

# Summary Plan Description

## UMWA 1993 Benefit Plan

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# INTRODUCTION

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This booklet is the 2003 edition of the summary plan description of the United Mine Workers of America 1993 Benefit Plan (the “UMWA 1993 Benefit Plan” or “1993 Benefit Plan”). The purpose of this booklet is to explain the plan in a way that can be more easily understood than the formal language of the actual plan document. All final eligibility and payment decisions, however, must be made according to the language of the actual plan document. To request a copy of the plan document, write to the UMWA Health and Retirement Funds in Washington, D.C.

***Special Notice for Beneficiaries Whose Employers Were Approved for Benefits on or After January 1, 2002 or Whose Employers First Became Obligated to Contribute on or After January 1, 2002***

In general, if your Employer was approved for benefits on or after January 1, 2002, the level of benefits you will receive under the 1993 Plan will not exceed the benefits your last Employer agreed to provide. Therefore, if your Employer agreed to provide you with a lower level of benefits than the standard plan provided under the National Bituminous Coal Wage Agreement, your benefits and copayments may be different from those shown in this booklet. Additionally, if your Employer first became obligated to contribute to this Plan on or after January 1, 2002, and it did not contribute substantially all amounts owed, you will also be covered under a reduced plan of benefits. If you are covered by such a different plan, you will be provided with a notice and a separate schedule of benefits. If you have any question about which schedule of benefits applies to you, please contact the Funds Call Center.

**About this  
Booklet**

When certain words and phrases are used in this booklet, they have special meanings. Most of these are technical terms and are explained in the section titled “Terms You Should Know.” The words *plan* and *participant* often appear, however, without qualifying words or phrases. When the word *plan* appears by itself, it means the UMWA 1993 Benefit Plan. When the word *participant* appears by itself, it means a participant in the UMWA 1993 Benefit Plan.

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

The text of this booklet often advises the reader to contact the Funds’ Call Center. The address and telephone number appears at the end of this booklet.

**Additional  
Information**

If you have questions about the UMWA 1993 Benefit Plan, you may call the Funds' Call Center, or write, or visit the Funds' main office in Washington, D.C. The plan is governed by the provisions of the Employee Retirement Income Security Act (ERISA) of 1974, and by regulations issued by the U.S. Departments of Labor and Treasury under ERISA, which are subject to change. In addition, the provisions of the plan may be changed by action of the Board of Trustees.

# GENERAL INFORMATION

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## UMWA 1993 BENEFIT PLAN

The 1993 Plan was established by the National Bituminous Coal Wage Agreement of 1993. The 1993 Plan's day-to-day operations are administered by the UMWA Health and Retirement Funds (the "Funds"), the same institution that administers the UMWA 1950 Pension Plan, the UMWA 1974 Pension Plan, the UMWA Combined Benefit Fund, the UMWA 1992 Benefit Plan and the UMWA Cash Deferred Savings Plan of 1988. (The UMWA 1974 Pension Plan is the trust which actually employs the staff of the Funds; the 1993 Plan contracts with the UMWA 1974 Pension Trust for administrative services, as do the other pension and benefit plans which the Funds administers.) The Funds provides pensions to classified employees in the bituminous coal industry and provides health benefits to certain retired or disabled mine workers and their families.

Health benefits for active mine workers and for most retired mine workers who receive pensions from the 1974 Pension Plan are provided through plans administered by their employers. The 1993 Plan is a group health plan that provides health benefits to certain retired mine workers (and to their eligible dependents and survivors) who satisfy certain conditions as outlined on pages 9 and 10 of this booklet.

## FUNDING

Article XX of the NBCWA of 2002 requires signatory employers to contribute money to the 1993 Benefit Plan. Most of these contributions are based upon the number of hours that employees work in classified jobs; however, some also are based upon the tonnage of coal purchased. The 1993 Plan also requires an annual per-family payment from beneficiaries that participate in the Plan. In order to address any resulting hardship, the UMWA 1950 and 1974 Pension Trusts have been amended to provide an additional payment each year to eligible beneficiaries intended to cover this amount. Contributions and annual payments are used to pay health benefits and to pay the cost of administering the plan. All money in excess of that which is required for these purposes is invested in stocks, bonds, or treasury notes, or is otherwise invested. Note, however, that the benefits provided by the plan shall be only those benefits as can be provided by the assets of the plan's trust. Accordingly, the terms of the plan, including the level of benefits, are subject to termination, suspension, revision or amendment by the trustees. Additionally, beginning January 31, 2004, if the Plan's net assets available for plan benefits are less than \$2 million, the Trustees must reduce Plan benefits to the extent necessary to assure that the Trust continues to be solvent and able to provide benefits.

