BENEFIT FUND ADMINISTRATION
(Employer Plan-Coal Industry Retiree)
Amended and Restated
Effective July 1, 2011

# INTRODUCTION

This Benefit Plan for Pensioners of _(Name of Employer)__("the Plan") is maintained pursuant to section 9711 of the Internal Revenue Code.

The Plan provides health and vision care for Pensioners and their eligible Dependents. These benefits are provided by (Name of Employer)__. through insurance carriers or professional contract administrators.

Each eligible Pensioner will receive an identification card.

## ARTICLE I DEFINITIONS

The following terms shall have the meanings herein set forth:

(1) "Employer" means (Insert Employer's Name) .

(2) "Wage Agreement" means the National Bituminous Coal Wage Agreement of 1988, as amended from time to time and any successor agreement.

(3) "Plan Administrator" shall be the Employer, a subsidiary of the Employer, an affiliated company of the Employer or an employee of the Employer, as designated by the Employer.

(4) "Pensioner" shall mean any person who is receiving a pension, other than (i) a deferred vested pension based on less than 20 years of credited service, or (ii) a pension based in whole or in part on years of service credited under the terms of Article II G of the 1974 Pension Plan, or any corresponding paragraph of any successor thereto, under the 1974 Pension Plan (or any successor thereto), whose last classified signatory employment was with the Employer, subject to the provisions of Article II of this Plan. Notwithstanding the foregoing, "Pensioner" shall not mean any person who had not met all age and service requirements for receiving benefits as of February 1, 1993, and shall not mean any person who retires from the coal industry after September 30, 1994.

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

(6)"Attains the age" shall mean on or after 12:01 A.M. of the anniversary date of one's birth.

(7) "Trustee" or "Trustees" shall mean the Trustees of the United Mine Workers of America 1992 Benefit Plan.

## ARTICLE II ELIGIBILITY

The persons eligible to receive the health benefits pursuant to Article III are those individuals who are entitled to receive such benefits under section 9711 of the Internal Revenue Code, subject to the eligibility provisions of the Employer Plan in effect on February 1, 1993, and to all other provisions of this Plan. Health benefits shall not be provided to an individual during any month in which such individual would be disqualified from receiving benefits under the terms of the Employer Plan in effect on February 1, 1993; provided, however, that the disqualification based on earnings shall apply during those months in which such individual is regularly employed at an earnings rate equivalent to at least $1,000 per month; and provided further that on, after and effective January 1, 2007, the disqualification based on earnings shall not apply or be required.

## ARTICLE III BENEFITS

Subject to Article IV, the benefits provided under this Plan are set forth in this Article III. Benefit payments shall not exceed reasonable and customary charges for covered services and supplies. Covered services shall be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at the appropriate level of care, or are otherwise provided for in the Plan. The fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary or that it is covered under this Plan. In determining questions of reasonableness and necessity, due consideration will be given to the customary practices of physicians in the community where the service is provided. Services which are not reasonable and necessary shall include, but are not limited to the following: procedures which are of unproven value or of questionable current usefulness; procedures which tend to be redundant when performed in combination with other procedures; diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly; procedures which are not ordered by a physician or which are not documented in timely fashion in the patient's medical records; procedures which can be performed with equal efficiency at a lower level of care. The benefits described in this Article are subject to any requirements implemented pursuant to Article IV. Covered services that are medically necessary will continue to be provided, and accordingly, while benefit payments may be subject to managed care and cost containment rules, this paragraph shall not be construed to detract from plan coverage or eligibility as described in this Article III.

A. Health Benefits

(1) Inpatient Hospital Benefits

(a) Semi-private room

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

Medically necessary services provided in a hospital include the following:

Operating, recovery, and other treatment rooms
Laboratory tests and x-rays
Diagnostic or therapy items and services

Drugs and medication (including take-home drugs which are limited to a 30-day supply):

Radiation therapy
Chemotherapy
Physical therapy
Anesthesia services
Oxygen and its administration
Intravenous injections and solutions
Administration of blood and blood plasma
Blood, if it cannot be replaced by or on behalf of the beneficiary

(b) Intensive Care Unit - Coronary Care Unit

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

(c) Private Room

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

(d) Renal Dialysis

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

(e) Mental Illness

Benefits are provided for up to a maximum of 30 days for a Beneficiary who is confined for mental illness in a hospital by a licensed psychiatrist. When medically necessary, hospitalization may be extended for a maximum of 30 additional days for confinements for an acute (short-term)

mental illness, per episode of acute illness. (More than 90 days of confinement for mental illness over a two-year period, (dating from the first day of hospital confinement, even if the first day of confinement occurred during a prior Wage Agreement) is deemed for purposes of this Plan to be a chronic (long-term) mental problem for which the Plan will not provide inpatient hospital benefits).

