

Summary Plan Description

UMWA 1992 Benefit Plan

November 2015

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INTRODUCTION

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

The Coal Act created two health plans, the 1992 Benefit Plan and the UMWA Combined Benefit Fund. The 1992 Benefit Plan was created to provide benefits for miners who retired prior to September 30, 1994, and their families, who are not covered by the Combined Benefit Fund, and who, based upon their age and service as of February 1, 1993, either, but for the enactment of the Coal Act, would have been eligible to receive benefits from the pre-Coal Act UMWA 1950 Benefit Plan or UMWA 1974 Benefit Plan, or are entitled to receive retiree health benefits from their last signatory employers but do not receive those benefits. The Coal Act states that participants will receive “substantially the same” health benefits as provided for previously under the UMWA 1950 and 1974 Benefit Plans, subject to managed care arrangements adopted by the Trustees to help control health care costs.

About this Booklet

This booklet is the 2015 edition of the summary plan description of the 1992 Benefit Plan. The purpose of this booklet is to explain the plan in a way that can be understood more easily than the formal language of the plan document. All final eligibility and payment decisions, however, must be made according to the language of the actual plan document, which is the sole controlling document over the plan. To request a copy of the plan document, write to the UMWA Health and Retirement Funds in Washington DC.

Certain words and phrases used in this booklet have special meanings. Most of these are technical terms and are explained in the section entitled “Terms You Should Know.” However, the words *plan* and *participant* often appear without qualifying words or phrases. When the word *plan* appears by itself, it means the 1992 Benefit Plan. When the word *participant* appears by itself, it means a person who is eligible or may become eligible to be a participant in the 1992 Benefit Plan under the provisions of the Coal Act.

References in this booklet to the United Mine Workers of America use the union’s initials, *UMWA*, as its name, and references to the UMWA Health and Retirement Funds generally use the abbreviated form the *Funds*. Also, the pronouns *he*, *his*, and *him* refer to people without regard to gender.

**Additional
Information**

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

If you have questions about the 1992 Benefit Plan, you may call the Funds' Call Center, or write, or go to the Funds' website www.umwafunds.org, or visit the Funds' main office in Washington DC. The plan is governed by the provisions of the Coal Act, the Employee Retirement Income Security Act of 1974 ("ERISA"), and by regulations issued by the U.S. Departments of Labor and Treasury under ERISA, which are subject to change.

GENERAL INFORMATION

Plan Administration

All major policy decisions for the 1992 Benefit Plan are made by the board of four trustees who are the plan administrator; this type of administration is known as trustee administration. The duties of the trustees include collecting premiums and other amounts owed the 1992 Benefit Plan, interpreting the provisions of the plan, paying benefits, and investing the assets of the trust.

As required by the Coal Act, the UMWA appoints two trustees and the Bituminous Coal Operators' Association, Inc. ("BCOA") appoints two trustees. Michael H. Holland and Carlo Tarley have been appointed by the UMWA, and Michael O. McKown and Joseph R. Reschini have been appointed by the BCOA. Mr. Holland is the chairman of the board of trustees. The trustees' address and phone number is: 2121 K Street NW Suite 350, Washington DC 20037, (202) 521-2200.

The 1992 Benefit Plan's day-to-day operations are administered by the UMWA Health and Retirement Funds ("Funds"), which is the collective name of the UMWA Combined Benefit Fund, the UMWA 1993 Benefit Plan, the 1992 Benefit Plan, the UMWA Prefunded Benefit Plan, the UMWA 1974 Pension Plan, the UMWA Cash Deferred Savings Plan of 1988 and the 2012 Retiree Bonus Account Plan. The UMWA 1974 Pension Plan is the trust that acts as the Master Administrative Entity and actually employs the staff of the Funds; the 1992 Benefit Plan contracts with the UMWA 1974 Pension Trust for administrative services, as do the other pension and benefit plans that the Funds administers.

The trustees have appointed David W. Allen, general counsel of the Funds, as agent for the service of legal process. Official court papers can be served on Mr. Allen or sent to him by mail to the extent permitted by court rules. Legal process can also be served on the trustees, who are the plan administrator. Letters to Mr. Allen and the trustees should be addressed to the Funds' office in Washington, D.C. The address and phone number for Mr. Allen and the plan administrator are: 2121 K Street NW Suite 350, Washington DC 20037, (202) 521-2200.

The 1992 Benefit Plan is independent and separate from the UMWA and bituminous coal industry employers. Created by the Coal Act, the 1992 Benefit Plan serves eligible miners who are retired or disabled and the families of those miners.

The UMWA and the BCOA, acting jointly, reserve the right at any time and from time to time to modify or amend in whole or in part any or all of the provisions of the plan, or to terminate the plan to the extent permitted by the Coal Act and other applicable law.

Funding

The method of funding the 1992 Benefit Plan was also established by the Coal Act, as amended by the Tax Relief and Health Care Act of 2006. The money to pay health benefits comes from the following sources:

- the payment of a monthly per beneficiary premium by each “last signatory operator” for each eligible beneficiary attributable to that operator under the terms of the Coal Act who is receiving benefits under the 1992 Benefit Plan;
- the provision of security (in the form of a bond, letter of credit or cash escrow) for a portion of the projected future costs to the 1992 Benefit Plan of providing health benefits for eligible and potentially eligible beneficiaries attributable to each “1988 last signatory operator;”
- annual transfers from the Abandoned Mine Reclamation Fund and the U.S. Treasury; and
- to the extent that the funding from the other funding sources is insufficient, the payment of a “backstop premium” for all eligible and potentially eligible beneficiaries attributable to a “1988 last signatory operator.”

These funds are used to pay health benefits and the cost of administering the plan. All money in excess of what is required for these purposes is invested in bonds, treasury notes or other investments.

The plan operates on a calendar year basis. The 1992 Benefit Plan’s fiscal year (also known as the “plan year”) begins on January 1 of the calendar year and ends on December 31 of the same calendar year. The Internal Revenue Service has assigned Employer Identification Number 52-1805437 to the plan’s board of trustees; the plan number is 501.

A complete list of the employers, last signatory operators and related persons that pay premiums to the plan is available for inspection at the Funds’ office in Washington DC. The Funds will also respond to written inquiries asking whether a particular employer, operator, or related person is paying premiums to the plan and will furnish the names and addresses of these upon request.

Subrogation

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

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

- (1) upon such individual taking all steps necessary or desirable to recover the costs thereof from any third party who may be obligated therefor, and
- (2) upon such individual executing documents that are reasonably required by the plan, 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, to protect and perfect the plan's right to reimbursement from the third party.

**Services
Rendered
Outside the U.S.**

Benefits are provided for health care rendered outside the U.S. on the same basis as if the health care had been rendered to the beneficiary in the U.S. The beneficiary in such a case will have to make payment of the expenses and file a claim with the trustees for reimbursement.

**Affordable
Care Act**

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

**Rights
Guaranteed By
ERISA**

ERISA is a Federal law which provides certain rights and protections to participants and requires the plan and its trustees to perform certain duties. This section describes some of the rights and responsibilities established by that law.

As a participant in the 1992 Benefit Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits
 - Examine, without charge, at the plan administrator's office and at other specified locations, such as the Funds' field offices, all documents governing the plan and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
 - Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage
 - Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Prudent Actions by Plan Fiduciaries
 - In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- Enforce Your Rights
 - If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
 - Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**HIPAA
Notice of
Privacy
Practices**

- Assistance with Your Questions
 - If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

UMWA Health and Retirement Funds' Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Funds is required by law to:

- Make sure that your protected health information is kept private;
- Give you this Notice about our legal duties and privacy practices with respect to your protected health information;
- Notify you following the breach of your unsecured protected health information; and
- Follow the terms of the Notice that is currently in effect.

