month of the death of such Employee. If life insurance benefits are not payable, health benefits shall be provided only to the end of the month in which the Employee died.

4. Surviving spouses of Employees described in section B.1. of this Article III, who died prior to receiving a pension and after receiving all Sickness & Accident Benefits, shall, if they are not entitled to or would not have been entitled to Surviving Spouse benefits under the 1974 Pension Plan as described in subsection 2 above, receive health benefits under Article IV until remarriage or for 36 months, whichever occurs first.

Health benefits shall continue for a surviving spouse until remarriage of such spouse, but if such spouse is entitled to such benefits under subsection 3 above, such health benefits will continue not longer than for the period specified in subsection 3 above.

At the death of an Employee described in subsection 1 above, health benefits will be continued for the children until they attain age 26, even if there is no surviving spouse or if the surviving spouse dies before they attain age 26. The children of a Surviving Spouse eligible under 2 above shall be eligible for health benefits until they attain age 26, so long as the Surviving Spouse is eligible for benefits. If at the death of an Employee described in subsection 3 above, there is no surviving spouse, or if the surviving spouse dies during any period in which health benefits are being continued, such health benefits will be continued for the children during the period in which such spouse would have been eligible for health benefits but in no event beyond their attaining age 26.

Notwithstanding the above or any other provision of this Plan, if any Employee had more than one spouse prior to the Employee's death, only one surviving spouse shall be eligible for health benefits from the Plan as a surviving spouse, and only the eligible children of such a surviving spouse shall be eligible for health benefits from the Plan if they otherwise satisfy the Plan's eligibility requirements.

ARTICLE IV BENEFITS UNDER IEP PROGRAM OF BENEFITS

The benefits provided under this Individual Employer Program of Benefits are as set forth in this Article IV. Benefit payments are based on negotiated rates applicable to services provided by hospitals, physicians, pharmacies and other providers on Participating Provider Lists (PPL's) adopted under Article V herein or operating under the requirements for lists of preferred drug products (PDP's) adopted under Article V herein.

During any period when PPLs are not in effect, and for covered services and supplies not offered under a PPL (or otherwise not subject to a PPL-related benefit limit), benefit payments shall not exceed reasonable and customary charges* for covered services and supplies. Covered

* 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 shall be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at the appropriate level of care, or are otherwise provided for in the Plan. 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 this 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.

Services which are not reasonable and necessary shall include, but are not limited to the following: 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 timely fashion in the patient's medical records; procedures which can be performed with equal efficiency at a lower level of care.

The benefits described in this Article are subject to any precertification, prescription drug formulary (PDP) requirements, and other utilization review requirements implemented pursuant to Article V. 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 as described in this Article IV.

A. Health Benefits

1. Inpatient Hospital Benefits

a. Semi-private room

When a Beneficiary is admitted by a licensed physician (hereinafter "physician") for treatment as an inpatient to an Accredited Hospital (hereinafter "hospital"), benefits will be provided for semi-private room accommodations (including special diets and general nursing care) and all medically necessary services provided by the hospital as set out below for the diagnosis and treatment of the Beneficiary's condition.

Medically necessary services provided in a hospital include the following:

- Operating, recovery, and other treatment rooms
- Laboratory tests and x rays
- Diagnostic or therapy items and services
- Drugs and medication (including take home drugs which are limited to a 30-day supply)
- Radiation therapy
- Chemotherapy
- Physical therapy
- Anesthesia services
- Oxygen and its administration
- Intravenous injections and solutions
- Administration of blood and blood plasma
- Blood, if it cannot be replaced by or on behalf of the Beneficiary

b. Intensive Care Unit -- Coronary Care Unit

Benefits will also be provided for treatment rendered in an Intensive Care or Coronary Care Unit of the hospital, if such treatment is certified as medically necessary by the attending physician.

c. Private Room

For confinement in a private room, benefits will be provided for the hospital's most common charge for semi private room accommodations and the Beneficiary shall be responsible for any excess over such charge except that private room rates will be paid when (i) the Beneficiary's condition requires him to be isolated for his own health or that of others, or (ii) the hospital has semi private or less expensive accommodations but they are occupied and the Beneficiary's condition requires immediate hospitalization. Semi-private room rates, not private room rates, will be paid beyond the date a semi-private room first becomes available and the Beneficiary's condition permits transfer to those accommodations.

d. Renal Dialysis

Benefits will be provided for renal dialysis provided that the renal dialysis therapy is administered in accordance with Federal Medicare regulations as in effect from time to time.

e. Mental Illness

Benefits are provided for a Beneficiary who is confined for mental illness in a hospital by a licensed psychiatrist on the same basis as any medically necessary hospitalization.

f. Alcoholism and Drug Abuse

Benefits are provided for a Beneficiary who requires emergency detoxification hospital care for the treatment of alcoholism or emergency treatment for drug abuse.

If treatment of a medical or mental condition is necessary following detoxification or emergency treatment for drug abuse, benefits may be provided under other provisions of this Plan and are subject to any requirements or limitations in such provisions.

See subsection 7.f. for information concerning other services related to treatment of alcoholism and drug abuse.

g. Oral Surgical/Dental Procedures

Benefits are provided for a Beneficiary who is admitted to a hospital for the oral surgical procedures described in subsection 3.e. provided hospitalization is medically necessary.

Benefits are also provided for a Beneficiary admitted to a hospital for dental procedures only if hospitalization is necessary due to a pre-existing medical condition and prior approval is received from the Plan Administrator.

h. Maternity Benefits

Benefits are provided for a female Beneficiary who is confined in a hospital for pregnancy. Such benefits will also be available for services pertaining to termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

i. General

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 United Mine Workers of America Combined Benefit Fund.

2. Outpatient Hospital Benefits

a. Emergency Medical and Accident Cases

Benefits are provided for a Beneficiary who receives emergency medical treatment or medical treatment of an injury as the result of an accident, provided that the beneficiary has acute medical symptoms and the absence of immediate medical attention could result in serious jeopardy of the individual's health or body.

b. Surgical Cases

Benefits are provided for a Beneficiary who receives surgical treatment in the outpatient department of a hospital.

c. Laboratory Tests and X rays

Benefits are provided for laboratory tests and x ray services performed in the outpatient department of a hospital which provides such services and when they have been ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

d. Chemotherapy and Radiation Therapy

Benefits are provided for chemotherapy treatments of a malignant disease or radiation treatments performed in the outpatient department of a hospital.

e. Physiotherapy

Benefits are provided for physiotherapy treatments performed in the outpatient department of a hospital. Such therapy must be prescribed and supervised by a physician.

f. Renal Dialysis

Benefits will be provided for outpatient renal dialysis rendered in accordance with Federal Medicare regulations as in effect from time to time.

3. **Physicians' Services and Other Primary Care**

a. **Surgical Benefits**

Benefits are provided for surgical services essential to a Beneficiary's care consisting of operative and cutting procedure (including the usual and necessary post-operative care) for the treatment of illnesses, injuries, fractures or dislocations, which are performed either in or out of a hospital by a physician.

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.

b. **Assistant Surgeons**

If the Beneficiary is an inpatient in a hospital, benefits will also be provided for the services of a physician who actively assists the operating physician in the performance of such surgical services when the condition of the Beneficiary and type of surgical service require such assistance.

c. **Obstetrical Delivery Services**

Benefits are provided for a female Beneficiary for obstetrical delivery services (including pre and post-natal care) performed by a physician. Benefits will also be provided if such delivery is performed by a midwife certified by the American College of Nurse Midwifery and licensed where such licensure is required.

Such benefits will also be provided for termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

d. **Anesthesia Services**

Benefits are provided for the administration of anesthetics provided either in or out of the hospital in surgical or obstetrical cases, when administered and billed by a physician, other than the operating surgeon or his assistant, who is not an employee of, nor compensated by, a hospital, laboratory or other institution; or by a nurse anesthetist.

e. **Oral Surgery**

Benefits are not provided for dental services, except for dental services for active employees as described below in Article IV. D. Benefits are provided to active employees and Pensioners for 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
Dental services required as the direct result of an accident

f. Surgical Services Limitations

Benefits are not provided for certain surgical services without prior approval of the Plan Administrator. Such surgical procedures include, but are not limited to, the following:

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 government programs
Organ transplants

g. In-hospital Physicians' Visits

If a Beneficiary is confined as an inpatient in a hospital because of an illness or injury, benefits are provided for in-hospital visits by the physician in charge of the case. Such benefits will also be provided concurrently with benefits for surgical, obstetrical and radiation therapy services when the Beneficiary has 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.

h. Home, Clinic, and Office Visits

Benefits are provided for services rendered to a Beneficiary at home, in a clinic (including the outpatient department of a hospital) or in the physician's office for the treatment of illnesses or injuries, if provided by a physician.

i. Emergency Treatment

When provided by a physician, benefits are provided for a Beneficiary who receives outpatient emergency medical treatment or treatment of an injury as the result of an accident, provided that the individual has the onset of acute medical symptoms and the absence of immediate medical attention could result in serious jeopardy of the individual's health or body.

j. Laboratory Tests and X rays

Benefits will be provided for laboratory tests and x rays performed in a licensed laboratory when ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

Such benefits 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.

k. Radiation and Chemotherapy Benefits

Benefits are provided for treatment by x ray, radium external radiation or radioactive isotope (including the cost of materials unless supplied by a hospital), provided in or out of a hospital, when performed and billed by a physician.

When a Beneficiary's condition requires radiation therapy services in conjunction with medical, surgical or obstetrical services, benefits will be provided for such radiation therapy in addition to the payment for such other types of covered services if the physician performing the radiation therapy services is not the same physician who performs the medical, surgical or obstetrical services.

Benefits are provided for treatment of malignant diseases by chemotherapy provided in or out of the hospital when prescribed and billed by a physician.

l. Medical Consultation

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 by a Beneficiary.

m. Specialist Care

Benefits will be provided for treatment prescribed or administered by a specialist if the treatment is for illness or injury which falls within the specialist's area of medical competence.

n. Primary Care Podiatrists' Services

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.

o. Primary Medical Care Miscellaneous

(1) Benefits are provided for care of newborn babies and routine medical care of children prior to attaining age 6, subject to the requirements of subsection (9) below regarding preventive services.

(2) Benefits are provided for immunizations, allergy desensitization injections, pap smears, screening for hypertension and diabetes, and examinations for cancer, blindness, deafness, and other screening and diagnostic procedures when medically necessary.

(3) Subject to the requirements of subsection (9) below regarding preventive services, benefits are provided for physical examinations when certified as medically necessary by a physician. Medically necessary will mean that a Beneficiary (i) has an existing medical condition under treatment by a physician, (ii) has attained age 55, (iii) is undergoing an annual or semi-annual routine examination by a gynecologist or (iv) is undergoing a routine examination prescribed by a specialist as part of such specialist's care of a medical condition.

(4) Benefits are provided for "physician extender" care or medical treatment administered by nurse practitioners, physician's assistants or other certified or licensed health personnel when such service is rendered under the supervision of a physician.

(5) Benefits are provided for a nominal fee covering instruction in preparation for natural childbirth, if rendered in a hospital or clinic.

(6) Benefits are provided for family planning counseling when rendered by a physician or by other appropriately trained and supervised health care professionals.

(7) Benefits are provided covering artificial insemination if the service is provided by a licensed gynecologist.

(8) Benefits are provided for sterilization procedures if such procedures are performed by a physician.

(9) Preventive care and preventive services meeting one of the following requirements are covered benefits and will not be subject to any deductible or co-payment when provided in-PPL:

(i) Evidenced-based items or preventive services, including various types of screenings (e.g., blood pressure screenings, cholesterol screenings, various STD screenings, diabetes screening, depression screenings, tobacco use counseling, breast cancer screenings, genetic counseling, and BRCA testing) with an "A" or "B" rating recommended by the United States Preventive Services Task Force (USPSTF), an independent panel of scientific experts;

(ii) Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, such as periodic tetanus shots or other vaccinations for diseases like polio, chickenpox, measles, whooping cough and hepatitis;

(iii) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents, such as regular pediatrician visits,

vision and hearing screening, developmental assessments and screening and counseling to address obesity; and

(iv) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA for women, including FDA-approved contraceptives and contraceptive counseling, as well as well-woman visits, domestic violence screening and counseling, HIV and other sexually transmitted disease counseling and breastfeeding support, supplies and counseling.

p. **Services Not Covered**

- (1) Services rendered by a chiropractor or naturopathic services.
- (2) Acupuncture therapy.
- (3) Home obstetrical delivery.
- (4) Telephone conversations with a physician in lieu of an office visit.
- (5) Charges for writing a prescription.
- (6) Medications dispensed by other than a licensed pharmacist.
- (7) Charges for medical summaries and medical invoice preparations.
- (8) Services of any practitioner who is not legally licensed to practice medicine, surgery, or counseling except as specifically provided herein.
- (9) Cosmetic surgery, unless pertaining to surgical scars or to correct results of an accidental injury or birth defects.
- (10) Physical examinations, except as specifically provided herein.
- (11) Removal of tonsils or adenoids, unless medically necessary.

4. **Prescription Drugs**

a. **Benefits Provided**

Benefits are provided for insulin and prescription drugs (only those drugs which by Federal or State law require a prescription) dispensed by a licensed pharmacist and prescribed by a (i) physician for treatment or control of an illness or a non-occupational accident or (ii) licensed dentist for treatment following the performance of those oral surgical services set forth in 3.e.

The initial amount dispensed shall not exceed a 90-day supply. Any original prescription may be refilled for up to twelve months as directed by the attending physician. Each such refill may be for an amount up to, but no more than, a 90-day supply. Benefits for refills beyond twelve months require a new prescription by the attending physician. Prescriptions filled by the

Plan's mail order provider, if any, are not subject to the limits on quantity set forth in this paragraph.

Reasonable charges for prescription drugs or insulin are covered benefits. Reasonable charges will consist of the lesser of:

- (1) The amount actually billed per prescription or refill;
- (2) The price of the applicable generic substitution drug, if AB or better-rated, approved by the federal Food and Drug Administration; or, in the event the prescribing physician determines that use of a brand name drug is medically necessary, the price of such brand name drug; or
- (3) The current price paid to participating pharmacies in any prescription drug program established by the Plan.

However, except as provided otherwise in this Plan, in no event will a Beneficiary be responsible to pay more for a single prescription than the appropriate co-payment set forth in this Plan, plus any difference between the price of the generic and the brand name drug, where applicable.

b. Benefits Excluded

Benefits shall not be provided under subsection 4.a. herein for the following:

- (1) Medications dispensed in a hospital (including take home drugs), skilled nursing facility or physician's office. (See Article IV. A.1.a. and 5.a. for benefits provided for drugs and medications during inpatient confinement in a hospital skilled nursing facility.)
- (2) Prescriptions dispensed by other than a licensed pharmacist.
- (3) Any medication not specifically provided for in a. above.

5. Skilled Nursing Care and Extended Care Units

a. Skilled Nursing Care Facility

Upon determination by the attending physician that confinement in a licensed skilled nursing care facility* is medically necessary, to the extent that benefits are not available from Medicare or other State or Federal programs, benefits will be provided for:

- (1) skilled nursing care provided by or under the supervision of a registered nurse;

* Skilled nursing care facility is limited to a skilled nursing care facility which is licensed and approved by Federal Medicare and by any appropriate state law, regulation or agency.

- (2) room and board;
- (3) physical, occupational, inhalation and speech therapy, either provided or arranged for by the facility;
- (4) medical social services;
- (5) drugs, immunizations, supplies, appliances, and equipment ordinarily furnished by the facility for the care and treatment of inpatients;
- (6) 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
- (7) other health services usually provided by skilled nursing care facilities.

Benefits in a licensed skilled nursing care facility will be provided up to a maximum of 100 days for an eligible Beneficiary.

The Plan will not pay for services in a nursing care facility that is not licensed or approved in accordance with Federal Medicare and state laws or regulations, unless the service is provided by or under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results.

Exclusions: Telephone, TV, radio, visitor's meals, private room or private nursing (unless necessary to preserve life), custodial care, and services not usually provided in a skilled nursing facility are not covered under the Plan.

b. **Extended Care Units**

Benefits are provided for up to two weeks of specialized medical services and daily treatments by licensed personnel in extended care units. When medically necessary, benefit may be provided for a longer period of time, subject to approval from 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.

Exclusions:

Services, drugs or other items which are not covered for hospital inpatients; and custodial care.

6. **Home Health Services & Equipment**

a. **General Provisions**

Benefits are provided for home health services, including nursing visits by registered nurses and home health aides, and various kinds of rehabilitation therapy, subject to the following conditions and approval of the Plan Administrator.

(1) The Beneficiary must be under the care of a physician.

(2) The Beneficiary's medical condition must require skilled nursing care, physical therapy, or speech therapy at least once in a 60-day period.

(3) The physician must initiate a treatment plan and specify a diagnosis, the Beneficiary's functional limitations and the type and frequency of skilled services to be rendered.

(4) The Beneficiary must be confined to his home. The services must be provided by a certified home health agency.

Benefits will be provided for up to a maximum of 60 visits per year.

b. **Physical and Speech Therapy**

Benefits are provided for physical and speech therapy services at home when prescribed by a physician to restore functions lost or reduced by illness or injury. Such services must be performed by qualified personnel. When the Beneficiary has reached his or her restoration potential, the services required to maintain this level do not constitute covered care.

c. **Skilled Nursing**

Benefits are provided for skilled nursing care rendered by a registered nurse as a home health service when a Beneficiary's condition has not stabilized and a physician concludes that the Beneficiary must be carefully evaluated and observed by a registered nurse. The Plan Administrator may request an evaluation visit to the Beneficiary's home.

d. **Medical Equipment**

Benefits are provided for rental or, where appropriate, purchase of medical equipment suitable for home use when determined to be medically necessary by a physician.

e. **Oxygen**

Benefits are provided for oxygen supplied to a Beneficiary subject to the following conditions when ordered by the attending physician:

(1) The patient is referred to a designated pulmonary consultant for testing.

(2) Such consultant's report is submitted to the Plan Administrator with the order for oxygen.

Benefits are also provided for services of inhalation therapists in the home with the attending physician's order.

f. **Coal Miners Respiratory Disease Program**

Benefits are provided for services or treatments administered by personnel employed by the Coal Miners Respiratory Disease Program to a Beneficiary in such Beneficiary's home when ordered or requested by a physician, except where such benefits are available under a governmental program and such Beneficiary is eligible, or upon application would be eligible, under such programs.

7. **Other Benefits**

a. **Orthopedic and Prosthetic Devices**

Benefits are provided for orthopedic and prosthetic devices prescribed by a physician when medically necessary.

The following types of equipment are covered:

(1) Prosthetic devices which serve as replacement for internal or external body parts, other than dental.

These include artificial eyes, noses, hands (or hooks), feet, arms, legs and ostomy bags and supplies.

(2) Prosthesis following breast removal.

(3) Leg, arm, back, and neck braces.

(4) Trusses.

(5) Stump stockings and harnesses when these devices are essential for the effective use of an artificial limb. An examination and recommendations by an orthopedic physician is required.

Note: Benefits are provided for repairs and adjustments for braces, trusses, stump stockings and harnesses as well as replacement of any of those devices which have been worn out and can no longer be repaired. Benefits will be provided for replacements for usable appliances and artificial limbs if they are needed because of a change in the Beneficiary's condition. Benefits will also be provided to cover repair and adjustment cost for appliances and artificial limbs.

If replacement of a prosthesis is required, the Beneficiary should in all cases be reevaluated by an orthopedic physician.

(6) Surgical stocking (up to two pairs per prescription with no refills) when prescribed by a physician for surgical or medical conditions. The Plan will not pay Beneficiaries for support hose, garter belts, etc.

(7) Orthopedic shoes when specifically prescribed by a physician or licensed podiatrist for a Beneficiary according to orthopedist specifications, including orthopedic shoes attached to a brace that have to be modified to accommodate the brace. Benefits will not be provided for stock orthopedic shoes.

(8) Orthopedic corrections added to ordinary shoes by a physician or licensed podiatrist. Benefits are provided for only the correction to the shoe.

b. Physical Therapy

Benefits are provided for physical therapy in a hospital, skilled nursing facility, treatment center, or in the Beneficiary's home. Such therapy must be prescribed and supervised by a physician and administered by a licensed therapist. The physical therapy treatment must be justified on the basis of diagnosis, medical recommendation and attainment of maximum restoration.

c. Speech Therapy

Benefits are provided for speech therapy rendered by a qualified licensed speech therapist if the Beneficiary is a stroke patient or has had conditions including ruptured aneurysm, brain tumors or autism and needs special instruction to restore technique of sound and to phonate, and needs direction in letter and word exercises in order to express basic needs. Benefits are also provided for speech therapy for child Beneficiaries with a speech impediment from a qualified speech therapist provided that the child cannot receive speech therapy through the public schools.

d. Hearing Aids

Benefits are provided for hearing aids recommended by a licensed otologist or otolaryngologist and a certified clinical audiologist. Such hearing aids must be purchased from a participating vendor. Benefits for necessary repairs and maintenance, except the replacement of batteries, will be provided after the expiration of the warranty period. Benefits will be provided for replacement hearing aids only if a new aid is needed because of a change in the Beneficiary's condition, or if the aid no longer functions properly. Benefits will not be provided for any fees for incorporating hearing aids into eyeglasses.

e. Ambulance and Other Transportation

Benefits are provided for ambulance transportation to or from a hospital, clinic, medical center, physician's office, or skilled nursing care facility, when considered medically necessary by a physician.

With prior approval from the Plan Administrator benefits will also be provided for other transportation subject to the following conditions:

(1) If the needed medical care is not available near the Beneficiary's home and the Beneficiary must be taken to an out of area medical center.

(2) If the Beneficiary requires frequent transportation between the Beneficiary's home and a hospital or clinic for such types of treatment as radiation or physical therapy or other special treatment which would otherwise require hospitalization, benefits will be provided for such transportation only when the Beneficiary cannot receive the needed care without such transportation.

(3) If the Beneficiary requires an escort during transportation, the attending physician must submit satisfactory evidence as to why the Beneficiary needs an escort.

f. Outpatient Mental Health, Alcoholism and Drug Addiction

Benefits are provided for: Psychotherapy, psychological testing, counseling, group therapy and alcoholism or drug rehabilitative programs.

Benefits are not provided for:

- (1) Encounter and self-improvement group therapy.
- (2) Custodial care related to intellectual disability and other intellectual deficiencies.
- (3) School related behavioral problems.
- (4) Services by private teachers.
- (5) Alcoholism and drug rehabilitation if an advance determination has not been made that the Beneficiary is a good candidate for rehabilitation.
- (6) Alcoholism and drug rehabilitation programs not approved by Medicare, certified or licensed by the applicable state, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or otherwise authorized by law.