The plan operates on a calendar year basis, so that a year begins on January 1 of one calendar year and ends on December 31 of the same calendar year. The Internal Revenue Service has assigned Employer Identification Number 52-1888497 to the plan's board of trustees; the plan number is 501. A complete list of the employers and UMWA affiliates which sponsor the plan is available for inspection at the Funds' offices in Washington, D.C. The Funds will also respond to written inquiries asking whether a particular employer or UMWA affiliate is a sponsor of the plan and will furnish the names and addresses of these plan sponsors upon request.

## **PLAN ADMINISTRATION**

All major policy decisions for the 1993 Benefit Plan are made by the board of four trustees who are the plan administrator; this type of administration is known as trustee administration. The duties of the trustees include collecting contributions and other funds owed to the 1993 Benefit Plan, interpreting the provisions of the plan and investing the assets of the trust.

The UMWA and the Bituminous Coal Operators' Association (BCOA) each appoint two trustees. Michael H. Holland and Marty D. Hudson, have been appointed by the UMWA, A. Frank Dunham and Elliot A. Segal have been appointed by the BCOA. Mr. Holland is chairman of the board of trustees.

The trustees have appointed David W. Allen, general counsel of the Funds, as agent for the service of legal process. Official court papers can be served on Mr. Allen. Legal process can also be served on the trustees. Letters to Mr. Allen or the trustees should be addressed to the Funds' office in Washington, D.C.

The 1993 Benefit Plan is independent and separate from the UMWA and bituminous coal industry employers. Created by collective bargaining between the UMWA and the coal companies, the 1993 Benefit Plan serves eligible mine workers who are retired or disabled and the families of those workers.

### ***Rights Guaranteed By ERISA***

The Employee Retirement Income Security Act (ERISA) of 1974 is a federal law which gives certain rights and protections to participants and requires the plan and its trustees to perform certain duties. This section describes some of the rights and responsibilities established by that law.

As a participant in the 1993 Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits
- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing

the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
- Prudent Action by Plan Fiduciaries
- In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- Enforce Your Rights
- If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relat-

ing to the decision without charge, and to appeal any denial, all within certain time schedules.

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
- Assistance with Your Questions
- If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. 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 N.W., Washington, D.C. 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.

# TERMS YOU SHOULD KNOW

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## *copayment*

The part of a bill for visits to physicians and for prescription drugs that the patient is required to pay. There is a \$20.00 copayment for each visit for medical care to a physician who is listed on a participating provider list, up to a maximum of \$400.00 per family per year. There is a \$30.00 copayment for each visit for medical care to a physician who is not listed on a participating provider list, up to a maximum of \$400 per family per year. Once you have paid \$400 in office visit copays for physicians in any calendar year, you will not be responsible for any further co-payments for physicians' services under the plan for the rest of the year. The plan will continue to pay providers that are not on a participating provider list at rates that are no higher than the rates for covered benefits provided by participating providers, but Hold Harmless protections (see page 19) will apply.

There is no copayment for inpatient hospital and related services provided by a hospital that is listed on a participating provider list. If you receive inpatient hospital and related services from a hospital not included on the participating provider list, you are responsible for charges that are in excess of 90 percent of the charges that the plan would have otherwise paid if you had received such inpatient hospital and related services from a hospital included on the plan's participating provider list. Once you have paid \$600 in charges for inpatient hospital and related services provided by a hospital not on the plan's participating provider list, you will not be responsible for any further co-payments for such hospital charges under the plan for the rest of the year. Regardless of whether you receive medical care from a provider that is or is not on a participating provider list, in no event will the plan pay for noncovered services or for services that are not medically necessary.

There is a \$15.00 copayment for each thirty-day (or fraction thereof) supply of a prescription drug filled by a pharmacy on a participating provider list. There is a \$30.00 copayment for each thirty-day (or fraction thereof) supply of a prescription drug filled by a pharmacy that is not on a participating provider list. There is a \$5 copayment for each ninety-day supply of prescription drugs filled through mail order service. No family will have to pay more than \$600 in copayments each year for prescriptions filled by pharmacies on the participating provider list or through the mail order service.