(f) Alcoholism and Drug Abuse

Benefits are provided for a Beneficiary who requires emergency detoxification hospital care for the treatment of alcoholism or emergency treatment for drug abuse. Such treatment is limited to 7 calendar days per inpatient hospital admission.

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

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

(g) Oral Surgical/Dental Procedures

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

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

(h) Maternity Benefits

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

(i) General

Accredited Hospital is a hospital which is operated primarily for the purpose of rendering inpatient therapy for the several classifications of medical and surgical cases and which is approved by the Joint Commission on Accreditation of Hospitals or which has been approved by the Trustees of the United Mine Workers of America 1950 Benefit Plan and Trust.

(2) Outpatient Hospital Benefits

(a) Emergency Medical and Accident Cases

Benefits are provided for a Beneficiary who receives emergency medical treatment or medical treatment of an injury as the result of an accident, provided such emergency medical treatment is rendered within 48 hours following the onset of acute medical symptoms or the occurrence of the accident.

(b) Surgical Cases

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

(c) Laboratory Tests and X-rays

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

(d) Chemotherapy and Radiation Therapy

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

(e) Physiotherapy

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

(f) Renal Dialysis

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

(3) Physicians' Services and Other Primary Care

(a) Surgical Benefits

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

When surgical services consist of necessary major surgery (primary) and the physician performs surgery additional to the primary surgery (incidental surgery), benefits payment for the incidental surgery will be provided but at a rate 50% lower than the physician's normal charge had he performed only the incidental surgery.

(b) Assistant Surgeons

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

(c) Obstetrical Delivery Service

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

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

(d) Anesthesia Services

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

(e) Oral Surgery

Benefits are not provided for dental services. However, benefits are provided for the following limited oral surgical procedures if performed by a dental surgeon or general surgeon.

Tumors of the jaw (maxilla and mandible)
Fractures of the jaw, including reduction and wiring
Fractures of the facial bones
Frenulectomy when related only to ankyloglossia (tongue tie)
Temporomandibular Joint Dysfunction, only when medically necessary and related to an oral orthopedic problem.
Biopsy of the oral cavity
Dental services required as the direct result of an accident

(f) Surgical Services Limitations

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

Plastic surgery, including mammoplasty
Reduction mammoplasty
Intestinal bypass for obesity
Gastric bypass for obesity
Cerebellar implants
Dorsal stimulator implants
Prosthesis for cleft palate if not covered by crippled children services
Organ transplants

(g) In-hospital Physicians' Visits

If a Beneficiary is confined as an inpatient in a hospital because of an illness or injury, benefits are provided for in-hospital visits by the physician in charge of the case. Such benefits will also be provided concurrently with benefits for surgical, obstetrical and radiation therapy services when the Beneficiary has a separate and complicated condition, the treatment of which requires skills not possessed by the physician who is rendering the surgical, obstetrical or radiation therapy services.

(h) Home, Clinic, and Office Visits

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

(i) Emergency Treatment

When provided by a physician, benefits are provided for a Beneficiary who receives outpatient emergency medical treatment or treatment of an injury as the result of an accident, provided such emergency medical treatment is rendered within 48 hours following the onset of acute medical symptoms or the occurrence of the accident.

(j) Laboratory Tests and X-rays

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

Such benefits will not cover laboratory tests and x-rays ordered in connection with a routine physical examination, unless the examination is considered medically necessary by a physician.

(k) Radiation and Chemotherapy Benefits

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

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

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

(l) Medical Consultation

Benefits are provided for services rendered, at the request of the attending physician in charge of the case, by a physician who is qualified in a medical specialty necessary in connection with medical treatment required by a Beneficiary.

(m) Specialist Care

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

(n) Primary Care - Podiatrists' Services

Benefits are provided for minor surgery rendered by a qualified licensed podiatrist. Routine care of the feet such as trimming of nails, the treatment of corns, bunions (except capsular or bone surgery therefor) and calluses is excluded.

