HEALTH CARE PLAN

FOR FULL-TIME EMPLOYEES

TABLE OF CONTENTS

INTRODUCTION

In order to provide protection for you and your dependents against unexpected medical expenses caused by accident or sickness, Apogee Coal Company (the "Company") provides you with a Comprehensive Health Care Plan (the "Plan"). The program is divided into six parts:

- The Hospital Expense Benefit covers a large part of your hospital and medical expenses.
- The Medical Surgical Services Benefit covers physicians' charges and related medical expenses.
- The Major Medical Expense Benefit pays benefits in addition to those paid by the Hospital Expense and Medical Surgical Services Benefits.
- The Chiropractic Care Benefit covers chiropractic fees and related charges.
- The Prescription Drug Benefit covers the cost of prescription drugs purchased outside of a hospital.
- Hearing Aid Benefits pays a large part of the cost of hearing aids for you and your dependents.

ELIGIBILITY

If you are a full-time employee of the Company, or a subsidiary Company or affiliate which adopts this program, you and your eligible dependents will be covered under the Plan on your first day of work.

Your eligible dependents include:

- Your spouse.
- Unmarried dependent children who have not reached their 19th birthday (or 25th birthday if attending school full-time). Dependent children mean your natural children, step-children, foster children, legally adopted children, or children for whom legal adoption proceedings have been started.
- Unmarried dependent children who are incapable of supporting themselves due to a mental or physical handicap are covered regardless of age, if they became handicapped before reaching age 19.

Pre-Existing Conditions

Pre-existing conditions are handled as follows:

- If you or any of your eligible dependents received treatment within three (3) months, or ninety (90) days prior to your effective date (or your eligible dependent's effective date) of hire for a diagnosis, illness, or injury, the Plan will not reimburse

for those pre-existing condition medical charges.

- For the first eighteen (18) months of employment, no pre-existing charges will be eligible for reimbursement.
- Pre-existing charges incurred after the eighteen (18) month employment period will be considered eligible for reimbursement.
- This also applies to pregnancy, but does not apply to Complications of Pregnancy* which occur after the effective date of a person's coverage.
- SPECIAL RULE FOR REHIRES: If you are terminated due to a reduction in force for more than six (6) months, your benefits begin as if you were a new hire.

COST OF COVERAGE

the Company pays 100% of the premium costs for your coverage under the Plan. However, certain portions of your health care coverage require deductibles (co-payments) to be met, and they are as follows:

- Hospital Expense Benefits - no cost to you.
- Medical Surgical Expense Benefits - no cost to you.
- Major Medical Expense Benefits - a $50.00 deductible per eligible family member per year.
- Chiropractic Care Benefits - a $60.00 deductible per eligible family member per year.
- Prescription Drug Benefits - a $5.00 or 20% co-pay (whichever is greater) per prescription.
- Hearing Aid Benefits - no cost to you.

It is also important to note the Plan will only reimburse 100% of the Usual and Customary charges as determined by HIAA. In addition, the Plan has certain coverage limitations for varying conditions (such as mental health/substance abuse coverage). These limitations are specifically stated throughout the Plan.

HOW TO ENROLL FOR COVERAGE

To enroll in our Health Care Plan, you simply complete, sign and return the enrollment form to your Human Resources Representative.

HOW THE HEALTH CARE PLAN WORKS

Your Health Care Plan is divided into six benefits which cover different expenses and pay different benefit amounts. Each of these benefits work together to provide you and your family with invaluable comprehensive protection.

The six benefits which make-up your Health Care Plan are:

The Hospital Expense Benefit
The Medical Surgical Services Benefit
The Major Medical Expense Benefit
Chiropractic Care Benefit
Prescription Drug Benefit
The Hearing Aid Benefit

Each will be discussed separately in this booklet. The benefits described in this booklet apply to charges for covered expenses. Covered expenses are limited to the Reasonable & Customary* allowance determined by the Plan and must be incurred while coverage is in effect. In addition, all hospitalization charges, most surgical fees, many outpatient procedures, chiropractic care programs, and physical therapy must be pre-approved by ReviewPLUS, the Pre-certification Review Program.

HOSPITAL EXPENSE BENEFIT

This portion of the Health Care Plan provides coverage for you and your dependents during hospitalization, and is not subject to a deductible.

What Is Covered Under The Hospital Expense Benefit

When you or one of your covered dependents is admitted to a Hospital for an illness or accidental injury, the Hospital Expense Benefit will provide up to 365 days of care during any one period of hospitalization.

Each period of hospital confinement for you or your dependent will count toward the individual 365 day maximum. However, a new 365 day period will be allowed in the following cases:

- In your case as an employee, if you have returned to active work with the Company or a subsidiary Company or affiliate which adopts this plan for at least one full day before the later confinement.

- In the case of your dependents when the two (2) confinements are due to the same or related cause and
  - your dependent fully recovers between them; or
  - the confinements are separated by six (6) months

*See Glossary

- In the case of your dependents when the two (2) confinements are **not** due to the same or related cause and
  - Your dependent recovers from the first disability before the later one begins.
  - The confinements are separated by at least three (3) months.

Under the Hospital Expense Benefit section of the Health Care Plan, coverage is provided for the following services:

- Room and Board*
- General Nursing Care
- Other Hospital Services and Supplies* including:
  - Operating, treatment and delivery rooms and equipment
  - Anesthesia
  - Drugs, medicines, and dressings
  - Oxygen and its administration
  - X-ray and other diagnostic examinations
  - Laboratory tests
  - Electrocardiograms
  - Dressings and casts
  - Administration of blood or plasma
  - Special diets
  - Radium therapy
  - Intravenous injections and solutions
- Certain Outpatient Expenses
- Ambulatory Surgery
- Physical therapy

NOTE: Non-emergency hospitalizations must be pre-approved by ReviewPLUS ten days before services are rendered, within 48 hours of admission in all emergency cases, or the next working day; between the 3rd and 4th visit for physical therapy before coverage will be allowed. See the section on ReviewPLUS for further details.

How Much The Hospital Expense Benefit Pays

Payment under the Hospital Expense Benefit depends upon the type of service you received.

- **Room and Board**

  Charges for Room and Board and general nursing care will be paid at the lesser of the Hospital's most common semi-private room rate or the Hospital's most common private room rate, for up to 365 days.

*See Glossary

- **Other Hospital Services and Supplies**

  In addition to Room and Board and general nursing care, the Reasonable and Customary* charges for most other covered Hospital Services and Supplies are paid in full for up to 365 days during any one period of hospitalization.

  Maternity benefits are payable the same as for any other Sickness. See the ReviewPLUS section for specific pre-certification requirements.

- **Inpatient Charges For Chemical Dependency Or Substance Abuse**

  Room and board and other hospital services and supplies are covered at 80% of the Reasonable and Customary* charge. Coverage is limited to 30 days per confinement with a lifetime maximum of 90 days of confinement.

- **Inpatient Charges For Mental Health Or Nervous Disorders**

  Room and board and other hospital services and supplies are covered at 80% of the Reasonable and Customary* charge. Coverage is limited to 180 days per confinement with a lifetime maximum of 180 days of confinement.

- **Outpatient Treatment**

  The following benefits apply to outpatient services in a Hospital

  Accidental Injury
  Notify ReviewPLUS within 48 hours of accident

  Minor Surgery
  Notify ReviewPLUS 10 days before the operation is to be performed

- **Outpatient Diagnostic Services** (Including Pre-Admission Testing)

  These include diagnostic testing, x-ray or laboratory exams which are done outside of the Hospital. They can be performed in the doctor's office, outpatient department of the hospital, or in a separate testing facility.