In the absence of medical necessity, if a brand name drug is prescribed where a generic equivalent is available, the mine worker (or dependent) is responsible, in addition to any required copayment, for the additional cost of the brand name drug over the cost of the generic substitute. You may also be responsible, in addition to the required copayment, for the additional cost of certain drugs that are not "preferred" drugs. For further details about the plan's Preferred Product Program, refer to page 18 of this booklet.

*copayment year*

The twelve-month period used for calculating copayment maximums. The copayment year begins on January 1 of the calendar year and ends December 31 of the same year.

*covered service*

A service which is covered under the terms of the plan, is reasonable and necessary for the diagnosis or treatment of an illness or injury and which is provided at the appropriate level of care.

*effective date*

The 1993 Plan became effective December 16, 1993. The terms described in this booklet became generally effective January 1, 2002.

*employer*

An employer that is signatory to the National Bituminous Coal Wage Agreement.

*inpatient care*

The care received when a plan participant stays overnight in a hospital or other health care institution such as a skilled nursing care facility.

*outpatient care*

The care received when a plan participant is not confined overnight in a hospital or other health care institution, even if it is furnished by a facility which also provides inpatient care. Also referred to as *ambulatory care*.

*surgery*

Any operative or cutting procedure.

# ELIGIBILITY FOR HEALTH BENEFITS

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## ELIGIBLE BENEFICIARIES

The 1993 Benefit Plan provides health benefits to certain 1950 Pension Plan and 1974 Pension Plan pensioners, disabled mine workers, and to the eligible survivors and dependents of such beneficiaries.

To receive benefits from the plan, a person must not receive benefits from a company-sponsored plan and he must meet one of the conditions below. In addition, a retired miner will generally be ineligible for benefits during any month in which he is regularly employed and earning at the rate of \$1,800 per month (\$2,000 per month beginning January 1, 2005), or during any month in which he is receiving a Special Permanent Layoff Pension from the 1974 Pension Plan prior to such retired miner's attainment of age 55.

- the retired miner would be eligible for benefits under the UMWA 1950 Benefit Plan but for the passage of the Coal Act and is not entitled to benefits under the Coal Act;
- the retired miner separated from classified employment prior to December 16, 1993, would be eligible for benefits under the UMWA 1974 Benefit Plan but for the passage of the Coal Act, is not entitled to benefits under the Coal Act, and his last signatory employer was no longer deriving revenue from the production of coal on December 16, 1993;
- the retired miner worked under the terms of the National Bituminous Coal Wage Agreement of 1974 (but not under the terms of the National Bituminous Coal Wage Agreement of 1978), has been or would have been denied a benefit by the United Mine Workers of America 1974 Benefit Plan and Trust solely because the miner did not work under the terms of a 1978 or subsequent National Bituminous Coal Wage Agreement; and is not eligible to receive benefits under the Coal Act; or
- the retired miner is retired under the 1974 Pension Plan and last worked in signatory classified employment for an employer who was obligated to contribute and contributed to the 1993 Benefit Plan, at the rates set forth in the wage agreement, but would cease to receive health benefits because his last signatory employer (including successors and assigns) is "no longer in business."

To establish that a company is no longer in business, it must be determined that it meets all of the following conditions—

- It has stopped all mining operations and has ceased employing persons under the wage agreement
- It does not plan to operate again

- It is financially unable to provide health benefits
- It has no successor, assign, parent, subsidiary or any other related division (whether covered by the wage agreement or not) that is financially able to provide health benefits;

Or, is a dependent of an individual described above.