8. Co-Payments and Deductibles

The benefits provided in this Plan shall be subject to the co-payments and deductibles set forth below and such co-payments and deductibles shall be the responsibility of the Beneficiary. The Plan Administrator shall implement such procedures as deemed appropriate to achieve the intent of these co-payments and deductibles. Beneficiaries and providers shall provide such information as the Plan Administrator may require to effectively administer these co-payments and deductibles, or such Beneficiaries or providers shall not be eligible for benefits or payments under this Plan. Any overpayments made to a provider who overcharges the Plan in lieu of collecting the applicable co-payment or deductibles from a participant or Beneficiary shall be repaid to the Plan Administrator by such provider.

Co-payments and deductibles for covered Health Benefits are established below.

Participating Provider Lists (PPL's) implemented by the Plan pursuant to Article V may include participating hospitals, physicians, pharmacies and other providers. The Plan payment for non-emergency hospital and related benefits provided from a non-PPL source will be limited to 90% of the amount that would have been paid by the Plan if the benefit had been provided by a provider on a PPL (or actual charges, if less). If a provider then bills the Beneficiary for any remaining amount, the protections of subsection 10.h.(2) (Hold Harmless) will not apply until the non-PPL out-of-pocket maximum is reached. In any case where a non-PPL provider is treated as being within the PPL, pursuant to the provisions of the managed care and cost containment programs incorporated by reference in Article V herein, the Beneficiary will be responsible for the co-payment that would apply to a PPL service. The Plan will pay the provider at no greater than the PPL rate, and the protections of subsection 10.h.(2) (Hold Harmless) will apply.

If an Employee or Pensioner is covered under this Plan and an Employer Plan (established pursuant to the Wage Agreement) by more than one signatory Employer during a calendar year, the total co-payments and deductibles made and documented by the Employee or Pensioner during such calendar year shall be counted toward the out-of-pocket maximum in the same manner as if they had been made under a single plan.

The following co-payments and deductibles are required under this Plan:

Out-of-PPL Costs

a. Hospitalization--Benefits for inpatient treatment by a non-PPL hospital are paid at 90% of the in-PPL rates. The Beneficiary is responsible for the remainder of the charges. Benefits for emergency care provided at a non-PPL hospital are paid at the PPL rate.

b. Doctor Visits--Each office visit to a non-PPL physician is subject to a \$35.00 copayment.

Prescription Drugs--Prescription drugs will be provided through the PPL at a copayment of \$20.00 per 30-day supply. Prescriptions bought Out of PPL are subject to a \$35.00 copayment per 30-day supply. Mail order prescription drugs, where available in PPL, will be subject to a \$10.00 copayment per 30-day supply. (See chart below.) The co-payment for a 90-day supply shall be three times the 30-day supply co-payment.

The required co-payments are:

	In-PPL	Out-of-PPL
Prescription Drugs 30-Day Supply	\$20.00 per prescription	\$35.00 per prescription
Prescription Drugs--Mail Order (where available) 30-Day Supply	\$10.00 per prescription	N/A
Prescription Drugs--Brand Name Where Generic is Available 30-Day Supply	\$20.00 Plus Additional Cost of Brand Name Drug	\$35.00 Plus Additional Cost of Brand Name Drug
Physician Charges	\$25.00 per office visit	\$35.00 per office visit
Hospital and Related Charges	\$25.00 per hospitalization	\$35.00 per hospitalization plus balance over 90% of PPL charges. \$25 per hospitalization resulting from a medical emergency.

Deductibles -- In addition to these co-payments, each family shall be responsible for an annual medical care deductible of \$300.00 per family, of which \$150.00 applies to physician and other non-hospital medical provider charges (including tests, lab work, etc.), and \$150.00 applies to hospital and related charges incurred by a hospital, clinic or similar institution (including tests, lab work, etc.). The deductible excludes the cost of prescription drugs, which are covered by a separate out-of-pocket maximum of \$1,000 per family per year as set forth below.

In addition:

- a. No family will have to pay more than \$1,000.00 in combined Physician office visits and Hospital and Related Charges in any year.
- b. No family will have to pay more than a Maximum Out-Of-Pocket of \$2,000.00 in combined Hospital and Related Charges, Physician office visits, and Prescription Drug Charges in any year.
- c. No family will have to pay more than \$1,000.00 in prescription drugs in any year.
- d. Emergency Room visits are subject to a \$35.00 copayment.
- e. Preventive care and preventive services meeting one of the requirements of Article IV. A.3.o.(9) are covered benefits and are not subject to any deductible or copayment when provided in-PPL:

For prescription drugs, the Trustees have implemented a formulary list of preferred drug products (PDP), subject to requirements set forth in Article V herein. If a Beneficiary fails to use a PDP, the following surcharges will apply:

Non-PDP surcharge:	Initial Prescription:	None
	First Refill:	\$15.00
	Second and Subsequent Refills:	\$30.00

Notwithstanding the foregoing, Beneficiaries may file an appeal to request that they be permitted to use a non-PDP drug and not pay a surcharge. If a Beneficiary fills a prescription for a non-PDP drug, a communication will be sent by the Plan to both the physician and the individual outlining the appeal process and the surcharge for additional purchases. If no appeal is received within 30 days, the next refill of the drug will be subject to a \$15.00 surcharge, and each following refill of that drug will be subject to a \$30.00 surcharge. If an appeal is filed, surcharges are suspended for 60 days, or until the date of the resolution of the appeal, if later.

If a Beneficiary uses a brand-name drug where a generic equivalent is available, the following shall apply:

In addition to the co-payment, the Beneficiary is responsible for the additional cost of the brand name drug over the cost of the generic substitute. A generic drug will not be considered “available” unless it has been approved by the federal Food and Drug Administration. In addition, if the prescribing physician determines that use of a brand name drug is medically necessary, the generic drug will not be considered “available,” and there will be no additional payment by the beneficiary for the use of the brand name drug.

For Out-of-PPL services, claim forms will be available at most hospitals, clinics, and physician offices. Generally, nothing more is required than signing the forms authorizing the hospital, clinic, or physician to bill the Plan for the services rendered. The Plan will keep individual records for each Beneficiary and dependent and will notify the Beneficiary of the co-payments and deductibles credited to his account. The hospital, clinic, or physician will bill the Beneficiary for the co-payment and deductible amount until the maximum is reached. In some instances, when the Beneficiary pays for services or drugs, the bills should be obtained and submitted with the claim form according to the instructions on the form. If the annual deductible and co-payment maximum has been reached, the Plan will remit to the Beneficiary the full payment for covered benefits.

When the non-PPL out-of-pocket maximum has been reached, the Plan will pay at no greater than the PPL rate for a covered benefit provided from a non-PPL source, but Hold Harmless protections will apply.

Covered drug prescriptions may be filled at drugstores, clinics and hospital prescription offices.

In an effort to address the problems generated by the ever-increasing cost of prescription drugs, while recognizing the importance of prescription drugs and their value in managing Beneficiary health care, and while maintaining a high level of benefits, the parties have mutually agreed to adopt managed care and cost containment programs incorporated by reference in Article V herein.

9. **Vision Care Program**

a. **Benefits Provided.**

Benefits	Actual Charge Up To Maximum Amount	Frequency Limits
Vision Examination	\$46.77	Once every 24 months
Per Lens (Maximum = 2)		
Single vision	\$23.39	Once every 24 months
-- Bifocal	\$35.09	Once every 24 months
-- Trifocal	\$46.77	Once every 24 months
-- Lenticular	\$58.47	Once every 24 months
-- Contact	\$35.09	Once every 24 months
-- Frames	\$33.13	Once every 24 months

Note: The 24-month period shall be measured from the date the examination is performed or from the date the lenses or frames are ordered, respectively, even if the last examination occurred during a prior Wage Agreement.

b. **Lenses** will not be covered unless the new prescription differs from the most recent one by an axis change of 20 degrees or .50 diopter sphere or cylinder change and the lenses must improve visual acuity by at least one line on the standard chart.

c. **Exclusions include:**

- (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), 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 worker's 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.

The exclusions in c. above shall not be read to limit or exclude coverage that may be contained elsewhere in the Plan.

10. **General Provisions**

a. **HMO Election**

Any Beneficiary as described in Article III, Sections A, B, and D 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 HMO's; provided, however, that all Beneficiaries in a family shall be governed by an HMO election.

If the monthly charge made by the HMO exceeds the monthly cost of this Plan to the Employer, the excess charge shall be paid by the Beneficiary.

b. **Administration**

The Trustees are authorized to promulgate rules and regulations to implement the Plan, and such rules and regulations shall be binding upon all persons dealing with and Beneficiaries claiming benefits under this Plan. Precedent under the resolution of disputes mechanism previously in place shall remain in effect.

c. **Services Rendered Outside the United States**

Benefits are provided for health care rendered outside of the United States on the same basis as if such care had been rendered in the United States. (The Eligible 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.)

d. **Medicare**

(1) For Disabled Employees and surviving spouses, the benefits provided under the Plan will not be paid to a Beneficiary otherwise eligible if such Beneficiary is eligible for Hospital Insurance coverage (Part A) of Medicare where a premium is not required and/or Medical Insurance coverage (Part B) of Medicare unless such Beneficiary is enrolled for each part of Medicare for which such Beneficiary is eligible. Any such Beneficiary who is

enrolled in a Medicare program shall receive the benefits provided under the Plan only to the extent such benefits are not provided for under Medicare.

(2) For Employees age-eligible for Medicare, the benefits provided under the Plan will be paid to a Beneficiary unless the company is furnished written notice of electing coverage under Medicare rather than coverage under the Plan. Alternatively, the participant may elect to enroll for Medicare as secondary payer.

The Plan Administrator shall give written notification of the obligation to enroll with respect to (1) above and of the options to enroll with respect to (2) above. For active Employees such notice shall be given prior to their Medicare-eligibility birthdays, but subsequent to their immediately preceding birthdays. Said notice shall explain the limited annual enrollment period and the effect of failing to enroll if retirement should occur prior to the next enrollment period. Failure to provide such notification shall not remove any obligation to enroll.

e. Subrogation

The Plan does not assume primary responsibility for covered medical expenses which another party is obligated to pay or which another insurance policy or other medical plan covers. Where there is a dispute between the carriers, the Plan shall, subject to provisions (1) and (2) immediately below, pay for such covered expenses but only as a convenience to the Beneficiary eligible for benefits under the Plan 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 or carrier.

Obligations to pay benefits on behalf of any Beneficiary shall be conditioned:

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

(2) upon such Beneficiary 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.

f. Non-Duplication

The health benefits provided under this Plan are subject to a non-duplication provision as follows:

(1) 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:

(i) does not include a coordination of benefits or non-duplication provision, or

(ii) includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.

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

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

(ii) Where both plans cover the patient as a dependent, the plan of the parent or step-parent whose birthday occurs earlier in the calendar year will be the primary plan.

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

(iv) In the event a surviving spouse is covered under another group plan by reason of his or her employment, the other group plan shall be the primary plan for such surviving spouse and their eligible dependents.

(3) 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 of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

(4) 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.

(5) For the purpose of this provision the Plan Administrator may, without consent or notice to any Beneficiary, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expense and benefits.

(6) Any Beneficiary claiming benefits under this Plan must furnish the Plan Administrator such information as may be necessary for the purpose of administering this provision.

g. Recovery of Family and Medical Leave Act Premium

The Employer may in its sole discretion recover the premium that it paid for maintaining coverage during a leave under section 102 of the Family and Medical Leave Act of 1993, if:

(1) the Employee fails to return to work after the period of leave to which the Employee is entitled has expired; and

(2) the Employee fails to return to work for a reason other than

(i) the continuation, recurrence, or onset of a serious health condition of the Employee,

(ii) the need of the Employee to care for the Employee's Spouse, son, daughter, or parent due to the continuation, recurrence, or onset of a serious health condition of such individual, or

(iii) other circumstances beyond the control of the Employee.

The Employer may in its sole discretion require a certification of a health provider attesting to the existence of the factors set forth in (i) or (ii), above.

h. Explanation of Benefits (EOB) and Hold Harmless

(1) Each Beneficiary shall receive an explanation of billing and payment rendered on behalf of such Beneficiary. Should full payment for a service be denied because of a charge that has been determined by the Plan Administrator to be in excess of the reasonable and customary charge, the UMWA may request that a copy of such EOB shall be forwarded to the UMWA (International Headquarters, Attention: Benefits Department).

(2) The Employer and the UMWA agree that excessive charges and escalating health costs are a joint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, 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 commenced 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. The "hold harmless" protections available under this subparagraph do not apply in the case of any service or supply obtained from a non-PPL source until the non-PPL out-of-pocket maximum is reached.

11. General Exclusions

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

(1) 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.

- (2) 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 as set forth in Article IV.A.2.a. and IV.A.3.i. herein.
- (3) 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.
- (4) Services furnished by tax supported or voluntary agencies.
- (5) Immunizations provided by local health agencies.
- (6) 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.
- (7) Private duty nursing. If necessary to preserve life and certified as medically necessary by the attending physician and an Intensive Care Unit is unavailable, benefits are provided for private duty nursing services 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.
- (8) Custodial care, convalescent or rest cures.
- (9) 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.
- (10) Charges for private room confinement, except as specifically described in the Plan.
- (11) Services for which a Beneficiary is not required to make payment.
- (12) Excessive charges
- (13) Charges related to gender transition services unless required by law.
- (14) Charges for reversal of sterilization procedures.
- (15) Charges in connection with a general physical examination, other than as specified in this Plan.

(16) Inpatient confinements solely for diagnostic evaluations which can be provided on an outpatient basis.

(17) Charges for medical services for inpatient or outpatient treatment for intellectual disability and other intellectual deficiencies.

(18) Finance charges in connection with a medical bill.

(19) Dental services except for covered dental services for active employees.

(20) Birth control devices and medications, except preventive care and preventive services meeting one of the requirements of subpart A.3.o (9) of this Article.

(21) Abortion, except as specifically described in the Plan.

(22) Eyeglasses or lenses, except when medically required because of surgically caused refractive errors or as otherwise provided in section A.9.

(23) Exercise equipment.

(24) Charges for treatment with new technological medical devices, therapy which are experimental in nature.

(25) 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.

(26) Charges for an autopsy or post-mortem surgery.

(27) Any types of services, supplies or treatments not specifically provided by the Plan.

(28) Any claim which is submitted for payment under the Plan after twelve (12) months or more from the date of service.

(29) Expenses incurred as a result of injury sustained by the covered individual who is actually operating any motor vehicle used for ground transportation with a blood alcohol level over the legal limit prescribed by the laws of the state in which the injury was sustained.

(30) Any condition, disability or expense incurred by a covered individual resulting from or sustained as a result of a felonious act by that covered individual; provided that this exclusion will not apply if the injury resulted from a medical condition or act of domestic violence.

12. **Health Benefit Provisions**

a. **Newborns' and Mothers' Health Protection Act**

The Plan shall provide maternity care benefits in accordance with the Newborns' and Mothers' Health Protection Act (the "Newborn's Act"). The Plan 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 from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours.)

b. **Mental Health Parity and Addiction Equity Act**

The Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Internal Revenue Code Section 9812 and ERISA Section 712, and the regulations thereunder.

(1) **Lifetime or Annual Dollar Limits.** The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(2) **Financial Requirement or Treatment Limitations.** The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

(3) **Criteria for medical necessity determinations.** The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

c. **Women's Health and Cancer Rights Act**

Medical and surgical benefits provided for mastectomies under the Plan will be provided in accordance with the Women's Health and Cancer Rights Act of 1998 (the "Women's Health Act"). In accordance with the Women's Health Act, coverage will be provided for the following: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and coverage for any complications in all stages of mastectomy, including lymphedema.

d. Compliance with GINA

The Plan shall be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act of 2008.

e. Patient Protections

To the extent applicable, group health coverage under the Plan shall comply with the patient protections regarding your choice of health care professionals and emergency care services under the Public Health Services Act §2719A.

f. No Lifetime or Annual Limits

The Plan shall not impose a lifetime or annual limit on the dollar value of Essential Health Benefits under any medical benefits available under the Plan unless the medical benefit is an Excepted Benefit (as defined under the Affordable Care Act) to which the Affordable Care Act does not apply.

“Essential Health Benefits” are health-related items and services that fall into the following categories, as defined in §1302 of the Affordable Care Act, and further determined by the Secretary of Health and Human Services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits under the Affordable Care Act, the Plan has chosen Ohio as its benchmark state.

g. No Preexisting Condition Exclusions

The Plan shall not impose a preexisting condition exclusion on any medical benefits available under the Plan.

h. No Rescission of Coverage

The Plan shall not cancel nor discontinue medical benefits under the Plan with a retroactive effect with respect to a Beneficiary except in the event of fraud or intentional misrepresentation.

i. Coverage of Clinical Trials

The Plan shall not deny a Beneficiary the right to participate in an approved clinical trial for which such Beneficiary is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A Beneficiary who is participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial. For purposes of this provision, the terms “qualified individual,” “life threatening disease or condition,” “approved clinical trial” and “routine patient costs” shall have the same meaning as found in § 2709 of the Public Health Services Act.

j. Claims and Appeals Procedures

Beneficiaries shall be provided benefits as set forth in the Plan. Beneficiaries seeking benefits under the Plan shall follow and comply with the procedures established herein. In general, for in-PPL services, no claim forms will be required. The in-PPL provider generally will be responsible for the submission of claims and other paperwork. For out-of-PPL services, claim forms generally will be available at most hospitals, clinics, and physician offices. For both in-PPL and out-of-PPL services, the hospital, clinic, or physicians’ office will bill the Beneficiary for the co-payment and deductible until the maximum is reached.

If a Beneficiary is requesting reimbursement for a covered expense paid by the Beneficiary, the Beneficiary must first seek to resolve the matter with the applicable Provider. All other claims for covered benefits must also be submitted first to the Provider. If the matter is not resolved by the Provider, the Beneficiary must file a claim with the Plan Administrator. All claims must be filed with the Plan Administrator within twelve (12) months of the date of service. Any claim that is submitted for payment under the Plan after twelve (12) months or more from the date of service is untimely and shall be denied.

Beneficiaries shall be reimbursed for benefits as set forth in the Plan. Beneficiaries seeking benefits under this Plan shall follow the claims procedures established for that particular benefit by the SPD. Such claims and appeals procedures shall comply with the requirements of ERISA Section 503, the Affordable Care Act (including external review rights), and any applicable regulations.

B. General Provisions

Life and accidental death and dismemberment insurance will be provided for eligible Employees directly by the Employer and not by the 1993 Plan. The following provisions apply only to health benefits under the 1993 Plan. For information concerning life and accidental death and dismemberment coverage, the Employer should be contacted.

1. Continuation of Coverage

a. Layoff

If an Employee ceases work because of layoff, continuation of health insurance coverage is as follows:

<u>Number of Hours Worked for the Employer in 24 Consecutive Calendar Month Period Immediately Prior to the Employee's Date Last Worked</u>	<u>Continuation of Coverage</u>
2,000 or more hours	Balance of month plus 12 months
500 or more but less 2,000 hours	Balance of month plus 6 months
Less than 500 hours	30 days

b. Disability

Except as otherwise provided in Article III, section C, if an Employee ceases work because of disability, the Employee will be eligible to continue health insurance coverage while disabled for the greater of the period as set forth in the schedule in (a) above.

c. Leave of Absence

(1) During any period for which an employee is granted an approved leave of absence for the purpose of accepting temporary employment with the United Mine Workers of America (UMWA) such Employee shall be eligible to continue health insurance coverage for a period not to exceed 120 calendar days within any 12-month period.

(2) During any period for which an Employee is granted an approved leave of absence for any other reason, such Employee's eligibility for health insurance coverage shall be terminated as of the day last worked and shall not be reinstated until the Employee returns to active work except as provided in subparagraph (3) below.

(3) If an Employee who is on an approved leave of absence is placed on lay off status, or would have been placed on lay off status had the Employee been actively at work, health coverage shall be reinstated as of the effective date of lay off. Such coverage shall continue for a period determined pursuant to the provisions of paragraph a. above using the

commencement date of the leave of absence in place of the date last worked for purpose of determining the number of hours worked. In no event shall coverage under this paragraph continue beyond the balance of the month plus 12 months from the effective date of lay off. An Employee who returns to work after having been on leave of absence shall not have the period for which such Employee was on leave of absence included in the 24-calendar month period as used in paragraph a. for determining eligibility for continuation of coverage.

d. Maximum Continuation of Coverage

In no event shall any combination of the provisions of a, b, c, e or g result in continuation of coverage beyond the balance of the month plus 12 months from the date last worked.

e. Quit or Discharge

If an Employee quits (for any reason) or is discharged, health coverage will terminate as of the date last worked. An Employee who ceases work and is determined to be eligible for health benefits from the 1993 Plan as a retiree on the first of the month subsequent to the date on which he last worked shall be eligible for benefits without interruption as provided by the Plan from the date he last worked.

f. Other Employment

Notwithstanding the foregoing, in the event an Employee accepts employment during a period of continued coverage under paragraph a., health coverage will terminate as of the date of such employment. If, however, such employment subsequently terminates prior to the date the Employee's coverage under paragraph a. otherwise terminates, such Employee's health coverage will be reinstated following the later of (i) termination of such employment or (ii) any continued health coverage resulting therefrom, and will continue to the date such coverage under paragraph a. would have otherwise terminated. It is the obligation of the Employee to notify the Employer within 10 days by certified mail of both the acceptance and termination of such employment; failure to provide such notice will result in permanent termination of coverage. Nothing in this paragraph shall extend coverage beyond the date determined pursuant to paragraph a.

g. Article III (j) Wage Agreement

An Employee terminated under the provisions of Article III(j) of the Wage Agreement shall not be treated as a quit or discharge for purposes of continuation of coverage. Such an Employee shall be entitled to continuation of coverage on the same basis as provided for in paragraph b. above; provided, however, hours worked and the period of continuation of coverage shall be determined as of the date last worked.

h. COBRA Continuation Coverage

Notwithstanding the foregoing, this Plan shall comply with the health care continuation coverage provisions of Sections 601-608 of ERISA and Section 4980B of the Internal Revenue Code. The Plan Administrator shall include appropriate language explaining the Employees' and Beneficiaries' rights under COBRA in the next Summary Plan description booklet distributed.