Covered minor surgery includes surgery for ingrown nails and surgery in connection with the treatment of flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

Benefits for major surgical procedures rendered by a licensed podiatrist are not provided, except if such surgery is rendered in a hospital.

(o) Primary Medical Care - Miscellaneous

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

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

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

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

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

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

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

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

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

(p) Services Not Covered

1. Services rendered by a chiropractor or naturopathic services.

2. Acupuncture therapy.

3. Home obstetrical delivery.

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

5. Charges for writing a prescription.

6. Medications dispensed by other than a licensed pharmacist.

7. Charges for medical summaries and medical invoice preparations.

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

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

10. Physical examinations, except as specifically provided herein.

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

DRUG FEE SCHEDULE
(Prescription Drugs)

(4) Prescription Drugs

(a) Benefits Provided

Benefits are provided for insulin and prescription drugs (only those drugs which by Federal or State law require a prescription) dispensed by a licensed pharmacist and prescribed by a (i) physician for treatment or control of an illness or a nonoccupational) accident or (ii) licensed dentist for treatment following the performance of those oral surgical services set forth in (3)(e). The initial amount dispensed shall not exceed a 30 day supply. Any original prescription may be refilled for up to six months as directed by the attending physician. The first such refill may be for an amount up to, but no more than, a 60 day supply. The second such refill may be for an amount up to, but no more than, a 90 day supply. Benefits for refills beyond the initial six months require a new prescription by the attending physician.

Reasonable charges for prescription drugs or insulin are covered benefits. Subject to any cost containment rules and procedures adopted pursuant to Article IV, reasonable charges will consist of the lesser of:

(1) The amount actually billed per prescription or refill, or

(2) The average wholesale price plus 25%, to be not less than $2.50 above nor more than $10.00 above the average wholesale price per prescription or refill, or the Plan Administrator may determine average wholesale price from either the American Druggist Blue Book, the Drugtopics Redbook, or the Medi-Span Prescription Pricing Guide.

(3) For a pharmacist participating in a Trustee-established prescription drug program, the current price paid by the Funds and available to the Employer in a piggybacked program.

4. The price of the applicable generic substitution drug, if AB or better-rated, approved by the federal Food and Drug Administration; or, in the event the prescribing physician determines that use of a brand name drug is medically necessary, the price of such brand name drug;

5. The rate for the drug listed on the formulary list of specific drugs along with payment rates adopted by the Plan Administrator and provided to Plan participants;

6. The current price paid to participating pharmacies on a Participating Provider List (PPL) adopted by the Employer pursuant to Article IV. The Employer will notify Beneficiaries of the need to use PPL pharmacies. If a Beneficiary purchases a prescription drug or insulin from a pharmacy that is not on the Employer's PPL, the Employer will advise the Beneficiary by letter regarding the future consequence of using a non-PPL pharmacy. If the Beneficiary fails to use a PPL pharmacy a second time, the Employer will contact the Beneficiary in person or by telephone to counsel the Beneficiary on the consequences of using a non-PPL pharmacy. Following such counseling, the "Hold Harmless" protections of section (10)(g)3 will cease to apply to prescription drugs and insulin purchased for such Beneficiary or his eligible Dependents from any pharmacy that is not on the Employer's PPL.

(b) Benefits Excluded

Benefits shall not be provided under paragraph (4)(a) for the following:

1. Medications dispensed in a hospital (including take-home drugs), skilled nursing facility or physician's office. (See Article III A (1)(a) and (5)(a) for benefits provided for drugs and medications during inpatient confinement in a hospital skilled nursing facility.)

2. Birth control prescriptions.

3. Prescriptions dispensed by other than a licensed pharmacist.

4. Any medication not specifically provided for in (a) above.

(5) Skilled Nursing Care and Extended Care Units

(a) Skilled Nursing Care Facility

Upon determination by the attending physician that confinement in a licensed skilled nursing care facility1 is medically necessary, to the extent that benefits are not available from Medicare or other State or Federal programs, benefits will be provided for:

1. skilled nursing care provided by or under the supervision of a registered nurse;

2. room and board;

3. physical, occupational, inhalation and speech therapy, either provided or arranged for by the facility;

4. medical social services;

5. drugs, immunizations, supplies, appliances, and equipment ordinarily furnished by the facility for the care and treatment of inpatients;

6. medical services, including services provided by interns or residents in an approved, hospital-run training program, as well as other diagnostic and therapeutic services provided by the hospital; and

7. other health services usually provided by skilled nursing care facilities.