In general, an eligible dependent is any of the following people:

- A spouse living with or supported by the retired mine worker.
- An unmarried, dependent natural or adopted child or stepchild under the age of twenty-two.
- A parent of the retired mine worker or his spouse if that parent has depended upon and has lived with him continuously for at least one year.
- An unmarried, dependent grandchild under the age of twenty-two if that grandchild lives with the retired mine worker.
- A dependent child of any age who is mentally retarded or who was disabled before the age of twenty-two if his disability is continuous and he lives with the retired mine worker or is confined to an institution for care and treatment. Health benefits for such children will continue as long as a surviving parent is eligible for health benefits.
- Surviving spouse or dependent child of deceased retired miners. The following general rules apply:
  - When a retired or disabled mine worker dies while he is receiving or eligible to receive a pension from the 1974 Pension Plan, his surviving spouse will remain eligible for health benefits until remarriage; surviving dependent children will remain eligible for health benefits until the age of twenty-two.
  - When a mine worker in a classified signatory job dies as the result of a mine accident that occurs after December 16, 1993, his surviving spouse will remain eligible for health benefits until remarriage; surviving dependent children will remain eligible for health benefits until the age of twenty-two.
  - When a disabled mine worker dies while he is receiving or eligible to receive sickness and accident benefits, his surviving spouse and dependent children will remain eligible for health benefits for sixty months after his death.

A surviving spouse or surviving dependent child will not be eligible to receive benefits during any month in which such person is regularly employed at an earnings rate of at least \$1,800 per month (\$2,000 per month beginning January 1, 2005).

## **COVERAGE ELECTION AND PAYMENT**

Effective January 1, 2002, to receive benefits from the plan, pensioners, surviving spouses, and disabled mine workers not eligible for immediate pension benefits, are required to make a payment of \$2,000 per family to the plan on a yearly basis. The payment to the plan is due 30 days following payment to you of \$2,250 from either the UMWA 1950 or 1974 Pension Plan for such year. Health benefits coverage under the plan will **permanently cease** for any family that does not elect coverage and make the required payment on time (either by direct payment from the UMWA 1950 or 1974 Pension Plan or otherwise) once each year. The required form(s) on which you may elect coverage and authorize direct payment to the plan will be sent to you by the Funds. You will not be required to make the \$2,000 payment required under the plan for any calendar year in which you do not receive the \$2,250 pension payment from the UMWA 1950 or 1974 Pension Plan.

## **APPLYING FOR BENEFITS**

For information about health benefits for which you may be eligible, first contact the last signatory company for which you worked in a classified job. If this company is no longer in business, maintains that it is not responsible for your retiree health benefits, or refuses to provide you with such retiree health benefits, contact the Funds' Call Center; trained personnel will help you apply for the health benefits which may be available from the 1993 Benefit Plan.

## **HEALTH SERVICES ID CARD AND PHARMACY ID CARD**

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

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

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

## **RIGHT OF APPEAL**

The 1993 Benefit Plan provides health benefits to Eligible Beneficiaries (see pages 9, 10, and 14) who may also be eligible for Medicare. If your application for health or other benefits is denied, in whole or in part, you will receive a written explanation of the denial. If you think the decision to deny health or other benefits to you is incorrect, you have the right to appeal that decision. As explained below, the timeframes for appealing a denial decision will be different depending on whether you are a Medicare or 1993 Benefit Plan beneficiary and whether the benefit is or is not covered by Medicare or by the 1993 Benefit Plan.

### *Rights of beneficiaries who are not eligible for Medicare*

If you are **not** a Medicare beneficiary, the Funds normally has up to 90 days to determine whether your request for medical care or treatment is medically appropriate and a covered service under the plan. Beginning July 1, 2002, the Funds will normally have up to 30 days to act on your claims for medical care. As explained below, in some cases you may have a right to a decision within 72-hours of your request for medical care or treatment. When the Funds receives a request for medical care or treatment from you, the Funds will determine if it is an urgent, pre-service, or post-service claim, or a request for a concurrent care decision.

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

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

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

make a decision regarding your claim, you must submit the additional information to us within 45 days.

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

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

If you are appealing a claim involving urgent care, you have a right to request, orally or in writing, an expedited appeal. You may submit all necessary information to the Funds by telephone, facsimile or other available similarly expeditious method. We must make a decision on expedited appeal within 72 hours. No extensions are permitted.

If you are appealing a claim for pre-service care, the Funds must make a decision on your appeal within 30 days. If you are appealing a claim for post-service care, the Funds must decide your appeal within 60 days. In either case, no extensions are permitted.