**I. HOW WE MAY USE AND DISCLOSE
YOUR PROTECTED HEALTH INFORMATION**

The Funds uses and discloses protected health information for many different reasons.

Below, we describe the different categories of our uses and disclosures and give you some examples of each category. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

1. **For Treatment.** The Funds will use and disclose your protected health information as needed for professionals to treat you. For example, we may send your doctor information related to your participation in one of our programs so that your doctor can develop a treatment plan for you.

2. **Payment.** Your protected health information will be used or disclosed, as needed, to provide payment for your health care services. This may include determining your eligibility and coverage for health care services, reviewing services provided to you to determine if they were medically necessary, and performing utilization review activities, such as pre-approving services before you receive them.

For example, the Funds may review your eligibility information to determine what your Funds benefits are. We may use your protected health information to approve a hospital or nursing home stay. The Funds may also use your protected health information to obtain payment from responsible third parties.

3. **Healthcare Operations.** The Funds may use or disclose, as needed, your protected health information in order to support the business activities of the Funds' health plans. For example, we may use your claims payment records to review the quality of our claims payment operations. We may also provide your claims payment information to our accountants, attorneys, consultants and others as necessary to make sure we are complying with the laws that affect us.

We may use or disclose your protected health information for underwriting purposes, but we are prohibited from using or disclosing any of your protected health information that is genetic information for underwriting purposes.

We may disclose your protected health information to the sponsor of your plan for the proper administration of the plan.

4. **Business Associates.** The Funds contracts with service providers – called business associates – to perform various functions on the Funds' behalf. For example, the Funds may contract with a service provider to perform the administrative functions necessary to pay your medical claims. To perform these functions or to provide the services, business associates will receive, create, maintain, use or disclose protected health information but only after the Funds and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your protected health information.

5. **Other Covered Entities.** The Funds may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain health care operations. For example, the Funds may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and the Funds may disclose protected health information to

another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing, or credentialing. This also means that the Funds may disclose or share your protected health information with other health care programs or insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if you or your family members have other health insurance or coverage.

6. Health-Related Benefits and Services. We may use or disclose your protected health information to tell you about health-related benefits or services that may be of interest to you. For example, we may use your protected health information to inform you about flu shot clinics, transportation services such as van services, or health fairs. Your protected health information may be used to ensure that the proper medications are being prescribed, that emergency room visits are the appropriate level of care, and that nursing home care is medically necessary and should be utilized. We may also use your protected health information to determine if your medical conditions put you at risk for maintaining your health and independent living.

7. As Required by Law. We will use or disclose your protected health information when required to do so by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

8. For Public Health Activities. We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may notify the appropriate government authority to report child abuse or neglect.

9. For Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These activities are necessary for the government to monitor the health care system, compliance with civil rights laws, and government programs such as Medicare. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization. We may disclose your protected health information to assist government programs in their study and development of programs for senior citizens.

10. Lawsuits and Other Legal Proceedings. The Funds may disclose your protected health information in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized). If certain conditions are met, the Funds may also disclose your protected health information in response to a subpoena, a discovery request, or other lawful process.

11. **Abuse or Neglect.** The Funds may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if the Funds believes you have been a victim of abuse, neglect, or domestic violence, it may disclose your protected health information to a governmental entity authorized to receive such information.

12. **For Law Enforcement.** We may disclose your protected health information for law enforcement purposes as required by law, in response to a court order or similar process, as necessary to locate or identify a suspect, fugitive, material witness or missing person, or in response to a law enforcement official's request for information about an individual who is or is suspected of being a victim of a crime.

13. **Coroners, Medical Examiners, and Funeral Directors.** The Funds may disclose protected health information to a coroner or medical examiner when necessary for identifying a deceased person or determining a cause of death. The Funds may also disclose protected health information to funeral directors as necessary to carry out their duties.

14. **Organ and Tissue Donation.** The Funds may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

15. **Research.** The Funds may use or disclose your protected health information for research when certain requirements are met.

16. **To Individuals Involved in Your Care or Payment for Your Care.** We may disclose your protected health information to a family member, other relative, friend, or any other person that you identify who is involved in your care or the payment for your health care, unless you object to such a disclosure or expressed your preference that we not do so before your death. We may also use or disclose your protected health information to notify or assist in notifying your family, personal representative or another person responsible for your care about your general condition, location, or death.

If you are unable to agree to or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

17. **To the Funds' Trustees.** We may disclose your protected health information to the Funds' Trustees as required to administer the Funds' health plans.

18. **To Avoid Harm.** We may use or disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to prevent the threat, such as law enforcement personnel. The Funds may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

19. **Military.** Under certain conditions, the Funds may use or disclose your protected health information if you are Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, the Funds may disclose, in certain circumstances, your information to the foreign military authority.

20. **National Security and Protective Services.** The Funds may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

21. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Funds may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the correctional institution.

22. **For Disaster Relief Efforts.** We may disclose your protected health information to an entity authorized by law or its charter to assist in disaster relief efforts to notify or assist in notifying your family, personal representative or another person responsible for your care about your general condition, location, or death.

23. **For Workers' Compensation Purposes.** We may disclose your protected health information in order to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

24. **To the Secretary of the U.S. Department of Health and Human Services.** The Funds is required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Funds' compliance with the HIPAA Privacy Rule.

25. **To You.** The Funds is required to disclose to you or your personal representative most of your protected health information when you request access to this information. The Funds will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant law. Prior to such a disclosure, however, the Funds must be given written documentation that

supports and establishes the basis for the personal representation. The Funds may not elect to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subject to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or the Funds determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

ALL OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

In any other situation not described above, we will ask for your written authorization before using or disclosing any of your protected health information and will only use or disclose your protected health information with your written authorization. We are generally required to obtain your authorization before we can use or disclose your psychotherapy notes. We are also required to obtain your authorization before using or disclosing your protected health information for marketing purposes or selling your protected health information. If you choose to sign an authorization to disclose your protected health information, you can revoke that authorization at any time in writing. This will stop any future uses and disclosures to the extent that we haven't taken any action based on the authorization.

II. YOUR RIGHTS REGARDING YOUR HEALTH AND PAYMENT INFORMATION

You have the following rights:

A. The Right to See and Get Copies of Your Protected Health Information.

In most cases, you have the right to look at or get copies of your protected health information held by the Funds. You must request this information in writing. You may send your request to the Funds' Privacy Officer at the address near the end of this Notice. We will respond within 30 days of receiving your request.

In certain situations, we may deny your request. If we do, we will tell you in writing our reasons for the denial and, if applicable, explain your right to have the denial reviewed.

B. The Right to Request Limits on the Uses and Disclosures of Your Protected Health Information for Healthcare Operations Purposes.

You have the right to ask that we limit how we use or disclose your protected health information for treatment, payment, or health care operations. Restrictions may include asking that we limit how we disclose your information to persons

you identify. You may not limit the uses and disclosures that we are legally required to make.

You may send your written request to the address listed near the end of this Notice. Your written request must state the specific restriction requested and to whom you want the restriction to apply. We will consider your request, although we are not legally required to agree to it. We will try to comply with your wishes that do not impede our operations. If we accept your request, we will put any limits in writing and abide by them except in emergency situations.

C. The Right to Request Confidential Communications.

If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that the Funds communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. You may request a confidential communication using the contact information near the end of this Notice. Your request must specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger. The Funds will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you.

D. The Right to Get a List of the Disclosures We Have Made.

You have the right to get a list of instances in which we have disclosed your protected health information. The list will not include uses or disclosures made for treatment, payment or health care operations, those made directly to you, or those that you authorized. The list also will not include disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.

You may send your request to the address listed near the end of this Notice. We will respond within 60 days of receiving your request. The list we will give you includes disclosures made in the last six years unless you request a shorter time. The list will include the date of disclosure, to whom the information was disclosed (including their address if known), a brief description of the information that was disclosed, and the reason for the disclosure. We will provide the list to you at no charge.

