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2016 UMWA EMPLOYER BENEFIT PLAN

2016 UMWA EMPLOYER BENEFIT FUND ADMINISTRATION (Employer Plan) PLAN DOCUMENT

Effective August 15, 2016

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2016 UMWA EMPLOYER BENEFIT FUND ADMINISTRATION (Employer Plan) INTRODUCTION

This Benefit Plan ("the Plan") for United Mine Workers of America ("UMWA") Represented Employees of _____ (Name of Employer) (the "Employer") and Pensioners of the Employer has been established pursuant to the provisions of Article XX of the National Bituminous Coal Wage Agreement of 2016.

The Plan provides health and vision care for Employees and Pensioners of the Employer and their eligible Dependents, and life insurance and accidental death and dismemberment insurance for Employees of the Employer. These benefits are provided by _____ (Name of Employer)__through insurance carriers, professional contract administrators, and/or the UMWA Health and Retirement Funds.

Each eligible Employee and Pensioner of the Employer will receive an identification card.

ARTICLE I - DEFINITIONS

The following terms shall have the meanings herein set forth:

(l) "Employer" means _____(Insert Employer's Name)___.

(2) "Wage Agreement" means the National Bituminous Coal Wage Agreement ("NBCWA") of 2016 and any conforming "me too" agreement that includes, among other things, an obligation to contribute to each of the UMWA Health and Retirement Funds at the rates set forth in the NBCWA of 2016.

(3) "Plan Administrator" shall be the Employer or as designated by the Employer.

(4) "Employee" shall mean a person working in a classified job for the Employer, eligible to receive benefits hereunder.

(5) "Pensioner" shall mean a former Employee of the Employer who is receiving a pension from the UMWA 1974 Pension Plan, and whose last signatory employment was with the Employer, other than:

(i) a person receiving a deferred vested pension based on less than 20 years of credited service

(ii) a person receiving 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 whose last classified signatory employment was with the Employer, subject to the provisions of Article II B of this Plan;

(iii) a person receiving a special permanent layoff pension or 30-and-Out pension under the terms of Article II E(3) or II E(4) of the 1974 Pension Plan, during any period prior to the person's attainment of age 55;

(iv) a person who was first hired by the Employer on or after January 1, 2007, who does not have a State Miner's Certificate dated prior to January 1, 2007; provided that this exclusion (iv) shall not apply to such a person who subsequently qualifies for and thereafter receives a Disability Retirement or Minimum Disability Retirement pension, or who subsequently becomes a Disabled Employee (within the meaning of Article II C, herein) and thereafter receives a pension;

(v) a person who has made a one-time, irrevocable election to have Enhanced Premium Contributions made to the Cash Deferred Savings Plan, as provided in Articles XX and XXB(d)(4) of the Wage Agreement; provided that this exclusion (v) shall not apply to such a person who subsequently qualifies for and thereafter receives a Disability Retirement or Minimum Disability Retirement pension, or who subsequently becomes a Disabled Employee (within the meaning of Article II C herein) and thereafter receives a pension; or

(vi) a person entitled to benefits under section 9711 of the Internal Revenue Code of 1986, as amended by the Coal Industry Retiree Health Benefit Act of 1992.

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

(7) "Dependent" shall mean any person described in Section D of Article II hereof.

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

(9) "Signatory Service" shall have the meaning assigned to such term in the United Mine Workers of America 1974 Pension Plan (the "1974 Pension Plan") or any successor thereto.

(10) "Trustee" or "Trustees" shall mean the Trustees of the United Mine Workers of America Health and Retirement Funds.

(11) "UMWA" means the United Mine Workers of America.

(12) "BCOA" means the Bituminous Coal Operators' Association, Inc.

(13) "Affordable Care Act" means the Patient Protection and Affordable Care Act of 2010.

ARTICLE II ELIGIBILITY

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

A. ACTIVE EMPLOYEES

Benefits under Article III shall be provided to any Employee who:

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

2. is on layoff or disabled from the Employer and had continuing eligibility as of the Effective Date of the Wage Agreement for coverage under the 2011 Employer's Benefit Plan ("prior Plan") as a laid off or disabled employee. Coverage for such laid-off or disabled Employees shall not continue beyond the date when they would no longer have been eligible for coverage under the provisions of the prior Plan.

3. is on leave under section 102 of the Family and Medical Leave Act of 1993, subject to Article III A10. g herein.