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

#### *Rights of beneficiaries who are eligible for Medicare*

If you are a Medicare beneficiary and the health service which was denied as non-covered is also a Medicare service, you may be entitled to additional levels

of appeal. We normally have up to 60 days to determine whether your request for a service is a medically appropriate and covered service. In some cases, you have a right to a decision within 72-hours of your request. You can get a fast decision if your health or ability to function could be seriously harmed by waiting 60 days for a standard decision. If you ask for a fast decision, we will decide whether you get a 72-hour/fast decision. If not, your request for a service will be processed within 60 days. If any doctor asks the Funds to give you a fast decision, we must give it to you.

#### *10 – Day Extension*

An extension up to 10 working days is permitted beyond the 72-hour period, if the extension of time benefits you; for example, if you need time to provide the Funds with additional information or if we need to have additional diagnostic tests completed.

#### *Oral and Written Requests*

You may file an oral or written request for a 72-hour decision. Specifically state that "I want an: expedited decision, fast decision or 72-hour decision." or "I believe that my health could be seriously harmed by waiting 60 days for a standard decision."

- To file a request orally, call 1-800-292-2288. The Funds will document the oral request in writing.
- To hand deliver your request our address is UMWA Funds, c/o National Health Services, 9200 Shelbyville Road, Suite 700, Louisville, KY 40222.
- To FAX your request, our number is 1-800-382-7792. If you are in a hospital or a nursing facility, you may request assistance in having your written request for a service transmitted to the Funds by use of a FAX machine.
- To mail a written request, our mailing address is: UMWA Funds, c/o National Health Services, 9200 Shelbyville Road, Suite 700, Louisville, KY 40222; however, the 72-hour review time will not begin until your request for appeal is received.

We will make a decision on your request for a service and notify you of our decision within 72-hours of receipt of your request.

If you have any questions concerning your right of appeal, you should contact the Funds' Call Center for more information. Remember, if a health service is denied as medically unnecessary or because it is an excessive charge, you will be held harmless by the Funds. See the section below entitled "Hold Harmless Program."

#### **THE FUNDS AND MEDICARE**

Under a special arrangement with the Centers for Medicare and Medicaid Services, the Funds administers Medicare benefits for Medicare Part B (primari-

ly physician and laboratory services) for 1993 Benefit Plan beneficiaries who are eligible for Medicare. This means that the Funds will pay for the portion of medical services covered by Medicare Part B and that Centers for Medicare and Medicaid Services will reimburse the Funds for these types of claims and for administrative expenses. Medicare coinsurance, hospital deductibles, and other charges covered by the Plan but not covered by Medicare will be paid by the Funds under provisions of the 1993 Benefit Plan including the application of copayments.

According to the terms of the arrangement between the Funds and the Centers for Medicare and Medicaid Services, the Funds is the only agency that can process and pay Medicare Part B benefits for 1993 Benefit Plan beneficiaries who are enrolled in Medicare.

The Funds also administers a cooperative program involving Part A of Medicare (primarily hospitalization and related benefits). Under this arrangement, your Part A Medicare benefits will continue to be processed through the Medicare intermediaries, as they have been in the past.

Under the terms of the plan, beneficiaries who are eligible for Medicare coverage must be enrolled in Medicare Part A and Medicare Part B to retain their eligibility for health benefits from the plan.

#### **THE FUNDS AND FEDERAL BLACK LUNG PROGRAM**

The U.S. Department of Labor (DOL) handles the exchange of information between the Funds and DOL's Black Lung fund for medical benefits. The Funds pays for covered services for eligible beneficiaries and then seeks reimbursement from DOL for prescription drug and medical services covered by the Black Lung program.

#### **CONTINUATION OF HEALTH BENEFITS COVERAGE**

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, as amended, you may be able to continue your health benefits coverage even if you are no longer eligible for these benefits under the 1993 Benefit Plan. COBRA, however, only applies in certain situations. If you become ineligible for health benefits coverage under the plan and elect continued coverage under COBRA, you will be charged a monthly premium for such coverage. Additional information regarding continued coverage under COBRA is available from the Eligibility Services Division in the Funds' central office in Washington, D.C.

#### **MEDICAL CHILD SUPPORT ORDERS**

Under the provisions of the Omnibus Budget Reconciliation Act of 1993, and Section 609 of ERISA, the plan will provide benefits pursuant to the terms of "qualified medical child support orders."

