



GMS
Mine Repair & Maintenance, Inc.

Group Benefit Plan
Employee Handbook

July 1, 2010

Group Benefit Plan

Administered by



Self Funding Administrators Corporation
Annapolis, Maryland

GMS Mine Repair & Maintenance, Inc.

To All Covered Employees and Dependents:

GMS Mine Repair & Maintenance, Inc. is pleased to provide this employee booklet which will help you understand the important provisions of your group insurance plan. We hope you will find the language to be clear and easy to understand. The benefits described in this booklet are available as of July 1, 2010.

If you have questions after reading this booklet, please call your Human Resources Department or Self Funding Administrators.

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UTILIZATION REVIEW REQUIREMENTS
Please Read Carefully

HOSPITAL CERTIFICATION

Non-emergency inpatient hospitalization must be precertified prior to admission or benefits will be reduced by \$100. Certification should be made 7 days in advance of admission. Please call **HealthCare Strategies** at **800-582-1535** for all certifications.

Urgent care admissions **do not** require precertification. Please call **HealthCare Strategies** at **800-582-1535** as soon as possible after you are admitted to notify them of the hospital stay.

A claim involving urgent care is any claim for medical care or treatment without which the life or health of the claimant or the claimant's ability to regain maximum function could be seriously jeopardized or in the opinion of a physician with knowledge of the claimant's medical condition would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim.

Section 1

**SCHEDULE OF BENEFITS FOR
GMS Mine Repair & Maintenance, Inc.**

Effective July 1, 2010

Maximum Lifetime Benefit per individual for Medical Care \$1,000,000

	<u>Preferred Provider Network</u>	<u>Out-of-Network Benefit Plan</u>
Calendar Year Deductible	\$100 per person \$200 per family	\$500 per person \$1,000 per family
Calendar Year Coinsurance		
Medical Plan Pays	100% ⁽¹⁾	70%
Patient Pays	0%	30%
Out-of-Pocket Maximum		
Out-of-Pocket Maximum (after deductible) for Medical Care.	None	\$2,500 per person \$5,000 per family

Expenses that do not apply to the out-of-pocket limit are:

- Expenses applied to your deductible;
- Penalties for non-certified hospital services;
- Non-covered services;
- Co-pay amounts;
- Prescription co-pays; and
- Charges in excess of usual, customary and reasonable charge.

BENEFITS AND SERVICES	PPO NETWORK PLAN PAYS (AFTER DEDUCTIBLE)	OUT-OF-NETWORK PLAN PAYS (AFTER DEDUCTIBLE)
Hospital Benefit I - Inpatient Medical or Surgical Care		
- Hospital benefits will be reduced by \$100 unless precertified.	100% of Allowable Expense after a \$150 Co-Pay per confinement.**	70% of UCR* Charge

⁽¹⁾ Unless otherwise indicated in the Schedule of Benefits.

* UCR means Usual, Customary and Reasonable Charges.

** Calendar year deductible does not apply.

BENEFITS AND SERVICES	PPO NETWORK PLAN PAYS (AFTER DEDUCTIBLE)	OUT-OF-NETWORK PLAN PAYS (AFTER DEDUCTIBLE)
Hospital Benefit II - Inpatient Mental Nervous - Hospital benefits will be reduced by \$100 unless precertified. Includes physician charges.	100% of Allowable Expense after a \$150 Co-Pay per confinement.**	70% of UCR Charge
Hospital Benefit III - Inpatient Substance Abuse Care - Hospital benefits will be reduced by \$100 unless precertified. Includes physician charges.	100% of Allowable Expense after a \$150 Co-Pay per confinement.**	70% of UCR Charge
Emergency Room Sickness & Accident Care - Emergency Room and miscellaneous emergency room charges related to visit. - Co-pay waived if admitted to hospital. - Physician Charges	100% of Allowable Expense after a \$125 Co-Pay** 100% of Allowable Expense after a \$15 Co-Pay**	70% of UCR Charge 70% of UCR Charge
Urgent Care Center - Visit Only - Other services will be paid according to the Schedule of Benefits.	100% of Allowable Expense after a \$15 Co-Pay**	70% of UCR Charge
Hospital Pre-Admission X-ray and Laboratory Testing - For X-ray and lab tests performed within 10 days prior to confinement.	100% of Allowable Expense	70% of UCR Charge
Hospice Benefits - Limited to 180 days per lifetime. Must be certified by a physician as medically necessary.	100% of Allowable Expense	70% of UCR Charge

** Calendar year deductible does not apply.

BENEFITS AND SERVICES	PPO NETWORK PLAN PAYS (AFTER DEDUCTIBLE)	OUT-OF-NETWORK PLAN PAYS (AFTER DEDUCTIBLE)
Convalescent/Extended Care and Skilled Nursing Facility - Combined benefit of 90 days per calendar year, must begin within 5 days after a hospital confinement.	100% of Allowable Expense	70% of UCR Charge
Surgical Benefit I - Inpatient Surgical Charges including Anesthesia.	100% of Allowable Expense	70% of UCR Charge
Surgical Benefit II - Outpatient Surgical Charges at Ambulatory Surgical Center or Outpatient Facility.	100% of Allowable Expense after a \$100 Co-Pay**	70% of UCR Charge
- Outpatient Surgical Charges performed in the provider's office.	100% of Allowable Expense after a \$15 Co-Pay**	70% of UCR Charge
Surgical Benefit III - Ambulatory Surgical Center or Outpatient Facility Charges related to outpatient surgery.	100% of Allowable Expense	70% of UCR Charge
Anesthesia	100% of Allowable Expense	70% of UCR Charge
NOTE: Bariatric Surgery of any type, Inpatient or Outpatient requires one year of continuous active coverage.		
Second Surgical Opinion	100% of Allowable Expense	70% of UCR Charge

** Calendar year deductible does not apply.

BENEFITS AND SERVICES	PPO NETWORK PLAN PAYS (AFTER DEDUCTIBLE)	OUT-OF-NETWORK PLAN PAYS (AFTER DEDUCTIBLE)
Oral Surgery - Benefits outlined in Section 5.	Treated as a surgical expense.	Treated as a surgical expense.
Doctors' Visits - Covers physician's visits and consultations. <ul style="list-style-type: none"> - Hospital - Office 	100% of Allowable Expense 100% of Allowable Expense after a \$15 Co-Pay per visit**	70% of UCR Charge 70% of UCR Charge
Private Duty Nursing - For services rendered by an RN, LPN, PHN or LVN.	100% of Allowable Expense	70% of UCR Charge
Home Health Care - Maximum of 100 visits per calendar year.	100% of Allowable Expense	70% of UCR Charge
Maternity Benefit - Hospital and Physician Charges.	As any other inpatient expense.	As any other inpatient expense.
Hospital Newborn Nursery Services - Routine hospital and physician services. - Charges for routine newborn care in the hospital are covered under the mother's maternity benefit.	As any other inpatient expense.	As any other inpatient expense.
Birthing Center - Services rendered by a birthing center and/or certified nurse midwife.	100% of Allowable Expense	70% of UCR Charge

** Calendar year deductible does not apply.

BENEFITS AND SERVICES	PPO NETWORK PLAN PAYS (AFTER DEDUCTIBLE)	OUT-OF-NETWORK PLAN PAYS (AFTER DEDUCTIBLE)
Infertility Treatment/Testing Benefit	NOT COVERED	NOT COVERED
- Fertility drugs	NOT COVERED	NOT COVERED
- In vitro fertilization and artificial insemination.	NOT COVERED	NOT COVERED
Elective Sterilization	Treated as a surgical expense.	Treated as a surgical expense.
Elective Termination of Pregnancy	NOT COVERED	NOT COVERED
Diagnostic X-Ray and Laboratory - For services performed on an outpatient basis.	100% of Allowable Expense after a \$15 Co-Pay per date of service**	70% of UCR Charge
Chemotherapy and Radiation Therapy - Covered outpatient services.	100% of Allowable Expense	70% of UCR Charge
Outpatient Mental/Nervous	100% of Allowable Expense after a \$15 Co-Pay per visit**	70% of UCR Charge
Outpatient Substance Abuse Benefit	100% of Allowable Expense after a \$15 Co-Pay per visit**	70% of UCR Charge
Chiropractic Benefit - Maximum payment of \$1,000 per calendar year.	100% of Allowable Expense after a \$15 Co-Pay per visit**	70% of UCR Charge

** Calendar year deductible does not apply.

BENEFITS AND SERVICES	PPO NETWORK PLAN PAYS (AFTER DEDUCTIBLE)	OUT-OF-NETWORK PLAN PAYS (AFTER DEDUCTIBLE)
Temporomandibular Joint Dysfunction (TMJ) and Myofascial Pain Dysfunction (MPD) - Maximum payment of \$2,000 per lifetime.	100% of Allowable Expense	70% of UCR Charge
Outpatient Physical, Occupational or Speech Therapy - For medically necessary services.	100% of Allowable Expense	70% of UCR Charge
Acupuncture Benefit	NOT COVERED	NOT COVERED
Allergy Injections	100% of Allowable Expense	70% of UCR Charge
Prescription Drug Card Benefit - Retail pharmacy purchase limited to a 30 day supply. - Mail order purchase limited to a 90-day supply. - Oral Contraceptives are covered. - See Section 5 for further details.	100% after a co-pay of: \$5 for generic drugs \$30 for preferred brand name drugs \$50 for non-preferred brand name drugs 100% after a co-pay of: \$10 for generic drugs \$60 for preferred brand name drugs \$100 for non-preferred brand name drugs	
<p>If a Generic drug is available and the physician does not write “Dispense as Written,” the employee will be responsible for the difference between the Generic and Name Brand Drug, plus the higher co-pay. Calendar year deductible does not apply to prescription expenses.</p> <p>All prescriptions for Specialty Medications should be provided by CuraScript Specialty Pharmacy. See Section 5, page 11 for more details.</p>		
Ambulance	100% of Allowable Expense	70% of UCR Charge

BENEFITS AND SERVICES	PPO NETWORK PLAN PAYS (AFTER DEDUCTIBLE)	OUT-OF-NETWORK PLAN PAYS (AFTER DEDUCTIBLE)
Durable Medical Equipment - Medically necessary Equipment or supplies.	100% of Allowable Expense	70% of UCR Charge
Preventive/Wellness Care Services - Well child care including immunizations, preventive care and routine testing. Birth to age 2.	100% of Allowable Expense after a \$15 Co-Pay per visit**	70% of UCR Charge
- Preventive Care (Age 2 and over) - Physical Exam & Related Tests \$250 calendar year maximum	100% of Allowable Expense after \$15 Co-Pay per visit**	70% of UCR Charge
- GYN Exam & PAP Test - Mammogram - Immunizations	100% of Allowable Expense**	70% of UCR Charge
Other Covered Benefits - See Section 5 for further details.	100% of Allowable Expense or 100% of Allowable Expense after a \$15 co-pay.**	70% of UCR Charge

** Calendar year deductible does not apply.

Section 2

**IMPORTANT INFORMATION ABOUT YOUR PLAN
(SUMMARY PLAN DESCRIPTION)**

This Summary Plan Description has been compiled in accordance with Public Law 93-406, known as the EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974; (“ERISA”).

- | | |
|--|---|
| 1. NAME OF PLAN | GMS Mine Repair & Maintenance, Inc.
Employee Medical Plan |
| ADDRESS OF PLAN | 32 Enterprise Drive
Oakland, MD 21550 |
| 2. TYPE OF PLAN ADMINISTRATION | Third Party Administration |
| 3. NAME OF HEALTH INSURANCE ISSUER | GMS Mine Repair & Maintenance, Inc. |
| ADDRESS OF HEALTH INSURANCE ISSUER | GMS Mine Repair & Maintenance, Inc.
32 Enterprise Drive
Oakland, MD 21550 |
| 4. ORIGINAL PLAN EFFECTIVE DATE | July 1, 2008 |
| 5. FISCAL YEAR OF PLAN | July 1 to June 30 |
| 6. TYPE OF BENEFITS | Medical, Prescription Drugs |
| 7. EMPLOYER (PLAN SPONSOR)
IDENTIFICATION NUMBER | 52-1908118 |
| 8. PLAN ADMINISTRATOR AND
AGENT FOR LEGAL PROCESS | GMS Mine Repair & Maintenance, Inc. |
| 9. CLAIMS PROCESSOR | Self Funding Administrators Corporation
PO Box 6596
Annapolis, Maryland 21401 |
| 10. PLAN NUMBER ASSIGNED
BY CLAIMS PROCESSOR | 3017 |

**IMPORTANT INFORMATION ABOUT YOUR PLAN
(SUMMARY PLAN DESCRIPTION)**

Continued

11. PLAN WAITING PERIOD

- A. Employees and dependents covered on the original effective date of the Plan: None
- B. Employees and dependents eligible after the original effective date of the Plan: First of the month following 90 days of full-time employment.