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

   Any Employee of the Employer who as of the Effective Date, was eligible for benefits under the prior Plan who is not scheduled to work within two weeks after the Effective Date of the Wage Agreement because of lack of work, will, if eligible under Article III D(1)(a) of this Plan, be considered eligible for coverage under this Plan as of the Effective Date of the Wage Agreement but as an Employee on layoff as of such date.

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

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

B. PENSIONERS

Health benefits under Article III hereof shall be provided to Pensioners as follows:

1. Any Pensioner who is not again employed in classified signatory employment subsequent to

   a. such Pensioner's initial date of retirement under the 1974 Pension Plan, and

   b. the Effective Date, shall be eligible for coverage as a Pensioner under, and subject to all other provisions of this Plan. Notwithstanding (i) and (ii) of the definition of Pensioner in Article I(5) of this Plan, any such Pensioner who was eligible for benefits under the 1974 Benefit Plan as a Pensioner on December 5, 1977, shall be eligible for such benefits, subject to all other provisions of this Plan.

   c. Notwithstanding subpart (i) of the definition of Pensioner in Article I (5) of this Plan, any such Pensioner who opts out of the UMWA 1974 Pension Plan and subsequently obtains more than 20 years of service based on the calculation of the number of combined years he has received 1974 Pension Plan credit hours and Supplemental Pension Contribution Hours, shall be eligible for such health benefits, subject to all other provisions of this Plan.

2. Any person who

   a. Has been covered as a Pensioner under this Plan, and

   b. is again employed in classified signatory employment after the Effective Date, with an employer signatory to the Wage Agreement, other than the Employer, shall have coverage under the Plan suspended during such period of employment. If such person is credited with at least three or more years of service under the 1974 Pension Plan after the Effective Date, while so employed with the same employer, coverage shall be terminated under this Plan.

3. Any person who

   a. has been receiving a pension under the 1974 Pension Plan,

b. has not been previously covered as a Pensioner under this Plan, and

c. is employed in a classified job by the Employer after the Effective Date, shall, upon subsequent retirement, be covered as a Pensioner under this Plan only if such person is a "Pensioner" within the meaning of Article I(5) herein, and is credited with at least three or more years of service under the 1974 Pension Plan subsequent to the most recent date of employment in a classified job with the Employer.

C. DISABLED EMPLOYEES

In addition to disabled Pensioners who are receiving pension benefits and are therefore entitled to receive health benefits under section B of this Article II, health benefits under Article III shall also be provided to any Employee who:

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

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

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

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

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

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

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

D. ELIGIBLE DEPENDENTS

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

(1) A spouse who is living with or being supported by an eligible Employee or Pensioner;

(2) Children of an eligible Employee or Pensioner who have not attained age 26.

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

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

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

For purposes of this section D, a grandchild or parent shall be considered dependent upon an eligible Employee, Pensioner or spouse if such Employee, Pensioner or spouse provides over one-half of the support to such person.

E. SURVIVING SPOUSE AND DEPENDENTS OF DECEASED EMPLOYEES OR PENSIONERS

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

1. As a result of a mine accident occurring on or after the effective date of the Plan while the Employee was working in a classified job for the Employer;

2. Under conditions which qualify such spouse for a Surviving Spouse benefit under the 1974 Pension Plan or any successor thereto, or would have so qualified the spouse had the Employee not been an Electing Miner;

3. At a time when such Employee or Pensioner is entitled to receive health benefits pursuant to section A, B, or C of this Article II, provided that (i) if such Employee or Pensioner died prior to the effective date of the Wage Agreement and the spouse is not eligible for a Surviving Spouse's benefit, then only for the period that the spouse is eligible to receive death benefits in installment payments, or (ii) if such Employee or Pensioner died on or after the Effective Date of the Wage Agreement as provided for in Article XXIX of the 2016 NBCWA and the spouse is not eligible for a Surviving Spouse's benefit and life insurance benefits or death benefits under any plan maintained pursuant to Article XX of the 2016 Wage Agreement that are payable in a lump sum, then only for 60 months following the month of the death of such Employee or only for 22 months following the month of death of such Pensioner. If life insurance benefits are not payable, health benefits shall be provided only to the end of the month in which the Employee or Pensioner died.

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

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

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

If at the death of an Employee or pensioner described in subsection (3) above, there is no surviving spouse, or if the surviving spouse dies during any period in which health benefits are being continued, such health benefits will be continued for the children during the period in

which such spouse would have been eligible for health benefits but in no event beyond their attaining age 26.