2. **Advanced COBRA Premiums**

In the event of an economic strike at the expiration of the 2020 Coal Wage Agreement or a reopener, the Employer will advance COBRA premiums for continued health coverage for the first 30 days of such strike. Such advanced premiums shall be repaid to the Employer by such Employees through a check off deduction upon their return to work. Should such a strike continue beyond 30 days, the Union or such Employees may elect to pay such premiums themselves.

3. **Qualified Medical Child Support Orders.**

The Plan shall comply with the provisions of Section 609 of ERISA as amended by the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993").

C. **Dental Benefits (Only for Active Employees and their Dependents)**

1. **Dental Care**

The IEP provides dental benefits for Employees and their eligible Dependents at a cost to each Employee of \$2 per month payable on a payroll deduction basis, or if applicable as a reduction in the Employee's Sickness and Accident Benefits if such Employee is disabled and receiving such Benefits from the Employer during the particular month.

2. **Eligibility**

- a. Dental benefits shall be provided to any Employee who has completed 6 months of classified employment with the Employer and:
 - b. is actively at work on the Effective Date of this Plan; or
 - c. is actively at work on or after the Effective Date of the Wage Agreement and is disabled and receiving or would, upon proper application, be eligible to receive Sickness and Accident Benefits from the Employer pursuant to the Wage Agreement.
- d. Except as provided in c. above, any Employee of the Employer who is not actively at work for the Employer on the Effective Date of this Plan will not be eligible for coverage under this Plan until the later of the date the Employee:
 - (1) returns to active employment with the Employer, or
 - (2) completes 6 months of classified employment with the Employer.
- e. A new Employee will not be eligible for coverage under this Plan until such Employee completes 6 months of classified employment with the Employer.

3. **Effective Date of Coverage**

Dental coverage will become effective as of the first day of the month following the date the Employee completes six months of classified employment with the Employer.

4. Eligible Dependents

The following individuals are also eligible for dental benefits under the IEP:

- a. A spouse who is living in the same household (residence) with the eligible Employee; or
- b. Children of an eligible Employee who have not attained age 26, without regard to the child's marital, student, or residential status.

5. Payment of Benefits

After application of a Benefit Year (October 1st--September 30th) deductible amount of \$50 for you and \$50 for each of your Dependents for other than preventive services (those procedures prefaced by an asterisk in the Schedule of Benefits), and subject to the maximums specified in this Plan, benefits are payable in accordance with the Schedule of Benefits set out in the 2020 Wage Agreement, but in no event will the benefit for a specific dental service be greater than the dentist's charge for the specific dental procedure.

6. Maximum Benefits

After application of the Benefit Year deductible(s) referred to in paragraph 5 above:

(1) The maximum benefit payable for all Covered Dental Expenses incurred during any Benefit Year (excluding orthodontic benefits which are not subject to this limitation) shall be \$1,754.50 for you and \$1,754.50 for each of your dependents on the Effective Date. Notwithstanding the foregoing, the Maximum Annual Benefits listed in this paragraph shall not be applicable to children age 18 and under.

(2) In applying the maximums referred to in (1) above, benefits for Covered Dental Expenses paid under any other group dental plan or program toward the cost of which the Employer contributes shall be considered to have been paid under this Plan.

(3) The maximum orthodontic benefit during any Benefit Year shall be \$974.37 on the Effective Date for each of your eligible Dependents prior to the attainment of age 26, with a lifetime maximum of \$2,923.09 on the Effective Date for each such Dependent.

7. Claims Not Requiring Predetermination Of Benefits

When Covered Dental Expenses are incurred by you or one of your Dependents for emergency treatment, routine oral examinations, X-rays, prophylaxis, fluoride treatments or a course of treatment, the charge for which is not expected to exceed \$150, predetermination of benefits (paragraph 8 below) is not required. The claims administrator will make the applicable benefit payment; however, any of the dentist's charges not payable under the provisions of the Dental Benefits coverage will be your responsibility.

8. Claims Requiring Predetermination Of Benefits

If a course of treatment for you or one of your Dependents can reasonably be expected to involve dentist's charges of \$150 or more, or if a course of treatment is for orthodontia, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the claims administrator prior to the commencement of the course of treatment.

For orthodontic procedures, the treatment plan must (1) provide a classification of malocclusion; (2) recommend and describe necessary treatment by orthodontic procedures; (3) estimate the duration over which treatment will be completed; (4) estimate the total charge for treatment; and (5) be accompanied by cephalometric x-rays, study models and other supporting evidence the claims administrator may require.

As used herein "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more dentists for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

The claims administrator will notify you and your dentist of the benefits certified as payable based upon such course of treatment within 30 days of receipt of the request for predetermination, or, if such certification cannot be made within 30 days, the claims administrator will notify you why a certification has been delayed. In determining the amount of benefits payable, consideration will be given to alternate procedures, services or courses of treatment that may be performed for such dental condition in order to accomplish the desired result. The amount included as certified dental expenses will be the appropriate amount determined in accordance with the provisions of paragraph 9e. below, subject to the maximums set forth in paragraph 6b. above and the limitations set forth in paragraph 10. below. If you and your dentist agree to a charge higher than the amount predetermined by the claims administrator, such excess will not be paid by the Plan and will be your responsibility.

If description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the claims administrator reserves the right to make a determination of benefits payable taking into account alternate procedures, services or courses of treatment, based on accepted standards of dental practice.

9. Covered Dental Expenses

Covered Dental Expenses are those procedures specified in the 2020 Wage Agreement incurred in connection with dental services which are performed by:

- (1) a licensed dentist practicing within the scope of his license, or
- (2) a licensed physician authorized by his license to perform the particular dental services rendered but only to the extent such charges are for services and supplies customarily employed for treatment of that dental condition and only if rendered in accordance with accepted standards of dental practice.

10. Limitations

The following limitations apply:

a. Routine oral examinations and prophylaxis (scaling and cleaning of teeth) are limited to not more than two in any period of 12 consecutive months.

b. Space maintainer (a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replaces prematurely lost teeth are provided only for eligible Dependents prior to the attainment of age 26.

c. Full mouth X-rays are limited to once in any period of 36 consecutive months and supplementary bitewing X-rays are limited to not more than two in any period of 12 consecutive months.

d. Relining or rebasing of dentures are limited to once in any period of 36 consecutive months, provided such relining or rebasing occurs more than six months after the initial installation or replacement.

e. Adjustments to partial or full removal dentures are limited to the first six months following the date of installation.

f. The addition of teeth to an existing partial removable denture or to bridgework is provided only if satisfactory evidence is presented that:

(i) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or

(ii) the existing denture or bridgework cannot be made serviceable and it was installed at least five years prior to the date of its replacement; or

(iii) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

Normally, dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a Covered Dental Expense.

g. Gold, Baked Porcelain Restorations, Crowns and Jackets -- If a tooth can be restored with a material such as amalgam, payment of the benefit, as contained in Article XXA, Section V of the 2020 Wage Agreement, for that procedure will be made toward the charge for another type of restoration which you and your dentist may select. In such case, you are responsible for the balance of the treatment charge.

h. Reconstruction--Payment of the benefit, as contained in Article XXA, Section V of the 2020 Wage Agreement, will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to alter

vertical dimension in restoring occlusion are provided only for eligible Dependents prior to the attainment of age 26.

i. Partial Dentures--If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the benefit, as contained in Article XXA, Section V of the 2020 Wage Agreement, for such procedure will be made toward a more elaborate or precision appliance that you and your dentist may choose to use; the balance of the cost remains your responsibility.

j. Precision Attachments--Benefits will not be provided for precision attachments when used for cosmetic purposes.

k. Dentures--If, in the provision of denture services, you and your dentist decide on personalized or specialized techniques as opposed to standard procedures, payment of the benefit, as contained in Article XXA, Section V of the 2020 Wage Agreement, for the standard denture services will be made toward such treatment and the balance of the cost remains your responsibility.

l. Replacement of Existing Dentures or Fixed Bridgework--Replacement of an existing denture or fixed bridgework will be a Covered Dental Expense only if the existing denture or fixed bridgework is unserviceable and cannot be made serviceable. Payment of the benefit, as contained in Article XXA, Section V of the 2020 Wage Agreement, for such service will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a Covered Dental Expense only if at least five years have elapsed since the date of the initial installation of that appliance.

m. Courses of Treatment in Progress on Effective Date of Dental Benefits:

Benefits are not provided for treatment received prior to commencement of coverage. Claims for a course of treatment which was started prior to commencement of coverage but completed while coverage is in force will be investigated to determine the amount of the entire fee which should be allocated to the treatment which was actually received while covered. Only that portion of the total fee which can be allocated to treatment received while covered will be included as a Covered Dental Expense.

11. Dental Plan Exclusions

Charges for the following are not covered Dental Expenses:

- a. Services other than those specifically listed in the Schedule of Benefits;
- b. Treatment by other than a licensed dentist or licensed physician, except (a) charges for scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the dentist; and (b) charges by a dental school if
 - (i) the services are not experimental,

- (ii) the dental school customarily charges for services and
 - (iii) the services are performed under the supervision of a licensed dentist;
- c. Local infiltration anesthetic;
 - d. Substances or agents which are administered to minimize fear or charges for analgesia, unless the patient is disabled by cerebral palsy, intellectual disability or spastic disorder;
 - e. Veneers (the coating or covering of plastic or porcelain on the outside of and bonded to a crown or false tooth to cause it to blend with the color of surrounding teeth) or similar properties of crowns and pontics placed on or replacing teeth, other than the 10 upper and lower anterior teeth;
 - f. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
 - g. Prosthetic devices (including bridges), crowns, inlays and onlays, and the fitting thereof which were ordered while the individual was not covered for Dental Benefits, or which were ordered while the individual was covered for Dental Benefits but are finally installed or delivered to such individual more than 60 calendar days after the date of termination of coverage;
- As used herein “ordered” means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays and onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.
- h. Replacement of a lost, missing or stolen prosthetic device;
 - i. Orthodontic procedures and/or treatment provided to anyone other than an eligible Dependent prior to the attainment of age 26;
 - j. Any services which are covered by any workers’ compensation laws or employer’s liability laws, or services which an employer is required by law to furnish in whole or in part;
 - k. Services rendered through a medical department, clinic or similar facility provided or maintained by the patient’s employer;
 - l. Services or supplies for which no charge is made that you are legally obligated to pay or for which no charge would be made in the absence of dental expense coverage;

- m. Services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;
- n. Services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature;
- o. Services or supplies received as a result of dental disease, defect or injury resulting from the commission of a felony or due to an act of war, declared or undeclared;
- p. Services or supplies which are obtained by you or your Dependent from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body;
- q. Any duplicate prosthetic device or any other duplicate appliance;
- r. Charges for any services to the extent for which benefits are payable under any health insurance program supported in whole or in part by funds of the federal government or any state or political subdivision thereof;
- s. Sealants (materials, other than fluorides, painted on the grooves of the teeth in an attempt to prevent future decay) and for oral hygiene and dietary instruction;
- t. A plaque control program (a series of instructions on the care of the teeth);
- u. Implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth); and
- v. Periodontal splinting.

12. Date Expenses Are Incurred

Benefits are provided only for Covered Dental Expenses incurred on a date when coverage by the Dental Benefits provisions in this Plan is in effect for you or your Dependent who incurs such expenses. Covered Dental Expenses are considered to have been incurred on the date when the applicable dental services, supplies or treatments are received, except as otherwise provided in paragraph 11.g.

13. Dental Plan Subrogation

The Plan does not assume primary responsibility for Covered Dental Expenses which another party is obligated to pay or which another insurance policy or other dental plan covers. Where there is a dispute between the carriers, the Plan shall, subject to provisions (a) and (b) immediately below, pay for such Covered Dental Expenses but only as a convenience to you or your Dependent 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 or carrier.

Obligations to pay benefits on behalf of you or your Dependent shall be conditioned upon you or your Dependent:

(a) taking all steps necessary or desirable to recover the costs thereof from any third party who may be obligated therefore; and

(b) upon you or your Dependent executing such documents as are reasonably required by the Plan Administrator, including, but not limited to, 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.

14. Non-Duplication

The Dental Benefits provided under this Plan are subject to a non-duplication provision as follows:

a. Benefits will be reduced by benefits provided under any other group plan so that the total paid by both plans does not exceed the total reasonable cost of the procedure, including a plan of another Employer signatory to the Wage Agreement, if the other plan:

(i) does not include a coordination of benefits or non-duplication provision; or

(ii) includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.

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

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

(ii) Where both plans cover the patient as a dependent child, the plan covering the patient as a dependent child of the individual whose birthday occurs earlier in the calendar year will be the primary plan.

(iii) Where the determination cannot be made in accordance with (i) and (ii) above, the plan which has covered the patient the longer period of time will be the primary plan.

c. As used herein, "group plan" means:

(i) any plan covering the individuals as members of a group and providing dental benefits or services through group insurance or a group prepayment arrangement; or

(ii) any plan covering individuals as employees of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

d. 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.

e. For the purpose of this provision the Plan Administrator may, without consent of or notice to you or your Dependent, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expense and benefits.

f. If you or your Dependent is claiming benefits under this Plan, you or such Dependent must furnish the Plan Administrator such information as may be necessary for the purpose of administering this provision.

15. Termination of Coverage

If an Employee ceases active work, coverage will be terminated as set forth below:

a. Disability

Coverage will terminate on the date such Employee ceases to be eligible for Sickness and Accident Benefits pursuant to the Wage Agreement.

b. Layoff

Coverage will terminate at the end of the month in which the Employee last worked.

c. Article III, Section (j)--Wage Agreement

Coverage will terminate at the end of the month in which the Employee last worked, unless the Employee is eligible for Sickness and Accident Benefits pursuant to the Wage Agreement.

d. Death Of Employee

Coverage for the eligible Dependents of the deceased Employee will terminate at the end of the month in which the Employee died.

e. Leave Of Absence Or Retirement

Coverage will terminate as of the last day worked.

f. Quit Or Discharge

Coverage will terminate as of the last day worked.

g. Self Pay For Continuation Coverage

Each Employee and eligible Dependent shall have the right to self pay for continuation - coverage pursuant to the requirements of Sections 601 *et seq.* of the Employee Retirement Income Security Act of 1974.

16. Schedule of Benefits

Article XXA of the 2020 Wage Agreement sets forth a complete schedule of benefits available under this Dental Plan and is incorporated by reference herein.

ARTICLE V

MANAGED CARE, COST CONTAINMENT UNDER IEP PROGRAM OF BENEFITS

The provisions of Part I, Article V of this Plan Document, entitled “Managed Care, Cost Containment Under Traditional Program of Benefits,” shall apply to the IEP Program of Benefits and are incorporated by reference herein.

For the avoidance of any doubt, neither the Plan nor the Employer shall in any way be responsible for the failure of a physician, health care facility, or other provider to satisfy any criteria set forth in the provisions incorporated by reference herein. Further, notwithstanding the implementation of any Participating Provider Lists or other managed care or cost containment rule or procedure, neither the Plan nor the Employer shall in any way be responsible for the outcome of any medical treatment or health care (or lack of such treatment or care).

ARTICLE VI

AMENDMENT AND TERMINATION OF IEP PROGRAM OF BENEFITS

A. **Mid-Term Amendments.** The UMWA and BCOA (and its successors or assigns) 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 this Plan or IEP Program of Benefits, or to terminate this Plan or IEP Program of Benefits, by written instrument between the UMWA and BCOA, without reopening or otherwise affecting the integrity of any other provision of the Wage Agreement.

B. **Post-Termination Amendments.** Subject to section C, following termination of the 2020 Wage Agreement, this Plan or the IEP Program of Benefits may be modified, amended, or terminated by BCOA and the UMWA, or by BCOA or the Employer as permitted by law.

C. **Special Rule.** The benefits and benefit levels provided by the Employer under this Plan are established for the term of the 2020 Wage Agreement only, and may be jointly amended or modified in any manner at any time after the expiration or termination of the 2020 Wage Agreement.

D. **Procedural Requirements.** Any written instrument executed by BCOA and the UMWA shall be signed by the President of BCOA and by the International President of the UMWA. In the event BCOA ceases to exist, then the Employer, acting through its designated representative, shall have the rights of BCOA under this Article.

E. Employers that wish to have the 1993 Benefit Plan administer health benefits to their active Employees (and their dependents) under this Individual Employer Program of

Benefits must, among other things, sign a Participation Agreement with the Trustees of the 1993 Plan.

F. Participating Employers shall have sole discretion to cease using the 1993 Benefit Trust for the administration of such benefits at any time and for any reason, provided that the Employers commence the administration of such benefits through an IEP with no disruption in benefits. The Employers shall be responsible for all costs incurred by the Trust in dis-enrolling the beneficiaries from the 1993 Benefit Plan and transitioning the beneficiaries to the Employers' Individual Employer Plan.

G. The eligible beneficiaries of Employers that participate in the 1993 Plan and who have their benefits administered by the 1993 Benefit Plan shall be considered beneficiaries of the 1993 Benefit Plan and shall be subject to the terms and conditions of this Plan and the management of the Trustees of the 1993 Plan and their authorized agents.

H. Notwithstanding any other provision of this Agreement and the Plan and Trust Documents for the 1993 Benefit Plan, all monies paid to the 1993 Plan and Trust by Employers pursuant to the Participation Agreement shall be separately accounted for and used by the Plan and Trust solely under the Individual Employer Program of Benefits to pay for health benefits for the Employers' own active Employees (including their eligible dependents) and applicable administrative expenses, and shall not be used for any other purpose, including but not limited to the provision of benefits to any other persons receiving benefits from the 1993 Benefit Plan. The assets contributed to the Plan and Trust by Employers pursuant to the Participation Agreement shall be used exclusively for the benefit of eligible active Employees of the Employers, shall not become part of the general assets of the 1993 Plan and Trust, and shall not be used to pay for benefits of either the pre-December 27, 2020 or post-December 27, 2020 "orphan" beneficiary population of the 1993 Benefit Plan, or for benefits under the UMWA Program of Benefits or the Crimson Oak Grove Individual Employer Program of Benefits. The Employers signatory to the Participation Agreement shall not be liable to pay for the benefits of any beneficiary of the Plan and Trust who is not the Employers' own active Employee (or their dependents). The Employers signatory to the Participation Agreement are obligated to pay for their own Employees under the Individual Employer Program of Benefits but are not obligated to pay for the benefits of active Employees and/or Pensioners (and their dependents) of other participating Employers or benefits under the UMWA Program of Benefits or Crimson Oak Grove Individual Employer Program of Benefits, and are not obligated to pay for any existing or future deficit of the 1993 Plan and Trust that is not based on the cost of providing benefits to the Employers' own active Employees (including their eligible dependents) in the Individual Employer Program of Benefits.

The hourly and tonnage contributions to the Plan required under the NBCWA of 2016, monies transferred to the Plan pursuant to Section 402(h) and (i) of the Surface Mining Control and Reclamation Act of 1977, as amended ("SMCRA"), and any earnings thereon, shall not be used to provide benefits to any IEP beneficiaries of the Employers participating in the 1993 Plan Individual Employer Program of Benefits.

I. **Applicable Law.** This Plan shall be construed, regulated and administered under Federal law. Among other things, the Trustees reserve the right to modify or amend the

provisions of this Plan and Program of Benefits to the extent provisions of the Affordable Care Act are repealed, replaced or modified, or otherwise to comply with law.

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PART IV--1993 PLAN UMWA PROGRAM OF BENEFITS

ARTICLE I INTRODUCTION OF UMWA PROGRAM OF BENEFITS

Part IV of this Plan Document for the 1993 Benefit Plan describes the 1993 Plan UMWA Program of Benefits (“UMWA Program of Benefits”). The purpose of this UMWA Program of Benefits is to provide health benefits to eligible employees and retirees of the UMWA and their eligible dependents and survivors (collectively “UMWA Beneficiaries”), provided that the UMWA is signatory to a Participation Agreement with the 1993 Benefit Plan. The benefits provided herein shall be funded by the UMWA pursuant to the terms of a Participation Agreement between the UMWA and the 1993 Benefit Trust. The UMWA Program of Benefits described herein shall be effective July 1, 2017.

ARTICLE II DEFINITIONS UNDER UMWA PROGRAM OF BENEFITS

The following terms shall have the meanings herein set forth:

1. “UMWA” means the United Mine Workers of America.
2. “BCOA” means the Bituminous Coal Operators’ Association, Inc.
3. “Employer” means the UMWA for purposes of the UMWA Program of Benefits.
4. “Wage Agreement” means the National Bituminous Coal Wage Agreement (“NBCWA”) of 2016.
5. “Plan Administrator” shall be the Trustees of the UMWA 1993 Benefit Plan.
6. “UMWA Health Plan” is the employee benefits plan established and administered by the UMWA.
7. “Employee” shall mean a person working for the UMWA and eligible to receive health benefits under the UMWA Health Plan.
8. “Pensioner” shall mean a person who is receiving a pension from the International Union, United Mine Workers of America Pension Plan and is eligible to receive health benefits from the UMWA Health Plan.
9. “Beneficiary” shall mean any person who is eligible to receive health benefits under the UMWA Program of Benefits.
10. “Dependent” shall mean any person eligible to receive health benefits as a dependent under the UMWA Health Plan.
11. “Attains the age” shall mean on or after 12:01 A.M. of the anniversary date of one’s birth.

12. “Trustee” or “Trustees” shall mean the Trustees of the United Mine Workers of America Health and Retirement Funds or, as applicable, the Trustees of the UMWA 1993 Benefit Plan.

13. “Affordable Care Act” means the Patient Protection and Affordable Care Act of 2010.

ARTICLE III ELIGIBILITY UNDER UMWA PROGRAM OF BENEFITS

The beneficiaries who are eligible to receive benefits under the UMWA Program of Benefits are those employees and pensioners (and their dependents and survivors) of the UMWA who are eligible for health benefits from the UMWA Health Plan, which is subject to amendment in writing by the UMWA.

ARTICLE IV BENEFITS UNDER UMWA PROGRAM OF BENEFITS

The 1993 Benefit Plan will provide to the UMWA Beneficiaries the applicable level of benefits negotiated by the UMWA and the BCOA in the National Bituminous Coal Wage Agreement of 2016, and as set forth in this Article IV herein. In general, the level of benefits is substantially the same as the level of benefits provided to UMWA-represented employees and retirees who work for or are retired from coal companies that are signatory to collective bargaining agreements with the UMWA and participate in the UMWA Health and Retirement Funds pursuant to a Participation Agreement. In administering the UMWA Program of Benefits, the 1993 Benefit Plan will utilize the provider networks, managed care programs, cost containment programs, and other cost saving measures available to and administered by the UMWA Health and Retirement Funds (“the Funds”). The Plan will implement and enforce the deductibles, co-payments, out-of-network charges, annual maximums, eligibility requirements, and other plan design provisions set forth in the UMWA Program of Benefits, which is subject to amendment in writing by the UMWA.