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

A "qualified" medical child support order (QMCSO) is an order that (A) either creates or recognizes the right of an "alternate recipient" (a participant's child who is recognized under a MCSO as having a right to be enrolled under the plan) or assigns to the alternate recipient the right to receive benefits for which a participant or other beneficiary is entitled under the plan, and (B) includes (i) the name and last known mailing address of the participant and the name and address of each alternate recipient, (ii) a reasonable description of the type of coverage to be provided by the group health plan or the manner in which such coverage is to be determined, (iii) the period for which coverage must be provided, and (iv) each plan to which the order applies, and (C) does not require the plan to provide any type or form of benefit, or any option, not otherwise provided under the plan (except to the extent necessary to meet requirements of Medicaid laws).

If a MCSO is received by the plan, the Funds shall apply the following procedures to determine if the order is qualified:

- (1) Following the receipt of the order, the Funds shall promptly notify the participant and each alternate recipient specified in the order, at the address(es) included in the order, of receipt of the order and the plan's procedures for determining the qualified status of the order.
- (2) Any alternate recipient specified in the order may designate a representative to receive copies of notices sent by the Funds to the alternate recipient with respect to the order.
- (3) Within a reasonable period after receipt of the order, the Funds shall determine whether the order is qualified and notify the Participant and any alternate recipient involved of the determination. The determination shall be made in accordance with the provisions of, and regulations under, ERISA, the Internal Revenue Code and the Social Security Act, as amended.

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

# HEALTH BENEFIT PAYMENTS

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## BILLING THE FUNDS FOR MEDICAL SERVICES

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

If your provider bills the Funds, you need to pay only the copayments for prescription drugs and visits to or by a physician. For visits to or by physicians who are on participating provider lists ("PPL"), copayments are \$20.00 for each visit. For visits to or by physicians who are not on participating provider lists, copayments are \$30.00 for each visit. The total copayments for physicians visits is limited to \$400 per year for a family.

Where hospital and related services are provided by a hospital that is not on a participating provider list, the retired mine worker (or dependent) is responsible for all charges in excess of 90 percent of the PPL rate for covered services that would have otherwise been paid for by the plan if such hospital and related services had been provided by a hospital on the PPL. In no event, and regardless of whether medical services were provided by a provider on a participating provider list, will the plan pay for noncovered services or services not medically necessary. Once your out of PPL hospital co-pays and balance billing charges (after the plan has paid 90% of the PPL rate) reach \$600.00 in any calendar year, you will not be responsible for any more co-pays for hospital charges.

For prescription drugs filled by pharmacies on participating provider lists, copayments are \$15.00 for each thirty-day (or fraction thereof) supply of a prescription drug. The copayment for prescriptions filled through the mail order service is \$5.00 for each ninety-day (or fraction thereof) supply. The copayment for prescription drugs filled by pharmacies not on participating provider lists is \$30.00 for each thirty-day (or fraction thereof) supply of a prescription drug. Total out-of-pocket copayments for prescription drugs is capped at \$600.

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

- ***Generic Drug Substitution Program***

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

- ***Preferred Product Program***

The Preferred Product Program requires you to obtain "preferred" medication products in eight selected drug categories for the standard co-payment. Certain cholesterol drugs, blood pressure drugs, pain/inflammation drugs, and gastrointestinal/stomach-related drugs are on the "preferred" drug list. "Non-preferred" medications from the twelve selected drug categories may still be obtained; however, in addition to the standard co-payment you will also have to pay an additional charge, depending on the dosage and the quantity prescribed.

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

For a complete list of "preferred" drugs, you should contact the Funds' Call Center or AdvancePCS. Appropriate addresses and telephone numbers appear at the end of this booklet.

## **VISION CARE PROGRAM**

In addition to coverage of medical services, the plan includes a vision care program. All beneficiaries who are eligible for health benefits, including dependents, are covered by this program which provides benefits for routine eye examinations, eyeglass frames and lenses, and contact lenses. For details, please refer to the "Summary of Health Benefits" section of this booklet under the heading "Routine Vision Care."