E. The Right to Correct or Update Your Protected Health Information.

If you believe that there is a mistake in your protected health information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. You may send your written request to the address listed near the end of this Notice. We will respond within 60 days of receiving your request.

We may deny your request in writing if the information is (i) correct and complete, (ii) not created by us (unless you provide us with a reasonable basis to believe that the originator of the information is no longer available to act on your request), (iii) not allowed to be disclosed to you or your personal representative, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and our denial be attached to all future disclosures of your protected health information.

If we approve your request, we will make the change to your information, tell you that we have done it, and tell others who need to know about the change.

F. The Right to Get This Notice by E-Mail or to Receive a Paper Copy of This Notice.

You have the right to get a paper copy of this Notice, even if you have agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact the Funds using the contact information below.

III. CHANGES TO THIS NOTICE

The Funds reserves the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to the information we already have as well as any information we receive in the future. The Funds will send a revised copy of this Notice to Funds' beneficiaries within sixty (60) days of any material change to this Notice.

IV. HOW TO EXERCISE YOUR RIGHTS

You may call the Funds' Call Center at 1-800-291-1425 for assistance. The Call Center will help you determine when you need to file a written request and provide you with the correct form and instructions.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think we have violated your privacy rights, or you disagree with a decision we made about access to your protected health information, you may file a complaint with the Funds' Privacy Officer. You also may send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Avenue SW, Washington DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this Notice or any complaints about our privacy practices, contact the Funds' Privacy Officer at:

Privacy Officer
UMWA Health & Retirement Funds
2121 K ST NW Suite 350
Washington DC 20037
202-521-2200

You may also contact the Privacy Officer to find out how to file a complaint with the Secretary of the Department of Health and Human Services.

VII. EFFECTIVE DATE OF THIS NOTICE

This Notice went into effect on April 14, 2003. Revised September 20, 2013.

TERMS YOU SHOULD KNOW

<i>attains the age</i>	An individual attains an age on or after 12:01 A.M. of the anniversary date of the individual's birth.
<i>coal wage agreement</i>	The National Bituminous Coal Wage Agreement, or any other agreement entered into between an employer in the coal industry and the UMWA that required or requires one or both of the following: 1) the provision of health benefits to retirees of such employer, eligibility for which is based on years of service credited under the UMWA 1950 Pension Plan or UMWA 1974 Pension Plan, or any predecessor of those plans, or 2) contributions to the UMWA 1950 Pension Trust, the UMWA 1974 Pension Trust, the UMWA 1993 Benefit Plan, or any predecessor to those plans.
<i>copayment</i>	<p>The part of a bill for visits to physicians and for prescription drugs which the patient is required to pay. There is a \$5.00 copayment for each visit to a physician for medical care, up to a maximum of \$100.00 per family per copayment year. There is a \$5.00 copayment for each prescription filled by a pharmacy, whether the prescription is for a 30, 60 or 90 day (or fraction thereof) supply, up to a maximum of \$50.00 per family per copayment year. There is no copayment for a prescription filled through mail order service.</p> <p>In the absence of demonstrated medical necessity, if a brand name drug is prescribed where a generic equivalent is available, the participant (or dependent) is responsible, in addition to any required copayment, for the additional cost of the brand name drug over the cost of the generic substitute. For further details about the Generic Drug Substitution program, refer to page 32. You may also be responsible, in addition to the required copayment, for the additional cost of certain drugs that are not "preferred" drugs. For further details about the plan's Preferred Product Program, refer to pages 32-33 of this booklet.</p>
<i>copayment year</i>	The twelve-month period used for calculating copayment maximums. The copayment year begins on January 1 of the calendar year and ends December 31 of the same year.
<i>covered service</i>	A service that is covered under the terms of the plan, is reasonable and necessary for the diagnosis or treatment of an illness or injury and which is provided at the appropriate level of care.
<i>classified signatory service</i>	Work in a classified job for a signatory employer; it may include certain periods in which a miner received state workers' compensation or Federal black lung benefits, served in the military, worked for the UMWA, or was eligible to receive sickness and accident benefits.

<i>inpatient care</i>	The care received when a plan participant or beneficiary stays overnight in a hospital or other health care institution such as a skilled nursing care facility.
<i>last signatory operator</i>	A signatory operator that was the most recent coal industry employer of a retiree. The term includes a successor in interest of such operator.
<i>1988 agreement operator</i>	A coal industry operator that signed the 1988 National Bituminous Coal Wage Agreement or an agreement containing similar pension and health care contribution and benefit provisions or one which made such contributions during the term of the 1988 NBCWA.
<i>1988 last signatory operator</i>	The last signatory operator which is a 1988 agreement operator.
<i>outpatient care</i>	The care received when a plan participant or beneficiary is not confined overnight to a hospital or other health care institution, even if it is furnished by a facility which also provides inpatient care. Also referred to as <i>ambulatory</i> care.
<i>signatory operator</i>	A person which is or was a signatory to a coal wage agreement.
<i>surgery</i>	Any operative or cutting procedure. Copayments are not required for office visits to physicians when surgical procedures are performed (outpatient surgery).
<i>surviving spouse</i>	A widow or widower of a former miner who was eligible for health benefits at the time of the miner's death.

ELIGIBILITY FOR HEALTH BENEFITS

Eligible Beneficiaries

Under the provisions of the Coal Act, an eligible beneficiary of the 1992 Benefit Plan is any individual who (A) but for the enactment of the Coal Act would be eligible to receive health benefits from the UMWA 1950 Benefit Plan and Trust or the UMWA 1974 Benefit Plan and Trust (under the rules in effect under those Plans on January 1, 1992) based upon age and service earned as of February 1, 1993; or (B) with respect to whom retiree medical coverage is required to be provided by his last signatory operator (under section 9711 of the Coal Act) but who does not receive such coverage from such last signatory operator or any related person (without regard to whether such last signatory operator or any related person remains in business). The individual must also (1) not be eligible to receive health benefits from the UMWA Combined Benefit Fund; and (2) have retired from the coal industry on or before September 30, 1994. The individual will not be eligible to receive health benefits during any month in which such individual would be disqualified from receiving health benefits under the earnings limitation. The earnings limitation also applies to the surviving spouse.

Generally, an eligible beneficiary is someone who:

- Is receiving a disability pension under the UMWA 1974 Pension Plan with an effective date before October 1, 1994; or
- Receives a pension under the UMWA 1950 or 1974 Pension Plan (other than a deferred vested pensioner with less than 20 years of service);
- Was at least age 55 on or before February 1, 1993;
- Completed 10 or more years of classified signatory service as of February 1, 1993;
- Retired from the coal industry and filed a pension application before October 1, 1994; and
- Does not receive health benefits from his last signatory employer or any related person.

Eligible Dependents

Or, is an eligible dependent of an individual described above.

- In general, an eligible dependent is anyone who would have been an eligible dependent under the terms of the UMWA 1950 Benefit Plan or the UMWA 1974 Benefit Plan. An eligible dependent under the rules of those plans is any of the following people:
 - A spouse living with or supported by the miner.