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

ARTICLE III. BENEFITS

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

During any period when PPLs are not in effect, and for covered services and supplies not offered under a PPL (or otherwise not subject to a PPL-related benefit limit), benefit payments shall not exceed reasonable and customary charges* for covered services and supplies. Covered services shall be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at the appropriate level of care, or are otherwise provided for in the Plan. The fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary or that it is covered under this Plan. In determining questions of reasonableness and necessity, due consideration will be given to the customary practices of physicians in the community where the service is provided.

Services which are not reasonable and necessary shall include, but are not limited to the following: procedures which are of unproven value or of questionable current usefulness; procedures which tend to be redundant when performed in combination with other procedures; diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly; procedures which are not ordered by a physician or which are not documented in timely fashion in the patient's medical records; procedures which can be performed with equal efficiency at a lower level of care.

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* The reasonable and customary charge for any service or supply is the usual charge for the service or supply in the absence of insurance. The usual charge may not be more than the general level of charges for illness or injury of comparable severity and nature made by other providers within the geographic area in which the service or supply is provided. This is determined by the use of prevailing health care charges guides such as that prepared by the Health Insurance Association of America (HIAA).

The benefits described in this Article are subject to any precertification, prescription drug formulary (PDP) requirements, and other utilization review requirements implemented pursuant to Article IV. Covered services that are medically necessary will continue to be provided, and accordingly, while benefit payments are subject to prescribed limits, this paragraph shall not be construed to detract from plan coverage or eligibility as described in this Article 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 a Beneficiary who is confined for mental illness in a hospital by a licensed psychiatrist on the same basis as any medically necessary hospitalization.

f. Alcoholism and Drug Abuse

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

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

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

g. Oral Surgical/Dental Procedures

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

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

h. Maternity Benefits

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

i. General

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

2. Outpatient Hospital Benefits

a. Emergency Medical and Accident Cases

Benefits are provided for a Beneficiary who receives emergency medical treatment or medical treatment of an injury as the result of an accident, provided 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 Services

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

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

d. Anesthesia Services

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

e. Oral Surgery

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

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

f. Surgical Services Limitations

Benefits are not provided for certain surgical services without prior approval of the 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) Preventive care and preventive services meeting one of the following requirements are covered benefits and will not be subject to any deductible or copayment when provided in-PPL:

(a). Evidenced-based items or preventive services, including various types of screenings (e.g., blood pressure screenings, cholesterol screenings, various STD screenings, diabetes screening, depression screenings, tobacco use counseling, breast cancer screenings, genetic counseling, and BRCA testing) with an "A" or

"B" rating recommended by the United States Preventive Services Task Force (USPSTF), an independent panel of scientific experts;

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

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

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

p. Services Not Covered

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

(2) Acupuncture therapy.

(3) Home obstetrical delivery.

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

(5) Charges for writing a prescription.

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

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

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

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

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

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

4. Prescription Drugs

a. Benefits Provided

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

The initial amount dispensed shall not exceed a 30-day supply. Any original prescription may be refilled for up to six months as directed by the attending physician. Each such refill may be for an amount up to, but no more than, a 90-day supply. Benefits for refills beyond the initial six months require a new prescription by the attending physician. Prescriptions filled by the Plan's mail order provider, if any, are not subject to the limits on quantity set forth in this paragraph.

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

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

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

(3) The current price paid to participating pharmacies in any prescription drug program established by the Plan.

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

b. Benefits Excluded

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

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

(2) Prescriptions dispensed by other than a licensed pharmacist.

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

(c) List of Preferred Drug Products (PDP)

1. Benefits are subject to the requirements of a PDP that has been certified by the Pharmacy Review Board as required in Article IV. Beneficiaries may file an appeal to request that they be permitted to use a non-PDP drug and not pay a surcharge. If a Beneficiary fills a prescription for a non-PDP drug, a communication will be sent to both the physician and the individual outlining the appeal process and the surcharge for additional purchases. If no appeal is received within 30 days, the next refill of the drug will be subject to a $10.00 surcharge, and each following refill of that drug will be subject to a $20.00 surcharge. If an appeal is filed, surcharges are suspended for 60 days, or until the date of the resolution of the appeal, if later.