The Plan will not pay for services in a nursing care facility:

1. that is not licensed or approved in accordance with state laws or regulations;

2. unless the service is provided by or under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results.

Exclusions: Telephone, T.V., radio, visitor's meals, private room or private nursing (unless necessary to preserve life), custodial care, services not usually provided in a skilled nursing facility.

(b) Extended Care Units

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1 Skilled nursing care facility is limited to a skilled nursing care facility which is licensed and approved by Federal Medicare.

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

The Plan will not pay for services in an extended care unit unless, in the case of a Medicare patient, such extended care has prior approval of Medicare.

Exclusions:

1. Services, drugs or other items which are not covered for hospital inpatients;

2. Custodial care.

(6) Home Health Services & Equipment

(a) General Provisions

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

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

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

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

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

(b) Physical and Speech Therapy

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

(c) Skilled Nursing

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

(d) Medical Equipment

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

(e) Oxygen

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

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

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

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

(f) Coal Miners Respiratory Disease Program

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

(7) Other Benefits

(a) Orthopedic and Prosthetic Devices

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

The following types of equipment are covered:

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

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

2. Prosthesis following breast removal.

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

4. Trusses.

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

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

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

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

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

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

(b) Physical Therapy

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

(c) Speech Therapy

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

(d) Hearing Aids

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

(e) Ambulance and Other Transportation

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

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

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

2. If the Beneficiary requires frequent transportation between the Beneficiary's home and a hospital or clinic for such types of treatment as radiation or physical therapy or other special

treatment which would otherwise require hospitalization, benefits will be provided for such transportation only when the Beneficiary cannot receive the needed care without such transportation.

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

(f) Outpatient Mental Health, Alcoholism and Drug Addiction

Benefits are provided for: Psychotherapy, psychological testing, counseling, group therapy and alcoholism or drug rehabilitative programs where free care sources are not available and when determined to be medically required by a physician.

Benefits are not provided for:

1. Encounter and self-improvement group therapy.

2. Custodial care related to mental retardation and other mental deficiencies.
3. School related behavioral problems.

4. Services by private teachers.

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

6. Alcoholism and drug rehabilitation programs not approved by Medicare.

(8) Co-Payments and Deductibles

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

Co-Payments for covered Health Benefits are established as follows:

| Benefit | Co-Payment |
|---|---|
| (a) Physician services as an outpatient as set forth in section A(2) and physician visits in connection with the benefits set forth in section A(3), paragraph (c) but only for pre- and post-natal visits if the physician charges separately for such visits in addition to the charge for delivery, and paragraph (g) through (m), paragraph(n) except inpatient surgery, paragraph (o) and section A(7), paragraph (f). | $5 per visit up to a maximum of $100 per 12-month period per family. |
| (b) Prescription drugs and insulin, as set forth in section A(4) and take-home drugs following hospital confinement set forth in section (A)(1)(a) | $5 per prescription or refill up to $50 maximum per 12-month period per family. Note: For purposes of this co-payment provision, a prescription or refill shall be deemed to be each 30 days (or fraction thereof) supply. |

The 12-month periods shall begin on March 27 of each year.

Additional Rule Regarding Brand Name Prescription Drugs where a generic equivalent is available:

In addition to the regular co-payment, the Beneficiary is responsible for the additional cost of the brand name drug over the cost of the generic substitute. A generic drug will not be considered "available" unless it has been approved by the federal Food and Drug Administration. In

addition, if the prescribing physician determines that use of a brand name drug is medically necessary, the generic drug will not be considered "available," and there will be no additional payment by the beneficiary for the use of the brand name drug. NOTE: "Hold Harmless" protections of section (10)(g)3 do not apply to brand name prescription drugs where a generic equivalent is available.

(9) Vision Care Program

| (a) Benefits | Actual Charge Up To Maximum Amount | Frequency Limits |
|---|---|---|
| Vision Examination | $20 | Once every 24 months |
| Per Lens (Maximum = 2) | | Once every 24 months |
| -- Single vision | 10 | |
| -- Bifocal | 15 | |
| -- Trifocal | 20 | |
| -- Lenticular | 25 | |
| -- Contact | 15 | |
| -- Frames | 14 | Once every 24 months |

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

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

(c) Exclusions include:

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

2. extra charges for photosensitive or anti-reflective lenses;

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

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

5. experimental services or supplies;

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

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

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

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

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

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

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

(10) General Provisions

(a) HMO Election

Any Beneficiary as described in Article II, Sections A, B, C, and E may elect coverage by a certified health maintenance organization (HMO) in lieu of the health benefits provided under this Plan, in accordance with Federal or State laws governing HMO's; provided, however, that all Beneficiaries in a family shall be governed by an HMO election.