- An unmarried, dependent natural or adopted child or stepchild under the age of twenty-two. Effective August 10, 1993, the plan covers adopted children effective at the time of placement for adoption irrespective of whether the adoption becomes "final." "Placement for Adoption" means the assumption and retention by a plan participant or beneficiary of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.
- A parent of the miner or his spouse if that parent depends upon and has lived with him for at least one year.
- An unmarried, dependent grandchild under the age of twenty-two if that grandchild lives with the retired or disabled miner.
- A dependent child of any age who is mentally retarded or who was disabled before the age of twenty-two if his disability is continuous and he lives with the miner or is confined to an institution for care and treatment.
- Surviving spouse or dependent child of a miner who died under certain circumstances. The following general rules apply:
 - When a retired or disabled miner dies while he is receiving or eligible to receive a pension from the 1950 Pension Plan or the 1974 Pension Plan, his surviving spouse will remain eligible for health benefits until remarriage; surviving dependent children will remain eligible for health benefits until the age of twenty-two, while the surviving spouse is still eligible for benefits. Surviving dependent children are not eligible for benefits as of the date of the eligible surviving spouse's death.
 - When a miner in a classified signatory job dies as the result of a mine accident that occurs after December 5, 1974, his surviving spouse will remain eligible for health benefits until remarriage; surviving dependent children will remain eligible for health benefits until the age of twenty-two.
 - When a disabled miner dies while receiving or eligible to receive sickness and accident benefits, his surviving spouse and dependent children will remain eligible for health benefits for sixty months after his death.

If an individual is an eligible beneficiary under section 9711 of the Coal Act, an eligible dependent is anyone who would have been an eligible dependent under the rules, as of January 1, 1992, set forth in the individual employer plan that was or would have been applicable to such eligible beneficiary.

Applying for Benefits

For information about health benefits for which you may be eligible, first contact the last signatory operator that you worked for in a classified job. If this company is no longer in business, maintains that it is not responsible for your retiree health benefits, or refuses to provide you with such retiree health benefits, contact the Funds' Call Center to help you apply for the health benefits which may be available from the 1992 Benefit Plan.

Right to Appeal Denial of Health Benefits Eligibility

If the Funds denies your application for health benefits from the 1992 Benefit Plan, you may ask the Funds to review its decision. The Funds will provide a detailed explanation of the reasons for the Funds' decision. If you do not fully understand the decision, you may discuss your case with a Funds' representative. You may call the Funds' Call Center at 1-800-291-1425 where a representative will answer your questions and explain how the decision was reached.

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

Health Services ID Card and Pharmacy ID Card

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

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

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

The Funds and Medicare

Under a special arrangement with the Centers for Medicare & Medicaid Services, the Funds administers Medicare benefits for Medicare Part B (physician, durable medical equipment, outpatient x-ray, and laboratory services) for 1992 Benefit Plan beneficiaries who are eligible for Medicare. This means that the Funds will pay for the portion of medical services covered by Medicare Part B and that the Centers for Medicare & Medicaid Services reimburse the Funds for those payments and for administrative expenses. Medicare coinsurance, hospital deductibles, and other charges covered by the plan but not covered by Medicare

will be paid by the Funds under provisions of the 1992 Benefit Plan including the application of copayments.

According to the terms of the arrangement between the Funds and the Centers for Medicare & Medicaid Services, the Funds is the only agency that can process and pay Medicare Part B benefits for 1992 Benefit Plan beneficiaries who are enrolled in Medicare. Your Part A Medicare benefits will continue to be processed through the Medicare intermediaries, as they have been in the past.

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

Beneficiaries are not required to enroll in Medicare Part D (prescription drug coverage). Beneficiaries who are eligible for Medicare Part D will receive a “Notice of Creditable Coverage” each year. The Notice of Creditable Coverage is proof that a beneficiary’s 1992 Benefit Plan drug coverage meets the standard set by Medicare and that the beneficiary does not need to enroll in a Medicare Part D prescription drug plan.

Appeals Procedures

Medical Care or Treatment

The 1992 Benefit Plan provides health benefits to eligible beneficiaries (see page 18) who may also be eligible for Medicare. If your claim for health benefits is denied, in whole or in part, you will receive a written explanation of the denial. If you think the decision to deny your claim is incorrect, you have the right to appeal that decision. As explained below, the timeframes for appealing a denial decision may be different depending on whether you are a Medicare-eligible beneficiary and /or whether the benefit is or is not covered by Medicare or by the 1992 Benefit Plan.

If you have any questions concerning your right of appeal, you should contact the Funds’ Call Center for more information. Remember, if a health service is denied as medically unnecessary or because it is an excessive charge, you may be held harmless by the Funds. See the section below entitled “**Hold Harmless Program**” on pages 34-35.

**Rights of
Beneficiaries
who are not
eligible for
Medicare**

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

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

- To file a request orally, call 1-800-292-2288. The Funds will document the oral request for a fast appeal in writing.
- To hand-deliver your request for appeal, our address is: KEPRO, UMWA Funds, 2170 W State Rd 434 Suite 450, Longwood FL 32779.
- To FAX your request for appeal, our number is 1-800-382-7792. If you are in a hospital or a nursing facility, you may request assistance in having your written request for a service transmitted to the Funds by use of a FAX machine.
- To mail a written request for appeal, our mailing address is: KEPRO, UMWA Funds, 2170 W State Rd 434 Suite 450, Longwood FL 32779. The 72-hour review time will not begin until your request for appeal is received.

We must make a decision on an expedited appeal within 72 hours. No extensions are permitted.

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

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

Rights of Beneficiaries who are eligible for Medicare

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

Appeal of a Denial of a Health Service

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

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

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

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

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

- To hand-deliver your appeal request, our address is: KEPRO, UMWA Funds, 2170 W State Rd 434 Suite 450, Longwood FL 32779.
- To FAX your appeal request, our number is 1-800-382-7792. If you are in a hospital or a nursing facility, you may request assistance in having your written appeal request for a service transmitted to the Funds by use of a FAX machine.
- To mail a written appeal request, our mailing address is: KEPRO, UMWA Funds, 2170 W State Rd 434 Suite 450, Longwood FL 32779. If it is a 72-hour appeal, the 72-hour review time will not begin until your appeal request is received.

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

Appeal of a Denial of Payment

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

- To request an appeal orally, call 1-800-292-2288. The Funds will document the oral appeal request in writing.
- To hand-deliver your appeal request, our address is: KEPRO, UMWA Funds, 2170 W State Rd 434 Suite 450, Longwood FL 32779.
- To FAX your appeal request, our number is 1-800-382-7792. If you are in a hospital or a nursing facility, you may request assistance in having your written request transmitted to the Funds by use of a FAX machine.
- To mail a written appeal request, our mailing address is: KEPRO, UMWA Funds, 2170 W State Rd 434 Suite 450, Longwood FL 32779.

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

**Rights of
Beneficiaries
who are not
eligible for
Medicare**

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

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

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

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

Right to File a Grievance

The Funds must notify you of its **concurrent care decision** to reduce or terminate (other than by amending or terminating the plan) any previously approved ongoing course of treatment that you are receiving over a period of time or number of treatments sufficiently in advance of the reduction or termination to allow you to appeal the concurrent care decision before the benefit is reduced or terminated. If you request the Funds to extend the course of treatment beyond the period of time or number of treatments and your claim involves urgent care (see definition above), the Funds must decide your claim as soon as possible but no later than 24 hours after the Funds receives your claim, provided that you file your claim at least 24 hours before the period of time or number of treatments would otherwise expire. If your claim is not filed at least 24 hours prior to the expiration, the Funds will have up to 72 hours to decide your claim.

As a beneficiary of the UMWA Health and Retirement Funds, you have the right to file a grievance or complaint with the Funds. A “grievance” is a complaint or dispute expressing dissatisfaction with the manner in which the Funds or certain other entities provide health care services and that may require further action on the part of the Funds. Some examples include dissatisfaction with physicians, facilities, providers, Funds’ staff or operations, or quality of care, as well as the timeliness, access, appropriateness or setting of a covered health care service or item. Grievances include complaints about an interpersonal aspect of care such as rudeness by a provider, failure to respect the rights of the beneficiary, or involuntary disenrollment of a beneficiary initiated by the Funds. If you have been denied coverage for a health claim or service, please see the “Right of Appeal” section beginning on page 21 of this document.