- **Outpatient Charges For Chemical Dependency Or Substance Abuse**

  The first ten (10) sessions are paid at 100% provided certification between the third (3rd) and fourth (4th) visits provide evidence of medical necessity. The call to ReviewPLUS ensures that you are

*See Glossary

receiving the most appropriate care and also enables ReviewPLUS to become involved with fee negotiation on your behalf. Thereafter, all sessions are reimbursed at 80% of Reasonable and Customary charges. The combined maximum payable under the hospital outpatient portion of this section and the major medical section of this plan is $3,000 per calendar year for all benefits paid in connection with chemical dependency and substance abuse.
REMEMBER: A $150.00 administrative penalty will be assessed if the call is not made between the third and fourth visits.

- **Outpatient Charges For Mental Health Or Nervous Disorders**

  The first ten (10) sessions are paid at 100% provided certification between the third (3rd) and fourth (4th) visits provide evidence of medical necessity. The call to ReviewPLUS ensures that you are receiving the most appropriate care and also enables ReviewPLUS to become involved with fee negotiation on your behalf. Thereafter, all sessions are reimbursed at 80% of Reasonable and Customary charges. The combined maximum payable under the hospital outpatient portion of this section and the major medical section of this plan is $3,000 per calendar year for all benefits paid in connection with a mental and/or nervous disorder.
  REMEMBER: A $150.00 administrative penalty will be assessed if the call is not made between the third and fourth visits.

- **Ambulatory Surgical Center**

  Benefits are payable when the surgical procedure required because of an injury, sickness or pregnancy, childbirth or related medical condition is performed in an ambulatory Surgical Center* on you or your dependent while covered. Payment will be made for the actual expense of the charges for services and supplies furnished by the center in connection with the procedure.

Services Not Covered Under The Hospital Expense Benefit

Services not covered under this portion of your Health Care Plan include:

- Physicians services or private duty nursing services.
- Charges in connection with a procedure where a local anesthetic is not administered by or under the supervision of a physician anesthesiologist.
- Prescription drugs while not confined in a Hospital.
- Any other charges, services or procedures not specifically listed as covered in the hospital benefit section of this Plan.

Additional exclusions are listed on pages 26 - 28.

*See Glossary

NOTE: These services may be covered under either the Medical Surgical Services or Major Medical Expense portions of the Plan. Refer to Pages 8 through 13 for more details.

MEDICAL SURGICAL SERVICES BENEFIT

This portion of your Health Care Plan provides coverage for medically necessary surgical procedures in or out of the Hospital, certain services while in the Hospital and Physician* charges for 365 days while you or one of your dependents are hospitalized.

What is Covered under the Medical Surgical Services Benefit

The surgical and anesthesia services covered are listed below:

- Surgeon's fees.
- When medically necessary, charges for an assistant surgeon if services of interns or resident physicians are not available.
- Administration of anesthesia by a Physician other than the operating surgeon or his assistant (local anesthesia is not included).
- Prolonged attendance by the Physician in furnishing constant bedside care to a critically ill bed patient.
- Intensive medical services to a Hospital bed patient when unusual and additional time and attendance are required by the Physician.
- Oral surgery which is necessary due to a tumor.
- Emergency physician services or ambulance charges for accidental injuries within 48 hours of the accident.
- Cosmetic Surgery or reconstructive surgery to:
  1. Correct a birth defect for a child who has been covered since birth.
  2. Replace diseased tissue removed while covered under the Plan.
  3. Correct a defect caused by an accident which occurred while covered under the Plan provided surgery is performed within one year of the accident.
- Diagnostic x-rays, laboratory examinations, and interpretations when confined to a Hospital, or, in the case of emergency illness or injury, in a Physician's office or the outpatient department of a Hospital.
- Radiation therapy rendered in or out of the Hospital.

*See Glossary

- Endoscopic Examinations in a Physician's office, Hospital and Ambulatory Surgical Center.
- Medical, surgical or obstetrical consultations for a Hospital bed patient when requested by the attending Physician.
- A Second Surgical Opinion* from a Board Certified Specialist*.

NOTE: Many surgical procedures must be pre-certified. See the ReviewPLUS section of this guide for details.

How Much The Medical Surgical Services Benefit Pays

You and your dependents will be fully reimbursed for up to 365 days for all Reasonable and Customary* charges for medical surgical and anesthesia services provided by a licensed Physician.

Services Not Covered Under the Medical Surgical Services Benefit

The following will not be covered under this part of the Health Care Plan:

- Drugs and medicines dispensed by a licensed pharmacist while you or one of your dependents are not confined to a Hospital.
- Hospital Room and Board and general nursing services.
- Treatment of the teeth or supporting tissues of the teeth, except tumors. Additional exclusions are listed on Pages 28.
- Any other charges, services or procedures not specifically listed as covered in the Medical Surgical Services Section of this benefit plan.

NOTE: These charges may be covered under the Hospital Expense Benefit or Major Medical Expense Benefit portions of the Plan. See Pages 9 through 14 for more details.

MAJOR MEDICAL EXPENSE BENEFITS

The Hospital Expense and Medical Surgical Services Expense Benefits provide coverage for almost all the Hospital and Surgical expenses and some medical expenses that you and your covered dependents might incur. However, when a serious accident or sickness strikes, expenses may exceed the coverage provided under these Benefits. That's when your Major Medical Expense Benefit comes into play to protect you and your family against those additional and often heavy expenses.

*See Glossary

The Major Medical Expense Benefit supplements the Hospital Expense and Medical Surgical Services Expense Benefits by covering expenses while not hospitalized, such as medical services of Physicians, nursing services, emergency ambulance service, Pap smears and Child Health Care.

What Is Covered Under The Major Medical Expense Benefit

Covered expenses include any Reasonable and Customary* charges for medical services and supplies which are performed or prescribed by a qualified physician or surgeon. These expenses may be incurred in or out of the Hospital and include:

- Medical and surgical services of legally qualified physicians or surgeons, including specialists, except as indicated for Mental and Nervous* conditions.
- Services of a trained nurse other than a nurse who ordinarily lives in your home or who is a member of your immediate family.
- Emergency ambulance service to and from the nearest facility where care can be given.
- Hospital charges for Room and Board, up to the Hospital's semi-private room rate, after the Hospital Expense Benefit coverage has been exhausted.
- Charges for Hospital Services and Supplies*.
- Oxygen and its administration.
- Diagnostic x-rays and laboratory examinations.
- Annual Pap smears and routine mammograms. Office visit charges related to these preventative treatments (i.e. Pap smears) are not reimbursable expenses.
- Child Health Care up to age six (for your dependent children).
- Anesthetics and their administration.
- Surgical supplies.
- Rental or purchase, if more cost effective, of durable equipment manufactured solely for the treatment of a medical condition.
- Initial purchase of artificial limbs or other prosthetic appliances if the loss occurs due to a surgical procedure or accident which occurs while covered under this Plan.
- Radiation therapy, x-ray, radon, radium and radioactive isotopes.

*See Glossary

- Physiotherapy prescribed by your doctor and performed by a duly qualified physiotherapist.
- Cost of blood or blood plasma.
- Initial pair of eyeglasses or contact lens following cataract surgery performed while covered under the Plan.
- Speech therapy to restore impaired speech due to stroke, surgery, accident or congenital defects which occur while covered under the Plan.
- Convalescent Facility Care if admitted to the facility immediately following a hospital confinement of at least five (5) days.
- Ambulatory Surgical Center services rendered within 48 hours from and in connection with a surgical procedure, or within 10 consecutive days before diagnostic procedures. This does not include the services of a physician or private nurse.