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

(b) Administration

The Plan Administrator is authorized to promulgate rules and regulations to implement and administer the Plan, and such rules and regulations shall be binding upon all persons dealing with the Beneficiaries claiming benefits under this Plan. The Trustees of the UMWA 1992 Benefit Plan will resolve any disputes, including excessive fee disputes, to assure consistent application of the Plan provisions which are identical to the benefit provisions of the 1992 Benefit Plan.

(c) Services Rendered Outside the United States

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

(d) Medicare

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

The Plan Administrator shall give written notification of the obligation to enroll. Failure to provide such notification shall not remove any obligation to enroll.

(e) Subrogation

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

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

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

2. upon such Beneficiary executing such documents as are reasonably required by the Plan Administrator, including, but not limited to, an assignment of rights to receive such third party payments, in order to protect and perfect the Plan's right to reimbursement from any such third party.

(f) Non-Duplication

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

1. Benefits will be reduced by benefits provided under any other group plan, including a plan of another Employer signatory to the Wage Agreement, if the other plan:

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

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

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

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

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

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

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

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

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

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

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

(g) Explanation of Benefits (EOB), Cost Containment and Hold Harmless

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

2. (i) Regarding health care cost containment, the Trustees of the UMWA 1992 Benefit Plan are authorized to establish managed care and cost containment rules and procedures pursuant to section 9712(c) of the Internal Revenue Code. Among other programs, the Trustees are authorized to take steps to contain prescription drug costs, including but not limited to, paying only the current average wholesale price encouraging the use of generic drugs instead of brand name drugs where medically appropriate, and encouraging the use of mail order drug programs when advantageous.

(ii) The Trustees shall make available to the Plan Administrator any special cost containment arrangements that they make with outside vendors and/or providers. Further, the Plan Administrator may "piggyback" the cost containment programs adopted by the Trustees, and may utilize the managed care and cost containment rules and programs adopted by the Trustees.

(iii) Disputes shall be resolved in accordance with (10)(b).

(iv) It is expressly understood that nothing contained in this Section shall diminish or alter any rights currently held by the Employer in the administration of this Plan.

3. The Employer and the UMWA agree that excessive charges and escalating health costs are a joint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, the Plan Administrator or his agent shall, with the written consent of the Beneficiary, attempt to resolve the matter, either by negotiating a resolution or defending any legal action commenced by the provider. Whether the Plan Administrator or his agent negotiates a resolution of a matter or defends a legal action on a Beneficiary's behalf, the Beneficiary shall not be responsible for any legal fees, settlements, judgments or other expenses in connection with the case, but may be liable for any services of the provider which are not provided under the Plan. The Plan Administrator or his agent shall have sole control over the

conduct of the defense, including the determination of whether the claim should be settled or an adverse determination should be appealed.

(11) General Exclusions

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

1. Cases covered by workers' compensation laws or employer's liability acts or services for which an employer is required by law to furnish in whole or in part.

2. Services rendered

(i) prior to the effective date of a Beneficiary's eligibility under the Plan,

(ii) subsequent to the period after which a Beneficiary is no longer eligible for benefits under the Plan; or

(iii) in a non-accredited hospital, other than for emergency services as set forth in A(2)(a) and (3)(i).

3. Services furnished by any governmental agency, including benefits provided under Medicaid, Federal Medicare and Federal and State Black Lung Legislation for which a beneficiary is eligible or upon proper application would be eligible.

4. Services furnished by tax-supported or voluntary agencies.

5. Immunizations provided by local health agencies.

6. Evaluation procedures such as x-rays and pulmonary function tests, in connection with applications for black lung benefits, or required by Federal or State Black Lung legislation.

7. Private duty nursing. If necessary to preserve life and certified as medically necessary by the attending physician and an Intensive Care Unit is unavailable, benefits are provided for private duty nursing services for up to 72 hours per inpatient hospital admission. In no event will payment be made for private duty nursing during a period of confinement in the Intensive Care Unit of a hospital.