How to File a Grievance

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

Written complaints should be mailed to:

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

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

Often complaints result from simple misunderstandings that can be resolved informally through discussions among the parties involved. The Call Center

representative will log your call or letter and the nature of the issue and attempt to resolve the problem. If we cannot immediately resolve your concern, we will investigate it and respond to you by phone or letter within 30 calendar days unless it is necessary to take an extension of up to 14 calendar days to gather additional information/medical records and the extension of time benefits you. You will be notified in writing if the Funds needs additional time (up to 14 calendar days) to consider a grievance case.

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

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

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

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

**Continuation of
Health Benefits
Coverage
(COBRA)**

Under the provisions of COBRA, you, a retired miner, may be able to continue your health benefits coverage even if you are no longer eligible for these benefits under the 1992 Benefit Plan. It can also become available to other members of your family who are covered under the 1992 Benefit Plan when they would otherwise lose their group health coverage. This information is intended to inform you of rights and obligations under COBRA, as amended and reflected in the final and proposed regulations published by the Department of the Treasury. It reflects the law and does not grant or take away any rights under the law.

COBRA continuation coverage is a continuation of 1992 Benefit Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Your spouse and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Each person who is a qualified beneficiary with respect to the qualifying event has an independent right to elect COBRA continuation coverage. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay premiums for such coverage.

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

- Your spouse dies and you remarry or exceed the monthly earnings limitation at any time during the 36-month period following the death
- You become divorced or legally separated from your spouse

A retired miner’s dependent children (not grandchildren) will become qualified beneficiaries if they lose coverage under the 1992 Benefit Plan because any of the following qualifying events happens:

- The parents die
- The retired miner dies and the surviving spouse-parent remarries within 36 months from the date of death
- The parents become divorced or legally separated
- The child loses “dependent child” status coverage under the 1992 Benefit Plan.

Notice Requirements

The 1992 Benefit Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. A qualified beneficiary is required to provide the following notices to the plan administrator:

- (1) Notice of the occurrence of a qualifying event that is a divorce or legal separation of the retired miner from his or her spouse;
- (2) Notice of the occurrence of a qualifying event that is a qualified beneficiary’s ceasing to be covered under the plan as a dependent child;
- (3) Notice that the retired miner or surviving spouse exceeded the monthly earnings limitation.

Any notice required by (1), (2) or (3) above must be furnished to the plan administrator no later than 60 days after the latest of: (i) the date of the occurrence of the qualifying event; (ii) the date on which the qualified beneficiary loses or would lose coverage under this plan as a result of the qualifying event; or (iii) the date that the qualified beneficiary is informed, through the furnishing of the plan's summary plan description or the general COBRA notice, of both the responsibility to provide the notice and the plan's procedure for providing such notice to the plan administrator.

To notify the plan administrator of the occurrence of a qualifying event, you and/or qualified beneficiaries must request a Notice of Qualifying Event form by contacting the plan administrator in writing at: UMWA 1992 Benefit Plan, 2121 K Street NW Suite 350, Washington DC 20037; or by telephoning the Special Payments Analyst at 1-800-291-1425. The form will be provided to you and/or the qualified beneficiaries at no cost and will request information about the qualifying event for the plan to provide continuation rights to you. The Notice of Qualifying Event form must be completed in full and returned within the periods set forth in this summary plan description. Within 14 days of receipt of the Notice of Qualifying Event form, the plan administrator will send you a Notice of Right to Elect Continuation Coverage form. If continuation coverage is not elected within 60 days of the date printed on the Notice of Right to Elect Continuation Coverage form, then your right to elect COBRA continuation coverage ceases. All questions should be directed to the plan administrator at the above contact information.

Benefits That May Be Continued Under COBRA

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

Maximum Time Periods

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

<i>Qualifying Event</i>	<i>Maximum Continuation Period</i>
Divorce or legal separation	36 months
Death of a participant	36 months
Dependent child loses eligibility	36 months
Death of participant and surviving spouse	36 months

When COBRA Continuation Coverage Ends

Continued coverage will cease on the earliest of:

- (1) The last day of the 36 month period.
- (2) The date for which timely payment is not made to this plan with respect to the qualified beneficiary.
- (3) The date upon which the plan administrator ceases to provide any group health plan (including successor plans) to any participant.
- (4) The date, after the election, that the qualified beneficiary first becomes covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, if any, other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified beneficiary.

Keep Your Plan Informed of Address Changes

In order to protect your family’s rights, you should keep the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator.

Under the provisions of the Omnibus Budget Reconciliation Act of 1993, and Section 609 of ERISA, and consistent with the terms of the Coal Act, effective August 10, 1993, the plan provides benefits pursuant to the terms of “qualified medical child support orders.”

A “medical child support order” (“MCSO”) includes any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction (typically, a state court which handles domestic relations matters) which (1) provides for child support with respect to a child of a participant under the plan or provides for health benefits coverage to such a child, is made pursuant to a state domestic relations law, and relates to benefits under the plan, or (2) enforces a medical child support law related to the Medicaid program.

A “qualified medical child support order” (“QMCSO”) is a medical child support order that (A) either creates or recognizes the right of an “alternate recipient” (a participant’s child who is recognized under a MCSO as having a right to be enrolled under the plan) or assigns to the alternate recipient the right to receive benefits for which a participant or other beneficiary is eligible under the plan, and (B) includes (i) the name and last known mailing address of the participant and the name and address of each alternate recipient, (ii) a reasonable description of the type of coverage to be provided to each alternate recipient by the group health plan or the manner in which such coverage is to be determined, and (iii) the period for which coverage must be provided, and (C) does not require the plan to

provide any type or form of benefit, or any option, not otherwise provided under the plan (except to the extent necessary to meet requirements of certain laws).

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

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

**Maternity or
Newborn Infant
Coverage**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HEALTH BENEFIT PAYMENTS

Billing the Funds for Medical Services

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

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

If your provider will not bill the Funds, you must submit an itemized bill and a completed claim form. Contact the Funds' Call Center for more information about submitting such claims and for copies of the appropriate forms. A list of the addresses to which to send the forms appears at the end of this booklet on page 50.

Generic Drug Substitution Program

The plan provides that, in the absence of medical necessity, if a brand name drug is prescribed where a generic equivalent is available, you are responsible, in addition to any required copayment, for the additional cost of the brand name drug over the cost of the generic substitute. You will not have to pay the additional cost for the brand name drug if your physician demonstrates to the plan that it is medically necessary for you to take the brand name drug. To obtain a waiver of the additional charges, your physician must complete a special form, which should be obtained from and returned to Caremark, the plan's pharmacy benefit manager, indicating the medical reason(s) why it is necessary for you to take the brand name drug. The address and telephone number of Caremark appear at the end of this booklet on page 50.

Preferred Product Programs

The **Preferred Product Program** requires you to obtain "preferred" medication products in seven selected drug categories for the standard copayment. Certain cholesterol drugs, blood pressure drugs, nasal steroid inhalations, DPP-4 inhibitors/combinations (drugs to treat diabetes), sleep aids, bladder control drugs, and gastrointestinal/stomach-related drugs are on the "preferred" drug list. "Non-preferred" medications from the seven selected drug categories may

still be obtained; however, in addition to the standard copayment, you will also have to pay an additional charge, depending on the dosage and the quantity prescribed.

In addition, the Funds has developed a **Specialty Preferred Product Program** for certain classes of medications called “specialty medications.” These are medications used to treat chronic conditions such as rheumatoid arthritis and multiple sclerosis. There are four (4) designated categories of specialty medications in this program currently. The categories are autoimmune drugs (used to treat rheumatoid arthritis and other inflammatory conditions), drugs to treat multiple sclerosis, drugs to treat hepatitis C infection, and growth hormone. Because they require significant monitoring, specialty medications in these categories must be obtained through the Funds’ Specialty Pharmacy Provider. In addition, the preferred product(s) within one of these four (4) specialty medication categories must be prescribed before a non-preferred drug in the same category will be covered by the Funds.