12. DEFINITION OF AN ELIGIBLE EMPLOYEE

Full-time Employee, working at least 40 Hours per Week

13. DEFINITION OF AN ELIGIBLE DEPENDENT

Spouse or Child(ren) of an Employee

14. DEPENDENT CHILDREN'S COVERAGE

Medical Plan Coverage begins:

- A. For Plan Benefits - at birth.
- B. Continues to age 19, if the dependent is **not** a full-time student.
- C. Continues to age 25, if the dependent is a full-time student and provides semi-annual certification of enrollment in an accredited school or college or is on a medically necessary leave of absence certified by the dependent's treating physician for less than one year.
- D. Continues indefinitely if the dependent is totally and permanently disabled or incapacitated when his coverage would otherwise terminate, as long as the employee continues to be covered under the Plan.

15. CONTRIBUTIONS TO THE PLAN

- A. The employee is required to pay a portion of the cost of the employee's coverage.
- B. The employee is required to pay a portion of the cost of the dependent's coverage.

Section 3

IMPORTANT PLAN PROVISIONS

PREEXISTING CONDITIONS

This provision applies to enrollees covered after July 1, 2008.

A preexisting condition is “a condition (whether physical or mental) for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date.”

The enrollment date is the earlier of enrollment in the plan or the beginning of the waiting period. Once it has been determined that a condition qualifies as preexisting as defined above, the following maximum period of limitation will be applied:

No benefits will be paid for the condition during the first 12 months.

However, the preexisting limitation period will be **reduced** by the number of days that the individual was covered under other *creditable coverage*:

- Creditable coverage includes coverage under a group or individual health plan, Medicare, Medicaid and other health plans, as set forth in the Health Insurance Portability and Accountability Act (HIPAA).
- Creditable coverage will be counted without regard to the specific benefits offered under the other plan.
- Creditable coverage is not counted if more than 63 days have elapsed from the date of loss of coverage until the new enrollment date. Waiting periods and HMO affiliation periods are not considered gaps in coverage.

Certificate of Coverage - This is the primary means by which individuals can prove prior creditable coverage. You should have received a certificate of creditable coverage from your prior plan. You may request a certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the certificate. You must present that certificate to your Employer in order for your creditable coverage to reduce your preexisting condition waiting period under this Plan.

Preexisting condition exclusions will **NOT** be applied to:

- Newborns - if enrolled within 30 days after birth;
- Adopted children - if adopted or in the process of being adopted before age 18 and enrolled within 30 days after adoption or placement;
- Pregnancy;
- Conditions based solely on genetic information.

A certificate of creditable coverage will be provided when you leave your employer or lose coverage. It will also be provided if requested at any time while you are covered under the plan and up to 24 months after coverage ceases. Contact Self Funding Administrators to obtain a certificate.

With respect to a qualified beneficiary who elects COBRA continuation coverage pursuant to the American Recovery and Reinvestment Act of 2009, the following periods shall be disregarded for purposes of determining the 63 day break in coverage period, as referred to in Section 701(c)(2) of ERISA:

- The period beginning on the date of the qualifying event; and
- The period ending with the start of COBRA continuation coverage.

TIME OF PAYMENT OF BENEFITS

All benefits will be paid by the claims processor as quickly as possible upon receipt of a clean claim as defined in Section 7. Written notice of a claim should be given to the claims processor within 90 days of the incurred date.

IN NO EVENT WILL CLAIMS BE PAID IF SUBMITTED AFTER 12 MONTHS FROM THE INCURRED DATE OF THE CLAIM UNLESS IT CAN BE SHOWN THAT IT WAS NOT POSSIBLE TO SUBMIT THE CLAIM DUE TO CIRCUMSTANCES BEYOND THE CONTROL OF THE COVERED INDIVIDUAL. IF THE ENTIRE GROUP PLAN TERMINATES, CLAIMS FOR COVERED PERSONS MUST BE SUBMITTED WITHIN 90 DAYS FROM THE TERMINATION DATE OR NO BENEFITS WILL BE PAYABLE.

REPLACEMENT OF PRIOR INSURANCE

If an employee or dependent was covered by the GMS Mine Repair & Maintenance, Inc. plan which was in force immediately prior to this Plan, and if there was no lapse of coverage between this Plan and the prior plan, the employee or dependents will be covered without interruption.

Preexisting condition limitations will not apply.

This provision applies to regular covered employees and their covered dependents. It also applies to employees and dependents who are covered under the prior plan's Continuation of Coverage as mandated under Public Law 99-272, Title X (COBRA).

COORDINATION OF BENEFITS

If a person is covered under this Plan and other health plans, the combined benefits payable by this Plan and all other plans will not exceed 100% of the eligible allowable expenses incurred. Other plans include group medical or dental plans, Medicare, Medicaid, Tricare and automobile policies. Benefits payable under this Plan will be coordinated with benefits provided (or required) by any no-fault auto insurance and/or any other auto insurance policies.

The claims administrator will determine which plan is considered to be the primary payer and which is considered the secondary payer(s).

Any health plan which does not contain a coordination of benefits provision will always be considered as the primary payer. In addition, this plan will always be secondary to any automobile policy regardless of that plan's coordination of benefits provisions.

This plan is secondary to any form of first party coverage which provides coverage for medical expenses, which includes homeowners and automobile policies. First party coverage pays policyholders and others covered by the policy in the event of injury, no matter who caused the accident. The benefits can include payment of medical expenses. This may also be called Personal Injury Protection (PIP) or Medical Payment.

Residents of no-fault states: This Plan does not pay for any expenses, services, or related charges in connection with a motor vehicle injury or accident until the member's available coverage through their automobile policy is exhausted.

Residents of non no-fault states: This Plan will pay for motor vehicle related accidents/injuries only after all other available benefits have been exhausted including any benefits available from any automobile insurance policy.

ORDER OF BENEFIT DETERMINATION

When all plans covering the person contain a coordination of benefits provision, the order of payment will be as follows:

1. **Employee/Dependent** - The benefits of a plan which covers the person as an employee are determined before those of a plan which covers the person as a dependent, a retiree or a laid off person.
 2. **Dependent Child of Parents Who are Legally Married**
 - a. The benefits of the plan covering the parent whose birthday falls earlier in the year are determined before those of the plan covering the parent whose birthday falls later in that year.
 - b. If both parents have the same birthday, the benefits of the plan covering the parent for a longer period of time are determined before those of the plan covering the parent for a shorter period of time.
- Note: If one of the coordinating plans does not contain the "birth date rule" as described above, the plan that does not contain the birth date rule will determine order of benefits.
3. **Dependent Child of Divorced or Separated Parents** - When all plans covering a person as a dependent child of divorced parents contain coordination of benefits, the order of payment will be:
 - a. The plan covering the dependent child of a natural parent designated by court order to be responsible for the child's health care expenses will be considered primary.
 - b. In the absence of a court order specifying otherwise, the plan covering the dependent child of the natural parent having legal custody of the child will be considered primary.
 - c. In the absence of a court order specifying otherwise, the plan covering the dependent child of a stepparent who is the spouse of the natural parent having legal custody of the child will be considered primary.
 4. **Active Employee/COBRA Beneficiary** - The benefits of a plan which cover a person as an active employee are determined before those of a plan which cover that person as a COBRA beneficiary.
 5. **Active/Inactive Employee** - The benefits of a plan which cover a person as an active employee are determined before those of a plan which cover that person as a laid off or retired employee.
 6. **Longer/Shorter Length of Coverage** - If none of the above rules determines the order of benefits, the benefits of the plan which covers the employee for a longer period of time are determined before those of the plan which covers the employee for a shorter period of time.

ALLOWABLE EXPENSE

If this Plan is considered to be secondary, it will reimburse the balance of the remaining allowable expenses **NOT TO EXCEED THE AMOUNT IT WOULD HAVE PAID IF IT HAD BEEN CONSIDERED PRIMARY.**

An allowable expense is generally any expense considered eligible under one or both coordinating plans; however, the allowable expense will be determined as follows in the situations described below:

- a) If the claim is an in-network claim for the primary carrier and for this plan, this plan will pay up to the lowest priced amount.
- b) If the claim is an out of network claim for the primary carrier and an in-network claim for this plan, this plan will pay up to the in-network priced amount.
- c) If the claim is an in-network claim for the primary carrier and an out of network claim for this plan, this plan will pay up to the primary carrier's priced amount.
- d) If the claim is an out of network claim for both plans, this plan will pay up to the lowest usual and customary rate.

SUBROGATION

WHEN THIS PROVISION APPLIES: If you, your spouse, one of your dependents, or anyone who receives benefits under this plan becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the plan are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of the plan.

As a condition of receiving benefits under this plan, the employee or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan 100% of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise from any funds recovered from such third party, any liability insurance or uninsured/underinsured motorist proceeds recovered as a result of the actions of the responsible third party. The person receiving benefits further agrees that any funds received by said person and/or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied. If the employee or covered person retains an attorney, then the employee or covered person agrees to only retain one who will not assert the Common Fund or Made-Whole Doctrines. The plan is entitled to be reimbursed first from any funds recovered without application of the Made Whole Doctrine or the Common Fund Doctrine. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or the other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The employee or covered person agrees to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the employee or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the plan may be divided up between the employee or covered person and their attorney if applicable. Any accident related claims made after satisfaction of this obligation shall be paid by the employee or covered person and not the plan.

The employee or covered person agrees to take no action which in any way prejudices the rights of the plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the employee or covered person, then the employee or covered person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Sponsor has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the plan may reduce or deny future benefits by the amount of any recovery received, but not reimbursed, by the Participant as it relates to an accident or injury for which the Plan paid benefits.

If the employee or covered person takes no action to recover money from any source, then the employee or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

MEDICARE

Plan participants who are age 65 or older and covered by this plan because they are either actively working, or are the dependent of a working spouse of any age must choose one of the following options:

1. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare; Medicare will pay secondary benefits).
2. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

Disability due to End Stage Renal Disease (ESRD) - If a participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of disability, in addition to the 3-month waiting period, or a maximum of 33 months, when applicable. After the initial 30 or 33 months, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Medicare Eligibility due to disability other than ESRD - Benefits that would otherwise have been payable under the Plan for any charge will be reduced by the amount of any medical benefit that either is payable for the charge under Medicare or would have been payable if the covered participant had enrolled for Medicare Part A and B.

Employers with 100 or More Employees - If a participant becomes eligible for benefits under Medicare as a result of a disability (other than End Stage Renal Disease) and chooses to remain covered under this Plan, the Plan will pay benefits first and Medicare will be the secondary payor.

Employers with less than 100 Employees - If a participant becomes eligible for benefits under Medicare as a result of a disability (other than End Stage Renal Disease) and chooses to remain covered under this Plan, Medicare will pay benefits first and the Plan will be the secondary payor. Benefits that would otherwise have been payable under the Plan for any charge will be reduced by the amount of any medical benefit that either is payable for the charge under Medicare or would have been payable if the covered person had enrolled in Medicare Parts A and B.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

COBRA and MEDICARE:

Medicare due to ESRD at the time of COBRA election - Medicare is the secondary payor for individuals entitled to Medicare due to ESRD who have COBRA coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payor.

Medicare due to Age or Disability at the time of COBRA election - Medicare is the primary payor for individuals entitled to Medicare due to age or disability and the plan covering an individual as a COBRA beneficiary is the secondary payor.

ELIGIBLE MEDICAL EXPENSE

This Plan will pay for only those medical expenses which are recommended by a licensed physician or practitioner who is acting within the scope of his license. Eligible expenses must be medically necessary for the treatment of a covered illness or accident. Treatment which is considered experimental or investigative by the American Medical Association, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry or any appropriate government agency such as the U.S. Department of Health and Human Services is not eligible for payment unless otherwise noted in this booklet.

MEDICAL PLAN FEATURES

Individual Deductible - Each participant's annual out of network deductible is listed in the Schedule of Benefits. This deductible must be met once each calendar year and applies to covered services indicated in the Schedule of Benefits.