NOTE: Some major medical expenses are subject to pre-certification by ReviewPLUS (such as mental and nervous treatment programs). Please see the ReviewPLUS section for details.

How Much The Major Medical Expense Benefit Pays

You and each of your covered dependents pay the first $50 of covered medical expenses (the deductible) over and above those paid by the Hospital Expense Benefit and Medical Surgical Services Benefit. The $50 deductible must be satisfied once each calendar year (January 1 - December 31) for each covered person before benefits under Major Medical will be paid.

Once you and your dependents have satisfied the required deductible(s), the Major Medical Expense Benefit will pay 80% of the Reasonable and Customary* charges for covered medical expenses up to a lifetime maximum of $1,000,000 per covered person. In any calendar year, covered Major Medical Expenses will automatically be restored up to $4,000 for the following year. (This does not apply to Mental and Nervous* conditions.) The full $1,000,000 maximum may be restored upon request by providing satisfactory evidence of insurability.

- **Deductible Carryover**

  The deductible, as described above, is an out-of-pocket expense that you must pay before eligible medical expenses under Major Medical Benefits are reimbursed.

  However, any Covered Expenses incurred in the last three months of any calendar year that are used to satisfy that year's deductible

*See Glossary

will also be used to reduce the following year's deductible. This means that a completely new deductible does not have to be met in the following year. For example, if you incur $20 of covered expenses between January and September and incur an additional $30 between October 1 and December 31, the $30 will be applied to the following year's deductible.

- **Common Accident Provision**

  If two or more members of your family are injured in the same accident, only one $50 deductible will apply to the expenses resulting from that accident during the calendar year in which the accident occurs.

Special Provisions Of The Major Medical Expense Benefit

Mental Or Nervous Disorders

Under the Major Medical Expense Benefit, Mental Health and Nervous* Disorders are paid as follows:

Inpatient and outpatient hospital services are covered under the hospital expense benefit section of this guide. Outpatient services, at a qualifying facility other than a hospital, are covered at 100% of the Reasonable and Customary* expense for the first 10 certified sessions, and 80% thereafter. **REMEMBER** to call ReviewPLUS between the third and fourth visits to certify your care and eliminate any possibility of assessing a $150.00 administrative penalty for failure to make the call.

The combined maximum payable under the Major Medical section of this plan and the outpatient portion of the Hospital section of this plan is $3,000 per calendar year for all benefits paid in connection with mental health and nervous disorders.

Chemical Dependencies Or Substance Abuse

Under The Major Medical Expense Benefit, Chemical Dependencies And Substance Abuses Are Paid As Follows:

Inpatient and outpatient hospital services are covered under the hospital expense benefit section of this guide. Outpatient services, at a qualifying facility other than a hospital, are covered at 100% of the Reasonable and Customary* expense for the first 10 certified sessions, and 80% thereafter. **REMEMBER** to call ReviewPLUS between the third and fourth visits to certify your care and eliminate any possibility of assessing a $150.00 administrative penalty for failure to make the call.

The combined maximum payable under the Major Medical section of this plan and the outpatient portion of the Hospital section of this plan is $3,000 per calendar year for all benefits paid in connection with chemical dependency and substance abuse.

*See Glossary

Physical Therapy

Under The Major Medical Expense Benefit, Physical Therapy Is Paid As Follows:

- The plan pays 80% of Reasonable and Customary* charges.
- ReviewPLUS must certify treatment programs prior to the fourth visit. Please see the ReviewPLUS section of the plan for details.

Services Not Covered Under The Major Medical Benefit

Charges for the following services will not be covered under this part of the Health Care Plan:

- Care and treatment of teeth and gums except due to an injury to natural teeth and for removal of tumors (see the Dental Care Plan).
- Eye refraction and eyeglasses (see the Vision Care Plan).
- Those caused by war or an international armed conflict.
- Services by any person who is a member of your immediate family or who resides in your home.
- No benefits will be paid for you or your eligible dependents for a pre-existing injury or illness which began prior to the effective date of a person's coverage. This also applies to pregnancy, but does not apply to Complications of Pregnancy* which occur after the effective date of a person's coverage. This provision will not apply to an injury or illness with which a child is born, provided the child is born while a parent is covered under the Plan.
- Prescription drugs and medicines (see the Prescription Drug Benefit section).
- Dental work, such as, but not limited to orthodontics, fixed or removable bridgework/dentures, inlays, onlays, crowns or equilibrations, whether done for dental or medical reasons in conjunction with TMJ and related care*.
- Any other charges, services or procedures not specifically listed as covered in the major medical section of this benefit plan.

Additional exclusions are located on Page 28.

AN EXAMPLE OF HOW THE HEALTH CARE PLAN WORKS

Here is an example of how the Hospital Expense Benefit, Medical Surgical Services Benefit and the Major Medical Expense Benefit work together to provide you with Health Care Expense protection.

*See Glossary

An employee is hospitalized for a serious heart problem and stays in a semi-private room for 30 days. His expenses and benefits might look like this:

Expenses in Hospital

	Reasonable* & Customary Expenses	Hospital Expense Plan Pays	Medical Surgical Plan Pays	Major Medical Plan Pays
30 days room & board @ $240	$ 7,200	$ 7,200	-0-	-0-
Hospital services & supplies	$10,000	$10,000	-0-	-0-
20 Days Private Nursing Care @ $80 per day	$1,600	-0-	-0-	$1,240*
Surgery	$3,000	-0-	$3,000	-0-
Physician's charges	$1,000	-0-	$1,000	-0-
Anesthesia	$1,750	-0-	$1,750	
	$24,550	$17,200	$ 5,750	$ 1,240

* There is a $50 deductible under the Major Medical Plan

To Summarize: The Total Expenses are $24,550

The Hospital Expense Plan
paid $17,200 - the total Room and Board and general service charges

The Medical Surgical Services
paid $5,750 - the total surgery related charges

The Major Medical Plan
paid $1,240 - 80% of the applicable charges after a $50 deductible

So, out of a total bill of $24,550, the Plan paid $24,190. The employee was only required to pay $360.

*See Glossary

CHIROPRACTIC CARE BENEFIT

The Plan pays for eligible chiropractic expenses and treatment processes as follows:

- There is a $60 calendar year deductible that you and each of your covered dependents must pay before any benefits under the program will be paid.
- Once the $60 deductible has been met, the Plan pays 80% of Reasonable and Customary* charges.
- ReviewPLUS must certify treatment programs between the third and fourth visit. Please see the ReviewPLUS section of the Plan for details. Failure to call between the third and fourth visits will result in your being assessed a $150.00 administrative penalty.

REVIEWPLUS

ReviewPLUS is a hospitalization utilization review program administered through Health Risk Management, Inc. The ReviewPLUS Program provides pre-admission review with assignment of authorized length of stay, continued stay review, appropriate setting, and medical necessity on all hospital admissions and certain outpatient procedures.

Calling ReviewPLUS does not guarantee coverage. If you need assistance please call CareCALL or your local Human Resources representative.

ReviewPLUS professionals include registered nurses, physicians from all medical specialties, psychologists, social workers and other qualified health care specialists. These specialists will work with your doctor any time overnight hospitalization or certain outpatient care is recommended for you or a covered family member.

You can call ReviewPLUS Monday through Friday between 7 a.m. and 7 p.m. Central Time. That's 8 a.m. to 5 p.m. from anywhere in the continental U.S. by dialing **1-800-245-0886**.