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

The Funds also has a **Generics First Specialty Preferred Product Program** for certain or select specialty medications used to treat cystic fibrosis, hepatitis C and pulmonary arterial hypertension. The preferred generic specialty drug in these designated categories must be prescribed before a non-preferred drug in the same category will be covered by the Funds. If your physician believes that you cannot take the “preferred generics first specialty” drug because of medical reasons, he must complete a special form, which should be obtained from and returned to Caremark, the plan’s pharmacy benefit manager, detailing the medical reason(s) why a “non-preferred” brand drug is medically necessary for you.

For a complete list of “preferred,” “preferred specialty,” and “preferred generics first specialty” drugs, you should contact the Funds’ Call Center or Caremark. Appropriate addresses and telephone numbers appear at the end of this booklet on page 50. You may also view the list of “preferred” drugs on-line at “<http://www.umwafunds.org>.”

Multi-ingredient compound prescriptions with a charge equal to or greater than \$300.00 may be subject to prior authorization requirements.

Vision Care Program

In addition to coverage of medical services, the plan includes a vision care program. All beneficiaries who are eligible for health benefits, including dependents, are covered by this program which provides benefits for routine eye examinations,

eyeglass frames and lenses, and contact lenses. For details, please refer to the "Summary of Health Benefits" section of this booklet under the heading "Routine Vision Care."

Claims for payment of vision care benefits may be submitted by you or your provider (ophthalmologist, optometrist, etc.). Contact the Funds' Call Center for more information about submitting such claims and for copies of the appropriate forms. The address to which to send the forms appears at the end of this booklet on page 50.

**Payment of
Claims;
Explanation of
Medical
Benefits**

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

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

When you have met the yearly copayment maximum for medical care, the EOB will state that your copay paid for the year to date is \$100. After you have met a maximum, show the EOB to your provider as proof that you are not required to make further copayments during the current copayment year. After you have met the yearly copayment maximum for prescription drugs, Caremark will inform your pharmacy automatically through its computerized network each time you fill a prescription at a participating pharmacy for the rest of the year. Remember that a **copayment year begins January 1 of the calendar year and ends December 31 of that calendar year.**

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

**Hold Harmless
Program**

When a provider attempts to collect excessive charges or charges for services not medically necessary, the trustees shall, with the written consent of the beneficiary,

attempt to resolve the matter either by negotiating a resolution or defending any legal action brought by the provider. The beneficiary is not to be responsible for any legal fees 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. You need to use the program only if a provider, a collection agency, or a lawyer tries to collect from you amounts denied by the Funds. If such an attempt to collect from you is made, you should immediately contact the Funds' Call Center.

The 1992 Benefit Plan includes provisions to control health care costs and to improve the quality of care without reducing benefits covered by the plan. Such cost containment programs may include pre-admission approval of inpatient hospital care and review of the length of stay, pre-certification of certain outpatient and surgical procedures, second surgical opinions, case management, and other quality of care programs. Programs to contain prescription drug costs include agreements with networks of pharmacies to accept certain levels of payment for drugs, encouraging the use of generic drugs when medically appropriate, and supplying drugs by mail when advantageous to the beneficiary.

1. Cooperating Provider Networks

The 1992 Benefit Plan has established Cooperating Provider Networks as part of its overall cost management strategy. The 1992 Benefit Plan has been successful in recruiting providers in areas where beneficiaries reside, including rural coal field communities. Cooperating providers agree to accept the 1992 Benefit Plan's Medicare-based fee schedules as payment in full for all covered services provided to you, regardless of your Medicare status. You can call the Funds' Call Center to find out if the Cooperating Provider Network is available in your area. The 1992 Benefit Plan also maintains a fully operational on-line provider directory at "<http://www.umwafunds.org>." It is also available by mail at no cost. This directory lists all providers who participate as cooperating providers, and is updated and enhanced on a regular basis.

The 1992 Benefit Plan has initiated a program to help ensure that you have access to transportation to medically necessary care in non-emergency situations through a Medical Transportation Network. In exchange for referral of beneficiaries who require transportation, providers in this network accept the 1992 Benefit Plan's reimbursement rates.

2. Primary Care Provider ("PCP") Networks

In addition to the Cooperating Provider Networks, the 1992 Benefit Plan has also established Primary Care Provider networks in a five county area around Birmingham, Alabama and in an eleven county area in southwestern Pennsylvania/northern West Virginia. Beneficiaries living in these areas may select a participating PCP, who may be a general practitioner or a specialist, to

be their Funds network PCP. The \$5 copayment for each visit to your physician is waived when you obtain medical care from a physician you select as your Funds network PCP. (If you do not live in a Funds PCP network area, then please refer to the Summary of Health Benefits section beginning on page 39.)

Participating PCPs coordinate the care of those beneficiaries who select the practitioner as their PCP, and they agree to obtain prior authorizations and pre-certifications for their panel of beneficiaries, as appropriate. You still retain the freedom to see physicians of your choice. However, you will be required to pay the copayment for each visit to a physician (until your family reaches the annual maximum for the copayment year) for medical care you obtain from a physician or specialist who is not a Funds network PCP. Refer to the General Scope of Benefits section on page 39 for more details.

The 1992 Benefit Plan maintains a fully operational on-line provider directory at "<http://www.umwafunds.org>." It is also available by mail at no cost. This directory lists all providers who participate as cooperating providers as well as those providers designated as a Funds network PCP, and is updated and enhanced on a regular basis.

3. Durable Medical Equipment ("DME") Network

The 1992 Benefit Plan has established a network of seven preferred DME vendors to meet your equipment needs. The DME network offers beneficiaries access to local and national service through the preferred vendors and their subcontractors. Some of the preferred vendors have national distribution networks, while others have subcontracts with locally based vendors. **Beneficiaries are required to obtain their durable medical equipment from one of the seven preferred network vendors.** Network vendors are the recommended, but not required, source for all medical supplies. Beneficiaries are required to utilize network vendors for all incontinence and diabetic supplies. You can call the Funds' Call Center to help you locate a network provider or answer any DME questions you may have.

CARE COORDINATION CONTINUUM

A. Care Coordination (Case Management and Disease Management)

KEPRO is the 1992 Benefit Plan's principal provider of care coordination—case management and disease management—services. Care coordination is a process designed to meet individual beneficiary needs by mobilizing and integrating appropriate resources and services offered by a variety of health care providers. The process entails identifying, discussing and adopting treatment alternatives in consultation with you, your doctor, your family and other providers. Your doctor remains in control of your care.

Care Coordinators at KEPRO coordinate the provision of agreed-upon care alternatives by the appropriate providers to patients with acute or chronic conditions. Case management uses data resources, assessment and implementation tools and oversight methods to achieve outcomes that meet the beneficiary's needs in a cost-effective manner. The core functions of case management include assessment of a beneficiary's needs, development of a plan to meet those needs, coordination of services specified in the plan and oversight of plan implementation and progress. Continual close contact is maintained with the beneficiary's physician, who remains in control of the patient's care.

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

B. Geriatric Care Management

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

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

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

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

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

Additionally, consideration will be given to expanding existing sites and to establishing new GCM sites to serve beneficiaries in other areas such as southwestern Virginia, southwestern Pennsylvania, southeastern Ohio, Colorado, New Mexico, Illinois and Indiana.

SUMMARY OF HEALTH BENEFITS

This section describes the medical, hospital, and other health care services covered by the 1992 Benefit Plan. Hospital care may be provided by any hospital accredited by the Joint Commission on Accreditation of Health Care Organizations, or by hospitals that have been approved by the Funds. Medical care may be provided by physicians and, in certain instances, by other appropriately trained and licensed health care professionals. Prescription drugs and medications may be provided by pharmacies, hospital outpatient clinics, and facilities such as hospitals and skilled nursing care facilities that provide health care services on an inpatient basis. Some services require prior approval; to obtain such approval, write to the address that appears at the end of this booklet.