2. Decisions of the Pharmacy Review Board are binding.

5. Skilled Nursing Care and Extended Care Units

a. Skilled Nursing Care Facility

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

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

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

(2) room and board;

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

(4) medical social services;

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

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

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

Benefits in a licensed skilled nursing care facility will be provided up to a maximum of 100 days for an eligible Beneficiary.
The Plan will not pay for services in a nursing care facility:

1. That is not licensed or approved in accordance with Federal Medicare and state laws or regulations;

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

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

b. Extended Care Units

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

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

Exclusions:

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

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.

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

b. Physical and Speech Therapy

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

c. Skilled Nursing

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

d. Medical Equipment

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

e. Oxygen

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

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

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

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

f. Coal Miners Respiratory Disease Program

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

7. Other Benefits

a. Orthopedic and Prosthetic Devices

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

The following types of equipment are covered:

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

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

(2) Prosthesis following breast removal.

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

(4) Trusses.

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

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

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

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

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

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

b. Physical Therapy

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

c. Speech Therapy

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

d. Hearing Aids

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

e. Ambulance and Other Transportation

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

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

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

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

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

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

f. Outpatient Mental Health, Alcoholism and Drug Addiction

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

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

8. Co-Payments and Deductibles

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

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

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

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

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

Out-of-PPL Costs

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

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

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

The required co-payments are:

	In-PPL	**Out-of-PPL**
Prescription Drugs 30-Day Supply	$20.00 per prescription	$35.00 per prescription
Prescription	$10.00 per	Not Applicable

Drugs--Mail Order (where available) 30-Day Supply	prescription	
Prescription Drugs--Brand Name Where Generic is Available 30-Day Supply	$20.00 Plus Additional Cost of Brand Name Drug	$35.00 Plus Additional Cost of Brand Name Drug
Physician Charges	$25.00 per office visit	$35.00 per office visit
Hospital and Related Charges	$25.00 per hospitalization	$35.00 per hospitalization plus balance over 90% of PPL charges

Deductibles -- In addition to these co-payments, each family shall be responsible for an annual medical care deductible of $650.00 per family, of which $325.00 applies to physician and other non-hospital medical provider charges (including tests, lab work, etc.), and $325.00 applies to hospital and related charges incurred by a hospital, clinic or similar institution (including tests, lab work, etc.). From the Effective Date to December 31, 2016, the $650.00 and $325.00 deductibles described above shall be $244.00 and $122.00 , respectively. The deductible excludes the cost of prescription drugs, which are covered by a separate out-of-pocket maximum of $1,000.00 per family per year ($375.00 from the Effective Date to December 31, 2016) as set forth below.

In addition:

a. No family will have to pay more than $1,000.00 in combined Physician office visits and Hospital and Related Charges in any year ($375.00 from the Effective Date to December 31, 2016).

b. No family will have to pay more than a Maximum Out-Of-Pocket of $2,000.00 in combined Hospital and Related Charges, Physician office visits, and Prescription Drug Charges in any year ($750.00 from the Effective Date to December 31, 2016).

c. No family will have to more than $1,000.00 in prescription drugs in any year ($375.00 from the Effective Date to December 31, 2016) .

d. Emergency Room visits are subject to a $35.00 copayment In-PPL and $40.00 Out of PPL.

e. Preventive care and preventive services meeting one of the requirements of Article III. A.3.o.(10) are covered benefits and are not subject to any deductible or copayment when provided in-PPL:

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

Non-PDP surcharge:	Initial Prescription:	None
	First Refill:	$10.00
	Second and Subsequent Refills:	$20.00

Notwithstanding the foregoing, if, within 30 days of the Employer's communication required under Article III.A(4)(c) outlining the appeal process and the surcharge for additional purchases of non-PDP drugs, the Beneficiary files an appeal, surcharges are suspended for 60 days, or until the date of the resolution of the appeal, if later.

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

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

If a medical service requiring precertifiction is utilized without obtaining the required precertification, the following payment is required as an additional deductible:

Any specified service obtained without required precertification	$300.00 not applied to annual out-of-pocket maximum

For Out-of-PPL services, claim forms will be available at most hospitals, clinics, and physician offices. Generally, nothing more is required than signing the forms authorizing the hospital, clinic, or physician to bill the insurance carrier for the services rendered. The insurance carrier will keep individual records for each Beneficiary and dependent and will notify the Beneficiary of the co-payments and deductibles credited to his account. The hospital, clinic, or physician will bill the Beneficiary for the co-payment and deductible amount until the maximum is reached. In some instances, when the Employee pays for services or drugs, the bills should be obtained and

submitted with the claim form according to the instructions on the form. If the annual deductible and co-payment maximum has been reached, the carrier will remit to the Beneficiary the full payment for covered benefits.