Deductible Carryover Provision - Although a new deductible will apply each calendar year, charges incurred during October, November and December which are applied to that year's deductible will also be applied toward the deductible for the next year and thus reduce or eliminate the next year's deductible.

Family Deductible - Under Family Coverage, when the deductible amounts accumulated by the members of a family reach the family maximum as outlined in the Schedule of Benefits during a calendar year, no further deductibles will apply to any family members for the rest of that calendar year.

Out-of-Pocket Limit - After you have met the deductible expense, the Plan will pay the amount specified in the Schedule of Benefits. The remaining percentage for which you are responsible is called the out-of-pocket expense. When your (or your family's) out-of-pocket expense reaches the limit shown in the Schedule of Benefits for claims incurred during a calendar year, the Plan will pay 100% of the reasonable and customary allowance of that individual's (or family's) eligible expenses for the remainder of the calendar year.

Co-Pay - The dollar amount (shown in the Schedule of Benefits) a participant pays for a covered service. This amount does not apply toward the deductible or out-of-pocket limit.

Lifetime Maximum - The lifetime maximum represents the maximum amount of benefits a participant is eligible to receive during the entire time he or she is covered under the Plan and includes all covered services described in the Plan.

Private Room Allowance - If a covered person is confined in a hospital's private room, the Plan will pay the private room rate only if:

1. The private room confinement is recommended by a physician and is medically essential for the necessary care and treatment of an injury or sickness, or
2. A semi-private room is not available and the use of a private room is therefore necessary.

Otherwise, the Plan will pay the semi-private room rate.

TRANSFER OF DEDUCTIBLE AND COINSURANCE

Credit will be given for the deductible and co-insurance or any part thereof that was considered by the employer's immediate prior group plan carrier for the calendar year in which this Plan originally became effective.

MANAGED HOSPITAL AND SURGICAL CARE PROGRAM

The Claims Processor contracts with the professional medical review company, HealthCare Strategies, to assist in determining appropriate care. The HealthCare Strategies program is not intended to diagnose or treat medical conditions, nor will it guarantee benefits or validate eligibility. The medical professionals who conduct the program focus their review on the appropriateness of hospital stays and proposed surgical procedures.

Required Hospital Admission Review - The covered person is required to call HealthCare Strategies at 800-582-1535 before any elective hospital admission (including mental/nervous and substance abuse). It will be necessary to provide the patient's name, the name of the physician and hospital, the reason for the hospitalization and any other information needed to complete the review.

Should the covered person need to stay in the hospital longer than initially approved by the managed health care professionals, he or the attending physician should call HealthCare Strategies for a second review of the original admission.

Inpatient hospitalization must be precertified or benefits will be substantially reduced, as shown in the Schedule of Benefits. The amount the patient pays when he does not comply with the managed health care program's review procedures does not apply toward his out-of-pocket maximums.

Precertification is not required for the first 48 hours for normal maternity delivery or the first 96 hours for Cesarean delivery, but is required for any period of confinement thereafter.

LARGE CASE MANAGEMENT

Patients with significant medical issues may be placed into Large Case Management through HealthCare Strategies. This program supports the patient and family in the decision making process from the onset of a disease. All Case Managers are Registered Nurses with clinical expertise in specialty areas of medicine and nursing practice.

The Nurse Case Manager acts on behalf of each patient and their family, providing confidential patient education and specific teaching to facilitate recovery and improve quality of life. The Case Manager assists the patient in navigating the health care system and accessing quality medical care, and also provides support to the patients and their treating physicians or practitioners to improve medical outcomes and limit out of pocket costs to the patient. Participants are assisted in accessing Centers of Medical Excellence for treatment of illness or injury. In general, the Nurse Case Manager collaborates, facilitates, coordinates and negotiates the needs of the patient and the family.

Participants and their families who are contacted by a Nurse Case Manager are urged to respond, and to take advantage of this valuable resource.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother of newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

PREFERRED PROVIDER ORGANIZATION

A Preferred Provider Organization (PPO) is a network of doctors, hospitals, laboratories and other health care providers that offer quality medical care at a competitive cost. Your use of a PPO benefits both you and our company by keeping health care costs down.

The choice to use a PPO provider is always your option. The program is completely voluntary. If you use the preferred providers, you can reduce your out-of-pocket expenses. If you do not choose to use one of the specified providers, you can still obtain benefits under the health plan by choosing a non-PPO physician or practitioner.

Using the PPO:

The Preferred Provider Organization will provide a directory listing of all participating providers or practitioners. Before you receive treatment from one of these providers, however, be sure to check if he is still a member of the PPO. Some doctors and hospitals may have changed their participation status after the date the directory was published.

You must present your Medical Identification Card to the participating provider and pay the co-pay (where applicable) at the time of your visit.

You do not need to complete a claim form. The PPO will send the claim to Self Funding Administrators (SFA). They will process the claim and payment will be sent directly to the provider of service.

Section 4

ENROLLMENT AND ELIGIBILITY

The provisions in this Eligibility and Enrollment section apply to employees and their dependents who are eligible for coverage after July 1, 2008.

Who is Eligible - A full-time employee working at least 40 hours per week for GMS Mine Repair & Maintenance, Inc. is eligible for coverage under this Plan.

An eligible dependent of a covered employee is also eligible for coverage under this Plan.

Effective Date for Plan Benefits:

If the employee enrolls for coverage:

Before the waiting period ends:

During the 31 day period following the waiting period:

More than 31 days following the waiting period:

Coverage will be effective:

Day following the completion of the actual waiting period

On the date the application is signed

Coverage may be added only in accordance with the Special Enrollment Periods provision below.

Special Enrollment Periods

This Plan provides special enrollment periods that allow you to enroll in the Plan, even if you declined enrollment during an initial or subsequent eligibility period.

If an employee experiences any of the following events, coverage may be added or changed as of the date of the event, subject to the standard preexisting limitations, if the employee applies for coverage within 30 days (unless otherwise noted) after the event:

1. a marriage or divorce;
2. the death of a spouse or child;
3. the birth, adoption or placement for adoption, of a child;
4. the termination or commencement of a spouse's employment;
5. a switch from full-time to part-time or part-time to full-time status by the employee or spouse;
6. an unpaid leave of absence by the employee or spouse;
7. a significant change in the health coverage of the employee or spouse attributable to the spouse's employment;
8. loss of other health insurance coverage, including reaching a lifetime limit on all benefits under a plan;
9. a change in the place of residence or work of the employee, spouse or dependent;
10. the employee's or dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the employee requests coverage under the Plan within 60 days after the termination; or
11. the employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the employee requests coverage under the Plan within 60 days after eligibility is determined.

If none of the above events (1-11) apply, the employee may be covered after application is made, subject to an extended preexisting condition waiting period of 18 months beginning on the first date of coverage. The pre-existing waiting period may be reduced by creditable coverage as outlined in Section 3, page 1.

An enrollee is **not** required to submit any type of health evidence in order to be covered under the plan.

Open Enrollment - The plan provides for open enrollment during the month of June each policy year. Employees and dependents covered under any of the employer's medical plans (HMOs, etc.) may enroll in this Plan during June for an effective date of July 1. Preexisting condition limitations do not apply.

Employees and dependents not covered under any of the employer's medical plans may also enroll in this Plan during June for an effective date of July 1. Preexisting condition limitations will apply.

COVERAGE FOR ADOPTED CHILDREN

Any child under age 18 who is adopted or in the process of being adopted by an eligible employee of GMS Mine Repair & Maintenance, Inc. will be eligible for coverage under the Plan.

Coverage will be effective as of the date the plan participant assumes legal obligation for the total or partial support of the child to be adopted.

Preexisting limitations and eligibility waiting periods will be waived.

Coverage will terminate whenever the legal support obligations for the child ends.

All other plan provisions apply.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The plan will provide benefits to the child/children of a plan participant who is required by a Qualified Medical Child Support Order (QMCSO) to provide health insurance coverage for the child/children.

A Medical Child Support Order must have all the following elements to qualify under ERISA Section 609(a)(2):

1. The name and last known mailing address of the Plan participant;
2. The name and address of each child;
3. A reasonable description of the type of coverage to be provided by the health plan or the manner in which coverage will be determined;
4. The period for which coverage must be provided; and
5. Each plan to which the order applies.

TERMINATION OF COVERAGE

1. Employee coverage will terminate on the earliest to occur of:
 - a. The date on which employment terminates;
 - b. The date on which the Plan is terminated;
 - c. The date on which contributions cease; or
 - d. The date the employee is no longer considered eligible under the Plan, including the date any family medical leave ceases or leave of absence ceases and employee does not return to work.

2. Dependent coverage will terminate on the earliest to occur of:
 - a. The date on which the employee's coverage terminates as outlined above;
 - b. The date on which the employee ceases to be included in a class of persons eligible for dependent coverage; or
 - c. The date on which the dependent is no longer within the definition of an eligible dependent under the Plan.
 - d. However, if a child of a covered employee reaches the age at which he would otherwise cease to be a covered dependent, and if the child is then mentally or physically incapable of earning his own living, the Plan will continue to consider the child as a dependent beyond such age, while he remains in such condition subject to all terms of the Plan. Dependent children must be covered under this Plan prior to the limiting age in order for coverage to be continued under this provision. The employee must continue to be covered under the Plan for this provision to apply.

STUDENT STATUS VERIFICATION

It is the employee's responsibility to provide to the employer written verification of full-time student status upon the child reaching age 19. Verification is required twice each year until the child's 25th birthday. If verification is not received, coverage will end on the last effective date.

Updated verification for the fall semester is effective through January 31 for all students, including those who have graduated. Verification provided for the spring semester is effective through August 31 for all students, including those who have graduated.

MICHELLE'S LAW NOTICE

A dependent child who is a full time student and is placed on a medically necessary leave of absence shall be eligible for continued coverage under this plan for the earlier of the following:

- a) one (1) year after the first day of the medically necessary leave of absence; or
- b) the date on which such coverage would otherwise terminate under the terms of the plan provided that the student's treating physician certifies that the leave is medically necessary and the student was a student at a post-secondary educational institution immediately before the first day of the medically necessary leave of absence.

TERMINATION DUE TO DISABILITY

If an employee becomes disabled while covered under this plan, he may continue to be covered up to 12 months from the original date of disability provided he continues to be classified by GMS Mine Repair & Maintenance, Inc. as an active employee under the plan.

TERMINATION DUE TO LAYOFF/REDUCTION IN HOURS

The company may provide an approved sick leave, or leave of absence, for the participant. Coverage may be continued during this time if the required contribution is made by the participant. All coverages described below will run concurrently with FMLA (Family and Medical Leave Act of 1983).

Temporary Lay Off - The participant may extend coverage under this Plan for a period of 30 days from the date of temporary layoff. If the participant returns to active full-time employment during the 30-day period, he will be eligible for coverage immediately. The waiting period and pre-existing conditions provisions will not apply.

Approved Leave of Absence - Coverage may be extended under this Plan for the participant at the employer's discretion for a maximum period of 6 months during an approved leave of absence. If employer approves the leave of absence, then the employer may pay the cost of this coverage.

Medical Leave of Absence - Coverage may be extended for a maximum period of 6 months during a medical leave of absence.

PLAN TERMINATION

GMS Mine Repair & Maintenance, Inc. may terminate the Plan, which shall be accomplished in writing and signed by an officer of the Plan Sponsor pursuant to authorization of the Plan Sponsor's Board of Directors. Upon termination, the rights of participants to benefits are limited to eligible claims incurred up to the date of termination. Any termination of the Plan will be communicated to participants. If the Plan is terminated, COBRA benefits are not available under this Plan. In the event of Plan termination, all claims incurred by a participant must be received by the Plan Sponsor within 90 days after the date of termination. Payment of claims will be made when funds are made available by the Plan Sponsor.

CONTINUATION OF COVERAGE (FAMILY AND MEDICAL LEAVE)

In compliance with the Family and Medical Leave Act of 1993, the Plan will allow continuation of the employee's and enrolled dependent's health care coverage on the same basis as prior to the qualified leave for up to 12 weeks in a 12 month period for childbirth, adoption or serious illness of the employee or his/her spouse, children or parent. In addition, the plan will allow continuation of coverage for up to 26 weeks in a 12 month period in the case of qualified military caregiver leave as defined by the FMLA.

For further information see your Personnel Director.

MILITARY LEAVE ACT

Notwithstanding anything in this Plan to the contrary, with respect to any employee or dependent who loses coverage under this Plan during the employee's absence from employment by reason of military service, no preexisting condition exclusion or waiting period may be imposed upon the reinstatement of such employee's or dependent's coverage upon reemployment of the employee unless such preexisting condition exclusion or waiting period would have otherwise applied to such employee or dependent had the employee not been on military leave of absence.