The benefits provided under this UMWA Program of Benefits are as set forth in this Article IV. Benefit payments are based on negotiated rates applicable to services provided by hospitals, physicians, pharmacies and other providers on Participating Provider Lists (PPL’s) adopted under Article V herein or operating under the requirements for lists of preferred drug products (PDP’s) adopted under Article V herein.

During any period when PPLs are not in effect, and for covered services and supplies not offered under a PPL (or otherwise not subject to a PPL-related benefit limit), benefit payments shall not exceed reasonable and customary charges* for covered services and supplies. Covered

* 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

services shall be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at the appropriate level of care, or are otherwise provided for in the Plan. 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 this 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.

Services which are not reasonable and necessary shall include, but are not limited to the following: 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 timely fashion in the patient's medical records; procedures which can be performed with equal efficiency at a lower level of care.

The benefits described in this Article are subject to any precertification, prescription drug formulary (PDP) requirements, and other utilization review requirements implemented pursuant to Article V. 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 as described in this Article IV.

A. Health Benefits

1. Inpatient Hospital Benefits

a. Semi-private room

When a Beneficiary is admitted by a licensed physician (hereinafter "physician") for treatment as an inpatient to an Accredited Hospital (hereinafter "hospital"), benefits will be provided for semi-private room accommodations (including special diets and general nursing care) and all medically necessary services provided by the hospital as set out below for the diagnosis and treatment of the Beneficiary's condition.

Medically necessary services provided in a hospital include the following:

- Operating, recovery, and other treatment rooms
- Laboratory tests and x rays
- Diagnostic or therapy items and services
- Drugs and medication (including take home drugs which are limited to a 30-day supply)
- Radiation therapy
- Chemotherapy

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 some home health and hospice services.

Physical therapy
Anesthesia services
Oxygen and its administration
Intravenous injections and solutions
Administration of blood and blood plasma
Blood, if it cannot be replaced by or on behalf of the Beneficiary

b. Intensive Care Unit -- Coronary Care Unit

Benefits will also be provided for treatment rendered in an Intensive Care or Coronary Care Unit of the hospital, if such treatment is certified as medically necessary by the attending physician.

c. Private Room

For confinement in a private room, benefits will be provided for the hospital's most common charge for semi private room accommodations and the Beneficiary shall be responsible for any excess over such charge except that private room rates will be paid when (i) the Beneficiary's condition requires him to be isolated for his own health or that of others, or (ii) the hospital has semi private or less expensive accommodations but they are occupied and the Beneficiary's condition requires immediate hospitalization. Semi-private room rates, not private room rates, will be paid beyond the date a semi-private room first becomes available and the Beneficiary's condition permits transfer to those accommodations.

d. Renal Dialysis

Benefits will be provided for renal dialysis provided that the renal dialysis therapy is administered in accordance with Federal Medicare regulations as in effect from time to time.

e. Mental Illness

Benefits are provided for a Beneficiary who is confined for mental illness in a hospital by a licensed psychiatrist on the same basis as any medically necessary hospitalization.

f. Alcoholism and Drug Abuse

Benefits are provided for a Beneficiary who requires emergency detoxification hospital care for the treatment of alcoholism or emergency treatment for drug abuse.

If treatment of a medical or mental condition is necessary following detoxification or emergency treatment for drug abuse, benefits may be provided under other provisions of this Plan and are subject to any requirements or limitations in such provisions.

See subsection 7.f. for information concerning other services related to treatment of alcoholism and drug abuse.

g. Oral Surgical/Dental Procedures

Benefits are provided for a Beneficiary who is admitted to a hospital for the oral surgical procedures described in subsection 3.e. provided hospitalization is medically necessary.

Benefits are also provided for a Beneficiary admitted to a hospital for dental procedures only if hospitalization is necessary due to a pre-existing medical condition and prior approval is received from the Plan Administrator.

h. Maternity Benefits

Benefits are provided for a female Beneficiary who is confined in a hospital for pregnancy. Such benefits will also be available for services pertaining to termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

i. General

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 United Mine Workers of America Combined Benefit Fund.

2. Outpatient Hospital Benefits

a. Emergency Medical and Accident Cases

Benefits are provided for a Beneficiary who receives emergency medical treatment or medical treatment of an injury as the result of an accident, provided that the beneficiary has acute medical symptoms and the absence of immediate medical attention could result in serious jeopardy of the individual's health or body.

b. Surgical Cases

Benefits are provided for a Beneficiary who receives surgical treatment in the outpatient department of a hospital.

c. Laboratory Tests and X rays

Benefits are provided for laboratory tests and x ray services performed in the outpatient department of a hospital which provides such services and when they have been ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

d. Chemotherapy and Radiation Therapy

Benefits are provided for chemotherapy treatments of a malignant disease or radiation treatments performed in the outpatient department of a hospital.

e. **Physiotherapy**

Benefits are provided for physiotherapy treatments performed in the outpatient department of a hospital. Such therapy must be prescribed and supervised by a physician.

f. **Renal Dialysis**

Benefits will be provided for outpatient renal dialysis rendered in accordance with Federal Medicare regulations as in effect from time to time.

3. **Physicians' Services and Other Primary Care**

a. **Surgical Benefits**

Benefits are provided for surgical services essential to a Beneficiary's care consisting of operative and cutting procedure (including the usual and necessary post-operative care) for the treatment of illnesses, injuries, fractures or dislocations, which are performed either in or out of a hospital by a physician.

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.

b. **Assistant Surgeons**

If the Beneficiary is an inpatient in a hospital, benefits will also be provided for the services of a physician who actively assists the operating physician in the performance of such surgical services when the condition of the Beneficiary and type of surgical service require such assistance.

c. **Obstetrical Delivery Services**

Benefits are provided for a female Beneficiary for obstetrical delivery services (including pre and post-natal care) performed by a physician. Benefits will also be provided if such delivery is performed by a midwife certified by the American College of Nurse Midwifery and licensed where such licensure is required.

Such benefits will also be provided for termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

d. **Anesthesia Services**

Benefits are provided for the administration of anesthetics provided either in or out of the hospital in surgical or obstetrical cases, when administered and billed by a physician, other than the operating surgeon or his assistant, who is not an employee of, nor compensated by, a hospital, laboratory or other institution; or by a nurse anesthetist.

e. **Oral Surgery**

Benefits are not provided for dental services, except for covered dental services for active employees as set forth below in Article III. D. herein. However, benefits are provided to active employees and pensioners for 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
- Dental services required as the direct result of an accident

f. **Surgical Services Limitations**

Benefits are not provided for certain surgical services without prior approval of the Plan Administrator. Such surgical procedures include, but are not limited to, the following:

- 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 government programs
- Organ transplants

g. **In-hospital Physicians' Visits**

If a Beneficiary is confined as an inpatient in a hospital because of an illness or injury, benefits are provided for in-hospital visits by the physician in charge of the case. Such benefits will also be provided concurrently with benefits for surgical, obstetrical and radiation therapy services when the Beneficiary has 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.

h. **Home, Clinic, and Office Visits**

Benefits are provided for services rendered to a Beneficiary at home, in a clinic (including the outpatient department of a hospital) or in the physician's office for the treatment of illnesses or injuries, if provided by a physician.

i. **Emergency Treatment**

When provided by a physician, benefits are provided for a Beneficiary who receives outpatient emergency medical treatment or treatment of an injury as the result of an accident, provided that the individual has acute medical symptoms and the absence of immediate medical attention could result in serious jeopardy to the individual's health or body.

j. **Laboratory Tests and X rays**

Benefits will be provided for laboratory tests and x rays performed in a licensed laboratory when ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

Such benefits 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.

k. **Radiation and Chemotherapy Benefits**

Benefits are provided for treatment by x ray, radium external radiation or radioactive isotope (including the cost of materials unless supplied by a hospital), provided in or out of a hospital, when performed and billed by a physician.

When a Beneficiary's condition requires radiation therapy services in conjunction with medical, surgical or obstetrical services, benefits will be provided for such radiation therapy in addition to the payment for such other types of covered services if the physician performing the radiation therapy services is not the same physician who performs the medical, surgical or obstetrical services.

Benefits are provided for treatment of malignant diseases by chemotherapy provided in or out of the hospital when prescribed and billed by a physician.

l. **Medical Consultation**

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 by a Beneficiary.

m. **Specialist Care**

Benefits will be provided for treatment prescribed or administered by a specialist if the treatment is for illness or injury which falls within the specialist's area of medical competence.

n. **Primary Care Podiatrists' Services**

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.

o. Primary Medical Care Miscellaneous

(1) Benefits are provided for care of newborn babies and routine medical care of children prior to attaining age 6, subject to the requirements of subsection (9) below regarding preventive services.

(2) Benefits are provided for immunizations, allergy desensitization injections, pap smears, screening for hypertension and diabetes, and examinations for cancer, blindness, deafness, and other screening and diagnostic procedures when medically necessary.

(3) Subject to the requirements of subsection (9) below regarding preventive services, benefits are provided for physical examinations when certified as medically necessary by a physician. Medically necessary will mean that a Beneficiary (i) has an existing medical condition under treatment by a physician, (ii) has attained age 55, (iii) is undergoing an annual or semi-annual routine examination by a gynecologist or (iv) is undergoing a routine examination prescribed by a specialist as part of such specialist's care of a medical condition.

(4) Benefits are provided for "physician extender" care or medical treatment administered by nurse practitioners, physician's assistants or other certified or licensed health personnel when such service is rendered under the supervision of a physician.

(5) Benefits are provided for a nominal fee covering instruction in preparation for natural childbirth, if rendered in a hospital or clinic.

(6) Benefits are provided for family planning counseling when rendered by a physician or by other appropriately trained and supervised health care professionals.

(7) Benefits are provided covering artificial insemination if the service is provided by a licensed gynecologist.

(8) Benefits are provided for sterilization procedures if such procedures are performed by a physician.

(9) Preventive care and preventive services meeting one of the following requirements are covered benefits and will not be subject to any deductible or copayment when provided in-PPL:

(i) Evidenced-based items or preventive services, including various types of screenings (e.g., blood pressure screenings, cholesterol screenings, various STD screenings, diabetes screening, depression screenings, tobacco use counseling, breast cancer

screenings, genetic counseling, and BRCA testing) with an “A” or “B” rating recommended by the United States Preventive Services Task Force (USPSTF), an independent panel of scientific experts;

(ii) Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, such as periodic tetanus shots or other vaccinations for diseases like polio, chickenpox, measles, whooping cough and hepatitis;

(iii) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents, such as regular pediatrician visits, vision and hearing screening, developmental assessments and screening and counseling to address obesity; and

(iv) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA for women, including FDA-approved contraceptives and contraceptive counseling, as well as well-woman visits, domestic violence screening and counseling, HIV and other sexually transmitted disease counseling and breastfeeding support, supplies and counseling.

p. Services Not Covered

- (1) Services rendered by a chiropractor or naturopathic services.
- (2) Acupuncture therapy.
- (3) Home obstetrical delivery.
- (4) Telephone conversations with a physician in lieu of an office visit.
- (5) Charges for writing a prescription.
- (6) Medications dispensed by other than a licensed pharmacist.
- (7) Charges for medical summaries and medical invoice preparations.
- (8) Services of any practitioner who is not legally licensed to practice medicine, surgery, or counseling except as specifically provided herein.
- (9) Cosmetic surgery, unless pertaining to surgical scars or to correct results of an accidental injury or birth defects.
- (10) Physical examinations, except as specifically provided herein.
- (11) Removal of tonsils or adenoids, unless medically necessary.

4. **Prescription Drugs**

a. **Benefits Provided**

Benefits are provided for insulin and prescription drugs (only those drugs which by Federal or State law require a prescription) dispensed by a licensed pharmacist and prescribed by a (i) physician for treatment or control of an illness or a non-occupational accident or (ii) licensed dentist for treatment following the performance of those oral surgical services set forth in 3.e.

The initial amount dispensed shall not exceed a 90-day supply. Any original prescription may be refilled for up to twelve months as directed by the attending physician. Each such refill may be for an amount up to, but no more than, a 90-day supply. Benefits for refills beyond twelve months require a new prescription by the attending physician. Prescriptions filled by the Plan's mail order provider, if any, are not subject to the limits on quantity set forth in this paragraph.

Reasonable charges for prescription drugs or insulin are covered benefits. Reasonable charges will consist of the lesser of:

- (1) The amount actually billed per prescription or refill;
- (2) The price of the applicable generic substitution drug, if AB or better-rated, approved by the federal Food and Drug Administration; or, in the event the prescribing physician determines that use of a brand name drug is medically necessary, the price of such brand name drug; or
- (3) The current price paid to participating pharmacies in any prescription drug program established by the Plan.

However, except as provided otherwise in this Plan, in no event will a Beneficiary be responsible to pay more for a single prescription than the appropriate co-payment set forth in this Plan, plus any difference between the price of the generic and the brand name drug, where applicable.

b. **Benefits Excluded**

Benefits shall not be provided under subsection 4.a. herein for the following:

- (1) Medications dispensed in a hospital (including take home drugs), skilled nursing facility or physician's office. (See Article IV.A.1.a. and 5.a. for benefits provided for drugs and medications during inpatient confinement in a hospital skilled nursing facility.)
- (2) Prescriptions dispensed by other than a licensed pharmacist.
- (3) Any medication not specifically provided for in a. above.

5. **Skilled Nursing Care and Extended Care Units**

a. **Skilled Nursing Care Facility**

Upon determination by the attending physician that confinement in a licensed skilled nursing care facility* is medically necessary, to the extent that benefits are not available from Medicare or other State or Federal programs, benefits will be provided for:

- (1) skilled nursing care provided by or under the supervision of a registered nurse;
- (2) room and board;
- (3) physical, occupational, inhalation and speech therapy, either provided or arranged for by the facility;
- (4) medical social services;
- (5) drugs, immunizations, supplies, appliances, and equipment ordinarily furnished by the facility for the care and treatment of inpatients;
- (6) 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
- (7) other health services usually provided by skilled nursing care facilities.

Benefits in a licensed skilled nursing care facility will be provided up to a maximum of 100 days for an eligible Beneficiary.

The Plan will not pay for services in a nursing care facility:

- (1) That is not licensed or approved in accordance with Federal Medicare and state laws or regulations;
- (2) Unless the service is provided by or under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results.

Exclusions: Telephone, TV, radio, visitor's meals, private room or private nursing (unless necessary to preserve life), custodial care, and services not usually provided in a skilled nursing facility are not covered under the Plan.

* Skilled nursing care facility is limited to a skilled nursing care facility which is licensed and approved by Federal Medicare and by any appropriate state law, regulation or agency.

b. Extended Care Units

Benefits are provided for up to two weeks of specialized medical services and daily treatments by licensed personnel in extended care units. When medically necessary, benefit may be provided for a longer period of time, subject to approval from 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.

Exclusions:

Services, drugs or other items which are not covered for hospital inpatients; and custodial care.

6. Home Health Services & Equipment

a. General Provisions

Benefits are provided for home health services, including nursing visits by registered nurses and home health aides, and various kinds of rehabilitation therapy, subject to the following conditions and approval of the Plan Administrator.

(1) The Beneficiary must be under the care of a physician.

(2) The Beneficiary's medical condition must require skilled nursing care, physical therapy, or speech therapy at least once in a 60-day period.

(3) The physician must initiate a treatment plan and specify a diagnosis, the Beneficiary's functional limitations and the type and frequency of skilled services to be rendered.

(4) The Beneficiary must be confined to his home. The services must be provided by a certified home health agency.

Benefits will be provided for up to a maximum of 60 visits per year.

b. Physical and Speech Therapy

Benefits are provided for physical and speech therapy services at home when prescribed by a physician to restore functions lost or reduced by illness or injury. Such services must be performed by qualified personnel. When the Beneficiary has reached his or her restoration potential, the services required to maintain this level do not constitute covered care.

c. Skilled Nursing

Benefits are provided for skilled nursing care rendered by a registered nurse as a home health service when a Beneficiary's condition has not stabilized and a physician concludes that the Beneficiary must be carefully evaluated and observed by a registered nurse. The Plan Administrator may request an evaluation visit to the Beneficiary's home.

d. Medical Equipment

Benefits are provided for rental or, where appropriate, purchase of medical equipment suitable for home use when determined to be medically necessary by a physician.

e. Oxygen

Benefits are provided for oxygen supplied to a Beneficiary subject to the following conditions when ordered by the attending physician:

- (1) The patient is referred to a designated pulmonary consultant for testing.
- (2) Such consultant's report is submitted to the Plan Administrator with the order for oxygen.

Benefits are also provided for services of inhalation therapists in the home with the attending physician's order.

f. Coal Miners Respiratory Disease Program

Benefits are provided for services or treatments administered by personnel employed by the Coal Miners Respiratory Disease Program to a Beneficiary in such Beneficiary's home when ordered or requested by a physician, except where such benefits are available under a governmental program and such Beneficiary is eligible, or upon application would be eligible, under such programs.

7. Other Benefits

a. Orthopedic and Prosthetic Devices

Benefits are provided for orthopedic and prosthetic devices prescribed by a physician when medically necessary.

The following types of equipment are covered:

- (1) Prosthetic devices which serve as replacement for internal or external body parts, other than dental.

These include artificial eyes, noses, hands (or hooks), feet, arms, legs and ostomy bags and supplies.

- (2) Prosthesis following breast removal.
- (3) Leg, arm, back, and neck braces.
- (4) Trusses.

(5) Stump stockings and harnesses when these devices are essential for the effective use of an artificial limb. An examination and recommendations by an orthopedic physician is required.

Note: Benefits are provided for repairs and adjustments for braces, trusses, stump stockings and harnesses as well as replacement of any of those devices which have been worn out and can no longer be repaired. Benefits will be provided for replacements for usable appliances and artificial limbs if they are needed because of a change in the Beneficiary's condition. Benefits will also be provided to cover repair and adjustment cost for appliances and artificial limbs.

If replacement of a prosthesis is required, the Beneficiary should in all cases be reevaluated by an orthopedic physician.

(6) Surgical stocking (up to two pairs per prescription with no refills) when prescribed by a physician for surgical or medical conditions. The Plan will not pay Beneficiaries for support hose, garter belts, etc.

(7) Orthopedic shoes when specifically prescribed by a physician or licensed podiatrist for a Beneficiary according to orthopedist specifications, including orthopedic shoes attached to a brace that have to be modified to accommodate the brace. Benefits will not be provided for stock orthopedic shoes.

(8) Orthopedic corrections added to ordinary shoes by a physician or licensed podiatrist. Benefits are provided for only the correction to the shoe.

b. Physical Therapy

Benefits are provided for physical therapy in a hospital, skilled nursing facility, treatment center, or in the Beneficiary's home. Such therapy must be prescribed and supervised by a physician and administered by a licensed therapist. The physical therapy treatment must be justified on the basis of diagnosis, medical recommendation and attainment of maximum restoration.

c. Speech Therapy

Benefits are provided for speech therapy rendered by a qualified licensed speech therapist if the Beneficiary is a stroke patient or has had conditions including ruptured aneurysm, brain tumors or autism and needs special instruction to restore technique of sound and to phonate, and needs direction in letter and word exercises in order to express basic needs. Benefits are also provided for speech therapy for child Beneficiaries with a speech impediment from a qualified speech therapist provided that the child cannot receive speech therapy through the public schools.

d. Hearing Aids

Benefits are provided for hearing aids recommended by a licensed otologist or otolaryngologist and a certified clinical audiologist. Such hearing aids must be purchased from a participating vendor. Benefits for necessary repairs and maintenance, except the replacement of

batteries, will be provided after the expiration of the warranty period. Benefits will be provided for replacement hearing aids only if a new aid is needed because of a change in the Beneficiary's condition, or if the aid no longer functions properly. Benefits will not be provided for any fees for incorporating hearing aids into eyeglasses.

e. Ambulance and Other Transportation

Benefits are provided for ambulance transportation to or from a hospital, clinic, medical center, physician's office, or skilled nursing care facility, when considered medically necessary by a physician.

With prior approval from the Plan Administrator benefits will also be provided for other transportation subject to the following conditions:

(1) If the needed medical care is not available near the Beneficiary's home and the Beneficiary must be taken to an out of area medical center.

(2) If the Beneficiary requires frequent transportation between the Beneficiary's home and a hospital or clinic for such types of treatment as radiation or physical therapy or other special treatment which would otherwise require hospitalization, benefits will be provided for such transportation only when the Beneficiary cannot receive the needed care without such transportation.

(3) If the Beneficiary requires an escort during transportation, the attending physician must submit satisfactory evidence as to why the Beneficiary needs an escort.

f. Outpatient Mental Health, Alcoholism and Drug Addiction

Benefits are provided for: Psychotherapy, psychological testing, counseling, group therapy and alcoholism or drug rehabilitative programs.

Benefits are not provided for:

(1) Encounter and self-improvement group therapy.

(2) Custodial care related to intellectual disability and other intellectual deficiencies.

(3) School related behavioral problems.

(4) Services by private teachers.

(5) Alcoholism and drug rehabilitation if an advance determination has not been made that the Beneficiary is a good candidate for rehabilitation.

(6) Alcoholism and drug rehabilitation programs not approved by Medicare, certified or licensed by the applicable state, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or otherwise authorized by law.

8. Co-Payments and Deductibles

The benefits provided in this Plan shall be subject to the co-payments and deductibles set forth below and such co-payments and deductibles shall be the responsibility of the Beneficiary. The Plan Administrator shall implement such procedures as deemed appropriate to achieve the intent of these co-payments and deductibles. Beneficiaries and providers shall provide such information as the Plan Administrator may require to effectively administer these co-payments and deductibles, or such Beneficiaries or providers shall not be eligible for benefits or payments under this Plan. Any overpayments made to a provider who overcharges the Plan in lieu of collecting the applicable co-payment or deductibles from a participant or Beneficiary shall be repaid to the Plan Administrator by such provider.

Co-payments and deductibles for covered Health Benefits are established below.

Participating Provider Lists (PPL's) implemented by the Plan pursuant to Article V may include participating hospitals, physicians, pharmacies and other providers. The Plan payment for non-emergency hospital and related benefits provided from a non-PPL source will be limited to 90% of the amount that would have been paid by the Plan if the benefit had been provided by a provider on a PPL (or actual charges, if less). If a provider then bills the Beneficiary for any remaining amount, the protections of subsection 10.h.(2) (Hold Harmless) will not apply until the non-PPL out-of-pocket maximum is reached. In any case where a non-PPL provider is treated as being within the PPL pursuant to the provisions of the Plan's managed care and cost containment programs incorporated by reference in Article V herein, the Beneficiary will be responsible for the co-payment that would apply to a PPL service. The Plan will pay the provider at no greater than the PPL rate, and the protections of subsection 10.h.(2) (Hold Harmless) will apply.