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

Where possible, for In-PPL services, no claim forms will be required. The PPL provider will generally be responsible for the submission of claims and other paperwork to the insurance carrier. Although a PPL provider may require payment by the Beneficiary of permitted co-payments, such a provider may not require payment by a Beneficiary of amounts that exceed the permitted copayments.

Covered drug prescriptions may be filled at drugstores, clinics and hospital prescription offices. In an effort to address the problems generated by the ever-increasing cost of prescription drugs, while recognizing the importance of prescription drugs and their value in managing employee health care, and while maintaining a high level of benefits, the parties have mutually agreed to adopt managed care and cost containment programs as described in Article IV herein.

9. Vision Care Program

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

-- Frames	$33.13	Once every 24 months

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

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

c. Exclusions include:

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

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

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

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

(5) experimental services or supplies;

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

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

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

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

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

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

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

10. General Provisions

a. 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 and Beneficiaries claiming benefits under this Plan.

The Trustees of the UMWA Health and Retirement Funds will resolve any disputes, including excessive fee disputes, to assure consistent application of the Plan provisions under the 2016 Wage Agreement. The Trustees shall develop procedures for the resolution of such disputes. In the event the Trustees decide such dispute, such decision of the Trustees shall be final and binding on the parties. If the Trustees are unable to resolve the dispute, such dispute shall be referred to a permanent arbitration panel of up to three members selected by mutual agreement of the UMWA and the BCOA and maintained by the Trustees. A dispute referred in this manner shall be decided by one member of the arbitration panel, determined on a rotating basis, whose decision shall be final and binding on the parties. Precedent under the resolution of disputes mechanism previously in place shall remain in effect, and the panel shall be required to cooperate to assure the consistent interpretation of provisions under the Employer Plans under the 2016 Wage Agreement.

The Plan Administrator shall give written notice to each Employee of the termination of coverage under the Benefit Plan. Such notice shall explain the conversion privileges of the Benefit Plan and the enrollment procedures to be followed. Failure to provide such notice shall not extend coverage beyond the period otherwise provided in the Benefit Plan.

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c. Services Rendered Outside the United States

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

d. Medicare

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

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

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

e. Subrogation

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

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

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

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

f. Non-Duplication

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

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

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

(b) 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:

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

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

(c) 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.

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

(3) As used herein, "group plan" means (i) any plan covering the individuals as members of a group and providing hospital or medical care benefits or services

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

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

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

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

g. Recovery of Family and Medical Leave Act Premium

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

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

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

1. the continuation, recurrence, or onset of a serious health condition of the Employee,

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

3. other circumstances beyond the control of the Employee.

The Employer may in its sole discretion require a certification of a health provider attesting to the existence of the factors set forth in 1 or 2, above.

h. Explanation of Benefits (EOB) and Hold Harmless

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

(2) The Employer and the UMWA agree that excessive charges and escalating health costs are a joint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, the Plan Administrator or their agent shall, with the written consent of the Beneficiary, attempt to resolve the matter, either by negotiating a resolution or defending any legal action commenced by the provider. Whether the Plan Administrator or their agent negotiates a resolution of a matter or defends a legal action on a Beneficiary's behalf, the Beneficiary shall not be responsible for any legal fees, settlements, judgments or other expenses in connection with the case, but may be liable for any services of the provider which are not provided under the Plan. The Plan Administrator or their agent shall have sole control over the conduct of the defense, including the determination of whether the claim should be settled or an adverse determination should be appealed. The "hold harmless" protections available under this subparagraph do not apply in the case of any service or supply obtained from a non-PPL source until the non-PPL out-of-pocket maximum is reached.

11. General Exclusions

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

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

(2) Services rendered

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

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

(c) 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 for reversal of sterilization procedures.

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

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

(16) Charges for medical services for inpatient or outpatient treatment for mental retardation and other mental deficiencies.

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

(18) Dental services.

(19) Birth control devices and medications, except preventive care and preventive services meeting one of the requirements of Article III. A.3.o.(10).

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

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

(22) Exercise equipment.

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

(24) 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.

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

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

(27) Any claim which is submitted for payment under the Plan after eighteen (18) months or more from the date of service.

(28) Expenses incurred as a result of injury sustained by the covered individual who is actually operating any motor vehicle used for ground transportation with a blood alcohol level over the legal limit prescribed by the laws of the state in which the injury was sustained.
(29) Any condition, disability or expense incurred by a covered individual resulting from or sustained as a result of a felonious act by that covered

individual; provided that this exclusion will not apply if the injury resulted from a medical condition or act of domestic violence.