UNIFORMED SERVICE (USERRA)

An employee covered by the GMS Mine Repair & Maintenance, Inc. Plan who is absent from employment (for more than 30 days) on account of being in “uniformed service” as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) may elect to continue participation in the GMS Mine Repair & Maintenance, Inc. Plan for the employee and dependents during this period of “uniformed service.” The employee shall be offered coverage for the lesser of 24 months or until the participant fails to apply for reinstatement or to return to employment with the employer following discharge from uniformed service. At the beginning of Military Leave, the employee will be offered coverage by the Plan Administrator at the same rates and in a manner similar to COBRA benefits as outlined below.

CONTINUATION OF COVERAGE (COBRA)

Public Law 99-272, Title X requires that most employers sponsoring group health plans offer enrolled employees and their dependents the opportunity for a temporary extension of health coverage (called “COBRA continuation coverage”) at group rates in certain instances where coverage under the Plan would otherwise end.

ELIGIBILITY FOR CONTINUATION

A person who is eligible for COBRA continuation coverage is called a “qualified beneficiary.” This person includes the employee or retired employee covered under the Plan, the covered employee’s spouse, or dependent children. The events making a person eligible for COBRA continuation coverage are called “qualifying events.” A qualified beneficiary must have coverage under the Plan the day before the qualifying event in order to be eligible for COBRA continuation coverage.

For a covered employee to become a qualified beneficiary, the employee must become ineligible for group coverage because of a qualifying event. A qualifying event for an employee may be one of the following:

1. Termination of employment (for any reason other than gross misconduct); or
2. Reduction of hours.

For a covered spouse or covered child to become a qualified beneficiary, the spouse or child must become ineligible for group coverage due to one of the following qualifying events:

1. Death of the employee;
2. Termination of the employee's employment (for any reason other than gross misconduct) or reduction in the number of hours of employment;
3. Divorce or legal separation;
4. The employee becoming covered under Medicare (Part A, Part B, or both); or
5. A dependent child ceasing to meet the definition of a “dependent.”

SUMMARY OF COVERAGE REQUIREMENTS

COBRA continuation coverage for qualified beneficiaries is the same as the coverage provided to active employees. However, the following terms and conditions apply:

1. Qualified beneficiaries who elect COBRA continuation coverage have the same rights under the plan as other participants or beneficiaries covered under the plan.
2. COBRA continuation coverage is in effect the day after termination of your present coverage, therefore, no lapse in coverage occurs.
3. You may only continue the coverage that was in effect on the day of termination or a lower level of coverage, if available.
4. Coverage is extended only to those individuals covered at the time of termination.
5. Coverage changes may be made due to a qualifying status change.
6. If you elect to continue the coverage, the total cost must be paid by you. The company will not supplement the cost.
7. Timely payment is required to remain actively covered.

PERIOD OF CONTINUATION

A qualified beneficiary may elect to continue the group coverage beyond the qualifying event up to:

1. 18 months, in a case where the qualifying event is termination of employment or reduction in hours;
2. 36 months, if the qualifying event is employee's Medicare entitlement, death of covered employee, divorce or legal separation from covered employee, or dependent child's loss of dependent status under the plan.

EXTENSION OF COBRA CONTINUATION COVERAGE

This section applies only to qualified beneficiaries who have experienced a loss of coverage due to an 18-month qualifying event.

Disability

If you are determined to be disabled under Title II or XVI of the Social Security Act, you are entitled to receive up to a total of 29 months of COBRA continuation coverage. Each qualified beneficiary who elected COBRA continuation coverage is entitled to the 11-month extension if one qualifies. Your disability "onset" date must be before your COBRA qualifying event date or within your first 60 days of COBRA continuation coverage. You must also provide the COBRA Administrator with a copy of your Social Security Act Determination within 60 days of issuance, if applicable, and before your initial 18 months of COBRA continuation coverage ends. COBRA premiums during the 11-month extension period are 150% of the current premium. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the plan administrator within 30 days of determination.

Second Qualifying Event

If a second qualifying event occurs during the original 18 months of COBRA continuation coverage, the affected qualified beneficiaries may extend COBRA continuation coverage for an additional 18 months. Such second qualifying events include death of covered employee, divorce or legal separation from covered employee, the covered employee's entitlement to Medicare, or dependent child's loss of dependent status under the plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan if the first qualifying event had not occurred. You must notify the plan administrator within 60 days of the second event occurrence to qualify for the extension.

ELECTION PERIOD

A qualified beneficiary may elect COBRA continuation coverage during the election period. The election period means the period which:

1. Is at least 60 days duration; and
2. Ends not earlier than 60 days after the later of:
 - a. The date coverage terminates under the group Plan because of the qualifying event; or
 - b. The date the Plan Administrator sends a COBRA notice of the qualifying event to the qualified beneficiary.

COBRA PREMIUM PAYMENTS

The initial payment must be postmarked within 45 days from the date you signed the election form. There is no extension of this due date. Once the initial payment is received, coverage is reinstated retroactively so that no lapse in coverage occurs. Thereafter, regular monthly premiums are due on the first day of each billing month. Regular monthly payments are still considered timely if postmarked within 30 days after the due date. Late payments will result in the cancellation of coverage, and once cancelled, there is no reinstatement.

COBRA and NON-MEDICARE PLANS

The Plan covering the individual as an employee, retiree, or as a dependent of an employee will be primary, and the plan providing continuation coverage (COBRA) will be secondary.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA continuation coverage will terminate on the earliest of the following dates:

1. Your failure to make a timely payment.
2. The date you first become, after the initial COBRA effective date, entitled to Medicare, or
3. The date you first become, after the initial COBRA effective date, covered under another group health plan. However, if this new group coverage contains any limitations of coverage for preexisting conditions, then you may continue COBRA continuation coverage until either the preexisting condition limitation terminates or your right to COBRA continuation coverage terminates.
4. The date you reach the end of your maximum eligibility period.
5. The date on which the company ceases to provide the plan to any employee.

NOTICE REQUIREMENTS

1. The covered employee or qualified beneficiary must notify the Human Resources Department or the Plan Administrator within 60 days of one of the following qualifying events:
 - a. Divorce or legal separation; or
 - b. A dependent child ceasing to meet the definition of “dependent.”
2. Notice must be provided in writing and must include the nature and date of the qualifying event. Appropriate documentation may be required in some circumstances.
3. Notice may be provided by the covered employee, qualified beneficiary, or a person acting on their behalf.
4. When requesting an extension of COBRA due to disability, the covered employee or qualified beneficiary must provide the Human Resources Department or the Plan Administrator with a copy of the Social Security Act Determination within 60 days of issuance, if applicable, and before the initial 18 months of COBRA continuation coverage ends. If the qualified beneficiary is determined by SSA to no longer be disabled, the Plan Administrator must be notified within 30 days of the determination.

Where it was the covered employee who gave notice of the qualifying event, the Plan Administrator must notify any qualified beneficiary “with respect to such event.”

The notice that must be given by the Plan Administrator to the beneficiary must be given within 14 days of the date on which the Plan Administrator received notice. Notification to a spouse is treated as notification of all other qualified beneficiaries residing with the spouse.

When coverage under the Plan ends, you may request proof of coverage directly from Self Funding Administrators.

SPECIAL COBRA PREMIUM ASSISTANCE OPPORTUNITY

The Federal Government through the passage of the “American Recovery and Reinvestment Act of 2009” has made a special COBRA opportunity available for certain assistance eligible individuals.

REDUCED COBRA PREMIUM

For a period defined by the federal government, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under the Plan if the individual pays 35% of the premium. Thus, if the assistance eligible individual pays 35% of the premium, the Plan will treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65% of the premium.

TERMINATION OF ELIGIBILITY FOR PREMIUM ASSISTANCE

The assistance eligible individual's eligibility for the subsidy terminates with the first month beginning on or after the earlier of:

- The date which is the first day of the month after the subsidy has expired, as determined by the federal government and subject to extension at the discretion of the federal government;
- The end of the maximum required period of continuation coverage for the qualified beneficiary under the Code's COBRA rules or the relevant State or Federal law (or regulation); or
- The date that the assistance eligible individual becomes eligible for Medicare benefits under Title XVIII of the Social Security Act or health coverage under another group health plan (including, for example, a group health plan maintained by the new employer of the individual or a plan maintained by the employer of the individual's spouse).

However, eligibility for coverage under another group health plan does not terminate eligibility for the subsidy if the other group health plan provides only dental, vision, counseling, or referral services (or a combination of the foregoing), is a health flexible spending account or health reimbursement arrangement, or is coverage for treatment that is furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care (or a combination of such care).

If a qualified beneficiary paying a reduced premium for COBRA continuation coverage under this provision becomes eligible for coverage under another group health plan or Medicare, then the qualified beneficiary is required to notify the Plan in writing. This notification must be provided to the Plan in the time and manner as is specified by the Secretary of Labor. If an assistance eligible individual fails to provide this notification at the required time and in the required manner, and as a result the individual's COBRA continuation coverage continues to be subsidized after the termination of the individual's eligibility for such subsidy, a penalty will be imposed by the Department of Labor that is equal to 110% of the subsidy provided after termination of eligibility.

SECOND COBRA ELECTION OPPORTUNITY

The provision provides a special 60 day election period for a qualified beneficiary who is eligible for a reduced premium and who has not elected COBRA continuation coverage as of the date of enactment. The 60 day election period begins on the date the notice is provided to the qualified beneficiary of the special election period. However, this special election period does not extend the period of COBRA continuation coverage beyond the original maximum required period and any COBRA continuation coverage elected pursuant to this special election period begins on the date of enactment and does not include any period prior to that date.

Thus, for example, if a covered employee involuntarily terminated employment on September 10, 2008, but did not elect COBRA continuation coverage and was not eligible for coverage under another group health plan, the employee would have 60 days after date of notification of this new election right to elect the coverage and receive the subsidy. If the employee made the election, the coverage would begin February 17, 2009, and does not include any period prior to that date. However, the coverage would not be required to last for 18 months. Instead the maximum required COBRA continuation coverage period would end no later than 18 months after September 10, 2008.

Individuals who were offered COBRA coverage due to a reduction in work hours and declined COBRA coverage, or allowed their COBRA coverage to lapse, may be eligible for another opportunity to elect COBRA coverage at the subsidized rate if they involuntarily lost their employment at a later date. Please see your plan administrator for details.

Section 5

ELIGIBLE PLAN EXPENSES

The Plan will allow the usual, customary and reasonable payment of eligible covered expenses for the treatment of a non-occupational illness or accidental bodily injury, subject to all Plan provisions.

HOSPITAL EXPENSE

The following are considered eligible expenses for inpatient care rendered by a general hospital, convalescent, rehabilitative, psychiatric or substance abuse hospital or other licensed treatment facility.

1. Room and Board Charges

- a. Semi-private room rate;
- b. Intensive care, cardiac care and isolation care;
- c. The private room rate if the facility contains no semi-private or ward rooms, otherwise the semi-private rate;
- d. Special diet needs as medically necessary.

2. Miscellaneous Hospital Charges

- a. Emergency room and outpatient charges;
- b. Use of operating rooms, other surgical treatment rooms, burn care units, recovery and delivery rooms;
- c. Anesthesia when administered by an employee of the hospital;
- d. Diagnostic x-ray, radium and radioactive isotopes;
- e. All laboratory examinations, including typing of blood donors and pathological laboratory services that are under the direction of a pathologist retained by the hospital;
- f. Pulmonary function evaluation;
- g. Physical therapy treatment and intermittent positive pressure breathing;
- h. Electro shock therapy, psychological testing including psychometric and other measuring tests;
- i. Oxygen and other gas therapy;
- j. The use of durable medical equipment such as inhalators, suction machines, respirators, oxygen tents and hyperbaric oxygen chambers;
- k. Prescription drugs, biologicals and solutions used while the covered person is in the hospital;
- l. Gauze, cotton, fabrics, solutions and other materials used in dressing and plaster casts;
- m. Routine nursery care of a newborn while the mother is hospital confined;
- n. Medical and surgical supplies for use in the hospital; including surgically implanted devices that are provided and billed by the hospital; and
- o. Intravenous injections and solutions.