Because ReviewPLUS is a patient-initiated program, it is **your responsibility** to make the call. **If you are unable to call, a family member, friend, your doctor, or the hospital may call for you.** Following are the instances when you must call ReviewPLUS.

- **Non-Emergency Hospitalization**: When your doctor recommends that you be hospitalized for a condition or surgery not involving a medical emergency, call at least **10 calendar days before** you are admitted.

  Your timely call gives the ReviewPLUS health care specialists the time they need to give your situation a complete and thorough review.

- **Emergency Hospitalization**: In a medical emergency no one expects you to call before you go to the hospital. Instead, you should follow your doctor's orders and get whatever care is necessary to safeguard your health and well-being. Then if you are admitted, the review will take place while you are hospitalized. The purpose of that review will be to let you go home as soon as it is safe for you to do so.

  Make sure that you call as soon as you are admitted, but no later than 48 hours or the next business day following your admission. If you are unable to make the call, a family member, friend, your doctor or the hospital may call for you.

- **Maternity**: You must call as soon as you begin to receive regular maternity care, but no later than **six months before** the expected delivery date. Your call is an important one for you because you also have the opportunity to participate in the Premature Birth Prevention Program. The purpose of the program is to identify if you are at risk for premature delivery and help you to delay or even prevent a premature birth. Then you must call again within **48 hours or on the next business day** after the baby is born.

- **Outpatient Care**: When your doctor recommends that you have outpatient surgery or a diagnostic test (listed below),you must call at least **10 calendar days before** the surgery or test.

  Diagnostic
  - CT Scan, spine (computerized analysis using a pinpoint radiographic beam)
  - MRI, spine (imaging using the body's electromagnetic field to supply information)
  - Myelogram (imaging of spine with use of radiopaque dye)

  Orthopedic
  - Bunionectomy (excision of bunion)
  - Hammertoe (correction of abnormally bent toe)
  - Heel surgery (includes heel spur)
  - Osteotomies (surgery on the bones of the foot)
  - Spine, removal of disc

  EENT
  - Adenoidectomy (removal of adenoids)
  - Eye lid, plastic surgery (blepharoplasty)
  - Myringotomy (ear tubes)
  - Nose, Nasal Septum, plastic surgery of (includes septoplasty, rhinoplasty, submucous resection, nasal septal reconstruction)
  - Sinus, maxillary (upper jaw) or ethmoid (lower forehead)
  - Tonsillectomy (removal of tonsils)

Outpatient Treatment between the 3rd and 4th visit
- Chiropractic
- Physical Therapy
- Mental Health and Chemical Dependency

- **Mental Health and Chemical Dependency**: Whenever you or a covered dependent needs treatment for mental illness or chemical dependency you must follow the same ReviewPLUS procedures as for any other emergency or non-emergency hospitalization. If you are receiving therapy on an outpatient basis, you must call ReviewPLUS **between the third** and **fourth visit**.

- **Chiropractic Care and Physical Therapy**: You must call **after the third visit and before the fourth visit** for chiropractic and physical therapy. This applies to you and your covered dependents.

How ReviewPLUS Works

The ReviewPlus specialist who answers the telephone will ask you for specific information needed to start the process. You can help ensure a timely review by having the following information ready each time you call.

- The name and location of your employer.
- Your name and Social Security number.
- The patient's name, birth date, address, and telephone number.
- The admitting doctor's name, address, and telephone number.
- The hospital name, address, and telephone number where care is to be received.
- The proposed date for hospitalization and surgery (if planned) and the reason (if known).

ReviewPLUS Evaluates The Request

This information is referred to a qualified ReviewPLUS health care professional who will call your doctor to discuss the details. Among other things, the professional will ask what the diagnosis is, how your doctor arrived at that diagnosis, and what treatment is being proposed. The specialist will evaluate the medical necessity of the proposed care by applying three important standards:

- The care is **proven**: it meets particular standards of care established by the medical community, published in recognized journals, and approved by the Food and Drug Administration.

- The care is **effective**: its beneficial effects can be expected to outweigh any harmful effects encountered while addressing the particular disease, injury or illness.

- The care is **appropriate**: its timing and setting are proper and cost-effective.

ReviewPLUS Notifies You

After the ReviewPLUS professionals have carefully considered all of the information, you will be notified by mailgram, no later than 10 days from your initial call, regarding the outcome of the review. Your physician and the hospital will receive notification by mail.

This procedure takes ten days because other options, options that involve less risk and inconvenience for you but are as effective, will have to be explored and agreed to.

Your Participation Is Important

In order for you to benefit from your participation in ReviewPLUS, it's important that you follow the program guidelines. Your timely call is especially important because for every late call or no call, the Company **will incur a $150 administrative expense** which will then be passed on to you. To avoid this expense, remember to call as follows:

- At least 10 days **before** a hospital admission, surgery, and certain outpatient procedures, including testing.
- Within 48 hours **after** an emergency hospital admission or the next business day.
- Six months **before** a maternity hospital admission.
- Within 48 hours **after** a baby's birth.
- Whenever a newborn must remain in the hospital after the mother's discharge.
- **Between the third and fourth** outpatient visit for outpatient psychiatric or chemical dependency treatment.
- **Between the third and fourth** outpatient visit for chiropractic care or physical therapy.
- If your doctor does not want to cooperate, you should explain to your doctor the financial impact on you. If your doctor **still** refuses to cooperate you may want to consider seeing another doctor. A call to CareCALL can help you locate other qualified doctors in your area. See page 19 for details on CareCALL.

In addition, hospital room and board benefits **will not be paid** in the following circumstances:

- If you proceed with a hospital stay or treatment ReviewPLUS cannot confirm as medically necessary.

- If you do not obtain a required second opinion.
- If you proceed with an inpatient admission, and treatment could have been provided on an outpatient basis.
- If your hospital stay exceeds the number of days ReviewPLUS has approved.

Also, outpatient surgery and diagnostic procedures which require pre-certification **will not be paid** in the following circumstances:

- If you proceed with surgery (inpatient or outpatient) or a diagnostic test ReviewPLUS cannot confirm as medically necessary.
- If you do not obtain a required second opinion.

Finally, outpatient psychiatric or chemical dependency visits, chiropractic visits and physical therapy treatment programs **will not be paid** in the following circumstances:

- If you proceed with a treatment program ReviewPLUS cannot confirm as medically necessary.
- If you do not obtain a required second opinion.

The deductibles or benefit reduction amount you experience for not following the plan procedures and guidelines will be in addition to any regular plan deductibles or copayments for that expense. In addition, you may expose yourself to the risk and inconvenience of treatment you don't need.

Coordinated Care Management

There are times when an illness or injury is severe enough to require more intensive and more prolonged medical treatment. At times like these many types of health care professionals may be involved and many decisions need to be made.

To help you and your family through these difficult times, your ReviewPLUS program includes a special feature: **Coordinated Care Management**. When potentially complex situations are identified by ReviewPLUS, a team of doctors and nurses under the direction of a care manager will work on your behalf. They will ensure that the care you receive and where you receive it is appropriate and that it is fairly priced. They'll help you locate special settings for continued care, help arrange the transfer, and assist in the planning of your discharge. In addition, they'll coordinate the efforts of the various health care professionals involved in your case, act as your advocate, and follow you right up to recovery.

Your Privacy Is Guaranteed

All ReviewPLUS telephone conversations are tape recorded to ensure that the information collected is complete and accurate. All information given to ReviewPLUS is kept strictly confidential and is used only for review and claim payment purposes. Your right to privacy is respected at all times.