8. Custodial care, convalescent or rest cures.

9. Personal services such as barber services, guest meals and cots, telephone or rental of radio or television and personal comfort items not necessary to the treatment of an illness or injury.

10. Charges for private room confinement, except as specifically described in the Plan.

11. Services for which a Beneficiary is not required to make payment.

12. Excessive charges

13. Charges related to sex transformation.

14. Charges for reversal of sterilization procedures.

15. Charges in connection with a general physical examination, other than as specified in this Plan.

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

17. Charges for medical services for inpatient or outpatient treatment for mental retardation and other mental deficiencies.

18. Finance charges in connection with a medical bill.

19. Dental services.

20. Birth control devices and medications.

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

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

23. Exercise equipment.

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

25. Charges for treatment of obesity, except for pathological, morbid forms of severe obesity (200% or more of desirable weight) when prior approval is obtained from the Plan Administrator.

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

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

(1) COBRA Continuation Coverage

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

(2) Conversion Privilege

Health Benefits

When health benefits coverage terminates, a Beneficiary may, upon application, convert, without medical examination, to a policy issued by the insurance carrier provided such application is made to the insurance carrier within 31 days after the date coverage terminates. The type of policy, coverage and premiums therefore are subject to the terms and conditions set forth by the insurance carrier.

## ARTICLE IV MANAGED CARE, COST CONTAINMENT

A. The Employer may adopt Participating Provider Lists (PPL's) of physicians, hospitals, pharmacies and other providers, provided that any such PPL has been approved for adoption under the Employer's benefit plan maintained pursuant to Article XX(c)(3)(i) of the National Bituminous Coal Wage Agreement of 1993 ("1993 NBCWA"). The Employer may also implement a formulary for prescription drugs; implement a mail-order procedure for prescription drugs, including appropriate limits on quantity and periodic physician review; and subject the prescription drug program to a rigorous review of appropriate use.

B. In addition, the Employer may implement certain other managed care and cost containment rules, which may apply to benefits provided both by PPL providers and by non-PPL sources, but which (except for the co-payments specifically provided for in the Plan) will not result in a reduction of benefits or additional costs for covered services provided under the Plan.

C. The Employer shall not in any way be responsible for the failure of a physician, health care facility, or other provider to satisfy any criteria established for PPL's under the 1993 NBCWA, where the PPL has been approved for adoption under the Employer's benefit plan maintained under the 1993 NBCWA. Further, notwithstanding the implementation of any PPL or other managed care or cost containment rule or procedure, the Employer shall not in any way be responsible for the outcome of any medical treatment or health care (or lack of such treatment or care).

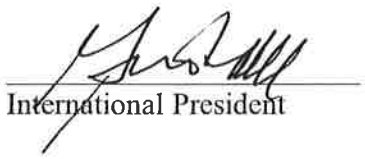
## ARTICLE V AMENDMENT AND TERMINATION

A. Amendments. The UMWA and BCOA (and its successors or assigns) reserve the right at any time during the term of the National Bituminous Coal Wage Agreement of 1993 to modify or amend in whole or in part any or all of the provisions of this Plan, or to terminate this Plan, by written instrument between the UMWA and BCOA. In addition, following termination of the 1993 NBCWA, this Plan may be modified, amended, or terminated, by written instrument, by BCOA and the UMWA, or by BCOA, or by the Employer acting through its _____, as may be permitted by law.

B. Procedural Requirements. Any written instrument executed by BCOA and the UMWA shall be signed by the President of BCOA and by the International President of the UMWA. In the event BCOA ceases to exist and there is no successor or assign, then the Employer, acting through its _____, shall have the rights of BCOA under this Article.

IN WITNESS WHEREOF, BCOA and the Union, pursuant to proper authority, have caused this amended and restated model plan, established under section 9711 of the Internal Revenue Code, to be signed by their proper officers or representatives on this 31st day of December, 2012. The plan is effective May ___, 1995, but consistent with action taken by the UMWA Combined Benefit Fund, the earnings rate limit of $1,000 per month, referred to in Article II, shall be effective January 1, 1995; provided that on, after and effective January 1, 2007, the disqualification based on earnings shall not apply or be required.

UNITED MINE WORKERS OF AMERICA



International President

BITUMINOUS COAL OPERATORS' ASSOCIATION, INC.

President