3. **Hospital - Emergency Care** - Hospital benefits are also payable for outpatient care if a covered person is treated in the hospital for a surgical operation or for an emergency accident. Also covered are emergency sicknesses within 72 hours after the occurrence.
 - a. An emergency sickness is a sudden and unexpected onset of a medical condition accompanied by severe symptoms which require immediate medical care. Benefits will be provided for care obtained within 72 hours after the onset. Emergency sicknesses include heart attacks, accidents, poisoning, loss of consciousness or respiration, convulsions and/or acute conditions. In any event, the diagnosis or the symptoms of the condition, or the degree of severity, must be such that immediate medical care is required.
 - b. An emergency accident is an unexpected injury which requires immediate care.
4. **Partial Hospitalization for Psychiatric or Substance Abuse Care** - A psychiatric/substance abuse rehabilitation service offered in a licensed hospital or in a psychiatric day care treatment center or a community mental health facility or residential rehabilitation facility providing medically directed intensive or intermediate short-term psychiatric / substance abuse treatment for a period of less than twenty-four (24) hours but more than four hours in a day for any individual patient.
5. **Hospital Pre-Admission X-Ray and Laboratory Testing** - The Plan will pay for tests and laboratory studies required in connection with a hospital admission, rendered by a hospital on an outpatient basis prior to a scheduled admission to the hospital. Pre-admission testing does not include tests or studies performed to establish a diagnosis.

Benefits apply only if the services are not repeated for the same purpose when the patient is admitted to the hospital as an inpatient.

Benefits for pre-admission testing will not be provided if the patient cancels or postpones the admission to the hospital as an inpatient. However, if the hospital or practitioner cancels or postpones the admission to the hospital as an inpatient, benefits will be provided.

Pre-admission testing must be conducted within 10 days prior to admission as a hospital inpatient.

HOSPICE BENEFITS

The Plan will cover as an eligible expense those charges incurred by a terminally ill patient and rendered by a hospice either in the patient's home or a hospice facility. These services must be developed by a hospice care program in consultation and in agreement with the patient's physician. The prognosis of the patient's physician for the patient's life expectancy must be 6 months or less.

The following are eligible expenses:

1. Room and board, including special diets;
2. Services of a physician, RN, LPN, home health aide, physical, occupational and respiratory therapist;
3. Drugs, nutritional supplements, medical supplies, laboratory tests, x-rays, diagnostic equipment, oxygen, durable medical equipment, and any other eligible expenses normally covered under this Plan; and
4. Family counseling directly related to the patient's terminal condition.

The Plan will not pay for:

1. Expenses for services of a person who resides in the patient's home or is a member of the patient's family;
2. Expenses solely in connection with research;
3. Expenses for services that do not meet medically acceptable standards of quality and sound principles of health care;
4. Expenses related to the organization or dispensation of non-medical personal, legal or financial affairs, such as preparation of a will, liquidation of an estate and other similar activities; and
5. Expenses subject to any general limitations set forth in this document.

CONVALESCENT/EXTENDED CARE OR SKILLED NURSING FACILITY

The Plan will cover expenses incurred for confinement in a convalescent care, extended care or a skilled nursing facility provided such confinement is medically necessary. Benefits are not available for custodial care.

The following are eligible expenses:

1. Semi-private accommodations;
2. General nursing service, meals;
3. Use of special treatment rooms;
4. Routine laboratory examinations;
5. Physical or speech therapy treatments;
6. Oxygen and other gas therapy;
7. Drugs, biologicals and solutions used while in the facility; and
8. Gauze, cotton, fabrics, solutions, plaster and other materials used in dressing and casts.

Benefits are available only as long as medically necessary for the proper care and treatment of a covered illness or accident of the patient. The Plan may require written certification by the attending physician as to the continuing need for this type of care.

SURGERY AND ANESTHESIA

1. **Surgery** - This Plan will cover as an eligible expense professional services of an operating physician including necessary pre- and post-operative care incurred as a result of an accidental injury or illness. Surgery may be performed on an inpatient or outpatient basis. Surgical procedure means any procedure in the categories listed below:
 - a. The incision, excision or electro-cauterization of any organ or part of the body;
 - b. The manipulative redirection of a fracture or dislocation;
 - c. The suturing of a wound;
 - d. Observation or removal of a foreign object from the body by endoscopic means.

The eligible surgical expense will be determined in accordance with medically accepted reasonable and customary fee schedules for the particular procedure in the geographical area in which the procedure was performed. The Plan also will cover charges for an assistant surgeon when services are rendered in connection with an eligible surgical procedure by other than an intern, a resident or an employee of the facility where surgery is performed.

If two or more surgical procedures are performed during the course of a single operation, reasonable and customary fees will be calculated as follows:

- a. For 2 or more procedures through the same incision: 100% of Plan benefits for the major procedure and 50% of Plan Benefits for the remaining procedures; and
 - b. For 2 or more procedures not performed through the same incision: as though separate operations were performed.
- 2. Anesthesia** - The Plan will cover as an eligible expense any charges for anesthesia and its administration rendered in connection with an eligible surgical procedure when administered by an anesthetist, anesthesiologist, physician or registered nurse (under the supervision of a physician) who is not a salaried employee of the facility where surgery is performed.
- 3. Second Surgical Opinion** - Expenses relating to a second (or third) opinion as to whether or not surgery is advisable and medically necessary are considered eligible under this Plan.
- 4. Oral Surgery Benefit** - The Plan will cover, as an eligible expense for oral surgery:
- a. The excision of partially or completely unerupted, impacted teeth;
 - b. Surgical procedures required to correct injuries of the jaw, cheeks, lips, tongue, roof and floor of the mouth;
 - c. Surgical reduction of dislocation or excision of temporomandibular joints;
 - d. Surgery involving accessory sinuses, salivary glands, or ducts;
 - e. Excision of tumors and cysts of the jaw, cheeks, roof and floor of the mouth when pathological examination is required;
 - f. Excision of exostosis of the jaw and hard palate when not related to the fitting of dentures;
 - g. Extraoral incision and drainage of abscesses; or
 - h. Maxillomandibular dysfunction.

For the purposes of the oral surgery covered by this benefit, the term "physician" includes a duly licensed dentist.

TRANSPLANT BENEFITS

Charges for hospital and surgical care in connection with organ transplants will be considered eligible under this Plan. Eligible expenses include charges for the recipient and the donor of the organ or tissue so long as the surgery is not considered "investigative" or "experimental" by the American Medical Association or any U.S. government agency such as the Department of Health and Human Services and so long as benefits are not available through any other group medical plan or government funded plan of any kind.

This provision is subject to all the conditions - including the Schedule of Benefits and the General Limitations - contained in the Plan Document, to the extent they are not in direct conflict with the following:

1. Covered Expenses

Covered expenses include the following, provided the transplant is incurred while covered for this benefit:

- a. Charges incurred for selective testing of potential donors from an organ registry. Benefits are not provided for screening of the general population;

- b. Charges for organ procurement, including donor expenses not covered under the donor's benefit plan including:
 - 1) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
 - 2) Coverage for organ procurement from a live donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant (up to a maximum payment of \$5,000.00), as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for the follow-up care;
 - 3) If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for treatment and storage costs of the marrow, up to the time of reinfusion;
- c. hospital and professional charges for assessment/evaluation and transplant related care prior to transplantation,
- d. transplantation services for a specified transplant,
- e. retransplantation services,
- f. Charges incurred for follow-up care, including hospital and professional charges for services rendered after discharge from the hospital and immuno-suppressant therapy.

Definitions

Transplant - The transplant of human solid organs, specifically: heart, heart/lung, lung, double lung, liver, pancreas, kidney, and cornea. "Transplant" shall also include bone marrow and/or peripheral blood stem cell transplant, transfusion and reinfusion. A transplant must be performed at a Transplant Facility as defined under this Plan. Specifically, human transplants other than those listed above, mechanical or non-human transplants are not covered.

Transplant Facility - An approved Transplant Facility as defined by the American Hospital Association.

Organ or Bone Marrow Procurement - the removal, preservation and transportation of the donated organ or bone marrow.

Retransplantation Services - inpatient care for a retransplantation of the same organ/tissue type performed within one year of the date of the initial transplant procedure.

The following services are not provided under the Organ Transplant benefit:

- 1. Travel, lodging and other non-medical expenses for your travel companion other than to accompany you to and from the Transplant Program Provider (see Special Transplant Benefit below). Non-medical expenses include but are not limited to: Charges for the repair or maintenance of a motor vehicle; Personal expenses incurred for the maintenance of your or your travel companion's residence. Examples of these are childcare costs, house-sitting costs, or kennel charges;

2. Reimbursement of any wages lost by you or your travel companion;
3. The services and medical expenses incurred by a donor (except as specified under covered services) as a result of such transplant procedure.
4. Expenses associated with clinical trials.

SPECIAL TRANSPLANT BENEFIT

In addition to the standard transplant benefit stated in this booklet, the following benefits may be available when a covered person participates in our Special Transplant Program. This Special Transplant Program is an enhancement to the standard transplant benefit and participation in the program is voluntary.

Additional Covered Benefits

1. Access to transplant Centers of Excellence across the United States
2. Reimbursement for travel and lodging expenses incurred during the transplant (immediately prior to and after the transplant) up to a \$5,000 maximum for the covered person and a companion. Travel and lodging discounts are also available with select airlines and hotels.
3. Waiver of covered person's deductible and out-of-pocket expenses, up to a \$1,500 maximum.
4. Services of a Transplant Facilitator, who will coordinate the cost savings.

These benefits are only available when a covered person fully participates in the Special Transplant Program and meets all of the following requirements:

1. Pre-notification of the upcoming transplant must be given by the covered person or their physician as soon as the covered person is identified as a potential transplant candidate. Pre-notification must be made to Self Funding Administrators at 1-800-424-8611.
2. Pre-certification must be obtained from Health Care Strategies; and
3. All transplant services must be rendered at a transplant Center of Excellence facility in the preferred transplant network.

If these requirements are not met, Special Transplant Program benefits may be reduced.

General Provisions

Early pre-certification to Self Funding Administrators at 1-800-424-8611 must be made as soon as the covered person is identified as a potential transplant candidate. Once enrolled in the program, a Transplant Facilitator will be assigned and will coordinate the cost savings with the patient and physician from hospital selection to travel arrangements to prescription drug options. The Transplant Facilitator will contact Self Funding Administrator for benefit information, as well as contact the covered person's referring physician for additional information. Information on the program will be forwarded to the covered person regarding network hospitals and other relevant information. The Transplant Facilitator will work with the covered person, his physician, and the third party administrator to ensure quality and continuity of care throughout the process, pre-transplant to post-transplant, including organ harvest.

DOCTOR VISITS

This Plan will cover as an eligible expense the charges made by a doctor for the treatment or diagnosis of an injury or illness in the hospital or at the doctor's place of practice.

However, no payment will be made for any expense incurred for visits made on the day a surgical operation is performed or for post-operative visits related to the surgery if these visits are made by the doctor who performed or assisted in the operation.

PRIVATE DUTY NURSING

Charges for private duty nursing (by a registered nurse, licensed practical nurse, public health nurse or licensed vocational nurse) that are recommended by a physician and are considered medically necessary are considered eligible expenses. No benefits are available for nursing care rendered by a family member of the covered person.

HOME HEALTH CARE SERVICES

Benefits are payable if a covered person incurs charges made by a licensed home health care agency for any home health services rendered to that person due to accidental injury or sickness. These services must be prescribed in lieu of hospital services and must be certified as medically necessary by a physician.

“Home Health Care Services” consist of:

1. Part-time nursing care rendered in the insured's home.
2. Physical, occupational, or speech therapy, or the use of medical appliances or equipment, provided in an outpatient or home setting by a home health agency, or by a hospital or other facility under an arrangement with a home health agency.

No payments under this benefit will be paid for charges incurred for routine custodial care such as cooking, cleaning, bed making and the like.

MATERNITY BENEFITS

Maternity benefits are available to covered female employees of the employer and/or covered dependent spouses of male employees. Maternity benefits are not available to dependent children.

1. **Physician and Hospital** - If a covered person is treated by a physician or confined as a registered bed patient in a hospital as a result of a pregnancy, the Plan will pay the amount charged by the physician for his services, and the amount charged by the hospital for room and board, and for necessary services and supplies in the same manner as expenses related to any other disability under this Plan.

As part of the mother's hospital expense benefits under the Plan, payment will be made for the following routine charges for the child:

- a. Routine hospital nursery charges and services and supplies for the newborn.
- b. Routine hospital x-rays and examination for the newborn.
- c. Hospital charges related to circumcision for the newborn.
- d. Doctor's charges related to circumcision and the child's initial checkup.