ReviewPLUS Fee Negotiation

Another feature of ReviewPLUS is fee negotiation with the doctor and the hospital. During the review process, a ReviewPLUS price control specialist will call your doctor and the hospital to discuss the fee each intends to charge for the care you receive.

Your medical plan pays a percentage of the cost for **medically necessary** care on the basis of the Reasonable and Customary* charge in your area for that service.

When you call ReviewPLUS, you give the specialist the opportunity to negotiate a reduced fee before you go to the hospital or receive treatment. They will do this by pointing out to your doctor what others in your area are charging and also by explaining the financial impact on you. This is especially important if your doctor plans to charge more than the Reasonable and Customary fee. If your doctor will not reduce his or her fees, the ReviewPLUS specialist will let you know and then leave the decision up to you whether to pay the higher fee, talk to the doctor about the fee, or find another doctor.

In addition, a ReviewPLUS price control specialist will discuss fees with the hospital. If the hospital charge is excessive or if the hospital refuses to discuss or negotiate fees, other area hospitals where your doctor practices will be called. You'll then be notified of the result of the discussion with the hospitals. At this point it will be up to you to pay the higher fee, discuss the fee with the hospital directly, or select another hospital. Remember, lower doctor and hospital fees mean lower out-of-pocket expenses for you.

PREMATURE BIRTH PROGRAM

Your program includes a Premature Birth Prevention Program to help you avoid the medical complications and expense associated with premature birth. The program is administered by the same organization that administers ReviewPLUS and CareCALL. Designed to identify those at risk for premature delivery, the program offers the information and support needed to delay and even prevent pre-term labor and delivery. In addition to working with you and your doctor, the program provides practical advice and direction should preterm labor begin.

How The Program Works:

When you call to report your pregnancy to ReviewPLUS you will be asked several questions about yourself and your medical history. If this preliminary screening indicates a risk for premature delivery, you will then be sent a questionnaire. The purpose of the questionnaire is to identify special needs or situations that will allow the program staff to give you the assistance you need. You **and** your doctor should complete and sign the questionnaire. Then return the completed questionnaire in the envelope provided.

If the responses to the questionnaire confirm the risk for premature delivery, you then will have the opportunity to work with a program professional, who is a registered nurse, throughout the remainder of your pregnancy. Acting as your advocate, the nurse will work with you to help you recognize the signs of premature labor, and understand what to do if premature labor occurs. In addition the nurse will be available to answer your questions, direct you to medical services, and develop, with you and your doctor, a home care plan to keep you at home and out of the hospital as long as possible.

Because you play an important part in preventing pre-term delivery, you will be given educational material explaining how to manage your pregnancy, recognize warning signs, and how to get help, quickly. Your participation will help ensure appropriate and effective care and may help prevent a premature birth.

CARECALL

CareCALL provides the answers you need to be a more informed buyer of medical care **and** to make better use of your medical benefits. Use of CareCALL is voluntary and there is no cost to you. The number is the same as for ReviewPLUS.

1-800-245-0886

CareCALL health care professionals help you through the health care system by giving you useful, easy-to-understand information:

- Describe diagnostic tests and procedures.
- Explain medical conditions, diseases, and terminology.
- Explain treatment prescribed and identify possible options.
- Advise you on how to communicate with a doctor.
- Explain the rights of medical consumers.

The CareCALL health care professionals and pharmacists give you the **facts** about medication as well as **practical advice** about the wise use of medication:

- What a drug is and what it is used for.
- How to interpret label instructions.
- What foods, drinks, and medications to avoid.
- What side effects to look for.
- How to save money on prescription drugs.
- How to discuss drug therapy with a doctor.

The CareCALL professionals give you information about the cost of medical care:

- Average lengths of stay for hospital care.
- Charges and services on a medical bill.
- Pointers on how to discuss medical bills with providers.

Using CareCALL's extensive database, CareCALL health care professionals can help you locate doctors and health care facilities anywhere in the United States.

- Locate board-certified physicians.
- Locate accredited hospitals.

CareCALL cannot replace personal medical care. Quality medical care cannot be provided over the telephone. Only a doctor who knows your medical history can give you medical advice or prescribe medication.

CareCALL helps you become a better informed consumer, but it does not:

- Give medical advice or diagnoses.
- Provide crisis intervention.
- Prescribe drugs.
- Interpret medical benefits.
- Second-guess the doctor or dentist.

PRESCRIPTION DRUG BENEFIT

Prescription drug costs have been the fastest growing element in health care programs. During the last three years, the average cost for prescription drugs has increased over 60%. The prescription drug program has been designed to provide coverage for almost all of the prescription drugs that you and your covered dependents might need.

What Is Covered Under The Prescription Drug Benefit

Covered expenses include the Reasonable and Customary* cost of prescription drugs, insulin, needles, and syringes (used for insulin only), purchased from a qualified pharmacy. The Plan utilizes a mandatory generic drug reimbursement formula. See the mandatory generic drug reimbursement section for details. The plan also offers a mail order drug feature. See the "CFI" Mail Order Pharmacy section for details.

How Much The Prescription Drug Benefit Pays

The prescription drug benefit is a co-pay program. After your, or your covered dependent(s), payment of the applicable co-pay, the plan pays the balance of the Reasonable and Customary* Expense. You and your covered dependents co-pay varies upon the type of drug purchased and where the purchase is made. The rules are as follows:

If the prescription is purchased from a licensed pharmacy, you pay the greater of:

a) $5.00, or
b) 20%
Plus, any charge in excess of the Reasonable and Customary* drug cost.
Per 100 units or a 34 day supply.

If a brand name drug is purchased when there is a generic equivalent, you also pay the difference between the cost of the brand name drug and the cost of the generic equivalent. (See the Mandatory Generic Drug Reimbursement Section.)

If the prescription is purchased from CFI, the Mail Order Pharmacy, you pay the greater of:

a) $5.00, or
b) 20%
If the drug is a name brand, or the greater of

a) $4.00, or
b) 20%
If the drug is a generic equivalent.

*See Glossary

If a brand name drug is purchased when there is a generic equivalent, you also pay the difference between the cost of the brand name drug and the cost of the generic equivalent.

Mandatory Generic Drug Reimbursement

The mandatory generic drug reimbursement policy was implemented January 1, 1992. We believe this is an excellent cost containment policy because it reduces the cost of prescription drugs and you and your dependents receive the same quality product without paying additional amounts. The mandatory generic reimbursement policy does **not** mandate that you use generic drugs. The policy is as follows:

- You may continue to obtain a prescription drug written for a brand name drug **when there is no generic equivalent available**, and pay the $5.00 or 20 percent deductible, whichever is greater.

- You may choose a generic equivalent drug product when there is one available and pay only the $5.00 or 20 percent deductible, which ever is greater.

- When there is an equivalent generic drug product available for a brand name product, and you still get the brand name, **you will be responsible for paying the pharmacist for the difference between the cost of that brand name drug and the cost of the generic equivalent plus the $5.00 or 20 percent deductible, whichever is greater.**

- If you have a prescription refilled and the original prescription was dispensed with a brand name drug, you will be responsible for the difference in cost as described above. You may wish to contact your doctor to request a new prescription written for the generic form of your medication.

Prescription Purchase Quantity Limitations

Effective January 1, 1992, prescription purchase quantity limitations were implemented as a cost containment provision to help limit the amount of medication purchased that is never utilized. The quantity limitations are as follows:

Prescriptions will be reimbursed as prescribed, up to and including a thirty-four (34) days supply or one hundred (100) units, whichever is greater.