12. Health Benefit Provisions

a. Newborns' and Mothers' Health Protection Act.

The Plan shall provide maternity care benefits in accordance with the Newborns' and Mothers' Health Protection Act (the "Newborn's Act"). In accordance with the Newborn's Act, the Plan shall provide benefits for a minimum of forty-eight (48) hours of inpatient hospital stay for a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital stay for caesarean section delivery unless the health care provider and the mother agree that discharge from the hospital shall occur earlier.

b. Mental Health Parity Act

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

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

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

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

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

c. Women's Health and Cancer Rights Act

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

d. No Lifetime or Annual Limits

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

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

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

For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits and cost sharing limits under the Affordable

Care Act, the Plan has chosen Ohio as its benchmark state.

e. No Preexisting Condition Exclusions

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

f. No Rescission of Coverage

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

g. Coverage of Clinical Trials

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

h. Claims and Appeals Procedures

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

If a Beneficiary is requesting reimbursement for a covered expense paid by the Beneficiary, the Beneficiary must first seek to resolve the matter with the applicable Provider. All other claims for covered benefits must also be submitted first to the Provider. If the matter is not resolved by the Provider, the Beneficiary must file a claim with the Plan Administrator. All claims must be filed with the Plan Administrator within eighteen (18) months of the date of service. Any claim

that is submitted for payment under the Plan after eighteen (18) months or more from the date of service is untimely and shall be denied.

If a Beneficiary believes he or she has been denied a covered benefit by the Plan Administrator, the Beneficiary shall have 180 days to file an appeal of a denied claim with the Trustees of the UMWA Health and Retirement Fund under the Resolution of Dispute ("ROD") Procedure established under Article XX(e)(5) of the NBCWA of 2016. Any appeal that is filed after 180 days or more from the date of the Plan Administrator's decision is untimely and shall be denied. The 180-day period shall not commence any earlier than the date of the final denial of any administrative appeal or appeal to an independent review organization, as applicable. The Trustees shall develop procedures for the resolution of such disputes. In the event the Trustees decide such dispute, such decision of the Trustees shall be final and binding on the parties. If the Trustees are unable to resolve the dispute, such dispute shall be referred to a neutral arbitrator selected by mutual agreement of the Trustees. A dispute referred in this manner by an arbitrator shall be final and binding on the parties. Precedent under the resolution of disputes mechanism previously in place shall remain in effect, and the arbitrator shall be required to cooperate to assure the consistent interpretation of provisions under the Employer Benefit Plan.

B. Life and Accidental Death and Dismemberment Insurance for Active Employees

Life and accidental death and dismemberment insurance will be provided for Employees, as described in Article II, Sections A and C(3) herein, in accordance with the following schedule:

(1) Upon the death of an Employee due to other than violent, external and accidental means on or after the Effective Dateand through December 31, 2021, life insurance in the amount of $90,000 will be paid to the Employee's named beneficiary.

(2) Subject to (4) below, upon the death of an Employee due solely to violent, external and accidental means as the result of an injury occurring while insured on or after the Effective Date and through December 31, 2021, life insurance in the amount of $180,000 will be paid to the Employee's named beneficiary.

(3) If an Employee shall lose two or more members due to violent, external and accidental means as the result of an injury occurring while insured on or after the Effective Dateand through December 31, 2021, such Employee shall receive a $120,000 dismemberment benefit. If an Employee shall lose one member due solely to violent, external and accidental means as the result of an injury occurring while insured from on or after the Effective Dateand through December 31, 2021, such Employee shall receive a $60,000 dismemberment benefit.

A member for the purpose of the above is (i) a hand at or above the wrist, (ii) a foot at or above the ankle or (iii) total loss of vision of one eye.

(4) Accidental death or dismemberment benefits are not payable if caused in whole or in part by disease, bodily or mental infirmity, ptomaine or bacterial infection, hernia, suicide, intentional self-inflicted injury, insurrection, or acts of war, whether declared or not, or is caused by or results from committing a felony.

C. Death Benefits

Death benefits for eligible Pensioners will be provided by the UMWA 1974 Pension Plan pursuant to the provisions of the 1974 Pension Plan.