This plan allows at least 48-hour hospital stays after vaginal deliveries, or 96-hour hospital stays following Cesarean deliveries. Refer to precertification requirements as they relate to maternity admission.

2. **Birth Center Benefits** - This Plan covers charges made by a birthing center on its own behalf for services and supplies furnished to a covered person in connection with a pregnancy covered by the Plan. Eligible charges include: (a) prenatal care, (b) delivery and post-delivery care rendered within 72 hours after the delivery, and (c) services by a certified nurse midwife.
3. **Sterilization** - Medical charges in connection with elective sterilization are considered eligible under this Plan.
4. **Infertility Benefits** - This Plan does not cover charges for expenses relating to diagnostic testing to determine the cause of infertility, fertility drugs or expenses incurred for treatment specifically related to infertility.

TERMINATION OF PREGNANCY

An abortion considered to be therapeutic and medically necessary for the mother's health is covered as an eligible expense as long as the mother is an eligible employee or dependent spouse under the Plan. Medical charges in connection with the elective termination of a pregnancy are not considered eligible under this Plan.

DIAGNOSTIC X-RAY AND LABORATORY TESTING (OUTPATIENT)

Eligible expenses under this Plan include charges for a covered person who undergoes an outpatient x-ray or laboratory examination which is recommended by a physician or surgeon for the diagnosis of sickness or accident.

However, no payment will be made under this Plan for any expenses incurred for, or in connection with, routine dental, eye or ear examinations or for elective physical checkups or routine physical examinations except if provided in the Schedule of Benefits.

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

Therapy must be rendered by a legally qualified physician or therapist. Benefits for therapy are available *only upon written orders of a physician.*

Benefits for speech therapy are available for speech loss or impairment due to an illness or injury or due to surgery performed for an illness, injury or congenital defect.

All therapy is subject to utilization guidelines established by the Plan Administrator and may be subject to review. The plan reserves the right to request and obtain a treatment plan before paying benefits. A treatment plan will include the diagnosis, prognosis, history and physical, type of therapy and frequency of therapy, treatment goals and expected costs.

CHEMOTHERAPY AND RADIATION THERAPY (OUTPATIENT)

This Plan will consider as eligible any charges for radiation or chemotherapy treatment for a covered sickness upon the recommendation of a doctor.

Benefits will be paid when treatment is rendered at a clinic, in a doctor's office or the outpatient department of a hospital.

MENTAL/NERVOUS DISORDERS

Covered Expenses for care, supplies and treatment of Mental Disorders and/or Nervous Disorders will be limited as followed:

1. Treatments that are meant to improve a condition or participant's health;
2. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option;
3. All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as determined elsewhere in this document; and
4. Psychiatrists (M.D.), psychologists (Ph.D), counselors (Ph.D), or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

SUBSTANCE ABUSE

Covered Expenses for care, supplies and treatment of Substance Abuse will be limited as followed:

1. Treatments that are meant to improve a condition or participant's health;
2. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option;
3. All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as determined elsewhere in this document;
4. Physician's visits are limited to one treatment per day and reimbursement is subject to the Schedule of Benefits; and
5. Psychiatrists (M.D.), psychologists (Ph.D), counselors (Ph.D), or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

DISCRETIONARY AUTHORITY

The Plan Administrator shall have sole, full and final discretionary authority in determining that a condition, treatment, or surgery meets the established criteria of a covered expense under the plan.

CHIROPRACTIC BENEFITS

Benefits are available for charges made by a chiropractor for spinal manipulation, associated x-rays and therapy as shown in the Schedule of Benefits. This includes the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column, any x-rays, medical supplies, equipment or Physical Therapy rendered by a chiropractor.

However, no payment will be made for nutritional supplements, routine maintenance therapy and the like.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) and MYOFASCIAL PAIN DYSFUNCTION (MPD)

Charges for the non-surgical treatment of TMJ and MPD are eligible under this Plan. Surgical treatment for bone degeneration, arthritis or a medical diagnosis related to TMJ or MPD is payable as any other surgical benefit.

ACUPUNCTURE

Charges made by a physician or by a licensed acupuncture therapist are not considered eligible under this Plan as shown in the Schedule of Benefits.

PRESCRIPTION DRUG BENEFIT

This Plan provides benefits for the payment of eligible prescription drug charges in excess of the co-pay per prescription to be paid by the covered person.

The Plan covers charges for drugs and medicines which can be obtained only by prescription, and subject to the following exceptions and limitations, bear the legend, "Caution, Federal Law Prohibits Dispensing Without a Prescription." However, insulin is considered a covered drug under this benefit. The maximum amount or quantity of prescription drugs per prescription may not exceed a 30-day supply.

Your doctor may prescribe a name brand drug which has a lower cost generic drug equivalent. If either drug is acceptable to your doctor, you are encouraged to choose the generic drug from your pharmacist. However, if you choose the name brand drug, you must pay the difference in cost between the generic and name brand plus the higher co-pay. If your physician specifies that the name brand drug must be dispensed as prescribed, you will only have to pay the higher co-pay.

THE PRESCRIPTION DRUG CARD PLAN WILL NOT CONSIDER AS AN ELIGIBLE EXPENSE:

1. Charges for non-legend, patent or proprietary medicine not requiring prescription, except insulin;
2. Charges for therapeutic devices or support garments and other non-medical substances, including but not limited to canes, crutches, wheelchairs or any means of conveyance or locomotion, braces, splints, dressings, bandages, sick room equipment or supplies, heat lamps or similar items, abdominal supports, trusses, oxygen, immunizing agents, cosmetics, dietary supplements, health or beauty aids;
3. Charges for biological sera, blood or blood plasma;
4. Charges for anorexiant;

5. Charges for contraceptive materials, contraceptive devices (except for oral contraceptives);
6. Novopen / Needles, BD Pen / Needles and/or Autopen / Unifine Needles;
7. Charges for fertility drugs;
8. Charges for fluoride products;
9. Charges for cosmetic indications;
10. Charges for Rogaine;
11. Charges for smoking cessation products;
12. Charges for vitamins and minerals, and vitamin prescriptions;
13. Charges for medication which is to be taken by, or administered to, in whole or part, the individual while he is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution; and
14. Charges for any drug limited by Federal Law to Investigational Use or for experimental drugs even though a charge is made to the individual.

SPECIALTY MEDICATION PROGRAM

Specialty drug prescriptions should be obtained through CuraScript Specialty Pharmacy, a subsidiary of Express Scripts. A specialty drug is a drug of limited distribution that is administered by injection, infusion or inhalation. Most specialty drugs are in excess of \$500 for a 30 day supply. CuraScript currently has prescription programs which include:

Multiple Sclerosis
Rheumatoid Arthritis
Hepatitis C
Psoriasis
Cancer
Growth Issues
Bleeding Disorders (hemophilia)
HIV
RSV

Your doctor may contact CuraScript directly and the drug can be shipped to his/her office as needed. You may also contact CuraScript to verify whether your prescribed drug is within their program. Through CuraScript's comprehensive patient care management programs, patients have access to a wide range of assistance, counseling and education, which can help to increase compliance to a prescribed medication regimen.

CuraScript can be reached at: 866 848-9870.

MEDICAL PLAN COVERED BENEFITS

Eligible covered expenses are those incurred for the services and supplies listed below which are recommended by a physician and are medically necessary for the care and treatment of an injury or sickness.

1. Treatment by a doctor or licensed covered facility for medical or surgical care.
2. Treatment by a licensed physiotherapist or occupational therapist under the direction of a physician.
3. Treatment by a speech therapist under the direction of a physician to restore the covered person's normal speech loss due to illness, accident or surgery.
4. Treatment by a dentist for accidental injuries to the sound natural teeth of a covered person, if treatment is started within 6 months of the date of the accident.
5. Treatment for cosmetic surgery necessary as the result of an accidental injury.
6. Treatment for a newborn child who is born with congenital defect (if a child is enrolled as a dependent of a covered employee).
7. Allergy testing and shots.
8. Blood and plasma, if not replaced, and the equipment for its administration.
9. Amniocentesis and/or ultrasound testing, but only if certified by a physician as medically necessary.
10. One pair of eyeglasses or contact lenses medically necessary after eye surgery.
11. Professional ambulance service when medically necessary to or from the nearest facility where adequate care and treatment can be given.
12. Charges for oxygen and the rental of equipment for administration thereof; x-ray, radium, or radioactive isotope therapy.
13. Charges for the rental of a wheelchair, hospital type bed, iron lung or other similar medical equipment required for medical care. Charges made for the rental of durable equipment are covered up to the dollar amount equal to the current purchase price of such equipment.
14. Charges for the purchase of trusses, braces, crutches or similar appliances, orthotics and orthopedic appliances, but not orthopedic or corrective shoes.
15. Charges for the purchase of and/or the fitting of necessary prosthetic appliances medically required for the replacement of natural parts of the body, but not dentures or dental prosthetics.
16. Charges for reconstruction of the breast on which a mastectomy has been performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance.

17. Charges for splints, dressings, bandages, ostomy supplies, and the like, if recommended by a physician.
18. Charges for gastric bypass or similar surgery for treatment of clinically severe obesity as defined under the terms of this Plan when medical documentation is provided demonstrating clinically severe obesity. One year of continuous active coverage is required.

Section 6

INELIGIBLE EXPENSES

Charges for the expenses listed below are not considered eligible under this Plan. Ineligible expenses cannot be applied towards satisfying a covered person's annual deductible or coinsurance (out-of-pocket) maximums.

No payment will be made by this Plan for charges:

1. In excess of the maximum allowable payment per treatment, per occurrence, per day, per year or per lifetime as shown in the Schedule of Benefits.
2. Used to satisfy the deductibles.
3. Eligible for consideration under any other plan of the employer.
4. For preparing medical reports, itemized bills, or claim forms.
5. For treatment not prescribed or recommended by a physician, licensed psychologist or psychotherapist in the case of outpatient mental/nervous care and/or substance abuse care.
6. Which are in excess of usual, customary and reasonable fees or for unnecessary care or treatment, even if recommended by a physician or practitioner.
7. Experimental and/or Investigational drugs and medicines, even though a charge is made to the covered person. See Section 7, page 5.
8. For complications arising from any non-covered surgery or treatment.
9. For drugs, medicines, or supplies that do not require a physician's prescription.
10. For kerato-refractive eye surgery (surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea including, but not limited to, radial keratotomy and keratomileusis surgery).
11. For hypnosis, biofeedback and massage therapy.
12. For routine physical examination, checkups or routine immunizations, except as noted in the Schedule of Benefits.
13. For marital counseling, family counseling or sex counseling.
14. For, or in connection with, dental services or supplies except as provided under the surgical benefit or for medically necessary hospitalization related to dental care; and/or unless specifically covered in the Schedule of Benefits of this booklet.
15. For eyeglasses or hearing aids or examinations for their prescription and fitting; unless specifically covered in the Schedule of Benefits of this booklet.

16. For, or in connection with, custodial care, education, educational testing or training expenses, except for diabetes self-management education programs. If a medical or psychological diagnosis is present, treatment would be covered for the medical/psychological condition only.
17. For nursing, medical or surgical care or treatment rendered by a spouse, child, brother, sister, parent, or parent of a spouse.
18. For cosmetic surgery except for treatment of an injury or for procedures performed to correct functional disorders or congenital anomalies.
19. For reversal of any reproductive sterilization procedure.
20. Related to artificial insemination, in-vitro fertilization, Gamete Intrafallopian Tube Transfer (GIFT), Zygote Intra-fallopian Tube Transfer (ZIFT), or Zona Drilling/Micro-injection.
21. For any treatment leading to, or in connection with, transsexual surgery.
22. Related to elective termination of pregnancy.
23. For medical or surgical treatment of any kind for obesity, weight reduction, or dietary control unless medical documentation is provided demonstrating clinically severe obesity, in which case, charges for gastric bypass or similar surgery will be covered.
24. For equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, waterbeds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an illness or injury.
25. For care to the extent that a covered person is reimbursed, entitled to reimbursement, or is in any way indemnified for those expenses by or through any public program.
26. For treatment, services or supplies received in a hospital owned or operated by the United States Government where no payment is required.
27. For sickness contracted or injury sustained while on duty as a member of the armed forces of any state or country.
28. For sickness contracted or injury sustained as a result of war, declared or undeclared, or any act of war.
29. To the extent that payment is prohibited by any law of jurisdiction in which the covered person resides at the time the expenses are incurred.
30. Which the covered person is not legally required to pay, or for charges which would not have been made if no coverage had existed.
31. For services for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a Workers' Compensation law, and to the extent the covered person is entitled to benefits under any Workers' Compensation or similar law.
32. Any condition, disability or expense sustained as a result of being engaged in an illegal occupation, willful commission or attempted commission of an assault or other illegal act, or participation in a civil revolution or a riot.