If your doctor prescribes medication which exceeds the quantity limitations, you should merely have your pharmacist fill the prescription up to the quantity limitation and go back for refills until the prescribed quantity has been consumed.

Nicorette, Nicoderm, Habitrol and Prostep

Effective April 1, 1992, the prescription drug benefit was changed to allow limited coverage for Nicorette, Nicoderm, Habitrol, and Prostep. The limitations for coverage are as follows:

- Prescriptions must be filled by CFI, the Mail Order Pharmacy.
- You and your dependents are limited to a maximum of three (3) months uninterrupted coverage for transdermal patches, and six (6) months for Nicorette gum. Coverage beyond six months has been determined by the FDA to be ineffective.

  Caution: Simultaneous use of patches and Nicorette are not recommended by the FDA.

- You and your dependents will be limited to one treatment program per lifetime. If you stop a program and then renew it, coverage will cease when the first program stops.

Expenses Not Covered Under The Prescription Drug Benefit

Following is a list of prescriptions that will not be covered under the Plan:

- Federal legend oral contraceptives.
- Items lawfully obtainable without prescription.
- Genetically engineered drugs (i.e. Protropin).
- Devices and Appliances.
- Prescriptions covered without charge under Federal, State or Local programs, to include Workmen's Compensation.
- Any charge for the administration of a drug or Insulin.
- Investigational or experimental drugs.
- Unauthorized refills.
- Immunization agents, biological sera, blood or plasma.
- Medication for an eligible employee or dependent confined to a rest home, nursing home, sanatorium, extended care facility, hospital or similar entity.
- Medication prescribed to treat a condition that is not approved by the FDA.

- Any charge where the Reasonable and Customary* charge is less than the Card member's deductible.

- Any charge above the Reasonable and Customary*, advertised or posted price, whichever is less than the scheduled amount.

NPA Pharmacy Network

Effective January 1, 1992, National Prescription Administrators (NPA) began administering the prescription drug benefit program. One of the benefits of being associated with NPA is the ability to use its pharmacy network. Currently, 49,000 pharmacies in all 50 states have contracted with NPA.

The Company encourages you and your dependents to purchase your prescription drugs from a pharmacy participating in the NPA network. Utilizing the NPA network benefits you in the following ways:

- Since NPA has a contract with each participating network pharmacy which defines the appropriate drug cost, you are assured that the cost of your prescription will not exceed the Reasonable and Customary* price.

- Each network pharmacy will only require you and your dependents to pay the applicable co-pay and the additional cost of name brand drugs in excess of generic equivalents. This relieves you of the responsibility of completing a claim form and waiting for a reimbursement.

CFI, The Mail Order Pharmacy

Another feature added to your benefit program on January 1, 1992 is the CFI, Mail Order Pharmacy. You should consider using CFI when purchasing maintenance drugs over long periods of time, such as blood pressure medicine. Utilization of the Mail Order Pharmacy is beneficial to you and your dependents in the following ways:

- Prescriptions are mailed directly to your home. There is no need to make that trip to a pharmacy.

- CFI purchases its inventory in volume, and passes the savings to its customers. If your co-pay is 20% of the cost of the prescription, you benefit by this savings.

- Since the plan pays less for generic drugs from CFI than other pharmacies, we can pass part of the savings to you and your dependents. You are only required to pay the greater of $4.00 or 20% of the cost of the prescription when you purchase a generic equivalent drug from CFI.

*See Glossary

- Before mailing, each prescription is checked by at least three different pharmacists. These safety procedures guarantee that your prescription is filled accurately with the highest level of quality.

HEARING AID BENEFIT

What Is Covered/How Much The Plan Pays

As good hearing is essential to happy, healthy living, we are providing this excellent benefit to you and your covered dependents.

When recommended by a medical doctor, one hearing aid for each ear is allowable every two years. The Plan will pay benefits in the amount of 80% of Reasonable and Customary* charges.

EXPENSES NOT COVERED UNDER THE HEALTH CARE PLAN

The following expenses are not covered by any part of the Health Care Plan:

- Routine health check-ups (except annual Pap smears, routine mammograms and Child Health/Services described on Page 9).
- Eyeglasses or examinations for prescriptions or fittings (see Vision Care Plan).
- Charges that you or your dependents are not required to pay where payment is received as a result of legal action or settlement (if benefits have been paid for expenses that are later recovered through legal action or settlement, the covered person will be required to reimburse the Plan Administrator for such benefits).
- Services which must be obtained with, or without, cost in accordance with laws or regulations of any government, or employers.
- Diseases contracted, injuries, or conditions sustained as a result of war, or any act of war, declared or undeclared.
- Charges for pre-existing conditions due to an injury or illness which began prior to the effective date of a person's coverage. (See Page 1 for specifics). This also applies to pregnancy, but does not apply to Complications of Pregnancy* which occur after the effective date of a person's coverage.

  This exclusion will not apply to an injury or illness with which a child is born, provided the child is born while a parent is covered under the Plan.

*See Glossary

- Charges for education, training and bed and board while you or your dependent are confined in an institution which is primarily a school or other institution for training, a place of rest, a place for the aged or a nursing home.

- Home health care and hospice care are non-covered expenses.

- Charges for custodial care.

- Charges incurred for immunizations and medical examinations or tests of any kind not incident or necessary to the treatment of a covered injury, sickness or pregnancy.

- Services incurred before coverage begins or after coverage ends.

- Cosmetic surgery or reconstructive surgery unless necessary to:
  - Correct a birth defect for a child who has been covered since birth.
  - Replace diseased tissue removed while covered under the Plan.
  - Correct a defect caused by an accident which occurred while covered under the Plan provided surgery is performed within one year of the accident.

- Expenses incurred outside the United States or Canada unless you or your dependent is a resident of the United States or Canada and the charges are incurred while traveling.

- Services performed by:
  - You or your spouse.
  - You or your spouse's parent, sister, brother or child.
  - Any person who normally resides in the patient's home.

- Radial keratotomies.

- An injury arising from any employment or occupation.

- An illness covered by Workers Compensation.

- Experimental and/or Investigational Services.

- Services or supplies for which you are not required to pay.

- Elective abortions unless the life of the mother would be in danger if pregnancy continued.

- Treatment or surgery to change gender or improve or restore sexual function.

- Procedures to reverse sterilization or birth control measures.

- Treatment or surgery for obesity, weight reduction, or weight control.

- Treatment of intentionally self-inflicted injury or treatment of conditions resulting from or in any way related to that injury.
- Food supplements, diet aids, or diet programs.
- Equipment or supplies made or used for physical fitness, athletic training, or general health maintenance.
- Orthodontic treatment for TMJ (see Page 12 for clarification).
- Usual and normal home medical supplies or first aid items.
- Any other charges, services or procedures not specifically listed as covered in any section of this Benefit Plan.

If you receive any payment (for medical services or otherwise) by award, settlement or for a condition, disease or injury resulting from employment, you must reimburse the Plan Administrator in full for all benefits received for such sickness or injury.

WHEN YOU ARE ELIGIBLE FOR MEDICARE

If you are an active employee when you and/or your spouse reach age 65, you and/or your spouse must choose whether you want primary coverage under either Medicare or the Company Health Care Plan. If you and/or your spouse choose to be covered under the Company Plan, the Company will be the primary payer and Medicare will pay secondary benefits. If Medicare is chosen, you and/or your spouse will not be eligible for any additional benefits under the Company Plan to supplement coverage that is provided by Medicare. Also, if you or a covered dependent qualify for Medicare because of a disability, you or your covered dependent will have the same choice with respect to the Company Health Care Plan and Medicare as an individual who has reached age 65. However, this will not apply to individuals eligible for Medicare due to renal (kidney) failure.