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

## **PAYMENT OF CLAIMS; EXPLANATION OF MEDICAL BENEFITS**

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

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

When you have met the yearly copayment maximum for medical care, the EOB will say "MaxMet." After you have met a maximum, show the EOB to your provider as proof that you are not required to make further copayments during the current copayment year. **Remember that a copayment year begins January 1 of one calendar year and ends December 31 of the same calendar year.**

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

## **HOLD HARMLESS PROGRAM**

When a provider attempts to collect excessive charges or charges for services not medically necessary, the trustees shall, with the written consent of the beneficiary, attempt to resolve the matter either by negotiating a resolution or defending any legal action brought by the provider. The beneficiary is not to be responsible for any legal fees or other expenses in connection with the case. This protection applies only to excessive charges or to charges for services that are not medically necessary, and does not apply to charges for benefits which are not covered by the plan. In other words, you may be liable for any services of the provider which are not provided under the Plan.

You need to use the program only if a provider, a collection agency, or a lawyer tries to collect from you amounts denied by the Funds. If such an attempt to collect from you is made, you should promptly contact the Funds' Call Center.

## CARE MANAGEMENT PROGRAMS

The 1993 Benefit Plan includes provisions to control health care costs and to improve the quality of care without reducing benefits covered by the plan. Such care management programs may include pre-admission approval of inpatient hospital care and review of the length of stay, precertification of certain outpatient and surgical procedures, second surgical opinions, case management, and other quality of care programs. (See pp. 21-30). Programs to contain prescription drug costs include agreements with networks of pharmacies to accept certain levels of payment for drugs, encouraging the use of generic and formulary drugs when medically appropriate, and supplying drugs by mail when advantageous to the beneficiary. (See pp. 18 and 27).

# SUMMARY OF HEALTH BENEFITS

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This section describes the medical, hospital, and other health care services covered by the 1993 Benefit Plan. Hospital care may be provided by any hospital accredited by the Joint Commission on Accreditation of Hospitals, or by non-accredited hospitals that have been approved by the Funds. Medical care may be provided by physicians and, in certain instances, by other appropriately trained and licensed health care professionals. Prescription drugs and medications may be provided by pharmacies, hospital outpatient clinics, and facilities such as hospitals and skilled nursing care facilities that provide health care services on an inpatient basis. Some services require prior approval; to obtain such approval, write to the address that appears at the end of this booklet.

This section is a simplified and condensed version of the 1993 Benefit Plan plan provisions for covered services. All final determinations concerning coverage of a particular service are subject to the specific provisions of the plan. If you cannot find the information that you want about a particular service, contact the Funds' Call Center.

## **PHYSICIANS' SERVICES AND OTHER PRIMARY CARE**

### *1. General Scope of Benefits*

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

In addition to primary care, the plan covers treatment prescribed or administered by a specialist if the treatment is for an illness or injury which falls within the specialist's area of competence. Consultations with specialists will be covered when the physician in charge of the case requests the consultation.

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

The plan does not cover dental services, acupuncture therapy, naturopathic therapy, home obstetrical delivery, and chiropractic services. As a Medicare Health Care Prepayment Plan (HCPP), the Funds will, however, pay for chiropractic services that are covered by Medicare Part B. The plan does not cover charges for writing prescriptions, preparing medical summaries and invoices, or telephone conversations with a physician in the place of an office visit.

## ***2. Preventive Care***

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

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

## ***3. Treatment of Illnesses and Injuries***

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

## ***4. Treatment for Mental Health and Substance Abuse***

When a physician determines that treatment is medically necessary and such treatment is not available at no cost from another source, the plan provides benefits for individual psychotherapy, group therapy, psychological testing, and counseling. The plan will only cover hospitalizations for acute (short-term) mental illnesses for up to a maximum of 90 days of care over a two-year period, and will provide benefits only for a maximum of thirty days of hospital care for each episode of acute mental illness. Benefits for an additional thirty days of hospital care for a single episode of mental illness may be provided subject to prior approval.

The plan will cover emergency hospital stays for a maximum of seven days when the reason for hospitalization is alcohol detoxification or treatment of drug abuse, but such services are subject to prior approval based upon the patient's prospects for rehabilitation. If a separate medical condition or mental illness requires a longer hospital stay, the usual plan coverages and limitations will apply. Copayments are required for all mental health services.

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

### *5. Surgical Services*

The plan defines surgical services as operative and cutting procedures, as well as usual and necessary postoperative care required for treatment of illnesses, injuries, and dislocations of bones. The plan will pay for surgical services whether you receive them in or out of a hospital.