If an Employee or Pensioner is covered under this Plan and an Employer Plan (established pursuant to the Wage Agreement) by more than one signatory Employer during a calendar year, the total co-payments and deductibles made and documented by the Employee or Pensioner during such calendar year shall be counted toward the out-of-pocket maximum in the same manner as if they had been made under a single plan.

The following co-payments and deductibles are required under this Plan:

Out-of-PPL Costs

a. **Hospitalization**--Benefits for inpatient treatment by a non-PPL hospital are paid at 90% of the in-PPL rates. The Beneficiary is responsible for the remainder of the charges. Benefits for emergency care provided at a non-PPL hospital are paid at the PPL rate.

b. **Doctor Visits**--Each office visit to a non-PPL physician is subject to a \$35.00 copayment.

Prescription Drugs--Prescription drugs will be provided through the PPL at a copayment of \$20.00 per 30-day supply. Prescriptions bought Out of PPL are subject to a \$35.00 copayment per 30-day supply. Mail order prescription drugs, where available in PPL, will be subject to a \$10.00 copayment per 30-day supply. (See chart below.) The co-payment for a 90-day supply shall be three times the 30-day supply co-payment.

The required co-payments are:

	In-PPL	Out-of-PPL
Prescription Drugs 30-Day Supply	\$20.00 per prescription	\$35.00 per prescription
Prescription Drugs--Mail Order (where available) 30-Day Supply	\$10.00 per prescription	N/A
Prescription Drugs--Brand Name Where Generic is Available 30-Day Supply	\$20.00 Plus Additional Cost of Brand Name Drug	\$35.00 Plus Additional Cost of Brand Name Drug
Physician Charges	\$25.00 per office visit	\$35.00 per office visit
Hospital and Related Charges	\$25.00 per hospitalization	\$35.00 per hospitalization plus balance over 90% of PPL charges. \$25.00 per hospitalization resulting from a medical emergency.

Deductibles -- In addition to these co-payments, each family shall be responsible for an annual medical care deductible of \$300.00 per family, of which \$150.00 applies to physician and other non-hospital medical provider charges (including tests, lab work, etc.), and \$150.00 applies to hospital and related charges incurred by a hospital, clinic or similar institution (including tests, lab work, etc.). The deductible excludes the cost of prescription drugs, which are covered by a separate out-of-pocket maximum of \$1,000.00 per family per year as set forth below.

In addition:

- a. No family will have to pay more than \$1,000.00 in combined Physician office visits and Hospital and Related Charges in any year.
- b. No family will have to pay more than a Maximum Out-Of-Pocket of \$2,000.00 in combined Hospital and Related Charges, Physician office visits, and Prescription Drug Charges in any year.
- c. No family will have to pay more than \$1,000.00 in prescription drugs in any year.
- d. Emergency Room visits are subject to a \$35.00 copayment.
- e. Preventive care and preventive services meeting one of the requirements of Article IV. A.3.o.(9) are covered benefits and are not subject to any deductible or copayment when provided in-PPL:

For prescription drugs, the Trustees have implemented a formulary list of preferred drug products (PDP), subject to requirements set forth in Article V herein. If a Beneficiary fails to use a PDP, the following surcharges will apply:

Non-PDP surcharge:	Initial Prescription:	None
	First Refill:	\$10.00
	Second and Subsequent Refills:	\$20.00

Notwithstanding the foregoing, Beneficiaries may file an appeal to request that they be permitted to use a non-PDP drug and not pay a surcharge. If a Beneficiary fills a prescription for a non-PDP drug, a communication will be sent by the Plan to both the physician and the individual outlining the appeal process and the surcharge for additional purchases. If no appeal is received within 30 days, the next refill of the drug will be subject to a \$10.00 surcharge, and each following refill of that drug will be subject to a \$20.00 surcharge. If an appeal is filed, surcharges are suspended for 60 days, or until the date of the resolution of the appeal, if later.

If a Beneficiary uses a brand-name drug where a generic equivalent is available, the following shall apply:

In addition to the co-payment, the Beneficiary is responsible for the additional cost of the brand name drug over the cost of the generic substitute. A generic drug will not be considered “available” unless it has been approved by the federal Food and Drug Administration. In addition, if the prescribing physician determines that use of a brand name drug is medically necessary, the generic drug will not be considered “available,” and there will be no additional payment by the beneficiary for the use of the brand name drug.

For Out-of-PPL services, claim forms will be available at most hospitals, clinics, and physician offices. Generally, nothing more is required than signing the forms authorizing the hospital, clinic, or physician to bill the Plan for the services rendered. The Plan will keep individual records for each Beneficiary and dependent and will notify the Beneficiary of the co-payments and deductibles credited to his account. The hospital, clinic, or physician will bill the Beneficiary for the co-payment and deductible amount until the maximum is reached. In some instances, when the Beneficiary pays for services or drugs, the bills should be obtained and submitted with the claim form according to the instructions on the form. If the annual deductible and co-payment maximum has been reached, the Plan will remit to the Beneficiary the full payment for covered benefits.

When the non-PPL out-of-pocket maximum has been reached, the Plan will pay at no greater than the PPL rate for a covered benefit provided from a non-PPL source, but Hold Harmless protections will apply.

Covered drug prescriptions may be filled at drugstores, clinics and hospital prescription offices.

In an effort to address the problems generated by the ever-increasing cost of prescription drugs, while recognizing the importance of prescription drugs and their value in managing Beneficiary health care, and while maintaining a high level of benefits, the parties have mutually agreed to adopt managed care and cost containment programs as described in Article V herein.

9. **Vision Care Program**

a. **Benefits Provided.**

Benefits	Actual Charge Up To Maximum Amount	Frequency Limits
Vision Examination	\$30.00	Once every 12 months
Per Lens (Maximum = 2)		
Single vision	\$20.00	Once every 12 months
-- Bifocal	\$27.50	Once every 12 months
-- Trifocal	\$32.50	Once every 12 months
-- Lenticular	\$65.00	Once every 12 months
-- Contact	\$115.00	Once every 12 months when provided in lieu of frames and lenses
-- Frames	\$40.00	Once every 24 months

Note: The 12-month period shall be measured from the date the examination is performed or from the date the lenses or frames are ordered, respectively, even if the last examination occurred during a prior Wage Agreement.

b. **Lenses** will not be covered unless the new prescription differs from the most recent one by an axis change of 20 degrees or .50 diopter sphere or cylinder change and the lenses must improve visual acuity by at least one line on the standard chart.

c. **Exclusions include:**

- (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), 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 worker's 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.

The exclusions in c. above shall not be read to limit or exclude coverage that may be contained elsewhere in the Plan.

10. **General Provisions**

a. **HMO Election**

Any Beneficiary as described in Article III 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 HMO's; provided, however, that all Beneficiaries in a family shall be governed by an HMO election.

If the monthly charge made by the HMO exceeds the monthly cost of this Plan to the Employer, the excess charge shall be paid by the Beneficiary.

b. **Administration**

The Trustees are authorized to promulgate rules and regulations to implement the Plan, and such rules and regulations shall be binding upon all persons dealing with and Beneficiaries claiming benefits under this Plan. Precedent under the resolution of disputes mechanism previously in place shall remain in effect.

c. **Services Rendered Outside the United States**

Benefits are provided for health care rendered outside of the United States on the same basis as if such care had been rendered in the United States. (The Eligible 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.)

d. **Medicare**

(1) For Pensioners, and surviving spouses, the benefits provided under the Plan will not be paid to a Beneficiary otherwise eligible if such Beneficiary is eligible for Hospital Insurance coverage (Part A) of Medicare where a premium is not required and/or Medical Insurance coverage (Part B) of Medicare unless such Beneficiary is enrolled for each part of Medicare for which such Beneficiary is eligible. Any such Beneficiary who is enrolled in

a Medicare program shall receive the benefits provided under the Plan only to the extent such benefits are not provided for under Medicare.

(2) For Employees age-eligible for Medicare, the benefits provided under the Plan will be paid to a Beneficiary unless the company is furnished written notice of electing coverage under Medicare rather than coverage under the Plan. Alternatively, the participant may elect to enroll for Medicare as secondary payer.

The Plan Administrator shall give written notification of the obligation to enroll with respect to (1) above and of the options to enroll with respect to (2) above. For active Employees such notice shall be given prior to their Medicare-eligibility birthdays, but subsequent to their immediately preceding birthdays. Said notice shall explain the limited annual enrollment period and the effect of failing to enroll if retirement should occur prior to the next enrollment period. Failure to provide such notification shall not remove any obligation to enroll.

e. Subrogation

The Plan does not assume primary responsibility for covered medical expenses which another party is obligated to pay or which another insurance policy or other medical plan covers. Where there is a dispute between the carriers, the Plan shall, subject to provisions (1) and (2) immediately below, pay for such covered expenses but only as a convenience to the Beneficiary eligible for benefits under the Plan 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 or carrier.

Obligations to pay benefits on behalf of any Beneficiary shall be conditioned:

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

(2) upon such Beneficiary 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.

f. Non-Duplication

The health benefits provided under this Plan are subject to a non-duplication provision as follows:

(1) 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:

(i) does not include a coordination of benefits or non-duplication provision, or

(ii) includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.

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

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

(ii) Where both plans cover the patient as a dependent, the plan of the parent or step-parent whose birthday occurs earlier in the calendar year will be the primary plan.

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

(iv) In the event a Pensioner or surviving spouse is covered under another group plan by reason of his or her employment, the other group plan shall be the primary plan for such Pensioner or surviving spouse and their eligible dependents.

(3) 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 of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

(4) 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.

(5) For the purpose of this provision the Plan Administrator may, without consent or notice to any Beneficiary, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expense and benefits.

(6) Any Beneficiary claiming benefits under this Plan must furnish the Plan Administrator such information as may be necessary for the purpose of administering this provision.

g. Recovery of Family and Medical Leave Act Premium

The Employer may in its sole discretion recover the premium that it paid for maintaining coverage during a leave under section 102 of the Family and Medical Leave Act of 1993, if:

(i) the Employee fails to return to work after the period of leave to which the Employee is entitled has expired; and

(ii) the Employee fails to return to work for a reason other than

(1) the continuation, recurrence, or onset of a serious health condition of the Employee,

(2) the need of the Employee to care for the Employee's Spouse, son, daughter, or parent due to the continuation, recurrence, or onset of a serious health condition of such individual, or

(3) other circumstances beyond the control of the Employee.

The Employer may in its sole discretion require a certification of a health provider attesting to the existence of the factors set forth in (1) or (2), above.

h. Explanation of Benefits (EOB) and Hold Harmless

(1) Each Beneficiary shall receive an explanation of billing and payment rendered on behalf of such Beneficiary. Should full payment for a service be denied because of a charge that has been determined by the Plan Administrator to be in excess of the reasonable and customary charge, the UMWA may request that a copy of such EOB shall be forwarded to the UMWA (International Headquarters, Attention: Benefits Department).

(2) The Plan and the UMWA agree that excessive charges and escalating health costs are a joint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, 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 commenced 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. The "hold harmless" protections available under this subparagraph do not apply in the case of any service or supply obtained from a non-PPL source until the non-PPL out-of-pocket maximum is reached.

11. General Exclusions

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

(1) 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.

- (2) 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 as set forth in Article IV.A.2.a. and IV.A.3.i.
- (3) 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.
- (4) Services furnished by tax supported or voluntary agencies.
- (5) Immunizations provided by local health agencies.
- (6) 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.
- (7) Private duty nursing. If necessary to preserve life and certified as medically necessary by the attending physician and an Intensive Care Unit is unavailable, benefits are provided for private duty nursing services 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.
- (8) Custodial care, convalescent or rest cures.
- (9) 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.
- (10) Charges for private room confinement, except as specifically described in the Plan.
- (11) Services for which a Beneficiary is not required to make payment.
- (12) Excessive charges.
- (13) Charges related to gender transition services unless required by law.
- (14) Charges for reversal of sterilization procedures.
- (15) Charges in connection with a general physical examination, other than as specified in this Plan.

(16) Inpatient confinements solely for diagnostic evaluations which can be provided on an outpatient basis.

(17) Charges for medical services for inpatient or outpatient treatment for intellectual disability and other intellectual deficiencies.

(18) Finance charges in connection with a medical bill.

(19) Dental services except for covered dental services for active employees.

(20) Birth control devices and medications, except preventive care and preventive services meeting one of the requirements of subpart A.3.o.(9) of this Article.

(21) Abortion, except as specifically described in the Plan.

(22) Eyeglasses or lenses, except when medically required because of surgically caused refractive errors or as otherwise provided in section A.9.

(23) Exercise equipment.

(24) Charges for treatment with new technological medical devices, therapy which are experimental in nature.

(25) 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.

(26) Charges for an autopsy or post mortem surgery.

(27) Any types of services, supplies or treatments not specifically provided by the Plan.

(28) Any claim which is submitted for payment under the Plan after twelve (12) months or more from the date of service.

(29) Expenses incurred as a result of injury sustained by the covered individual who is actually operating any motor vehicle used for ground transportation with a blood alcohol level over the legal limit prescribed by the laws of the state in which the injury was sustained.

(30) Any condition, disability or expense incurred by a covered individual resulting from or sustained as a result of a felonious act by that covered individual; provided that this exclusion will not apply if the injury resulted from a medical condition or act of domestic violence.

12. **Health Benefit Provisions**

a. **Newborns' and Mothers' Health Protection Act**

The Plan shall provide maternity care benefits in accordance with the Newborns' and Mothers' Health Protection Act (the "Newborn's Act"). The Plan 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 from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours.)

b. **Mental Health Parity and Addiction Equity Act**

The Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Internal Revenue Code Section 9812 and ERISA Section 712, and the regulations thereunder.

(1) **Lifetime or Annual Dollar Limits.** The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(2) **Financial Requirement or Treatment Limitations.** The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

(3) **Criteria for medical necessity determinations.** The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

c. **Women's Health and Cancer Rights Act**

Medical and surgical benefits provided for mastectomies under the Plan will be provided in accordance with the Women's Health and Cancer Rights Act of 1998 (the "Women's Health Act"). In accordance with the Women's Health Act, coverage will be provided for the following: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and coverage for any complications in all stages of mastectomy, including lymphedema.

d. Compliance with GINA

The Plan shall be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act of 2008.

e. Patient Protections

To the extent applicable, group health coverage under the Plan shall comply with the patient protections regarding your choice of health care professionals and emergency care services under the Public Health Services Act §2719A.

f. No Lifetime or Annual Limits

The Plan shall not impose a lifetime or annual limit on the dollar value of Essential Health Benefits under any medical benefits available under the Plan unless the medical benefit is an Excepted Benefit (as defined under the Affordable Care Act) to which the Affordable Care Act does not apply.

“Essential Health Benefits” are health-related items and services that fall into the following categories, as defined in §1302 of the Affordable Care Act, and further determined by the Secretary of Health and Human Services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits under the Affordable Care Act, the Plan has chosen Ohio as its benchmark state.

g. No Preexisting Condition Exclusions

The Plan shall not impose a preexisting condition exclusion on any medical benefits available under the Plan.

h. No Rescission of Coverage

The Plan shall not cancel nor discontinue medical benefits under the Plan with a retroactive effect with respect to a Beneficiary except in the event of fraud or intentional misrepresentation.

i. Coverage of Clinical Trials

The Plan shall not deny a Beneficiary the right to participate in an approved clinical trial for which such Beneficiary is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A Beneficiary who is participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial. For purposes of this provision, the terms “qualified individual,” “life threatening disease or condition,” “approved clinical trial” and “routine patient costs” shall have the same meaning as found in § 2709 of the Public Health Services Act.

j. Claims and Appeals Procedures

Beneficiaries shall be provided benefits as set forth in the Plan. Beneficiaries seeking benefits under the Plan shall follow and comply with the procedures established herein. In general, for in-PPL services, no claim forms will be required. The in-PPL provider generally will be responsible for the submission of claims and other paperwork. For out-of-PPL services, claim forms generally will be available at most hospitals, clinics, and physician offices. For both in-PPL and out-of-PPL services, the hospital, clinic, or physicians’ office will bill the Beneficiary for the co-payment and deductible until the maximum is reached.

If a Beneficiary is requesting reimbursement for a covered expense paid by the Beneficiary, the Beneficiary must first seek to resolve the matter with the applicable Provider. All other claims for covered benefits must also be submitted first to the Provider. If the matter is not resolved by the Provider, the Beneficiary must file a claim with the Plan Administrator. All claims must be filed with the Plan Administrator within twelve (12) months of the date of service. Any claim that is submitted for payment under the Plan after twelve (12) months or more from the date of service is untimely and shall be denied.

Beneficiaries shall be reimbursed for benefits as set forth in the Plan or Summary Plan Description (“SPD”), as applicable. Beneficiaries seeking benefits under this Plan shall follow the claims procedures established for that particular benefit by the SPD. Such claims and appeals procedures shall comply with the requirements of ERISA Section 503 and the Affordable Care Act (including external review rights) and shall be performed by an appeals administrator named in the SPD.

B. General Provisions

1. COBRA Continuation Coverage

Notwithstanding the foregoing, this Plan shall comply with the health care continuation coverage provisions of Sections 601-608 of ERISA and Section 4980B of the Internal Revenue Code. The Plan Administrator shall include appropriate language explaining the Employees', Beneficiaries' and Pensioners' rights under COBRA in the next Summary Plan description booklet distributed.

2. Qualified Medical Child Support Orders.

The Plan shall comply with the provisions of Section 609 of ERISA as amended by the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993").

ARTICLE V

MANAGED CARE, COST CONTAINMENT UNDER UMWA PROGRAM OF BENEFITS

The provisions of Part I, Article V of this Plan Document, entitled "Managed Care, Cost Containment Under Traditional Program of Benefits," shall apply to the UMWA Program of Benefits and are incorporated by reference herein.

For the avoidance of any doubt, neither the Plan nor the UMWA shall in any way be responsible for the failure of a physician, health care facility, or other provider to satisfy any criteria set forth in the provisions incorporated by reference herein. Further, notwithstanding the implementation of any Participating Provider Lists or other managed care or cost containment rule or procedure, neither the Plan nor the Employer shall in any way be responsible for the outcome of any medical treatment or health care (or lack of such treatment or care).

ARTICLE VI

GENERAL PROVISIONS UNDER UMWA PROGRAM OF BENEFITS

1. The UMWA shall fund the benefits that are administered by the 1993 Benefit Plan for the UMWA Beneficiaries on a pay-as-you-go basis, commencing July 1, 2017, pursuant to the terms of the Participation Agreement between the UMWA and the 1993 Benefit Plan ("the Participation Agreement").

2. The eligible employees and retirees of the UMWA that participate in the Plan and who have their benefits administered by the 1993 Benefit Plan are beneficiaries of the 1993 Benefit Plan during the time their benefits are administered by the Funds and the 1993 Plan.

3. Notwithstanding any other provision of this Agreement and the Plan and Trust Documents for the 1993 Benefit Plan, all monies paid into the Plan by the UMWA pursuant to the Participation Agreement shall be separately accounted for and used by the Plan solely to pay for the provision of health benefits to the UMWA Beneficiaries (and related administrative expenses) and shall not be used for any other purpose. The assets contributed to the Plan by the UMWA pursuant to the Participation Agreement shall be used exclusively for the benefit of the UMWA Beneficiaries, shall not become part of the general assets of the 1993 Plan, and shall not be used to pay for benefits of (a) individuals whose benefits are subject to governmental transfers pursuant to Sections 402(h) and 402(i) of the Surface Mining Control and Reclamation Act of 1977, as amended ("SMCRA"), (b) retirees whose benefits are funded through collectively

bargained contributions under the NBCWA, or (c) employees or retirees who participate in the Plan pursuant to a participation agreement with a signatory Employer. The UMWA shall not be liable to pay for the benefits of any beneficiary of the Plan who is not a UMWA Beneficiary. The UMWA is not obligated to pay for any existing or future deficit of the Plan that is not based on the cost of providing benefits to the UMWA Beneficiaries.

4. Any benefits required to be provided by the UMWA to the UMWA Beneficiaries, including life insurance and accidental death and dismemberment benefits, shall remain the responsibility of the UMWA.

5. Federal transfers to the 1993 Plan pursuant to Section 402(h) and 402(i) of SMCRA, or federal transfers to the 1993 Plan pursuant to related legislation, and any earnings thereto, shall not be used to provide benefits to any UMWA Beneficiaries participating in the 1993 Plan under the Participation Agreement, or to pay any administrative costs incurred or allocated to the UMWA under the Agreement. Similarly, signatory Employer contributions and payments to the 1993 Plan pursuant to a collective bargaining agreement or participation agreement with a signatory Employer, shall not be used to provide benefits to any UMWA Beneficiaries participating in the 1993 Plan under the Participation Agreement, or to pay any administrative costs incurred or allocated to the UMWA under the Agreement. Rather, the benefits provided pursuant to the Participation Agreement, including any associated or allocated administrative costs, shall be paid solely from the amounts provided to the 1993 Plan by the UMWA pursuant to this Agreement.

6. This Plan shall be construed, regulated and administered under Federal law. Among other things, the Trustees reserve the right to modify or amend the provisions of this Plan and Program of Benefits to comply with applicable law.

7. Amendments. The UMWA Program of Benefits may be amended in writing by the UMWA as provided for under the UMWA's Participation Agreement with the 1993 Plan.

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**PART V--1993 PLAN CRIMSON OAK GROVE INDIVIDUAL EMPLOYER PROGRAM
(CRIMSON OAK GROVE IEP) OF BENEFITS**

ARTICLE I

INTRODUCTION OF CRIMSON OAK GROVE IEP PROGRAM OF BENEFITS

Part V of this Plan Document for the 1993 Benefit Plan describes the 1993 Plan Individual Employer Program of Benefits for employees of Crimson Oak Grove Resources, LLC (“Crimson Oak Grove IEP”). The purpose of this Crimson Oak Grove IEP is (a) to provide health, vision, and dental benefits to eligible active employees and their dependents of Crimson Oak Grove Resources, LLC (“Crimson Oak Grove”), and (b) to provide health and vision benefits to certain disabled miners and spouses of miners who died as a result of a mine accident, provided that Crimson Oak Grove is signatory to a Participation Agreement with the 1993 Benefit Plan. This program of benefits has been established pursuant to the provisions of Article XX of the Murray Oak Grove, LLC Wage Agreement dated April 20, 2019 and effective April 30, 2019, which was assumed by Crimson Oak Grove on December 11, 2020.