WHEN YOU RETIRE

While you are an active employee, if you elect Normal Retirement and have earned at least ten years of Pension Credited Service in the Company Employees Pension Plan, you retain the same coverage as an active employee as a supplement to Medicare Parts "A" and "B" for yourself and eligible dependents. This coverage is provided at no cost to you. You pay for Medicare Part "B" premiums.

While you are an active employee, if you elect Early Immediate Retirement and have earned at least ten years of Pension Credited Service in the Company Pension Plan, you retain the same coverage as an active employee until your normal retirement age. At your normal retirement date, your coverage is handled the same as Normal Retirement benefits.

NOTE: If you terminate your employment with the Company for any reason, including layoff, prior to your Normal Retirement Date without electing Early Immediate Retirement, your benefits will terminate the day you stop active work.

NOTE: The Company may terminate or amend this Plan at any time.

WHEN YOUR COVERAGE TERMINATES

Your coverage under the Health Care Plan will terminate on the earliest of:

- The day you stop active work as a result of termination of employment for any reason, including lay-off.
- No later than 365 days from the day last worked if off due to disability caused by an illness or injury if you have less than 15 years of service as a full-time employee before termination.
- The date this Plan is terminated.

Dependent coverage will terminate on the earliest of:

- The date they no longer qualify as eligible dependents.
- Three months after the date of your death. However, if you die after you retire or are eligible for Early Immediate, Normal or Disability Retirement, coverage on your spouse will be continued until
  - The date your surviving spouse remarries.
  - The date your surviving spouse becomes eligible for Medicare. The Company Plan will then be secondary.
- The date this Plan is terminated.

NOTE: Although the Company expects to continue this Plan, they reserve the right to terminate or amend it at any time.

YOU MAY CONTINUE YOUR COVERAGE (COBRA)

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provisions of the new law. (Both you and your spouse should take the time to read this section carefully. It is located in the back of your handbook).

COORDINATION OF BENEFITS (COB)

The purpose of the Health Care Plan is to help you meet the covered expenses that you and your dependents actually incur. Sometimes, though, because a husband and wife are both working, members of a family may be covered under more than one group medical plan. This kind of duplicate coverage can frequently result in two plans paying benefits for the same expense. This kind of overpayment unnecessarily raises the cost of the insurance.

To help guard against overpayments so that we can ensure you obtain maximum benefits at a minimum cost, our Plan has a Coordination of Benefits provision. The important point to remember about "Coordination of Benefits" is that its purpose is to ensure that you receive all the benefits you are entitled to under all group plans. In addition, this provision keeps the cost of your coverage reasonable by preventing anyone from being reimbursed for more than 100% of their total health expenses. Detailed information for Coordination of Benefits is located in your handbook.

Celtic Conversion Program 12/94

CONVERSION PRIVILEGE WHEN COVERAGE ENDS

An individual policy providing Hospital and Surgical benefits may be obtained within 31 days after termination of coverage:

- By you, if your coverage is terminated due to termination of your employment.
- By your surviving spouse, if your dependent coverage is terminated due to your death.
- By your child, when he or she ceases to be an eligible dependent while your dependent coverage is still in force, or when your dependent's coverage is terminated due to termination of your employment or death if this child is then age 19 or older.

The rules of the Plan Administrator and the laws of the jurisdiction you live in at the time you make an application for an individual policy will determine the type of policy you obtain under this provision. The benefit amounts under the policy will not necessarily be identical to those provided by the Company.

HOW TO FILE FOR BENEFITS

How To File A Claim With Health Risk Management For Hospitalization, Surgical, Major Medical and Chiropractic-Related Expenses

Forms for filing claims may be obtained in the Human Resources Department. You or your provider should complete these forms and mail them with itemized bills to:

Arch Mineral Corporation and
Subsidiaries Health Care Program
Claims Processing Unit
P.O. Box 59345
Minneapolis, MN 55459-0345

Itemized bills submitted for payment should contain the following information:

- Patient's name.
- Date of service.
- Diagnosis or condition.
- Type of service rendered.
- Charge for service.
- Provider (doctor) name.

There are separate forms for filing claims under the medical, dental and vision portions of the Plan. Also, a separate form is available for predetermination of benefits. Please be sure to use the appropriate forms for the charges being submitted.

Payment of Plan benefits is made directly to you unless you assign benefits to the person providing the service.

Timely filing of your claims will ensure prompt reimbursement. You must file your claim within two years from the date the charges are incurred or the services provided. Claims filed after this date will not be accepted and the charges will not be eligible for benefit consideration.

Your Human Resources Representative can assist you in filing your claim. Any question as to procedures should be directed to him or her.

How To File A Claim With NPA

If you purchase your prescription from a pharmacy not in NPA's network, you will be required to pay the full cost of the medication and file a claim with NPA to request reimbursement. Your Human Resources representative has a supply of NPA claim forms. You should accurately complete the claim form and mail it with the original payment receipt to NPA at the following address:

N.P.A.
P.O. Box 2187
Clifton, New Jersey (NJ) 07015

or you may call NPA at **1-800-526-7813**, if you have any questions regarding a prescription reimbursement.

How To File A Claim With CFI - The Mail Order Pharmacy

Your Human Resources Representative has a supply of CFI mailing envelopes. Simply include your script from your physician along with your co-pay amount. To make sure you remit the correct co-pay amount, call **1-800-628-0717** and a CFI representative will assist you. Then mail your prescription and co-pay amount in the pre-addressed envelope to:

C F I
P.O. Box 98
Totowa, NJ 07511-0088

CLAIMS DENIAL AND THE APPEAL PROCESS

Payment or denial of an application for benefits will be made within 90 days from the date a claim is filed.

If an application for these benefits is denied either in whole or in part, you will receive written notification. The notifications will include the reason(s) for the denial with reference to the specific plan provisions on which the denial was based, a description of any additional information that might cause the insurance carrier to reconsider the decision, and an explanation of the claim review procedure.

Within 60 days after receiving the denial (or if no notice is received within 150 days after filing a claim), your area duly authorized representative may then submit to the plan administrator a written request for a review of the decision. Requests should be directed to:

Arch Mineral Corporation
Director - Compensation & Benefits
CityPlace One
St. Louis, MO 63141

Any such request should be accompanied by documents or records in support of the appeal. You, or a duly authorized representative, may review all pertinent documents and submit issues and comments in writing.

The Plan Administrator will review the claim and within 90 days (or 120 days in special circumstances) will provide a written response to the appeal, explaining the reasons for the decision with specific reference to the Plan provision on which the decision was based.

The Plan Administrator shall possess and exercise discretionary authority to make determinations as to a Participant's eligibility for benefits and to construe the terms of the Plan. The decision of the Plan Administrator shall be final and non-reviewable unless found to be arbitrary and capricious by a court of competent review. Such decision will be binding upon the Employer and the Claimant.

GLOSSARY

The following definitions will help you to better understand your coverage under the Health Care Plan.

Ambulatory Surgical Center

A specialized facility where patients can have minor surgery performed without having to be confined overnight. Such centers could include an ambulatory surgery unit of a Hospital, a free-standing ambulatory surgery facility, a minor emergency center, or a Physician's office:

1. Where coverage of such a facility is required by law, and has been licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction where it is located; or

2. Where coverage of such a facility is not required by law but meets all of the following requirements:

   A. It is established, equipped and operated according to the laws in the area where it is located primarily for the purpose of performing surgical procedures.