D. General Provisions

(1) Continuation of Coverage

(a) Layoff

If an Employee ceases work because of layoff, continuation of health, life and accidental death and dismemberment insurance coverage is as follows:

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

(b) Disability

Except as otherwise provided in Article II, section C, if an Employee ceases work because of disability, the Employee will be eligible to continue health, life and accidental death and dismemberment insurance coverage while disabled for the greater of (i) the period of eligibility for Sickness and Accident benefits, or (ii) the period as set forth in the schedule in (a) above.

(c) Leave of Absence

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

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

3. If an Employee who is on an approved leave of absence is placed on lay-off status, or would have been placed on lay-off status had the Employee been actively at work, health, life and accidental death and dismemberment coverage shall be reinstated as of the effective date of lay-off. Such coverage shall continue for a period determined pursuant to the provisions of paragraph (a) above using the commencement date of the leave of absence in place of the date last worked for purpose of determining the number of hours worked. In no event shall coverage under this paragraph continue beyond the balance of the month plus 12 months from the effective date of lay-off. An Employee who returns to work after having been on leave of absence shall not have the period for which such Employee was on leave of absence included in the 24-calendar-month period as used in paragraph (a) for determining eligibility for continuation of coverage.

(d) Maximum Continuation of Coverage

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

(e) Quit or Discharge

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

(f) Other Employment

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

(g) Article III (j) - Wage Agreement

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

(h) COBRA Continuation Coverage

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

(2) Advanced Insurance Premiums

In the event of an economic strike at the expiration of the 2016 Wage Agreement or a reopener, the Employer will advance the premiums for its health, vision care, and life and accidental death and dismemberment insurance coverage for the first 30 days of such strike. Such advanced premiums shall be repaid to the Employer by such Employees through a check-off deduction upon their return to work. Should such a strike continue beyond 30 days, the Union or such Employees may elect to pay premiums themselves.

(3) Conversion Privilege

(a) Life Insurance

Upon application to the insurance carrier within 31 days after life insurance coverage terminates, the Employee may, subject to applicable state insurance laws, arrange to continue life insurance protection under an individual policy, for an amount not greater than $50,000 without evidence of insurability. Such individual policy may be on any one of the forms of policy then customarily issued by the insurance company, other than a policy of term insurance or one which provides disability benefits in the event of accidental death, and will be issued at the rate applicable to the Employee's age and class of risk at the time.

(b) Health Benefits

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

(4) Qualified Medical Child Support Orders.

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

ARTICLE IV. MANAGED CARE, COST CONTAINMENT

A. (1) The Employer may adopt Participating Provider Lists (PPL's) of physicians, hospitals, pharmacies and other providers, subject to the requirements set forth in C., below. The Employer may implement a formulary list of preferred drug products (PDP), subject to the requirements set forth in D., below.

(2) 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 deductible and 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.

B. The Employer will comply with any UMWA-BCOA agreed-upon procedure for determining whether a PPL satisfies appropriate criteria, and for identifying specific procedures

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subject to precertification. 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, where any agreed-upon procedure has been followed. 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).

C. The following requirements apply to a PPL implemented under this Plan:

1. Initial Certification and recertification--All Participating Provider Lists (PPLs) must be certified prior to their implementation to ensure that they meet the required standards, and recertified at least once during the term of this Agreement, in accordance with a procedure to be agreed-to between the UMWA and the BCOA.

The costs of certification and recertification will be borne by the Employer.

2. Ongoing review--Continued compliance of each PPL with the required standards will be subject to ongoing review.

3. Criteria--A PPL established by an Employer must meet the necessary criteria. The following is a general statement of the required elements:

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

5. Reduction of Paperwork and Prohibition on Prepayment--Eligible individuals utilizing PPL providers shall, to the extent possible, not be required to fill out or submit claims forms. In addition, such individuals shall not be required to pay a PPL provider any amount other than the copayment and any outstanding annual deductible permitted under this Agreement.

6. Quality Certification--All providers must meet quality standards.

7. Accessibility

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

b. There will be adequate numbers of providers in the different specialties to ensure that each member will have a sufficient choice.

c. Providers must be available to see covered individuals within a reasonable period, depending upon the nature of the problem.

8. Breadth of Scope--The PPL shall include adequate diversification of specialties and facilities.

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

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

11. Emergencies--Emergency treatment is covered in full (subject to applicable deductible and copayments) whether or not provided within the PPL.