ARTICLE II

DEFINITIONS UNDER CRIMSON OAK GROVE IEP PROGRAM OF BENEFITS

The following terms shall have the meanings herein set forth:

1. “Employer” means Crimson Oak Grove Resources, LLC (“Crimson Oak Grove”).
2. “Wage Agreement” means the Murray Oak Grove Coal, LLC Wage Agreement dated April 20, 2019 and effective April 30, 2019, which was assumed by Crimson Oak Grove on December 11, 2020.
3. “Plan Administrator” shall be the Trustees of the UMWA 1993 Benefit Plan.
4. “Employee” shall mean a person working in a classified job for the Employer, eligible to receive benefits hereunder.
5. “Disabled Employee” means (a) a miner of the Employer who becomes permanently and totally disabled as a result of a mining accident occurring after April 1, 2019, and (b) the surviving spouse of a miner of the Employer who died as a result of a mine accident occurring after April 1, 2019.
6. “Beneficiary” shall mean any person who is eligible pursuant to the Plan to receive health benefits as set forth in Article III hereof.
7. “Dependent” shall mean any person described in Section C of Article III hereof.
8. “Attains the age” shall mean on or after 12:01 A.M. of the anniversary date of one’s birth.

9. “Signatory Service” shall have the meaning assigned to such term in the United Mine Workers of America 1974 Pension Plan (the “1974 Pension Plan”).

10. “Trustee” or “Trustees” shall mean the Trustees of the United Mine Workers of America Health and Retirement Funds or, as applicable, the Trustees of the UMWA 1993 Benefit Plan.

11. “UMWA” means the United Mine Workers of America.

12. “BCOA” means the Bituminous Coal Operators’ Association, Inc.

13. “Affordable Care Act” means the Patient Protection and Affordable Care Act of 2010.

14. “Effective Date” means the effective date of the Wage Agreement. Notwithstanding the forgoing, nothing herein shall require the Plan to duplicate any benefits provided by the Employer Plan maintained by the Employer pursuant to the Wage Agreement.

ARTICLE III

ELIGIBILITY UNDER CRIMSON OAK GROVE IEP PROGRAM OF BENEFITS

The persons eligible to receive the health benefits pursuant to Article IV are as follows:

A. Active Employees

Benefits under Article IV of the Crimson Oak Grove IEP shall be provided to any Employee who:

1. is actively at work* for the Employer on the Effective Date of the Wage Agreement; or

2. is on leave under section 102 of the Family and Medical Leave Act of 1993, subject to Article IV.A.10.f. herein.

3. Except as provided in subsections 2 above, any Employee of the Employer who is not actively at work* for the Employer on the Effective Date of the Wage Agreement will not be eligible for coverage under the Plan until he returns to active employment with the Employer.

4. A new Employee will be eligible for health benefits from the first day worked with the Employer.

* Actively at work includes an Employee of the Employer who was actively at work on the Effective Date and who returns to active work with the Employer two weeks after the Effective Date of the Wage Agreement, which is April 30, 2019.

B. Disabled Employees

Health benefits under Article IV of this Crimson Oak Grove IEP shall be provided to any Employee who becomes permanently and totally disabled as a result of a mine accident occurring after the Effective Date of the Wage Agreement. Upon his death, his widow will continue to be eligible for retiree medical coverage until her death or remarriage.

C. Eligible Dependents

Health benefits under Article IV of this Crimson Oak Grove IEP shall be provided to the following members of the family of any Employee receiving health benefits pursuant to sections A or B of this Article III:

1. A spouse who is living with or being supported by an eligible Employee.
2. Children of an eligible Employee who have not attained age 26;
3. A parent of an eligible Employee or spouse, if the parent has been dependent upon and living in the same household (residence) with the eligible Employee for a continuous period of at least one year;
4. Unmarried dependent grandchildren of an eligible Employee or spouse who have not attained age 22 and are living in the same household (residence) with such Employee;
5. Dependent children (age 26 or older), of an eligible Employee or spouse, who are intellectually disabled or who become disabled prior to attaining age 26 and such disability is continuous and are either living in same household with such Participant or are confined to an institution for care or treatment. Health benefits for such children will continue as long as a surviving parent is eligible for health benefits;
6. For purposes of this section C, a grandchild or parent shall be considered dependent upon an eligible Employee or spouse if such Employee or spouse provides over one half of the support to such person.

D. Surviving Spouse And Dependents Of Deceased Employees

Health benefits under Article IV of this Crimson Oak Grove IEP shall be provided to (i) any unmarried surviving spouse (who was living with or being supported by the Employee immediately prior to the Employee's death) and (ii) such spouse's surviving children as defined in subsection 2 of section C herein and such spouse's dependent children as defined in subsection 5 of section C herein, of an Employee who died as a result of a mine accident occurring on or after the effective date of the Wage Agreement while the Employee was working in a classified job for the Employer.

At the death of an Employee described in this section D, health benefits will be continued for the children until they attain age 26, even if there is no surviving spouse or if the surviving spouse dies before they attain age 26. The children of a surviving spouse eligible under this

section shall be eligible for health benefits until they attain age 26, so long as the surviving spouse is eligible for benefits.

If at the death of an Employee described in this section D, there is no surviving spouse, or if the surviving spouse dies during any period in which health benefits are being continued, such health benefits will be continued for the children during the period in which such spouse would have been eligible for health benefits but in no event beyond their attaining age 26.

Notwithstanding the above or any other provision of this Plan, if any Employee had more than one spouse prior to the Employee's death, only one surviving spouse shall be eligible for health benefits from the Plan as a surviving spouse, and only the eligible children of such a surviving spouse shall be eligible for health benefits from the Plan if they otherwise satisfy the Plan's eligibility requirements.

ARTICLE IV

BENEFITS UNDER CRIMSON OAK GROVE IEP PROGRAM OF BENEFITS

The benefits provided under this Crimson Oak Grove Individual Employer Program of Benefits are as set forth in this Article IV. Benefit payments are based on negotiated rates applicable to services provided by hospitals, physicians, pharmacies and other providers on Participating Provider Lists (PPL's) adopted under Article V herein or operating under the requirements for lists of preferred drug products (PDP's) adopted under Article V herein.

During any period when PPLs are not in effect, and for covered services and supplies not offered under a PPL (or otherwise not subject to a PPL-related benefit limit), benefit payments shall not exceed reasonable and customary charges for covered services and supplies. Covered services shall be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at the appropriate level of care, or are otherwise provided for in the Plan. 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 this 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.

Services which are not reasonable and necessary shall include, but are not limited to the following: 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 timely fashion in the patient's medical records; procedures which can be performed with equal efficiency at a lower level of care.

The benefits described in this Article are subject to any precertification, prescription drug formulary (PDP) requirements, and other utilization review requirements implemented pursuant to Article V. 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 as described in this Article IV.

A. Health Benefits

1. Inpatient Hospital Benefits

a. Semi-private room

When a Beneficiary is admitted by a licensed physician (hereinafter “physician”) for treatment as an inpatient to an Accredited Hospital (hereinafter “hospital”), benefits will be provided for semi-private room accommodations (including special diets and general nursing care) and all medically necessary services provided by the hospital as set out below for the diagnosis and treatment of the Beneficiary’s condition.

Medically necessary services provided in a hospital include the following:

- Operating, recovery, and other treatment rooms
- Laboratory tests and x rays
- Diagnostic or therapy items and services
- Drugs and medication (including take home drugs which are limited to a 30-day supply)
- Radiation therapy
- Chemotherapy
- Physical therapy
- Anesthesia services
- Oxygen and its administration
- Intravenous injections and solutions
- Administration of blood and blood plasma
- Blood, if it cannot be replaced by or on behalf of the Beneficiary

b. Intensive Care Unit -- Coronary Care Unit

Benefits will also be provided for treatment rendered in an Intensive Care or Coronary Care Unit of the hospital, if such treatment is certified as medically necessary by the attending physician.

c. Private Room

For confinement in a private room, benefits will be provided for the hospital’s most common charge for semi private room accommodations and the Beneficiary shall be responsible for any excess over such charge except that private room rates will be paid when (i) the Beneficiary’s condition requires him to be isolated for his own health or that of others, or (ii) the hospital has semi private or less expensive accommodations but they are occupied and the Beneficiary’s condition requires immediate hospitalization. Semi-private room rates, not private room rates, will be paid beyond the date a semi-private room first becomes available and the Beneficiary’s condition permits transfer to those accommodations.

d. Renal Dialysis

Benefits will be provided for renal dialysis provided that the renal dialysis therapy is administered in accordance with Federal Medicare regulations as in effect from time to time.

e. Mental Illness

Benefits are provided for a Beneficiary who is confined for mental illness in a hospital by a licensed psychiatrist on the same basis as any medically necessary hospitalization.

f. Alcoholism and Drug Abuse

Benefits are provided for a Beneficiary who requires emergency detoxification hospital care for the treatment of alcoholism or emergency treatment for drug abuse.

If treatment of a medical or mental condition is necessary following detoxification or emergency treatment for drug abuse, benefits may be provided under other provisions of this Plan and are subject to any requirements or limitations in such provisions.

See subsection 7.f. for information concerning other services related to treatment of alcoholism and drug abuse.

g. Oral Surgical/Dental Procedures

Benefits are provided for a Beneficiary who is admitted to a hospital for the oral surgical procedures described in subsection 3.e. provided hospitalization is medically necessary.

Benefits are also provided for a Beneficiary admitted to a hospital for dental procedures only if hospitalization is necessary due to a pre-existing medical condition and prior approval is received from the Plan Administrator.

h. Maternity Benefits

Benefits are provided for a female Beneficiary who is confined in a hospital for pregnancy. Such benefits will also be available for services pertaining to termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

i. General

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 United Mine Workers of America Combined Benefit Fund.

2. **Outpatient Hospital Benefits**

a. **Emergency Medical and Accident Cases**

Benefits are provided for a Beneficiary who receives emergency medical treatment or medical treatment of an injury as the result of an accident, provided that the beneficiary has acute medical symptoms and the absence of immediate medical attention could result in serious jeopardy of the individual's health or body.

b. **Surgical Cases**

Benefits are provided for a Beneficiary who receives surgical treatment in the outpatient department of a hospital.

c. **Laboratory Tests and X rays**

Benefits are provided for laboratory tests and x ray services performed in the outpatient department of a hospital which provides such services and when they have been ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

d. **Chemotherapy and Radiation Therapy**

Benefits are provided for chemotherapy treatments of a malignant disease or radiation treatments performed in the outpatient department of a hospital.

e. **Physiotherapy**

Benefits are provided for physiotherapy treatments performed in the outpatient department of a hospital. Such therapy must be prescribed and supervised by a physician.

f. **Renal Dialysis**

Benefits will be provided for outpatient renal dialysis rendered in accordance with Federal Medicare regulations as in effect from time to time.

3. **Physicians' Services and Other Primary Care**

a. **Surgical Benefits**

Benefits are provided for surgical services essential to a Beneficiary's care consisting of operative and cutting procedure (including the usual and necessary post-operative care) for the treatment of illnesses, injuries, fractures or dislocations, which are performed either in or out of a hospital by a physician.

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.

b. Assistant Surgeons

If the Beneficiary is an inpatient in a hospital, benefits will also be provided for the services of a physician who actively assists the operating physician in the performance of such surgical services when the condition of the Beneficiary and type of surgical service require such assistance.

c. Obstetrical Delivery Services

Benefits are provided for a female Beneficiary for obstetrical delivery services (including pre and post-natal care) performed by a physician. Benefits will also be provided if such delivery is performed by a midwife certified by the American College of Nurse Midwifery and licensed where such licensure is required.

Such benefits will also be provided for termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

d. Anesthesia Services

Benefits are provided for the administration of anesthetics provided either in or out of the hospital in surgical or obstetrical cases, when administered and billed by a physician, other than the operating surgeon or his assistant, who is not an employee of, nor compensated by, a hospital, laboratory or other institution; or by a nurse anesthetist.

e. Oral Surgery

Benefits are not provided for dental services, except for dental services for active employees as described below in Article IV. D. Benefits are provided to active employees and Pensioners for 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
- Dental services required as the direct result of an accident

f. Surgical Services Limitations

Benefits are not provided for certain surgical services without prior approval of the Plan Administrator. Such surgical procedures include, but are not limited to, the following:

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 government programs
Organ transplants

g. In-hospital Physicians' Visits

If a Beneficiary is confined as an inpatient in a hospital because of an illness or injury, benefits are provided for in-hospital visits by the physician in charge of the case. Such benefits will also be provided concurrently with benefits for surgical, obstetrical and radiation therapy services when the Beneficiary has 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.

h. Home, Clinic, and Office Visits

Benefits are provided for services rendered to a Beneficiary at home, in a clinic (including the outpatient department of a hospital) or in the physician's office for the treatment of illnesses or injuries, if provided by a physician.

i. Emergency Treatment

When provided by a physician, benefits are provided for a Beneficiary who receives outpatient emergency medical treatment or treatment of an injury as the result of an accident, provided that the individual has acute medical symptoms and the absence of immediate medical attention could result in serious jeopardy of the individual's health or body.

j. Laboratory Tests and X rays

Benefits will be provided for laboratory tests and x rays performed in a licensed laboratory when ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

Such benefits 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.

k. Radiation and Chemotherapy Benefits

Benefits are provided for treatment by x ray, radium external radiation or radioactive isotope (including the cost of materials unless supplied by a hospital), provided in or out of a hospital, when performed and billed by a physician.

When a Beneficiary's condition requires radiation therapy services in conjunction with medical, surgical or obstetrical services, benefits will be provided for such radiation therapy in addition to the payment for such other types of covered services if the physician performing the radiation therapy services is not the same physician who performs the medical, surgical or obstetrical services.

Benefits are provided for treatment of malignant diseases by chemotherapy provided in or out of the hospital when prescribed and billed by a physician.

l. Medical Consultation

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 by a Beneficiary.

m. Specialist Care

Benefits will be provided for treatment prescribed or administered by a specialist if the treatment is for illness or injury which falls within the specialist's area of medical competence.

n. Primary Care Podiatrists' Services

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.

o. Primary Medical Care Miscellaneous

(1) Benefits are provided for care of newborn babies and routine medical care of children prior to attaining age 6, subject to the requirements of subsection (9) below regarding preventive services.

(2) Benefits are provided for immunizations, allergy desensitization injections, pap smears, screening for hypertension and diabetes, and examinations for cancer, blindness, deafness, and other screening and diagnostic procedures when medically necessary.

(3) Subject to the requirements of subsection (9) below regarding preventive services, benefits are provided for physical examinations when certified as medically necessary by a physician. Medically necessary will mean that a Beneficiary (i) has an existing medical condition under treatment by a physician, (ii) has attained age 55, (iii) is undergoing an annual or semi-annual routine examination by a gynecologist or (iv) is

undergoing a routine examination prescribed by a specialist as part of such specialist's care of a medical condition.

(4) Benefits are provided for "physician extender" care or medical treatment administered by nurse practitioners, physician's assistants or other certified or licensed health personnel when such service is rendered under the supervision of a physician.

(5) Benefits are provided for a nominal fee covering instruction in preparation for natural childbirth, if rendered in a hospital or clinic.

(6) Benefits are provided for family planning counseling when rendered by a physician or by other appropriately trained and supervised health care professionals.

(7) Benefits are provided covering artificial insemination if the service is provided by a licensed gynecologist.

(8) Benefits are provided for sterilization procedures if such procedures are performed by a physician.

(9) Preventive care and preventive services meeting one of the following requirements are covered benefits and will not be subject to any deductible or copayment when provided in-PPL:

(i) Evidenced-based items or preventive services, including various types of screenings (e.g., blood pressure screenings, cholesterol screenings, various STD screenings, diabetes screening, depression screenings, tobacco use counseling, breast cancer screenings, genetic counseling, and BRCA testing) with an "A" or "B" rating recommended by the United States Preventive Services Task Force (USPSTF), an independent panel of scientific experts;

(ii) Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, such as periodic tetanus shots or other vaccinations for diseases like polio, chickenpox, measles, whooping cough and hepatitis;

(iii) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents, such as regular pediatrician visits, vision and hearing screening, developmental assessments and screening and counseling to address obesity; and

(iv) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA for women, including FDA-approved contraceptives and contraceptive counseling, as well as well-woman visits, domestic violence screening and counseling, HIV and other sexually transmitted disease counseling and breastfeeding support, supplies and counseling.

p. **Services Not Covered**

- (1) Services rendered by a chiropractor or naturopathic services.
- (2) Acupuncture therapy.
- (3) Home obstetrical delivery.
- (4) Telephone conversations with a physician in lieu of an office visit.
- (5) Charges for writing a prescription.
- (6) Medications dispensed by other than a licensed pharmacist.
- (7) Charges for medical summaries and medical invoice preparations.
- (8) Services of any practitioner who is not legally licensed to practice medicine, surgery, or counseling except as specifically provided herein.
- (9) Cosmetic surgery, unless pertaining to surgical scars or to correct results of an accidental injury or birth defects.
- (10) Physical examinations, except as specifically provided herein.
- (11) Removal of tonsils or adenoids, unless medically necessary.

4. **Prescription Drugs**

a. **Benefits Provided**

Benefits are provided for insulin and prescription drugs (only those drugs which by Federal or State law require a prescription) dispensed by a licensed pharmacist and prescribed by a (i) physician for treatment or control of an illness or a non-occupational accident or (ii) licensed dentist for treatment following the performance of those oral surgical services set forth in 3.e.

The initial amount dispensed shall not exceed a 90-day supply. Any original prescription may be refilled for up to twelve months as directed by the attending physician. Each such refill may be for an amount up to, but no more than, a 90-day supply. Benefits for refills beyond twelve months require a new prescription by the attending physician. Prescriptions filled by the Plan's mail order provider, if any, are not subject to the limits on quantity set forth in this paragraph.

Reasonable charges for prescription drugs or insulin are covered benefits. Reasonable charges will consist of the lesser of:

- (1) The amount actually billed per prescription or refill;

(2) The price of the applicable generic substitution drug, if AB or better-rated, approved by the federal Food and Drug Administration; or, in the event the prescribing physician determines that use of a brand name drug is medically necessary, the price of such brand name drug; or

(3) The current price paid to participating pharmacies in any prescription drug program established by the Plan.

However, except as provided otherwise in this Plan, in no event will a Beneficiary be responsible to pay more for a single prescription than the appropriate co-payment set forth in this Plan, plus any difference between the price of the generic and the brand name drug, where applicable.

b. Benefits Excluded

Benefits shall not be provided under subsection 4.a. herein for the following:

(1) Medications dispensed in a hospital (including take home drugs), skilled nursing facility or physician's office. (See Article IV. A.1.a. and 5.a. for benefits provided for drugs and medications during inpatient confinement in a hospital skilled nursing facility.)

(2) Prescriptions dispensed by other than a licensed pharmacist.

(3) Any medication not specifically provided for in a. above.

5. Skilled Nursing Care and Extended Care Units

a. Skilled Nursing Care Facility

Upon determination by the attending physician that confinement in a licensed skilled nursing care facility is medically necessary, to the extent that benefits are not available from Medicare or other State or Federal programs, benefits will be provided for:

(1) skilled nursing care provided by or under the supervision of a registered nurse;

(2) room and board;

(3) physical, occupational, inhalation and speech therapy, either provided or arranged for by the facility;

(4) medical social services;

(5) drugs, immunizations, supplies, appliances, and equipment ordinarily furnished by the facility for the care and treatment of inpatients;

(6) 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

(7) other health services usually provided by skilled nursing care facilities.

Benefits in a licensed skilled nursing care facility will be provided up to a maximum of 100 days for an eligible Beneficiary.

The Plan will not pay for services in a nursing care facility that is not licensed or approved in accordance with Federal Medicare and state laws or regulations, unless the service is provided by or under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results.

Exclusions: Telephone, TV, radio, visitor's meals, private room or private nursing (unless necessary to preserve life), custodial care, and services not usually provided in a skilled nursing facility are not covered under the Plan.

b. **Extended Care Units**

Benefits are provided for up to two weeks of specialized medical services and daily treatments by licensed personnel in extended care units. When medically necessary, benefit may be provided for a longer period of time, subject to approval from 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.

Exclusions:

Services, drugs or other items which are not covered for hospital inpatients; and custodial care.

6. **Home Health Services & Equipment**

a. **General Provisions**

Benefits are provided for home health services, including nursing visits by registered nurses and home health aides, and various kinds of rehabilitation therapy, subject to the following conditions and approval of the Plan Administrator.

(1) The Beneficiary must be under the care of a physician.

(2) The Beneficiary's medical condition must require skilled nursing care, physical therapy, or speech therapy at least once in a 60-day period.

(3) The physician must initiate a treatment plan and specify a diagnosis, the Beneficiary's functional limitations and the type and frequency of skilled services to be rendered.

(4) The Beneficiary must be confined to his home. The services must be provided by a certified home health agency.

Benefits will be provided for up to a maximum of 60 visits per year.

b. Physical and Speech Therapy

Benefits are provided for physical and speech therapy services at home when prescribed by a physician to restore functions lost or reduced by illness or injury. Such services must be performed by qualified personnel. When the Beneficiary has reached his or her restoration potential, the services required to maintain this level do not constitute covered care.

c. Skilled Nursing

Benefits are provided for skilled nursing care rendered by a registered nurse as a home health service when a Beneficiary's condition has not stabilized and a physician concludes that the Beneficiary must be carefully evaluated and observed by a registered nurse. The Plan Administrator may request an evaluation visit to the Beneficiary's home.

d. Medical Equipment

Benefits are provided for rental or, where appropriate, purchase of medical equipment suitable for home use when determined to be medically necessary by a physician.

e. Oxygen

Benefits are provided for oxygen supplied to a Beneficiary subject to the following conditions when ordered by the attending physician:

(1) The patient is referred to a designated pulmonary consultant for testing.

(2) Such consultant's report is submitted to the Plan Administrator with the order for oxygen.

Benefits are also provided for services of inhalation therapists in the home with the attending physician's order.

f. Coal Miners Respiratory Disease Program

Benefits are provided for services or treatments administered by personnel employed by the Coal Miners Respiratory Disease Program to a Beneficiary in such Beneficiary's home when ordered or requested by a physician, except where such benefits are available under a

governmental program and such Beneficiary is eligible, or upon application would be eligible, under such programs.