   B. It is operated under the full-time supervision of a staff of physicians. In addition, it permits a surgical procedure to be performed only by a duly qualified Physician, who at the time the procedure is performed, is allowed to perform such a procedure in at least one Hospital (as defined) in the area.

   C. It requires, in all cases other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist or a certified registered nurse anesthetist administer the anesthetic and remain present throughout the surgical procedure.

   D. It provides at least two operating rooms and at least one postanesthesia recovery room; is equipped to perform diagnostic x-ray and laboratory examinations; and has trained personnel and necessary equipment available to handle foreseeable emergencies, including but not limited to a defibrillator, a tracheotomy set, and a blood bank or other blood supply.

   E. It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating room and in the postanesthesia recovery room.

   F. It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require post-operative confinement.

G. It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a pre-operative examination report, medical history and laboratory test and/or x-rays, an operative report and a discharge summary.

Board Certified Specialist

A physician who has been certified by a Medical Board as a specialist in the field in which he or she practices. If a "Board Certified Specialist" is not available in your area, a physician who is (a) qualified to perform surgery and (b) a member of the staff of an approved hospital may be utilized.

Care of Spinal Conditions

Care connected with the detection or correction by manual or mechanical means of:

1. Structural imbalance
2. Distortion
3. Subluxation

where such care is for purposes of removing nerve interference and its effect, where interference is the result of or related to distortion, misalignment or subluxation of or in the spinal column.

Complications of Pregnancy - "Complications of Pregnancy" means:

1. Conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

2. Non-elective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which viable birth is not possible.

Convalescent Facility

Legally operating institution or a distinct part of one which:

1. Is supervised by a resident Physician or a resident registered graduate nurse.

2. Requires that the health care of each patient be under the supervision of a Physician.

3. Requires that a Physician be available to furnish necessary medical care in emergencies.

4. Provides 24 hour nursing service.

5. Is approved or is qualified to receive approval for payment of Medicare benefits.

6. Keeps clinical records on all patients.

Custodial Care

Care given primarily to assist a person in the activities of daily living, routine maintenance, or supportive care, which need not be provided in an institutional-type setting by skilled professional medical personnel.

Experimental and/or Investigational Services

Services which have not been clinically proven to be safe and effective based upon available professional assessments. The Company reserves the right to make the final determination in case a dispute should arise.

Full Time Student

An eligible dependent who participates in a full-time degreed program at approved universities/schools. Full-time students are required to submit a registar's statement every January and September verifying their full-time status.

Hospital

As used in this booklet, the term Hospital means an institution which is engaged primarily in providing medical care and treatment of sick and injured people on an in-patient basis at the patient's expense and which meets the tests listed below:

(1) It is an institution legally operating as a Hospital.

(2) (A) It is a hospital accredited by the Joint Commission on Accreditation of Hospitals.

(B) It is a Hospital, a psychiatric Hospital or a tuberculosis Hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under, and in accordance with, the provisions of Medicare.

(3) It is an Institution which fully meets all of the following tests:

(A) It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured people by and under the supervision of a staff of duly qualified physicians.

(B) It continuously provides on the premises 24 hour a day nursing service by or under the supervision of registered graduate nurses.

(C) It is operated continuously with organized facilities for operative surgery on the premises except that benefits for:

(a) Psychiatric disorders.
(b) Mental or nervous conditions.
(c) Alcoholism.
(d) Drug dependence.
(e) The medical complications of mental illness or mental retardation.

The above shall not be denied because of confinement in a particular facility if the facility has a bona fide arrangement with a Hospital that has facilities for operative surgery on the premises.

In no event will "Hospital" include any institution:

(A) Which is run mainly as a rest, nursing or convalescent home or residential treatment center.

(B) Which any part is mainly for the care of the aged.

(C) Which is engaged in schooling of its patients.

Injury

Accidental bodily injury, which requires treatment by a Physician

Medicare

Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is now or as it may be amended.

Mental or Nervous Disorder

Neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

Other Hospital Services and Supplies

Services and supplies furnished and required for treatment other than Room and Board, the professional services of any Physician and any private duty or special nursing services (including intensive nursing).

Physician

1. A legally licensed Physician or Surgeon.

2. Any other legally licensed practitioner of the healing arts rendering services:

   (A) Which are covered under the Plan.
   (B) For which benefits are required by law to be provided when rendered by such a practitioner.
   (C) Which are within the scope of the individual's license.

Room and Board

Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the Hospital, but not including professional services of Physicians or special nursing services rendered outside of an intensive care unit.

Second Surgical Opinion

An assessment by a Board Certified Specialist regarding the medical necessity of a listed procedure. The opinion must be given prior to the date surgery is performed and must be rendered by a Board Certified Specialist other than the surgeon who is to perform the operation.

Sickness

A bodily sickness or disease, including a mental disorder of any kind, which requires treatment by a Physician and includes with respect to a female employee or dependent, the terms pregnancy, childbirth, abortion, miscarriage and complications of pregnancy unless otherwise limited by the Plan.

TMJ and Related Care

Non-surgical care connected with the detection or correction of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves, and other tissues related to that joint.

Reasonable and Customary* Charge and Reasonable and Customary* Fee

For any service or supply, the Reasonable and Customary* Charge or the Reasonable and Customary* Fee will not exceed the lesser of:

1. The amount customarily charged by the provider for it; and

2. The charge for the service or supply made by providers of comparable services or supplies in the same locality.

A special provision will apply when there are no providers of comparable services or supplies in the same locality, or in the event of an unusual type of service or supply. When this happens, Health Risk Management will decide whether the charge is appropriate, based on:

(A) The complexity involved.

(B) The degree of professional skill required.

(C) The cost of supplies.

(D) Other pertinent factors.

Health Risk Management may decline to pay flat rate charges when procedures, fees and/or time involved are not itemized.

GENERAL INFORMATION

This summary data applies to all parts of the Health Care Plan.

Name of Plan:	Arch Mineral Corporation & Subsidiaries Health Care Plan
Type of Plan:	Hospital, Medical/Surgical, Major Medical, Hearing Aid, Dental, Vision Benefits and Prescription Drug
Plan Sponsor:	Apogee Coal Company & Subsidiaries CityPlace One CityPlace Drive St. Louis, MO 63141 Telephone: (314) 994-2700
Plan Administrator:	Arch Mineral Corporation Vice President - Human Resources CityPlace One CityPlace Drive St. Louis, MO 63141 Telephone: (314) 994-2700
Plan Number:	501
Plan Costs:	Paid by Employer
Plan Coverage:	Employees of Apogee Coal Company or a subsidiary or affiliate Company which adopts this program
Employer Identification Number:	43-0921172
Type of Plan Administration:	Administrative Services only with specific and aggregate reinsurance through Health Risk Management, Inc., 8000 W. 78th Street, Minneapolis, Minnesota 55439 and National Prescription Administrator's Inc., P.O. Box 2187 Clifton, NJ 07015
Plan Year:	January 1 - December 31

Agent for Service of Legal Process:	The Plan Administrator
Funding:	Unfunded plan benefits paid from general assets of employer, but administered by Health Risk Management, Inc., 8000 W. 78th Street, Minneapolis, Minnesota 55439 and National Prescription Administrator's Inc., P.O. Box 2187 Clifton, NJ 07015
Claim Administrator:	Health Risk Management, Inc. 8000 W. 78th Street Minneapolis, Minnesota 55439 and National Prescription Administrator's Inc., P.O. Box 2187 Clifton, NJ 07015

YOUR RIGHTS UNDER THE PLAN

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). A Statement of your ERISA rights can be found at the end of the benefits handbook.