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

13. Transition--Out of PPL--If a beneficiary has begun to undergo a course of treatment with a non-PPL provider prior to the establishment of the PPL (or with a PPL provider that leaves the PPL), completion of that course of treatment will not be considered "out of PPL" as follows:

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

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

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

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

16. Precertification--Precertification for services (including hospitalization) performed by PPL providers is the responsibility of the provider, and not the covered individual. In addition,

precertification in the event a covered individual is referred to a provider outside the PPL is the responsibility of the PPL provider making the referral.

Failure to precertify a non-emergency hospital admission to a non-PPL hospital (other than by referral from a PPL provider) or certain other specified inpatient and out-patient procedures performed by a non-PPL provider, will subject the Beneficiary to a $300 deductible.

D. The following requirements apply to a PDP implemented under this Plan:

1. The UMWA and BCOA will mutually agree to the appointment and retention of a third party Pharmacy Expert. The individual appointed must have actively practiced as a pharmacist and currently be a registered pharmacist.

2. The Pharmacy Expert cannot be an employee of any Pharmacy Benefit Manager or Pharmaceutical Manufacturer.

3. The Pharmacy Expert will participate on a Pharmacy Review Board composed of one member appointed by the UMWA, one member appointed by the Employer, and the Pharmacy Expert. The Pharmacy Review Board will certify the PDP. Any PDP that is currently in use by the Employer must be certified.

4. The initial certification process must be completed within 120 days after the appointment of a Pharmacy Expert. An Employer may continue to use the current PDP of its Plan during the selection of a Pharmacy Expert and during the 120-day certification process.

Certification of the PDP by the Pharmacy Review Board will be based on the following criteria:

a. The PDP was recommended by the P&T Committee at the Employer's Pharmacy Benefits Manager (PBM).

b. The Pharmacy Expert, as a member of the Pharmacy Review Board, should evaluate the PDP based on the following standards of quality:

Safety, Efficacy, Comparison Studies, Approved Indications, Adverse Effects, Contraindications/Warnings/Precautions, Pharmacokinetics, Patient Administration/Compliance Considerations, Medical Outcome and Pharmacoeconomic studies.

5. Election, Removal or Change of the Pharmacy Expert.

a. The Pharmacy Expert must be selected on or before September 30, 2016.

b. The Pharmacy Expert can be removed and/or replaced at any time subject to the mutual agreement of the UMWA and BCOA. The current Pharmacy Expert will remain in his or her position until a replacement is selected. The replacement process cannot exceed 120 days.

6. Ongoing Review

a. The PDP will be reviewed annually.

b. Interim review will be performed as necessary, if mutually agreed upon by the UMWA and the Employer.

c. Changes in the PDP may only be adopted as part of an annual or interim review.

7. Decisions of the Pharmacy Review Board are binding.

8. The Employer will communicate changes in the PDP to plan participants and network physicians. Any change to the PDP will be communicated 90 days prior to taking effect.

9. If a participant fills a prescription for a non-PDP drug, a communication will be sent to both the physician and the individual outlining the appeal process and the surcharge for additional purchases. Refills are subject to the surcharges set forth in Article III.A.(4)(b).

ARTICLE V AMENDMENT AND TERMINATION

A. Mid-Term Amendments. The UMWA and BCOA (and its successors or assigns) reserve the right at any time and from time to time to modify or amend in whole or in part any or all of the provisions of this Plan, or to terminate this Plan, by written instrument between the UMWA and BCOA, without reopening or otherwise affecting the integrity of any other provision of the Wage Agreement.

B. Post-Termination Amendments. Subject to section C, following termination of the 2016 Wage Agreement, this Plan may be modified, amended, or terminated by BCOA and the UMWA, or by BCOA or the Employer as permitted by law.

C. Special Rule for Certain Pensioners. The Employer will provide, for life, only the benefits of its own eligible Pensioners who retired between the Effective Date and December 31, 2021. The benefits and benefit levels provided by the Employer under this Plan are established for the term of the 2016 Wage Agreement only, and may be jointly amended or modified in any manner at any time after the expiration or termination of the 2016 Wage Agreement.

D. Procedural Requirements. Any written instrument executed by BCOA and the UMWA shall be signed by the President of BCOA and by the International President of the UMWA. In the event BCOA ceases to exist 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 model plan, established under Article XX of the National Bituminous Coal Wage Agreement of 2016 and effective as of August 15, 2016, (the "Effective Date"), to be signed by their proper officers or representatives on this ____ day of _____, 2016.

UNITED MINE WORKERS OF AMERICA

_____
International President

BITUMINOUS COAL OPERATORS' ASSOCIATION, INC.

_____
President