33. For any full body scan, partial body scan, virtual colonoscopy, heart scan or lung scan that does not have a diagnostic referral from a physician.
34. For replacement of lost or stolen durable medical equipment, or any of the equipments components.
35. Serious, clearly preventable adverse events (“never events”). These never events include:
 - Surgery performed on the wrong body part;
 - Surgery performed on the wrong patient;
 - Wrong surgical procedure performed on a patient;
 - Unintentional retention of a foreign object in a patient after surgery or other procedure;
 - Inoperative or immediate postoperative death in an ASA Class I patient;
 - Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility;
 - Patient death or serious disability associated with the use or function of a device in a patient in which the device is used or functions other than as intended;
 - Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility;
 - Infant discharged to the wrong person;
 - Patient death or serious disability associated with patient leaving the facility without permission;
 - Patient suicide, or attempted suicide resulting in a serious disability, while being cared for in a healthcare facility;
 - Patient death or serious disability associated with a medication error (e.g. error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparations, or wrong route of administration);
 - Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;
 - Maternal death or serious disability associated with labor and delivery in a low-risk pregnancy while being cared for in a healthcare facility;
 - Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility;
 - Death or serious disability associated with failure to identify and treat hyperbilirubinemia (condition where there is a high amount of bilirubin in the blood) in newborns;
 - Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility;
 - Patient death or serious disability due to spinal manipulative therapy;
 - Artificial insemination with the wrong donor sperm or wrong egg;
 - Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility;
 - Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
 - Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility;
 - Patient death associated with a fall while being cared for in a healthcare facility;
 - Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility;
 - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other provider;
 - Abduction of patient of any age;
 - Sexual assault of a patient within or on the grounds of a healthcare facility; and
 - Death or significant injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare facility.

Section 7

DEFINITIONS

The following words and phrases, when used in this booklet, will have the following definitions:

Accident or Injury - An accidental bodily injury occurring directly and independently of all other causes.

Administrator or Plan Administrator - GMS Mine Repair & Maintenance, Inc., who are responsible for the operation of the Plan.

Allowable Expense – With regard to Preferred Provider Organization (PPO) expenses, the amount that the network provider agrees to accept as payment in full.

Ambulatory Surgical Center - A facility which is operated primarily for the purpose of providing the specialized outpatient care and treatment for which it was duly licensed and meets all the following tests:

1. Provides 24-hour nursing service under the supervision of a physician or a graduate registered nurse (R.N.).
2. Maintains daily clinical records on each patient and has available the services of a physician under an established agreement.
3. Provides appropriate methods of dispensing and administering drugs and medicines.
4. Has transfer arrangements with one or more hospitals and a utilization review plan in effect.
5. Qualifies under the Health Insurance provided by Title XVIII of the Social Security Act, as amended.

Amendment - A formal document signed by an authorized representative of the Plan sponsor. The amendment adds, deletes or changes the provisions of the Plan and applies to all covered persons, including those persons covered before the amendment becomes effective, unless otherwise specified.

Assistance eligible individual - means any qualified beneficiary who elects COBRA continuation coverage, and has satisfied all of the following conditions:

- The qualifying event occurred at any time during the period that begins with September 1, 2008, and the qualified beneficiary was eligible for COBRA continuation coverage during this period;
- The covered employee or qualified beneficiary must elect COBRA or applicable state continuation coverage;
- The qualifying event with respect to the COBRA continuation coverage consists of the involuntary termination of the covered employee's employment and occurred during such period; and
- The covered employee must have had a modified adjusted gross income of less than \$145,000, if single, or \$290,000, if married filing jointly, for each tax year in which the subsidy is received. Note that the available COBRA subsidy will be reduced for years in which the covered employee's gross income exceeds \$125,000 (or \$250,000 for joint returns).

Birthing Center - A public or private facility, other than private offices or clinics of physicians, which meets the free standing birthing center requirements of the State Department of Health in the state where the covered person receives the services.

The birthing center must provide: (a) a facility which has been established, equipped and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; (b) supervision of at least one specialist in obstetrics and gynecology; (c) a physician or certified nurse midwife at all births and immediate postpartum period; (d) extended staff privileges to physicians who practice obstetrics and gynecology in an area hospital; (e) at least 2 beds or 2 birthing rooms; (f) full-time nursing services directed by an R.N. or certified nurse midwife; (g) arrangements for diagnostic x-ray and lab services; and (h) the capacity to administer local anesthetic or to perform minor surgery.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a hospital for emergency transfers and maintain medical records on each patient and child.

Calendar Year - The 12-month period from January 1 through December 31 each year.

Cardiac Rehabilitation Program - The Plan provides benefits for cardiac rehabilitation programs for a heart attack, heart surgery, or diagnosis of angina pectoris when services are rendered by a hospital-based cardiac rehabilitation program or a program coordinated with a hospital.

Certified Nurse Midwife - A fully licensed and certified graduate registered nurse (R.N.) who manages the care of pregnant females and assists or performs the delivery of newborns.

Chiropractic Services - The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. This includes the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column, any x-rays, medical supplies, equipment or Physical Therapy rendered by a chiropractor.

Claims Processor - Self Funding Administrators Corporation is retained by the administrator and is responsible for the calculation and processing of claims in accordance with the Schedule of Benefits contained in the Plan Document.

Clean Claim – A claim may be processed without obtaining additional information from the provider, insured or a third party.

Clinically Severe Obesity - A diagnosed condition in which the body weight exceeds the normal weight by either 100 pounds or is twice the normal weight of a person the same height. The excess weight must cause a condition such as physical trauma, pulmonary, and circulatory insufficiency, diabetes, or heart disease.

Coinsurance - The percentage of the eligible expense to be paid by the patient and by the Plan.

Concurrent Review – the act of reviewing treatment plans and current care on an ongoing basis to monitor the continued appropriateness of the care, medical necessity, and the progress of discharge plans

Convalescent Hospital or Rehabilitation Hospital - An institution, or part thereof, constituted and operated pursuant to law which:

1. Provides room and board and 24-hour skilled nursing service under the full-time supervision of a physician or a graduate registered nurse (R.N.);
2. Maintains a daily medical record for each patient;
3. Has a written agreement or arrangement with a physician to provide emergency care for its patients;
4. Qualifies as an “Extended Care Facility” under the Health Insurance provided by Title XVIII of the Social Security Act, as amended; and
5. (For those which are not an integral part of a hospital) has a written agreement with one or more hospitals providing for the transfer of patients and medical information between the hospital and convalescent hospital.

In no event, however, will a convalescent hospital be deemed to include an institution which is, other than incidentally a place for rest, a place for the aged, a place for alcoholics, drug addicts, the blind or deaf, mentally ill or retarded.

Cosmetic Surgery - Benefits are **ONLY** provided to correct a condition resulting from non-cosmetic surgery or an accidental bodily injury or to correct a congenital anomaly.

Note: Reconstructive surgery is covered only if such surgery is to restore bodily function or correct deformity resulting from non-cosmetic surgery, an accidental bodily injury, or a congenital defect. This includes reconstruction of the breast on which a mastectomy has been performed. Following surgery of the breast for cancer, benefits are provided for surgery and reconstruction of the other breast to produce a symmetrical appearance. There is also coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Covered Dependent -

1. The legal spouse of a covered employee.
2. An unmarried child within the age bracket specified for non-students.
3. An unmarried child within the age bracket specified for students who is in regular attendance at an approved school, college or university and is primarily dependent upon the covered employee for financial support and maintenance.
4. An unmarried child within the age bracket specified for students who is enrolled in a post secondary educational institution and has been on a medically necessary leave of absence pursuant to a certification by a treating physician for less than one year.

The word "child" shall include the covered person's natural or legally adopted child. It will also include any stepchild who is primarily dependent on the covered person for support and maintenance, and lives with the covered person in a regular parent/child relationship. It will also include any foster child or any child for whom the covered person is legal guardian and who is primarily dependent on the covered person for support and maintenance and lives with the covered person in a regular parent/child relationship.

However, if a child is eligible for employee coverage, such child shall not be deemed to be a dependent.

If a child covered under this Plan reaches the age at which he would otherwise cease to be a covered dependent, and if such child is mentally or physically incapable of earning his own living, the Plan will continue to consider such a child as a dependent beyond such age, while he remains in such condition subject to all terms of the Plan, provided the covered employee has submitted to the claim administrator proof of the child's incapacity as described above, and approval is granted by the insuring carrier. Dependents must be covered under this Plan prior to limiting age as shown in Section 2 in order for coverage to be continued under this provision.

Covered/Eligible Expense - An expense incurred for necessary medical services and supplies which is:

1. Recommended by a physician or practitioner acting within the scope of their license;
2. Necessary for the treatment of a non-occupational sickness or injury; and
3. Considered to be usual, customary and reasonable and meets the criteria of medically necessary care.
4. Not specifically excluded in section 6 of this plan document.

The Plan Administrator has the final authority in determining if a treatment meets the definition of an eligible expense.

Covered Mental Health Service Providers - To be covered under this Plan, services must be rendered by (1) a psychiatrist (M.D.), (2) a licensed psychologist (Ph.D., Ed.D., Psy.D.), (3) a licensed psychotherapist, (4) a licensed clinical social worker (L.C.S.W.), who is licensed to practice psychotherapy, or (5) a mental health practitioner who is licensed or certified to provide such services by the state or jurisdiction where the services are rendered.

Psychiatrists (M.D.), psychologists (Ph.D.) or counselors licensed to provide individual psychotherapy without supervision in the State they are practicing, may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

Covered Person - An employee or a dependent who is (a) eligible for coverage, who has (b) completed the applicable waiting period, and who has been properly enrolled in the Plan. If an employee is enrolled for family coverage, any additionally acquired dependents will automatically be added upon notification to the administrator. The effective date of coverage will be the date the dependent was acquired.

A covered employee who has no dependents and who is enrolled for single coverage may elect to enroll in dependent coverage, without evidence of insurability, within 30 days after acquiring a dependent(s) through marriage, adoption, legal guardianship, or, in the case of a female employee, within 30 days after the birth of her first child.

If an employee has a spouse (but no dependent children) who is not covered under the Plan and if the employee acquires his first dependent child, then that child may be enrolled without evidence of insurability within 30 days after the date the employee acquires that child. This provision applies even though the spouse may or may not be considered a late enrollee.

Creditable Coverage - Coverage under almost any other type of medical plan including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan of a state or local government, a Peace Corps Plan and public health plans, including those of a foreign country and State Children's Health Insurance Programs. Creditable coverage is measured in days. Each day of creditable coverage reduces by one day any preexisting condition waiting period under this Plan; however, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any creditable coverage, and you will be subject to the full preexisting condition waiting period.

Custodial Care - Care or service which is designed essentially to assist a person in the activities of daily living. Such care includes, but is not limited to, bathing, feeding, preparation of special diets, assistance in walking, assistance in getting into or out of bed, dressing, and supervision over medication which can normally be self administered.

Diagnostic X-Ray & Laboratory - Usual and customary x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

Durable Medical Equipment - Medical equipment that satisfies all of the following criteria:

1. Can withstand repeated use;
2. Is used primarily and customarily for a medical purpose, rather than for convenience or comfort;
3. Generally is not useful to a person in the absence of an illness or injury;
4. Is appropriate for use in the home;
5. Is prescribed by a physician; and
6. Is medically necessary.

Elective Hospital Admission - Any non-emergency hospital admission which may be scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment.

Elective Surgical Procedure - Any non-emergency surgical procedure which may be scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment.

Experimental and/or Investigational - means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
3. if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Fiduciary - GMS Mine Repair & Maintenance, Inc., who may be required to:

1. Exercise any discretionary authority or control with respect to management or disposition of any Plan assets;
2. Render any investment advice for a fee or other compensation; or
3. Exercise any discretionary authority or responsibility for the administration of the Plan.

Home Health Care Agency - A special care unit of a hospital or a public or private agency or organization which is primarily operated to provide home nursing care or therapeutic service. It must: (a) be approved or licensed by appropriate state or local licensing authorities; (b) have policies established by a professional group associated with the organization or agency, including at least 1 physician and 1 graduate registered nurse; and (c) maintain clinical records on each patient, and (d) be approved for payment of Medicare benefits.