This section is a simplified and condensed version of the 1992 Benefit Plan provisions for covered services. All final determinations concerning coverage of a particular service are subject to the specific provisions of the plan document. If you cannot find the information that you want about a particular service, contact the Funds' Call Center or write to the address that appears at the end of this booklet and request a copy of the plan document.

Physicians' Services and Other Primary Care

1. General Scope of Benefits

Primary care encompasses treatment of illnesses and injuries as well as preventive care. A primary care physician is a physician of first contact, often a general or family practitioner, pediatrician or an internist; however, he may also be a specialist such as a cardiologist or an obstetrician/gynecologist. There are copayments for all visits to physicians for medical care until your family reaches the annual maximum for the copayment year.

In addition to primary care, the plan covers treatment prescribed or administered by a specialist if the treatment is for an illness or injury that falls within the specialist's area of competence.

The plan also covers certain services rendered by physician extenders such as nurse practitioners, physician assistants, and other appropriately trained and licensed health care professionals. However, with the exception of Certified Nurse Anesthetists ("CRNAs"), services of physician extenders will be covered only when provided under the supervision of and billed by a physician.

The plan does not cover dental services, acupuncture therapy, naturopathic therapy, or chiropractic services. However, as a Medicare Health Care Prepayment Plan, the Funds will pay for chiropractic services that are covered

by Medicare Part B for Medicare-eligible beneficiaries. The plan does not cover charges for writing prescriptions, preparing medical summaries and invoices, or telephone conversations with a physician in the place of an office visit.

2. Preventive Care

The plan covers physical examinations, and any laboratory tests and X-rays ordered in connection with such examinations, if they are medically necessary. Examinations that the plan defines as medically necessary include those performed when your age places you in a high-risk group (defined by the plan as under age six or age fifty-five or over) or when you are being treated for a specific condition or chronic illness. Annual or semiannual routine examination by a gynecologist is also considered medically necessary. The plan also covers preventive health care services such as immunizations, pap smears, screenings for hypertension, diabetes, and other conditions, and tests to detect cancer, blindness and deafness when medically necessary. Copayments are required for all examinations covered by the plan.

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

3. Treatment of Illnesses and Injuries

The plan covers visits to a physician in his office, by a physician in your home or in a hospital if you are being treated for an illness or injury; copayments are required for all such visits. The plan also covers laboratory tests and X-rays ordered for diagnostic purposes when they are performed by an appropriately licensed provider or facility. If you are being treated for cancer, the plan will cover the cost of medically appropriate chemotherapy and radiation therapy. Emergency medical treatment rendered by a physician in an emergency room is covered if you receive care within 48 hours following the onset of acute medical symptoms or the occurrence of the accident.

4. Treatment of Mental Illnesses

When a physician determines that treatment is medically necessary and such treatment is not available at no cost from another source, the plan provides benefits for individual psychotherapy, group therapy, psychological testing, and counseling. The cost of an alcoholism or drug rehabilitation program may also be covered, but such services are subject to prior approval based upon the

patient's prospects for rehabilitation. Copayments are required for all mental health services, including rehabilitation.

The plan does not cover encounter and self-improvement group therapy, custodial care of a mentally retarded or mentally deficient individual, services rendered by private teachers, or treatment intended to correct school-related behavior problems.

5. Surgical Services

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

When more than one surgical procedure is performed at the same time, the plan may pay the physician's normal fee for the primary procedure but may pay less than the physician's normal fee for the incidental procedure. If you are an inpatient in a hospital, the plan will also pay for an assistant surgeon when your condition and the type of surgical service that you receive requires an assistant surgeon. In addition to fees for surgical services, the plan will cover the cost of anesthesia and charges for administering it when billed by certain physicians or CRNAs other than the operating surgeon or the assistant surgeon.

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

Oral Surgery	The plan covers limited oral surgery procedures when necessary to treat tumors of the jaw, fractures of the jaw or facial bones, and tongue-tie. It may also cover surgery for TMJ dysfunction, when medically necessary and related to an oral orthopedic problem. Biopsy of the oral cavity and oral surgical services required as the direct result of an accident are also covered. (Benefits are not provided for dental services like orthodontia and orthodontic treatments).
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Podiatrists: The plan covers minor surgical services performed by a qualified licensed podiatrist in his office such as surgery to correct ingrown nails; however, prior approval is required for all major surgical services performed by podiatrists, and such services will not be covered unless they are performed in a hospital. In addition, the plan does not cover nonsurgical services performed by podiatrists, nor does it cover routine foot care such as trimming nails and treating corns, calluses and bunions by nonsurgical means unless it is medically necessary for a participant who has diabetes, peripheral vascular disease, or peripheral neuropathy of the foot.

Other services that are subject to prior approval are organ transplants, intestinal or gastric bypass for obesity, cerebellar and dorsal stimulator implants, and insertion of a prosthesis for cleft palate if it cannot be obtained from a crippled children's program. The plan covers plastic surgery that is necessary to correct surgical scars, the effects of an injury, or birth defects. The plan does not cover tonsillectomies and adenoidectomies unless they are medically necessary.

6. Obstetrical and Family Planning Care

The plan covers prenatal and postnatal care, classes in natural childbirth techniques given at hospitals and clinics, delivery and administration of anesthesia during delivery. A covered delivery may be performed by a physician or by a midwife who is certified by the American College of Nurse Midwifery and is licensed as required by law. Prenatal and postnatal care visits are subject to the copayment provisions of the plan if they are not included in the delivery fee, that is, if the visits and the delivery are billed separately.

The plan covers an abortion performed by a licensed gynecologist or surgeon when a physician certifies that it is medically necessary. It also covers all sterilization procedures performed by physicians and family planning services furnished by physicians and other appropriately trained and licensed health care professionals who practice under the supervision of a physician. Fees for artificial insemination are covered when the procedure is performed by a licensed gynecologist.

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

7. Eye Care

The plan covers fees for medical and surgical treatment of eye diseases and injuries and the cost of eyeglasses or contact lenses if you have cataract surgery. These coverages are separate from the routine eye care provided by the vision care program, described on page 46.

If you are hospitalized for the diagnosis or medically necessary treatment of a covered illness, injury, or obstetrical condition, the plan will cover the following:

- Semi-private room and board including charges for special diets. Additional fees for a private room will be covered only if isolation is necessary for your health or the health of other patients or if a semiprivate room is not available. If you are put into a private room because no semiprivate room is available, the plan will not cover the additional fee for the private room beyond the day on which a semiprivate room first becomes available and your condition permits transfer to a semiprivate room.
- Intensive and coronary care unit services if your physician certifies that it is medically necessary for you to be in such a unit.
- Private duty nursing care if there is no space in the hospital's intensive care unit and your physician certifies that private duty nursing is necessary to preserve life. The plan may cover this care for up to 72 hours.
- Use of hospital facilities such as operating, delivery, and recovery rooms.
- Diagnostic or therapeutic items and services such as laboratory tests, X-rays, chemotherapy, radiation therapy, and physical therapy.
- Drugs and medications, including take-home drugs, which are limited to a 30 day supply, following a hospital stay. The plan also covers anesthesia, intravenous injections and solutions, and oxygen and its administration.
- Administration of blood and blood plasma, as well as the cost of the blood itself if it is not replaced by you or replaced by someone else on your behalf.
- Renal dialysis when the method of administration is in accordance with Federal Medicare regulations.

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

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

The plan will not cover admission to a hospital for diagnostic procedures which could be performed on an outpatient basis, nor will the plan cover personal items such as telephones, televisions, barber services, and meals for guests.