7. Other Benefits

a. Orthopedic and Prosthetic Devices

Benefits are provided for orthopedic and prosthetic devices prescribed by a physician when medically necessary.

The following types of equipment are covered:

(1) Prosthetic devices which serve as replacement for internal or external body parts, other than dental.

These include artificial eyes, noses, hands (or hooks), feet, arms, legs and ostomy bags and supplies.

(2) Prosthesis following breast removal.

(3) Leg, arm, back, and neck braces.

(4) Trusses.

(5) Stump stockings and harnesses when these devices are essential for the effective use of an artificial limb. An examination and recommendations by an orthopedic physician is required.

Note: Benefits are provided for repairs and adjustments for braces, trusses, stump stockings and harnesses as well as replacement of any of those devices which have been worn out and can no longer be repaired. Benefits will be provided for replacements for usable appliances and artificial limbs if they are needed because of a change in the Beneficiary's condition. Benefits will also be provided to cover repair and adjustment cost for appliances and artificial limbs.

If replacement of a prosthesis is required, the Beneficiary should in all cases be reevaluated by an orthopedic physician.

(6) Surgical stocking (up to two pairs per prescription with no refills) when prescribed by a physician for surgical or medical conditions. The Plan will not pay Beneficiaries for support hose, garter belts, etc.

(7) Orthopedic shoes when specifically prescribed by a physician or licensed podiatrist for a Beneficiary according to orthopedist specifications, including orthopedic shoes attached to a brace that have to be modified to accommodate the brace. Benefits will not be provided for stock orthopedic shoes.

(8) Orthopedic corrections added to ordinary shoes by a physician or licensed podiatrist. Benefits are provided for only the correction to the shoe.

b. Physical Therapy

Benefits are provided for physical therapy in a hospital, skilled nursing facility, treatment center, or in the Beneficiary's home. Such therapy must be prescribed and supervised by a physician and administered by a licensed therapist. The physical therapy treatment must be justified on the basis of diagnosis, medical recommendation and attainment of maximum restoration.

c. Speech Therapy

Benefits are provided for speech therapy rendered by a qualified licensed speech therapist if the Beneficiary is a stroke patient or has had conditions including ruptured aneurysm, brain tumors or autism and needs special instruction to restore technique of sound and to phonate, and needs direction in letter and word exercises in order to express basic needs. Benefits are also provided for speech therapy for child Beneficiaries with a speech impediment from a qualified speech therapist provided that the child cannot receive speech therapy through the public schools.

d. Hearing Aids

Benefits are provided for hearing aids recommended by a licensed otologist or otolaryngologist and a certified clinical audiologist. Such hearing aids must be purchased from a participating vendor. Benefits for necessary repairs and maintenance, except the replacement of batteries, will be provided after the expiration of the warranty period. Benefits will be provided for replacement hearing aids only if a new aid is needed because of a change in the Beneficiary's condition, or if the aid no longer functions properly. Benefits will not be provided for any fees for incorporating hearing aids into eyeglasses.

e. Ambulance and Other Transportation

Benefits are provided for ambulance transportation to or from a hospital, clinic, medical center, physician's office, or skilled nursing care facility, when considered medically necessary by a physician.

With prior approval from the Plan Administrator benefits will also be provided for other transportation subject to the following conditions:

(1) If the needed medical care is not available near the Beneficiary's home and the Beneficiary must be taken to an out of area medical center.

(2) If the Beneficiary requires frequent transportation between the Beneficiary's home and a hospital or clinic for such types of treatment as radiation or physical therapy or other special treatment which would otherwise require hospitalization, benefits will be provided for such transportation only when the Beneficiary cannot receive the needed care without such transportation.

(3) If the Beneficiary requires an escort during transportation, the attending physician must submit satisfactory evidence as to why the Beneficiary needs an escort.

f. **Outpatient Mental Health, Alcoholism and Drug Addiction**

Benefits are provided for: Psychotherapy, psychological testing, counseling, group therapy and alcoholism or drug rehabilitative programs.

Benefits are not provided for:

- (1) Encounter and self-improvement group therapy.
- (2) Custodial care related to intellectual disability and other intellectual deficiencies.
- (3) School related behavioral problems.
- (4) Services by private teachers.
- (5) Alcoholism and drug rehabilitation if an advance determination has not been made that the Beneficiary is a good candidate for rehabilitation.
- (6) Alcoholism and drug rehabilitation programs not approved by Medicare, certified or licensed by the applicable state, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or otherwise authorized by law.

8. **Co-Payments and Deductibles**

The benefits provided in this Plan shall be subject to the co-payments and deductibles set forth below and such co-payments and deductibles shall be the responsibility of the Beneficiary. The Plan Administrator shall implement such procedures as deemed appropriate to achieve the intent of these co-payments and deductibles. Beneficiaries and providers shall provide such information as the Plan Administrator may require to effectively administer these co-payments and deductibles, or such Beneficiaries or providers shall not be eligible for benefits or payments under this Plan. Any overpayments made to a provider who overcharges the Plan in lieu of collecting the applicable co-payment or deductibles from a participant or Beneficiary shall be repaid to the Plan Administrator by such provider.

Co-payments and deductibles for covered Health Benefits are established below.

Participating Provider Lists (PPL's) implemented by the Plan pursuant to Article V may include participating hospitals, physicians, pharmacies and other providers. The Plan payment for non-emergency hospital and related benefits provided from a non-PPL source will be limited to 90% of the amount that would have been paid by the Plan if the benefit had been provided by a provider on a PPL (or actual charges, if less). If a provider then bills the Beneficiary for any remaining amount, the protections of subsection 10.g.(2) (Hold Harmless) will not apply until the non-PPL out-of-pocket maximum is reached. In any case where a non-PPL provider is treated as being within the PPL, pursuant to the provisions of the managed care and cost containment programs incorporated by reference in Article V herein, the Beneficiary will be responsible for the co-payment that would apply to a PPL service. The Plan will pay the provider at no greater than the PPL rate, and the protections of subsection 10.g.(2) (Hold Harmless) will apply.

If an Employee is covered under this Plan and an Employer Plan (established pursuant to the National Bituminous Coal Wage Agreement of 2016) by more than one signatory Employer during a calendar year, the total co-payments and deductibles made and documented by the Employee during such calendar year shall be counted toward the out-of-pocket maximum in the same manner as if they had been made under a single plan.

The following co-payments and deductibles are required under this Plan:

Out-of-PPL Costs

a. Hospitalization--Benefits for inpatient treatment by a non-PPL hospital are paid at 90% of the in-PPL rates. The Beneficiary is responsible for the remainder of the charges. Benefits for emergency care provided at a non-PPL hospital are paid at the PPL rate.

b. Doctor Visits--Each office visit to a non-PPL physician is subject to a \$20.00 copayment.

Prescription Drugs--Prescription drugs will be provided through the PPL at a copayment of \$5.00 per 30-day supply. Prescriptions bought Out of PPL are subject to a \$10.00 copayment per 30-day supply. There is no copayment for mail order prescription drugs.

The required co-payments are:

	In-PPL	Out-of-PPL
Prescription Drugs 30-Day Supply	\$5.00 per prescription	\$10.00 per prescription
Prescription Drugs--Mail Order (where available) 30-Day Supply	\$00.00 per prescription	N/A
Prescription Drugs--Brand Name Where Generic is Available 30-Day Supply	\$5.00 Plus Additional Cost of Brand Name Drug	\$10.00 Plus Additional Cost of Brand Name Drug
Physician Charges	\$12.00 per office visit	\$20.00 per office visit
Hospital and Related Charges	\$00.00 per hospitalization	Balance over 90% of PPL Charges. No co-payment for hospitalization resulting from a medical emergency.

In addition:

a. No family will have to pay more than \$240.00 for in-PPL Physician office visits per year.

b. No family will have to pay more than \$1,600 in combined Out-of-PPL Hospital and Out-of-PPL Physician office visits per year.

c. Preventive care and preventive services meeting one of the requirements of Article III.A.3.o(9) are covered benefits and are not subject to any deductible or co-payment when provided in-PPL.

For prescription drugs, the Trustees have implemented a formulary list of preferred drug products (PDP), subject to requirements set forth in Article V herein. If a Beneficiary fails to use a PDP, the following surcharges will apply:

Non-PDP surcharge: Initial Prescription:	None
First Refill:	\$7.50
Second and Subsequent Refills:	\$15.00

Notwithstanding the foregoing, Beneficiaries may file an appeal to request that they be permitted to use a non-PDP drug and not pay a surcharge. If a Beneficiary fills a prescription for a non-PDP drug, a communication will be sent by the Plan to both the physician and the individual outlining the appeal process and the surcharge for additional purchases. If no appeal is received within 30 days, the next refill of the drug will be subject to a \$7.50 surcharge, and each following refill of that drug will be subject to a \$15.00 surcharge. If an appeal is filed, surcharges are suspended for 60 days, or until the date of the resolution of the appeal, if later.

If a Beneficiary uses a brand-name drug where a generic equivalent is available, the following shall apply:

In addition to the co-payment, the Beneficiary is responsible for the additional cost of the brand name drug over the cost of the generic substitute. A generic drug will not be considered “available” unless it has been approved by the federal Food and Drug Administration. In addition, if the prescribing physician determines that use of a brand name drug is medically necessary, the generic drug will not be considered “available,” and there will be no additional payment by the beneficiary for the use of the brand name drug.

For Out-of-PPL services, claim forms will be available at most hospitals, clinics, and physician offices. Generally, nothing more is required than signing the forms authorizing the hospital, clinic, or physician to bill the Plan for the services rendered. The Plan will keep individual records for each Beneficiary and dependent and will notify the Beneficiary of the co-payments and deductibles credited to his account. The hospital, clinic, or physician will bill the Beneficiary for the co-payment and deductible amount until the maximum is reached. In some instances, when the Beneficiary pays for services or drugs, the bills should be obtained and submitted with the claim form according to the instructions on the form. If the annual deductible and co-payment maximum has been reached, the Plan will remit to the Beneficiary the full payment for covered benefits.

When the non-PPL out-of-pocket maximum has been reached, the Plan will pay at no greater than the PPL rate for a covered benefit provided from a non-PPL source, but Hold Harmless protections will apply.

Covered drug prescriptions may be filled at drugstores, clinics and hospital prescription offices.

In an effort to address the problems generated by the ever-increasing cost of prescription drugs, while recognizing the importance of prescription drugs and their value in managing Beneficiary health care, and while maintaining a high level of benefits, the parties have mutually agreed to adopt managed care and cost containment programs incorporated by reference in Article V herein.

9. Vision Care Program

a. Benefits Provided.

Benefits	Actual Charge Up To Maximum Amount	Frequency Limits
Vision Examination	\$46.77	Once every 24 months
Per Lens (Maximum = 2)		
Single vision	\$23.39	Once every 24 months
-- Bifocal	\$35.09	Once every 24 months
-- Trifocal	\$46.77	Once every 24 months
-- Lenticular	\$58.47	Once every 24 months
-- Contact	\$35.09	Once every 24 months
-- Frames	\$33.13	Once every 24 months

Note: The 24-month period shall be measured from the date the examination is performed or from the date the lenses or frames are ordered, respectively, even if the last examination occurred during a prior Wage Agreement.

b. **Lenses** will not be covered unless the new prescription differs from the most recent one by an axis change of 20 degrees or .50 diopter sphere or cylinder change and the lenses must improve visual acuity by at least one line on the standard chart.

c. Exclusions include:

- (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), 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 worker's 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.

The exclusions in c. above shall not be read to limit or exclude coverage that may be contained elsewhere in the Plan.

10. General Provisions

a. Administration

The Trustees are authorized to promulgate rules and regulations to implement the Plan, and such rules and regulations shall be binding upon all persons dealing with and Beneficiaries claiming benefits under this Plan. Precedent under the resolution of disputes mechanism previously in place shall remain in effect.

b. Services Rendered Outside the United States

Benefits are provided for health care rendered outside of the United States on the same basis as if such care had been rendered in the United States. (The Eligible 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.)

c. Medicare

(1) For disabled Employees, and surviving spouses, the benefits provided under the Plan will not be paid to a Beneficiary otherwise eligible if such Beneficiary is eligible for Hospital Insurance coverage (Part A) of Medicare where a premium is not required and/or Medical Insurance coverage (Part B) of Medicare unless such Beneficiary is enrolled for each part of Medicare for which such Beneficiary is eligible. Any such Beneficiary who is enrolled in a Medicare program shall receive the benefits provided under the Plan only to the extent such benefits are not provided for under Medicare.

(2) For Employees age-eligible for Medicare, the benefits provided under the Plan will be paid to a Beneficiary unless the company is furnished written notice of electing coverage under Medicare rather than coverage under the Plan. Alternatively, the participant may elect to enroll for Medicare as secondary payer.

The Plan Administrator shall give written notification of the obligation to enroll with respect to (1) above and of the options to enroll with respect to (2) above. For active Employees such notice shall be given prior to their Medicare-eligibility birthdays, but subsequent to their immediately preceding birthdays. Said notice shall explain the limited annual enrollment period and the effect of failing to enroll if retirement should occur prior to the next enrollment period. Failure to provide such notification shall not remove any obligation to enroll.

d. Subrogation

The Plan does not assume primary responsibility for covered medical expenses which another party is obligated to pay or which another insurance policy or other medical plan covers. Where there is a dispute between the carriers, the Plan shall, subject to provisions (1) and (2) immediately below, pay for such covered expenses but only as a convenience to the Beneficiary eligible for benefits under the Plan 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 or carrier.

Obligations to pay benefits on behalf of any Beneficiary shall be conditioned:

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

(2) upon such Beneficiary 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.

e. Non-Duplication

The health benefits provided under this Plan are subject to a non-duplication provision as follows:

(1) 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:

(i) does not include a coordination of benefits or non-duplication provision, or

(ii) includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.

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

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

(ii) Where both plans cover the patient as a dependent, the plan of the parent or step-parent whose birthday occurs earlier in the calendar year will be the primary plan.

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

(iv) In the event a Pensioner or surviving spouse is covered under another group plan by reason of his or her employment, the other group plan shall be the primary plan for such Pensioner or surviving spouse and their eligible dependents.

(3) 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 of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

(4) 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.

(5) For the purpose of this provision the Plan Administrator may, without consent or notice to any Beneficiary, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expense and benefits.

(6) Any Beneficiary claiming benefits under this Plan must furnish the Plan Administrator such information as may be necessary for the purpose of administering this provision.

f. Recovery of Family and Medical Leave Act Premium

The Employer may in its sole discretion recover the premium that it paid for maintaining coverage during a leave under section 102 of the Family and Medical Leave Act of 1993, if:

(1) the Employee fails to return to work after the period of leave to which the Employee is entitled has expired; and

- (2) the Employee fails to return to work for a reason other than
 - (i) the continuation, recurrence, or onset of a serious health condition of the Employee,
 - (ii) the need of the Employee to care for the Employee's Spouse, son, daughter, or parent due to the continuation, recurrence, or onset of a serious health condition of such individual, or
 - (iii) other circumstances beyond the control of the Employee.

The Employer may in its sole discretion require a certification of a health provider attesting to the existence of the factors set forth in (i) or (ii), above.

g. Explanation of Benefits (EOB) and Hold Harmless

(1) Each Beneficiary shall receive an explanation of billing and payment rendered on behalf of such Beneficiary. Should full payment for a service be denied because of a charge that has been determined by the Plan Administrator to be in excess of the reasonable and customary charge, the UMWA may request that a copy of such EOB shall be forwarded to the UMWA (International Headquarters, Attention: Benefits Department).

(2) The Employer and the UMWA agree that excessive charges and escalating health costs are a joint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, 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 commenced 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. The "hold harmless" protections available under this subparagraph do not apply in the case of any service or supply obtained from a non-PPL source until the non-PPL out-of-pocket maximum is reached.

11. General Exclusions

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

- (1) 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.
- (2) Services rendered

- under the Plan,
- (i) prior to the effective date of a Beneficiary's eligibility
 - (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 as set forth in Article IV.A.2.a. and IV.A.3.i. herein.
- (3) 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.
 - (4) Services furnished by tax supported or voluntary agencies.
 - (5) Immunizations provided by local health agencies.
 - (6) 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.
 - (7) Private duty nursing. If necessary to preserve life and certified as medically necessary by the attending physician and an Intensive Care Unit is unavailable, benefits are provided for private duty nursing services 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.
 - (8) Custodial care, convalescent or rest cures.
 - (9) 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.
 - (10) Charges for private room confinement, except as specifically described in the Plan.
 - (11) Services for which a Beneficiary is not required to make payment.
 - (12) Excessive charges
 - (13) Charges related to gender transition services unless required by law.
 - (14) Charges for reversal of sterilization procedures.
 - (15) Charges in connection with a general physical examination, other than as specified in this Plan.

(16) Inpatient confinements solely for diagnostic evaluations which can be provided on an outpatient basis.

(17) Charges for medical services for inpatient or outpatient treatment for intellectual disability and other intellectual deficiencies.

(18) Finance charges in connection with a medical bill.

(19) Dental services except for covered dental services for active employees.

(20) Birth control devices and medications, except preventive care and preventive services meeting one of the requirements of subpart A.3.o (9) of this Article.

(21) Abortion, except as specifically described in the Plan.

(22) Eyeglasses or lenses, except when medically required because of surgically caused refractive errors or as otherwise provided in section A.9.

(23) Exercise equipment.

(24) Charges for treatment with new technological medical devices, therapy which are experimental in nature.

(25) 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.

(26) Charges for an autopsy or post mortem surgery.

(27) Any types of services, supplies or treatments not specifically provided by the Plan.

(28) Any claim which is submitted for payment under the Plan after twelve (12) months or more from the date of service.

(29) Expenses incurred as a result of injury sustained by the covered individual who is actually operating any motor vehicle used for ground transportation with a blood alcohol level over the legal limit prescribed by the laws of the state in which the injury was sustained.

(30) Any condition, disability or expense incurred by a covered individual resulting from or sustained as a result of a felonious act by that covered individual; provided that this exclusion will not apply if the injury resulted from a medical condition or act of domestic violence.

12. **Health Benefit Provisions**

a. **Newborns' and Mothers' Health Protection Act**

The Plan shall provide maternity care benefits in accordance with the Newborns' and Mothers' Health Protection Act (the "Newborn's Act"). The Plan 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 from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours.)

b. **Mental Health Parity and Addiction Equity Act**

The Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by Internal Revenue Code Section 9812 and ERISA Section 712, and the regulations thereunder.

(1) **Lifetime or Annual Dollar Limits.** The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(2) **Financial Requirement or Treatment Limitations.** The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

(3) **Criteria for medical necessity determinations.** The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

c. **Women's Health and Cancer Rights Act**

Medical and surgical benefits provided for mastectomies under the Plan will be provided in accordance with the Women's Health and Cancer Rights Act of 1998 (the "Women's Health Act"). In accordance with the Women's Health Act, coverage will be provided for the following: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and coverage for any complications in all stages of mastectomy, including lymphedema.

d. Compliance with GINA

The Plan shall be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act of 2008.

e. Patient Protections

To the extent applicable, group health coverage under the Plan shall comply with the patient protections regarding your choice of health care professionals and emergency care services under the Public Health Services Act §2719A.

f. No Lifetime or Annual Limits

The Plan shall not impose a lifetime or annual limit on the dollar value of Essential Health Benefits under any medical benefits available under the Plan unless the medical benefit is an Excepted Benefit (as defined under the Affordable Care Act) to which the Affordable Care Act does not apply.

“Essential Health Benefits” are health-related items and services that fall into the following categories, as defined in §1302 of the Affordable Care Act, and further determined by the Secretary of Health and Human Services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits under the Affordable Care Act, the Plan has chosen Ohio as its benchmark state.

g. No Preexisting Condition Exclusions

The Plan shall not impose a preexisting condition exclusion on any medical benefits available under the Plan.

h. No Rescission of Coverage

The Plan shall not cancel nor discontinue medical benefits under the Plan with a retroactive effect with respect to a Beneficiary except in the event of fraud or intentional misrepresentation.

i. Coverage of Clinical Trials

The Plan shall not deny a Beneficiary the right to participate in an approved clinical trial for which such Beneficiary is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. A Beneficiary who is participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial. For purposes of this provision, the terms “qualified individual,” “life threatening disease or condition,” “approved clinical trial” and “routine patient costs” shall have the same meaning as found in § 2709 of the Public Health Services Act.

j. Claims and Appeals Procedures

Beneficiaries shall be provided benefits as set forth in the Plan. Beneficiaries seeking benefits under the Plan shall follow and comply with the procedures established herein. In general, for in-PPL services, no claim forms will be required. The in-PPL provider generally will be responsible for the submission of claims and other paperwork. For out-of-PPL services, claim forms generally will be available at most hospitals, clinics, and physician offices. For both in-PPL and out-of-PPL services, the hospital, clinic, or physicians’ office will bill the Beneficiary for the co-payment and deductible until the maximum is reached.

If a Beneficiary is requesting reimbursement for a covered expense paid by the Beneficiary, the Beneficiary must first seek to resolve the matter with the applicable Provider. All other claims for covered benefits must also be submitted first to the Provider. If the matter is not resolved by the Provider, the Beneficiary must file a claim with the Plan Administrator. All claims must be filed with the Plan Administrator within twelve (12) months of the date of service. Any claim that is submitted for payment under the Plan after twelve (12) months or more from the date of service is untimely and shall be denied.

Beneficiaries shall be reimbursed for benefits as set forth in the Plan. Beneficiaries seeking benefits under this Plan shall follow the claims procedures established for that particular benefit by the SPD. Such claims and appeals procedures shall comply with the requirements of ERISA Section 503, the Affordable Care Act (including external review rights), and any applicable regulations.

B. General Provisions

1. Continuation of Coverage

a. Layoff

If an Employee ceases work because of layoff, continuation of health, life and accidental death and dismemberment insurance coverage is as follows:

<u>Number of Hours Worked for the Employer in 24 Consecutive Calendar Month Period Immediately Prior to the Employee's Date Last Worked</u>	<u>Continuation of Coverage</u>
2,000 or more hours	Balance of month plus 12 months
500 or more but less 2,000 hours	Balance of month plus 6 months
Less than 500 hours	30 days

b. Disability

Except as otherwise provided in Article III, section B, if an Employee ceases work because of disability, the Employee will be eligible to continue health, life and accidental death and dismemberment insurance coverage while disabled for the greater of (i) the period of eligibility for Sickness and Accident benefits, or (ii) the period as set forth in the schedule in (a) above.

c. Leave of Absence

(1) During any period for which an employee is granted an approved leave of absence for the purpose of accepting temporary employment with the United Mine Workers of America (UMWA) such Employee shall be eligible to continue health, life and accidental death and dismemberment insurance coverage for a period not to exceed 120 calendar days within any 12-month period.