Hospice - A health care program providing a coordinated set of services rendered at home, in outpatient settings, or in institutional settings for covered persons suffering from a condition that has a terminal prognosis by a physician (life expectancy of less than 6 months). It must provide care by an interdisciplinary team consisting of at least 1 physician and 1 graduate registered nurse, and it must maintain central clinical records on all patients. A hospice must meet the standards of the National Hospice Organization (NHO) and any applicable state licensing requirements.

Hospital - An institution which meets all of the following tests:

1. Is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of such persons by or under the supervision of a staff of legally qualified physicians.
2. Continuously provides 24-hour-a-day nursing service by graduate registered nurses and is operated continuously with organized facilities for operative surgery.
3. A facility operating primarily for the treatment of Substance Abuse provided it meets the following requirements:
 - a) Is accredited by the Joint Commission on Accreditation of Hospitals or is licensed by the appropriate state licensing authority as a substance abuse treatment center.
 - b) Is engaged mainly in providing diagnostic/therapeutic services and facilities for the treatment of alcoholism or substance abuse. The services include room, board and 24-hour-a-day nursing services.
 - c) The services are supervised by a physician who is continuously available 24 hours a day.
 - d) Maintains daily clinical records.
 - e) Must not be mainly a place of rest, a place for the aged, a nursing or convalescent home.
 - f) Provides 24-hour nursing care by graduate nurses (R.N.).
 - g) Has a full-time psychiatrist on staff.

A Residential Substance Abuse Facility must meet all of the above requirements except "b."

In no event, however, will a hospital be deemed to include an institution which is used principally as a rest facility for the aged.

Incurred Expense - Services and supplies rendered to a covered person. Such expenses shall be considered to have occurred at the time or date the service or supply is actually provided.

Ineligible Expense - An expense incurred which is not considered to be eligible for payment under this Plan. Ineligible expenses do not apply to any deductibles or coinsurance maximums under the Plan. The fact that a physician may have prescribed, recommended or approved the expense does not necessarily mean it is eligible under this Plan.

Infertility - The inability or diminished ability, due to physical impairment, to produce offspring.

Lifetime Maximum or Lifetime Benefit - The amount of benefits payable during the period of time that the covered person participates in this Plan.

Medical Care – Any covered expenses included as a benefit under this plan.

Medically Necessary - To be medically necessary the services, supplies or treatments that are required to identify or treat the illness or injury which a physician has diagnosed or reasonably suspects must be:

1. Consistent with the diagnosis and treatment of the patient's condition;
2. Consistent with professionally recognized standards of health care;
3. Meant to improve a condition or a patient's health;
4. Not solely for the convenience of the patient, physician or supplier; and
5. Performed in the least costly setting required by the patient's medical condition.
6. Not specifically excluded by the plan.

The fact that a physician may have prescribed, ordered, recommended, or approved the services, supplies or treatment does not necessarily mean that they satisfy the above criteria. The Plan Administrator will have the final say in determining that care is medically necessary.

Medicare - The medical care program offered under Title XVIII of the Social Security Act of 1965, as amended, consisting of Part A benefits and Part B benefits.

Mental Hospital - A licensed institution which specializes in the diagnosis and treatment of a mental illness or functional nervous disorder which is operated pursuant to law and meets the following tests:

1. Is licensed to give medical treatment.
2. Is operated under the supervision of a physician.
3. Offers nursing service by graduate registered nurses (R.N.) or licensed practical nurses (L.P.N.).
4. Provides on the premises all the necessary facilities for medical treatment.

Mental/Nervous Disorder – To be a Mental Disorder or Nervous Disorder, the disease or condition, regardless of whether the cause is organic, must be classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. See the Covered Services section of this book for further details.

Nurse - A full-time Graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Public Health Nurse (P.H.N.) or Licensed Vocational Nurse (L.V.N.).

Physician - A legally qualified doctor or dentist rendering services within the scope of his license or certificate and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.) or Doctor of Chiropractic (D.C.), and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

Plan Sponsor - GMS Mine Repair & Maintenance, Inc., who have sponsored the Plan.

Practitioner - A physician or person acting within the scope of applicable state license and holding the degree of Doctor of Optometry (O.D.), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Ed.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Welfare (M.S.W.), Speech Therapist, Acupuncturist, Nurse Practitioner, Licensed Audiologist or a Mental Health/ Substance Abuse practitioner licensed or certified to provide such services by the state or jurisdiction where the services are rendered.

Primary Care Physician - A physician who is a family practitioner, general practitioner, internist, pediatrician or obstetrician/gynecologist. A psychiatrist, psychologist, psychotherapist, licensed clinical social worker (LCSW,) or master of social welfare (MSW) would NOT be considered a primary care physician.

Pronoun Usage (He/She) - This booklet is written using the masculine pronouns he (meaning he or she), his (meaning his or hers) and him (meaning him or her).

Sickness - A disease including all complications and all related conditions and reoccurrences.

Skilled Nursing Facility - A facility approved as such by Medicare or accredited by the Joint Commission on Accreditation of Hospitals. It is engaged primarily in providing inpatient services for rehabilitative care and these services are performed by, or under the supervision of, a graduate registered nurse (R.N.). The services also must be under the general direction of a physician. It must not be mainly a place of rest, a place for the aged, or a nursing home.

Substance Abuse - The excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)
 2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
 3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)
- B. The symptoms have never met the criteria for Substance Dependence for this class of substance

Substance Dependence - Substance use history includes the following: (1) substance abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

The Plan - The medical benefits as set forth in the Schedule of Benefits and explained in this booklet and the Plan Document which is on file with the sponsor of the Plan, GMS Mine Repair & Maintenance, Inc.

Total Disability or Totally Disabled - An employee will be considered totally disabled during any period when, as a result of injury or sickness, he is unable to perform the duties of his occupation and is not performing any other work or engaging in any other occupation or employment for wage or profit and is under the care of a physician. A dependent will be considered totally disabled when he is unable to engage in the normal activities of a person in good health of the same age and sex and is not confined in a medical facility.

Transplant - The transplant of human solid organs, specifically: heart, heart/lung, lung, double lung, liver, pancreas, kidney, and cornea. "Transplant" shall also include bone marrow and/or peripheral blood stem cell transplant, transfusion and reinfusion. A transplant must be performed at a Transplant Facility as defined under this Plan. Specifically, human transplants other than those listed above, mechanical or non-human transplants are not covered.

Transplant Facility - An approved Transplant Facility as defined by the American Hospital Association.

Treatment Facility - A residential or non-residential facility which is licensed to provide specialized care or treatment and is supervised by a physician or practitioner as defined by the Plan.

Usual, Customary and Reasonable Charges - Charges made for medical services or supplies essential to the care of the covered person will be considered usual, customary and reasonable (UCR) if they are equal to the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers for comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are usual, customary and reasonable, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or experience.

Section 8

GENERAL CLAIM PROVISIONS

Facility of Payment of Benefits - If a covered person is a minor or, in the opinion of the claims processor, is not competent to receive payment for benefits due him under this Plan and if no request for payment has been received by the claims processor from a duly appointed guardian or other legally appointed representative of the covered person, the claims processor may, at his option, make direct payment to the individual or institution appearing to have assumed the custody or the principal support of the covered person.

Medical expense benefits provided by this Plan may, at the option of the claims processor be paid directly to the individual or institution on whose charges the claim is based. Any medical expense benefits which remain unpaid at the covered person's death may be paid directly to the individual or institution on whose charges claim is based or to his spouse, mother, father, child or children, brothers or sisters; or to his executors or administrators.

Right to Recover Benefits - If the claims processor mistakenly makes a payment to you or to a provider on your behalf, and you are not eligible for all or a part of that payment, then the Plan has the right to recover the payment from you or the provider who received the payment. The Plan's right to recover a mistaken payment includes the right to deduct the amount paid by mistake from future benefits.

SOURCE OF FINANCING OF THE PLAN

The Plan's benefits are funded by a combination of employer and employee contributions. The employer contributes for the cost of the group coverage partially from its funds. The employee's contribution is a fixed rate as determined from time to time. The total contributions are based on the anticipated cost of claims paid under the Plan plus administrative expenses. This is not an insurance policy, however, the employer has purchased excess risk insurance to insure its liability for catastrophic losses under the Plan. Self Funding Administrators processes the claims in accordance with the employer's Plan Document.

ERISA CLAIMS PROCEDURES

Employee benefit plans are covered under the terms of the Employee Retirement Income Security Act of 1974 (ERISA). Section 503 of ERISA imposes certain obligations on employee benefit plans to provide reasonable steps for timely processing of claims and for a full and fair review of an adverse benefit determination.

If a claim has been partially or wholly denied, you, the claimant, have the right to have the claim reviewed. You should make a written request to the Plan Administrator (GMS Mine Repair & Maintenance, Inc.) or the claims processor (Self Funding Administrators Corporation) within 180 days after notice of a denial is received. An authorized representative will review the claim, along with your written request, fully and fairly. You have the right to review documents pertinent to the claim and to do so, you should make a written request to the Plan Administrator or claims processor. There will be no fees imposed to you as the result of any appeal that is made.

A detailed explanation of the ERISA claims procedures will be provided to a plan participant at no charge upon request. Please call Self Funding Administrators at 800-424-8611 to request a copy.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office all Plan documents, including insurance contracts, any collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all Plan participants and beneficiaries.

No one, including your employer, a union, or any other person, may fire you or discriminate against you to prevent you from obtaining any benefits under the Plan or exercising your rights under ERISA.

If your claim for benefits under the Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You or an authorized representative have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the Plan and do not receive them, you may file suit in a federal court. If you have a claim for benefits and you receive an adverse benefit determination, and you have not been notified, you may file suit in the state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may need assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who will pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Pension and Welfare Benefits Administration, U.S. Labor Management Service Administration, Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The GMS Mine Repair & Maintenance, Inc. Employee Medical Plan will use a participant's Protected Health Information (PHI), in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), only for required uses or purposes related to health care treatment, payment for health care, and/or health care operations. However, if a plan participant provides a signed authorization, the plan may use and disclose PHI as permitted and directed by the authorization.

Further, the Plan will disclose to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions:

With respect to PHI, the Plan Sponsor agrees to:

- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law.
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI.
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual that is the subject of the PHI.
- Make PHI available to an individual in accordance with HIPAA's access requirements.
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.
- Make available upon request an accounting of disclosures.
- Make available to the Health and Human Services Secretary internal practices, books and records relating to the use and disclosure of PHI received from the Plan, for purposes of determining the Plan's compliance with HIPAA.
- If feasible, return or destroy all PHI received from the Plan when such PHI is no longer needed for the purpose for which disclosure was made.

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan sponsor on behalf of the Plan, the Plan sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- A. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- B. Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. §164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- C. Plan sponsor shall ensure that any agent, including a subcontractor to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- D. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - 1. Plan sponsor shall report to the Plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, Modification or destruction of the Plan's Electronic Protected Health Information; and
 - 2. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis every year, or more frequently upon the Plan's request.

To All Covered Employees and Dependents:

This booklet is intended to provide you with an easy to understand summary of your Group Benefit Plan; it is not a contract. While every effort has been made to make this description as complete and accurate as possible, the booklet of necessity cannot contain a full restatement of the terms and provisions of the master contracts. More detailed information is available upon request.

If there is any discrepancy between the benefits described in the Schedule of Benefits section and in any other section of this booklet, the wording in the Schedule of Benefits will take precedence in all cases.

NO VERBAL MODIFICATIONS - The Plan participant shall not rely on any oral statement from any employee of Self Funding Administrators which:

1. Modifies or otherwise affects the benefits, general limitations and exclusions, or other provisions of this Plan;
2. Increases, reduces, waives or voids any coverages or benefits under this Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under this Plan.

Any written or oral verification received from Self Funding Administration is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a participant.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

PHYSICIANS' FEES

Your doctor will be glad to discuss his fees with you. It is important that you reach an understanding in advance regarding the amount you will be charged for treatment or operative procedures. Benefits offered under this Plan are limited to “usual, customary and reasonable” charges in your community.

CLAIMS PROCESSOR

Self Funding Administrators Corporation
Post Office Box 6596
Annapolis, Maryland 21401

410-757-4200 (Annapolis, Maryland Area)
800-424-8611 (Outside Annapolis)
410-349-9724 (Fax)

Any changes in Federal Statutes will automatically be included in your Plan as such changes occur.