Outpatient Hospital Services

The plan covers surgery, chemotherapy, radiation therapy and physical therapy furnished on an outpatient basis by a hospital; renal dialysis is also covered when provided in accordance with Federal Medicare regulations. The plan covers laboratory tests and X-rays performed on an outpatient basis when they are necessary for diagnosis or treatment of a definite illness, injury, or medical condition. Emergency room services will be covered by the plan if you receive such emergency medical treatment within 48 hours following the onset of acute medical symptoms or the occurrence of the accident.

Skilled Nursing Care Facilities

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

During approved stays in skilled nursing care facilities, the plan will cover room and board; skilled nursing care provided by or under the supervision of a registered nurse; physical, occupational or speech therapy provided by or arranged for by the facility; drugs; immunizations; supplies; appliances; equipment; medical social services; and other health services usually furnished by skilled nursing care facilities.

Among the services not covered by the plan are private duty nursing unless it is necessary to preserve life; personal items such as telephones, televisions, barber services, and meals for guests; and additional fees for a private room.

Extended Care Units

All stays in extended care units are subject to **prior approval** by the Funds. The plan may cover an initial stay in an extended care unit for up to two weeks; an extension may be granted when requested by a physician. If you are covered by Medicare, the plan will cover only stays in extended care units that have been approved by Medicare.

Home Health Services and Equipment

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

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

Your physician must document the need for home health services by submitting a treatment plan which includes a diagnosis and specific information about your functional limitations. The treatment plan must specify the kinds and frequency of services which are needed.

1. Medical Services

The plan will cover skilled nursing care services rendered in your home if your condition is unstable and a physician concludes that evaluation and observation by a registered nurse are necessary.

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

2. Durable Medical Equipment and Supplies

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

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

3. Coal Miners Respiratory Disease Program

The plan covers services or treatment provided in your home by the Coal Miners Respiratory Disease Program if ordered or requested by a physician.

Drugs and Medications

Such services are subject to prior approval and will be covered by the plan only if similar services cannot be obtained under a government program for which you are or would be eligible.

The plan covers reasonable charges for insulin and drugs which by law require a prescription. The plan does not cover over-the-counter drugs even if they are prescribed by a physician. Participating network pharmacies directly submit claims for prescription drug benefits and accept the Funds' reimbursement for prescription drugs as payment in full.

The plan covers drugs prescribed by a physician for treatment or control of an illness or non-occupational injury when they are dispensed by a licensed pharmacist. The plan does not cover medications prescribed for birth control, and certain covered medications may have per prescription quantity limits or require that you obtain the prior authorization of the Funds before the Funds will pay for it. Caremark will inform your pharmacy automatically through its computerized network each time you fill a prescription that has a quantity limit or requires prior authorization at a participating pharmacy. You may obtain further information about any quantity limits or drugs that require the prior authorization of the Funds by contacting the Funds' Call Center or Caremark. Appropriate addresses and telephone numbers appear at the end of this booklet on page 50.

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

If you are confined to a hospital, skilled nursing care facility, or extended care unit for treatment of a covered illness, injury, or obstetrical condition, the plan will cover the cost of certain medications administered during your stay in the facility.

Copayments are not required for drugs and medications administered during your stay in an inpatient facility. However, you will be required to make a copayment for each 30 day supply or less of a drug or medication filled by a pharmacy on an outpatient basis as well as for take-home supplies of drugs following a hospital stay. These copayments will continue until your family reaches the annual maximum for the copayment year. **There is no copayment for prescriptions filled through the Funds' mail order service.**

Routine Vision Care

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

<i>Benefit</i>	<i>Actual Charge to Maximum Amount</i>
Vision examination	\$20 per exam
Per lens (maximum of two)	
Single vision lens	\$10 per lens
Bifocal lens	\$15 per lens
Trifocal lens	\$20 per lens
Lenticular lens	\$25 per lens
Contact lens	\$15 per lens
Eyeglasses frames	\$14 per set

The vision care program does not cover the cost of new lenses unless there is an axis change of 20 degrees or a .50 diopter sphere or cylinder change in your prescription and the new lenses improve your vision by at least one line on the standard eye chart. These prescription limitations and the frequency limitations described above apply even if you lose or break your eyeglasses or contact lenses. The vision care program does not cover sunglasses, anti-reflective lenses, photosensitive lenses, oversized lenses, designer frames, or other optional features; it will, however, cover the cost of two very light tints which are sometimes prescribed for medical reasons (tints No. 1 and No. 2).

Other Benefits

1. Prosthetic Devices

The plan will cover the cost of prosthetic devices that serve as replacements for internal and external body parts, if they are prescribed by a physician and deemed medically necessary. Types of prostheses which are covered include artificial eyes, noses, hands or hooks, feet, arms, and legs, and breast prostheses for patients who have undergone mastectomies. The plan does not cover any dental prostheses.

2. Orthopedic Appliances

Orthopedic appliances may be covered if they are prescribed by a physician. Among the appliances covered by the plan are leg, arm, back and neck braces, and trusses. In addition, the plan will cover the cost of repair or adjustment of orthopedic appliances and replacement of appliances which have worn out and can no longer be repaired. Replacements of usable appliances will be covered only if they are needed due to a change in your condition.

3. Orthopedic Shoes

The plan covers the cost of specially-built orthopedic shoes and shoes that must be modified to accommodate a brace, provided that the shoes are prescribed

by an orthopedist or a licensed podiatrist. When prescribed by an orthopedist, podiatrist, family practitioner, or pediatrician, the cost of adding orthopedic modifications to ordinary shoes may also be covered; however, the cost of the shoes themselves will not be covered.

4. Physical Therapy

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

5. Speech Therapy

The same general limitations which apply to physical therapy also apply to speech therapy. The plan may cover speech therapy rendered by an approved licensed therapist for stroke patients, patients who have had a ruptured aneurism or brain tumor, and autistic individuals. Speech therapy may also be covered for children who have speech impediments if they are unable to obtain speech therapy through the public school system.

6. Hearing Aids

The plan covers hearing aids only if they are recommended by an otologist, or otolaryngologist and a certified clinical audiologist. To be covered, hearing aids must be purchased from approved, participating hearing aid dispensers; a list of these network dispensers can be obtained from the Funds' Call Center. Unless prior approval has been granted, the plan will cover the cost of a hearing aid for only one ear.

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

7. Ambulance and Other Transportation

The plan will pay for ambulance transportation to or from a hospital, clinic, physician's office, or skilled nursing care facility provided that the ambulance transportation is considered medically necessary by a physician, is an emergency, and meets Medicare ambulance transportation guidelines.

The Funds also pays for non-emergency transportation. With **prior approval**, the plan may provide non-emergency transportation coverage to a hospital or clinic for essential treatment, such as radiation or physical therapy, if hospitalization would be the only feasible alternative to the non-emergency transportation coverage in order for the participant to receive the needed treatment. Under certain, limited circumstances, the plan may also cover the services of an escort.

For more complete information about the plan's coverage of non-emergency transportation for medical services, please contact the Funds' Call Center.

8. Chiropractic Care for Medicare-Eligible Beneficiaries

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

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

FUNDS ADDRESSES AND PHONE NUMBERS

Central Office

UMWA Health and Retirement Funds
2121 K Street NW Suite 350
Washington DC 20037
Telephone: (202) 521-2200

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

CLAIMS SUBMISSIONS

Prescription Drugs

Caremark
UMWA Health and Retirement Funds
PO Box 52136
Phoenix AZ 85072-2136
Toll Free: 1-800-294-4741

Medical Services, Supplies and Vision Care

UMWA Health and Retirement Funds
PO Box 99002
Lubbock TX 79490-9002
Toll Free: 1-888-865-5290

Care Management

KEPRO
UMWA Funds
2170 W State Rd 434 Suite 450
Longwood FL 32779

PRIOR APPROVAL AND MANAGED CARE PROGRAMS

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

UMWA Health and Retirement Funds
2121 K Street NW Suite 350
Washington DC 20037



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