(2) During any period for which an Employee is granted an approved leave of absence for any other reason, such Employee's eligibility for health, life and accidental death and dismemberment insurance coverage shall be terminated as of the day last worked and shall not be reinstated until the Employee returns to active work except as provided in subparagraph (3) below.

(3) If an Employee who is on an approved leave of absence is placed on lay off status, or would have been placed on lay off status had the Employee been actively at work, health, life and accidental death and dismemberment coverage shall be reinstated as of the effective date of lay off. Such coverage shall continue for a period determined pursuant to the provisions of paragraph a. above using the commencement date of the leave of absence in place of the date last worked for purpose of determining the number of hours worked. In no event

shall coverage under this paragraph continue beyond the balance of the month plus 12 months from the effective date of lay off. An Employee who returns to work after having been on leave of absence shall not have the period for which such Employee was on leave of absence included in the 24-calendar month period as used in paragraph a. for determining eligibility for continuation of coverage.

d. Maximum Continuation of Coverage

In no event shall any combination of the provisions of a, b, c, e or g result in continuation of coverage beyond the balance of the month plus 12 months from the date last worked.

e. Quit or Discharge

If an Employee quits (for any reason) or is discharged, health, life and accidental death and dismemberment insurance coverage will terminate as of the date last worked.

f. Other Employment

Notwithstanding the foregoing, in the event an Employee accepts employment during a period of continued coverage under paragraph a., health, life and accidental death and dismemberment insurance coverage will terminate as of the date of such employment. If, however, such employment subsequently terminates prior to the date the Employee's coverage under paragraph a. otherwise terminates, such Employee's health, life and accidental death and dismemberment insurance coverage will be reinstated following the later of (i) termination of such employment or (ii) any continued health coverage resulting therefrom, and will continue to the date such coverage under paragraph a. would have otherwise terminated. It is the obligation of the Employee to notify the Employer within 10 days by certified mail of both the acceptance and termination of such employment; failure to provide such notice will result in permanent termination of coverage. Nothing in this paragraph shall extend coverage beyond the date determined pursuant to paragraph a.

g. Article III(j) Wage Agreement

An Employee terminated under the provisions of Article III(j) of the Wage Agreement shall not be treated as a quit or discharge for purposes of continuation of coverage. Such an Employee shall be entitled to continuation of coverage on the same basis as provided for in paragraph b. above; provided, however, hours worked and the period of continuation of coverage shall be determined as of the date last worked.

h. COBRA Continuation Coverage

Notwithstanding the foregoing, this Plan shall comply with the health care continuation coverage provisions of Sections 601-608 of ERISA and Section 4980B of the Internal Revenue Code. The Plan Administrator shall include appropriate language explaining the Employees', Beneficiaries' and Pensioners' rights under COBRA in the next Summary Plan description booklet distributed.

2. **Advanced COBRA Premiums**

In the event of an economic strike at the expiration of the Wage Agreement or a reopener, the Employer will advance COBRA premiums for continued health coverage for the first 30 days of such strike. Such advanced premiums shall be repaid to the Employer by such Employees through a check off deduction upon their return to work. Should such a strike continue beyond 30 days, the Union or such Employees may elect to pay such premiums themselves.

3. **Qualified Medical Child Support Orders**

The Plan shall comply with the provisions of Section 609 of ERISA as amended by the Omnibus Budget Reconciliation Act of 1993 (“OBRA 1993”).

C. **Dental Benefits (Only for Active Employees and their Dependents)**

1. **Dental Care**

The Crimson Oak Grove IEP provides dental benefits for active Employees and their eligible Dependents at a cost to each Employee of \$2 per month payable on a payroll deduction basis, or if applicable as a reduction in the Employee’s Sickness and Accident Benefits if such Employee is disabled and receiving such Benefits during the particular month.

2. **Eligibility**

a. Dental benefits shall be provided to any Employee who has completed 6 months of classified employment with the Employer and:

b. is actively at work on the Effective Date of this Plan; or

c. is actively at work on or after the Effective Date of the Wage Agreement and is disabled and receiving or would, upon proper application, be eligible to receive Sickness and Accident Benefits pursuant to the Wage Agreement.

d. Except as provided in c. above, any Employee of the Employer who is not actively at work for the Employer on the Effective Date of this Plan will not be eligible for coverage under this Plan until the later of the date the Employee:

(1) returns to active employment with the Employer, or

(2) completes 6 months of classified employment with the Employer.

e. A new Employee will not be eligible for coverage under this Plan until such Employee completes 6 months of classified employment with the Employer

3. **Effective Date of Coverage**

Dental coverage will become effective as of the first day of the month following the date the Employee completes six months of classified employment with the Employer.

4. **Eligible Dependents**

The following individuals are also eligible for dental benefits under the Crimson Oak Grove IEP:

- a. A spouse who is living in the same household (residence) with the eligible Employee; or
- b. Children of an eligible Employee who have not attained age 26, without regard to the child's marital, student, or residential status.

The term "Dependents" does not include a person who is covered under any other group dental plan or program toward the cost of which the Employer contributes or who is covered as an Employee under this Plan.

Benefits.

a. **Payment of Benefits**

After application of a Benefit Year (October 1st--September 30th) deductible amount of \$50 for you and \$50 for each of your Dependents for other than preventive services (those procedures prefaced by an asterisk in the Schedule of Benefits), and subject to the maximums specified in this Plan, benefits are payable in accordance with the Schedule of Benefits set out in the Wage Agreement, but in no event will the benefit for a specific dental service be greater than the dentist's charge for the specific dental procedure.

b. **Maximum Benefits**

After application of the Benefit Year deductible(s) referred to in paragraph a above:

(1) The maximum benefit payable for all Covered Dental Expenses incurred during any Benefit Year (excluding orthodontic benefits which are not subject to this limitation) shall be \$1,754.50 for you and \$1,754.50 for each of your dependents on the Effective Date. Notwithstanding the foregoing, the Maximum Annual Benefits listed in this paragraph shall not be applicable to children age 18 and under.

(2) In applying the maximums referred to in (1) above, benefits for Covered Dental Expenses paid under any other group dental plan or program toward the cost of which the Employer contributes shall be considered to have been paid under this Plan.

(3) The maximum orthodontic benefit during any Benefit Year shall be \$974.37 on the Effective Date for each of your eligible Dependents prior to the attainment of age 26, with a lifetime maximum of \$2,923.09 on the Effective Date for each such Dependent.

c. **Claims Not Requiring Predetermination Of Benefits**

When Covered Dental Expenses are incurred by you or one of your Dependents for emergency treatment, routine oral examinations, X-rays, prophylaxis, fluoride treatments or a course of treatment, the charge for which is not expected to exceed \$150, predetermination of

benefits (paragraph d below) is not required. The claims administrator will make the applicable benefit payment; however, any of the dentist's charges not payable under the provisions of the Dental Benefits coverage will be your responsibility.

d. Claims Requiring Predetermination Of Benefits

If a course of treatment for you or one of your Dependents can reasonably be expected to involve dentist's charges of \$150 or more, or if a course of treatment is for orthodontia, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the claims administrator prior to the commencement of the course of treatment.

For orthodontic procedures, the treatment plan must (1) provide a classification of malocclusion; (2) recommend and describe necessary treatment by orthodontic procedures; (3) estimate the duration over which treatment will be completed; (4) estimate the total charge for treatment; and (5) be accompanied by cephalometric x-rays, study models and other supporting evidence the claims administrator may require.

As used herein "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more dentists for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

The claims administrator will notify you and your dentist of the benefits certified as payable based upon such course of treatment within 30 days of receipt of the request for predetermination, or, if such certification cannot be made within 30 days, the claims administrator will notify you why a certification has been delayed. In determining the amount of benefits payable, consideration will be given to alternate procedures, services or courses of treatment that may be performed for such dental condition in order to accomplish the desired result. The amount included as certified dental expenses will be the appropriate amount determined in accordance with the provisions of paragraph e. below, subject to the maximums set forth in paragraph b. above and the limitations set forth in paragraph f. below. If you and your dentist agree to a charge higher than the amount predetermined by the claims administrator, such excess will not be paid by the Plan and will be your responsibility.

If description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the claims administrator reserves the right to make a determination of benefits payable taking into account alternate procedures, services or courses of treatment, based on accepted standards of dental practice.

e. Covered Dental Expenses

Covered Dental Expenses are those procedures specified in the Wage Agreement incurred in connection with dental services which are performed by:

- (1) a licensed dentist practicing within the scope of his license, or

(2) a licensed physician authorized by his license to perform the particular dental services rendered but only to the extent such charges are for services and supplies customarily employed for treatment of that dental condition and only if rendered in accordance with accepted standards of dental practice.

f. **Limitations**

The following limitations apply:

(1) Routine oral examinations and prophylaxis (scaling and cleaning of teeth) are limited to not more than two in any period of 12 consecutive months.

(2) Space maintainer (a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replaces prematurely lost teeth are provided only for eligible Dependents prior to the attainment of age 26.

(3) Full mouth X-rays are limited to once in any period of 36 consecutive months and supplementary bitewing X-rays are limited to not more than two in any period of 12 consecutive months.

(4) Relining or rebasing of dentures are limited to once in any period of 36 consecutive months, provided such relining or rebasing occurs more than six months after the initial installation or replacement.

(5) Adjustments to partial or full removal dentures are limited to the first six months following the date of installation.

(6) The addition of teeth to an existing partial removable denture or to bridgework is provided only if satisfactory evidence is presented that:

(i) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or

(ii) the existing denture or bridgework cannot be made serviceable and it was installed at least five years prior to the date of its replacement; or

(iii) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

Normally, dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a Covered Dental Expense.

(7) Gold, Baked Porcelain Restorations, Crowns and Jackets -- If a tooth can be restored with a material such as amalgam, payment of the benefit, as contained in Section V, for that procedure will be made toward the charge for another type of restoration which you and your dentist may select. In such case, you are responsible for the balance of the treatment charge.

(8) Reconstruction--Payment of the benefit, as contained in Section V, will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to alter vertical dimension in restoring occlusion are provided only for eligible Dependents prior to the attainment of age 26.

(9) Partial Dentures--If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the benefit, as contained in Section V, for such procedure will be made toward a more elaborate or precision appliance that you and your dentist may choose to use; the balance of the cost remains your responsibility.

(10) Precision Attachments--Benefits will not be provided for precision attachments when used for cosmetic purposes.

(11) Dentures--If, in the provision of denture services, you and your dentist decide on personalized or specialized techniques as opposed to standard procedures, payment of the benefit, as contained in Article XXA, Section V of the Wage Agreement, for the standard denture services will be made toward such treatment and the balance of the cost remains your responsibility.

(12) Replacement of Existing Dentures or Fixed Bridgework--Replacement of an existing denture or fixed bridgework will be a Covered Dental Expense only if the existing denture or fixed bridgework is unserviceable and cannot be made serviceable. Payment of the benefit, as contained in Article XXA, Section V of the Wage Agreement, for such service will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a Covered Dental Expense only if at least five years have elapsed since the date of the initial installation of that appliance.

(13) Courses of Treatment in Progress on Effective Date of Dental Benefits:

Benefits are not provided for treatment received prior to commencement of coverage. Claims for a course of treatment which was started prior to commencement of coverage but completed while coverage is in force will be investigated to determine the amount of the entire fee which should be allocated to the treatment which was actually received while covered. Only that portion of the total fee which can be allocated to treatment received while covered will be included as a Covered Dental Expense.

g. Exclusions

Charges for the following are not covered Dental Expenses:

(1) Services other than those specifically listed in the Schedule of Benefits;

(2) Treatment by other than a licensed dentist or licensed physician, except (a) charges for scaling or cleaning of teeth and topical application of fluoride may be

performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the dentist; and (b) charges by a dental school if

- (i) the services are not experimental,
 - (ii) the dental school customarily charges for services and
 - (iii) the services are performed under the supervision of a licensed dentist;
- (3) Local infiltration anesthetic;
- (4) Substances or agents which are administered to minimize fear or charges for analgesia, unless the patient is disabled by cerebral palsy, intellectual disability or spastic disorder;
- (5) Veneers (the coating or covering of plastic or porcelain on the outside of and bonded to a crown or false tooth to cause it to blend with the color of surrounding teeth) or similar properties of crowns and pontics placed on or replacing teeth, other than the 10 upper and lower anterior teeth;
- (6) Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
- (7) Prosthetic devices (including bridges), crowns, inlays and onlays, and the fitting thereof which were ordered while the individual was not covered for Dental Benefits, or which were ordered while the individual was covered for Dental Benefits but are finally installed or delivered to such individual more than 60 calendar days after the date of termination of coverage;

As used herein “ordered” means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays and onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.

- (8) Replacement of a lost, missing or stolen prosthetic device;
- (9) Orthodontic procedures and/or treatment provided to anyone other than an eligible Dependent prior to the attainment of age 26;
- (10) Any services which are covered by any workers’ compensation laws or employer’s liability laws, or services which an employer is required by law to furnish in whole or in part;
- (11) Services rendered through a medical department, clinic or similar facility provided or maintained by the patient’s employer;

(12) Services or supplies for which no charge is made that you are legally obligated to pay or for which no charge would be made in the absence of dental expense coverage;

(13) Services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;

(14) Services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature;

(15) Services or supplies received as a result of dental disease, defect or injury resulting from the commission of a felony or due to an act of war, declared or undeclared;

(16) Services or supplies which are obtained by you or your Dependent from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body;

(17) Any duplicate prosthetic device or any other duplicate appliance;

(18) Charges for any services to the extent for which benefits are payable under any health insurance program supported in whole or in part by funds of the federal government or any state or political subdivision thereof;

(19) Sealants (materials, other than fluorides, painted on the grooves of the teeth in an attempt to prevent future decay) and for oral hygiene and dietary instruction;

(20) A plaque control program (a series of instructions on the care of the teeth);

(21) Implantology (an insert set firmly or deeply into or onto the part of the bone that surrounds and supports the teeth); and

(22) Periodontal splinting.

h. Date Expenses Are Incurred

Benefits are provided only for Covered Dental Expenses incurred on a date when coverage by the Dental Benefits provisions in this Plan is in effect for you or your Dependent who incurs such expenses. Covered Dental Expenses are considered to have been incurred on the date when the applicable dental services, supplies or treatments are received, except as otherwise provided in paragraph g.(7).

i. Dental Plan Subrogation

The Plan does not assume primary responsibility for Covered Dental Expenses which another party is obligated to pay or which another insurance policy or other dental plan covers. Where there is a dispute between the carriers, the Plan shall, subject to provisions (1) and (2)

immediately below, pay for such Covered Dental Expenses but only as a convenience to you or your Dependent 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 or carrier.

Obligations to pay benefits on behalf of you or your Dependent shall be conditioned upon you or your Dependent:

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

(2) upon you or your Dependent executing such documents as are reasonably required by the Plan Administrator, including, but not limited to, 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.

j. Non-Duplication

The Dental Benefits provided under this Plan are subject to a non-duplication provision as follows:

(1) Benefits will be reduced by benefits provided under any other group plan so that the total paid by both plans does not exceed the total reasonable cost of the procedure, including a plan of another Employer signatory to the Wage Agreement, if the other plan:

(i) does not include a coordination of benefits or non-duplication provision; or

(ii) includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.

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

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

(ii) Where both plans cover the patient as a dependent child, the plan covering the patient as a dependent child of the individual whose birthday occurs earlier in the calendar year will be the primary plan.

(iii) Where the determination cannot be made in accordance with (i) and (ii) above, the plan which has covered the patient the longer period of time will be the primary plan.

(3) As used herein, "group plan" means:

(i) any plan covering the individuals as members of a group and providing dental benefits or services through group insurance or a group prepayment arrangement; or

(ii) any plan covering individuals as employees of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

(4) 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.

(5) For the purpose of this provision the Plan Administrator may, without consent of or notice to you or your Dependent, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expense and benefits.

(6) If you or your Dependent is claiming benefits under this Plan, you or such Dependent must furnish the Plan Administrator such information as may be necessary for the purpose of administering this provision.

5. **Termination of Coverage**

If an Employee ceases active work, coverage will be terminated as set forth below:

a. **Disability**

Coverage will terminate on the date such Employee ceases to be eligible for Sickness and Accident Benefits pursuant to the Wage Agreement.

b. **Layoff**

Coverage will terminate at the end of the month in which the Employee last worked.

c. **Article III, Section (j)--Wage Agreement**

Coverage will terminate at the end of the month in which the Employee last worked, unless the Employee is eligible for Sickness and Accident Benefits pursuant to the Wage Agreement.

d. **Death Of Employee**

Coverage for the eligible Dependents of the deceased Employee will terminate at the end of the month in which the Employee died.

e. **Leave Of Absence Or Retirement**

Coverage will terminate as of the last day worked.

f. **Quit Or Discharge**

Coverage will terminate as of the last day worked.

g. **Self Pay For Continuation Coverage**

Each Employee and eligible Dependent shall have the right to self pay for continuation - coverage pursuant to the requirements of Sections 601 et seq. of the Employee Retirement Income Security Act of 1974.

6. **Schedule of Benefits**

Article XXA of the Wage Agreement sets forth a complete schedule of benefits available under this Dental Plan and is incorporated by reference herein.

ARTICLE V

MANAGED CARE, COST CONTAINMENT UNDER CRIMSON OAK GROVE IEP PROGRAM OF BENEFITS

The provisions of Part I, Article V of this Plan Document, entitled “Managed Care, Cost Containment Under Traditional Program of Benefits,” shall apply to the Crimson Oak Grove IEP Program of Benefits and are incorporated by reference herein.

For the avoidance of any doubt, neither the Plan nor the Employer shall in any way be responsible for the failure of a physician, health care facility, or other provider to satisfy any criteria set forth in the provisions incorporated by reference herein. Further, notwithstanding the implementation of any Participating Provider Lists or other managed care or cost containment rule or procedure, neither the Plan nor the Employer shall in any way be responsible for the outcome of any medical treatment or health care (or lack of such treatment or care).

ARTICLE VI

AMENDMENT AND TERMINATION OF CRIMSON OAK GROVE IEP PROGRAM OF BENEFITS

A. **Mid-Term Amendments.** The UMWA and the Employer (and its successors or assigns) 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 this Crimson Oak Grove IEP Program of Benefits, or to terminate this Crimson Oak Grove IEP Program of Benefits, by written instrument between the UMWA and the Employer, without reopening or otherwise affecting the integrity of any other provision of the 2020 Wage Agreement.

B. Post-Termination Amendments. The benefits and benefit levels under the Crimson Oak Grove IEP Program of Benefits are established only for the term of the Wage Agreement. Following termination of the Wage Agreement, this Crimson Oak Grove IEP Program of Benefits may be modified, amended, or terminated by the Employer and the UMWA, or by the Employer as permitted by law.

C. The Employer shall have sole discretion to cease using the 1993 Benefit Trust for the administration of such benefits at any time and for any reason, provided that the Employer commences the administration of such benefits through an IEP with no disruption in benefits. The Employer shall be responsible for all costs incurred by the Trust in dis-enrolling the beneficiaries from the 1993 Benefit Plan and transitioning the beneficiaries to the Employer's Individual Employer Plan.

E. The eligible beneficiaries of Employer that participate in the 1993 Plan and who have their benefits administered by the 1993 Benefit Plan shall be considered beneficiaries of the UMWA Health and Retirement Funds and the 1993 Benefit Plan and shall be subject to the terms and conditions of this Plan and the management of the Trustees of the 1993 Plan and their authorized agents.

F. Notwithstanding any other provision of the Participation Agreement between the Employer and the Plan, or the Plan and Trust Documents for the 1993 Benefit Plan, all monies paid to the 1993 Plan and Trust by the Employer pursuant to the Participation Agreement between the Employer and the Plan shall be separately accounted for and used by the Plan and Trust solely under the Crimson Oak Grove Individual Employer Program of Benefits to pay for health benefits for the Employer's own active Employees and eligible Disabled Employees (including their eligible dependents) and applicable administrative expenses, and shall not be used for any other purpose, including but not limited to the provision of benefits to any other persons receiving benefits from the 1993 Benefit Plan. The assets contributed to the Plan and Trust by the Employer pursuant to the Participation Agreement shall be used exclusively for the benefit of eligible active Employees and Disabled Employees of the Employer, shall not become part of the general assets of the 1993 Plan and Trust, and shall not be used to pay for benefits under the Traditional Program of Benefits, the Post-Legislative Program of Benefits, the IEP Program of Benefits, or the UMWA Program of Benefits. The Employer shall not be liable to pay for the benefits of any beneficiary of the Plan and Trust who is not the Employer's own active Employee or eligible Disabled Employee (or their dependents). The Employer is obligated to pay for its own Employees and eligible Disabled Employees under the Crimson Oak Grove Individual Employer Program of Benefits but is not obligated to pay for the benefits of active Employees, Disabled Employees, and Pensioners (and their dependents) of other participating employers, and are not obligated to pay for any existing or future deficit of the 1993 Plan and Trust that is not based on the cost of providing benefits to the Employer's own active Employees and eligible Disabled Employees (including their dependents) in the Crimson Oak Grove Individual Employer Program of Benefits.

The hourly and tonnage contributions to the Plan required under the NBCWA of 2016, monies transferred to the Plan pursuant to Section 402(h) and (i) of the Surface Mining Control and Reclamation Act of 1977, as amended ("SMCRA"), and any earnings thereon, shall not be used to provide benefits to any Crimson Oak Grove IEP beneficiaries of the Employer.

G. **Applicable Law.** This Plan shall be construed, regulated and administered under Federal law. Among other things, the Trustees reserve the right to modify or amend the provisions of this Program of Benefits to the extent provisions of the Affordable Care Act are repealed, replaced or modified, or otherwise to comply with law.

[Remainder of this page intentionally left blank]

This Plan shall be construed, regulated, and administered under Federal law.

IN WITNESS WHEREOF, the Trustees of the UMWA 1993 Benefit Plan, pursuant to proper authority, have caused this Plan, established under Article XX of the National Bituminous Coal Wage Agreement of 2016 and Article XX of the 2020 Coal Wage Agreement, and in accordance with the provisions of Sections 402(h) and 402(i) of the Surface Mining Control and Reclamation Act of 1977, as amended, to be revised as of June 1, 2024 and signed on this 26 day of June, 2024.



Trustee



Trustee



Trustee



Trustee