When more than one surgical procedure is performed at the same time, the plan will pay the physician's normal fee for the primary procedure but may pay less than the physician's normal fee for the incidental procedure. If your condition or the nature of the procedure necessitates an assistant surgeon, the plan will also pay for it. In addition to fees for surgical services, the plan will cover the cost of anesthesia and charges for administering it when billed by a physician or CRNA other than the operating surgeon or the assistant surgeon.

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

*Oral Surgery:* The plan covers oral surgery only when necessary to treat tumors of the jaw, fractures of the jaw or facial bones, and tongue-tie. It may also cover surgery for TMJ dysfunction, when medically necessary and related to an oral orthopedic problem. Biopsy of the oral cavity and services required as the direct result of an accident are also covered.

*Podiatrists:* The plan covers minor surgical services performed by a podiatrist in his office such as surgery to correct ingrown nails; however, prior approval is required for all major surgical services performed by podiatrists, and such services will not be covered unless they are performed in a hospital. In addition, the plan does not cover nonsurgical services performed by podiatrists, nor does it cover routine foot care such as trimming nails and treating corns, calluses, and bunions by nonsurgical means unless it is medically necessary for a participant who has diabetes, peripheral vascular disease, or peripheral neuropathy of the foot.

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

#### **6. Obstetrical and Family Planning Care**

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

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

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

#### **INPATIENT HOSPITAL SERVICES**

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

- Semi-private room and board including charges for special diets. Additional fees for a private room will be covered only if isolation is necessary for your health or the health of other patients or if a semiprivate room is not available. If you are put into a private room because no semiprivate room is available, the plan will not cover the additional fee for the private room beyond the day on which a semiprivate room first becomes available and your condition permits transfer to the semiprivate room.
- Intensive and coronary care unit services if your physician certifies that it is medically necessary for you to be in such a unit.

- Private duty nursing care if there is no space in the hospital's intensive care unit and your physician certifies that private duty nursing is necessary to preserve life. The plan will cover this care for up to seventy-two hours.
- Use of hospital facilities such as operating, delivery, and recovery rooms.
- Diagnostic or therapeutic items and services such as laboratory tests, X-rays, chemotherapy, radiation therapy, and physical therapy.
- Drugs and medications, including thirty-day take-home supplies of drugs following a hospital stay. The plan also covers anesthesia, intravenous injections and solutions, and oxygen and its administration.
- Administration of blood and blood plasma, as well as the cost of the blood itself.
- Renal dialysis when the method of administration is such that benefits can be coordinated with Medicare.

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

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

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

#### **OUTPATIENT HOSPITAL SERVICES**

The plan covers surgery, chemotherapy, radiation therapy, and physiotherapy treatments furnished on an outpatient basis by a hospital; renal dialysis is also covered when the method of administration is such that benefits can be coordinated with Medicare. The plan covers laboratory tests and X-rays performed on an outpatient basis when they are necessary for diagnosis or treatment of a definite illness, injury, or medical condition. Emergency room services will be covered by the plan if you seek such emergency medical treatment within forty-eight hours of the onset of acute medical symptoms or the occurrence of an injury.

## **SKILLED NURSING CARE FACILITIES**

Coverage for stays in skilled nursing care facilities is subject to prior approval. For the plan to cover such stays, skilled nursing care services must be medically required. The plan will not pay for confinement in a skilled nursing care facility for custodial care or for a rest cure. Only stays in nursing facilities which are licensed and Medicare-certified will be authorized, and the plan will provide coverage only to the extent that it is not provided by state or federal programs.

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

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

## **EXTENDED CARE UNITS**

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

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

## **HOME HEALTH SERVICES, EQUIPMENT AND SUPPLIES**

Home health services will be covered by the plan on a prior approval basis if your condition is such that you are confined to your home and you require skilled nursing care, physical therapy, or speech therapy on an intermittent basis. Bills will be paid only for services ordered by physicians and provided by licensed personnel employed by certified home health agencies.

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

### ***1. Medical Services***

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

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

### ***2. Durable Medical Equipment***

The plan will cover the cost of rental or purchase of durable medical equipment suitable for home use when a physician determines that the equipment is necessary and the rental or purchase is from a vendor that is participating in the Funds DME Vendor Network program. Rentals or purchases not acquired from a participating DME network provider may not be paid for by the plan. Whether or not rented or purchased from a DME network provider, exercise equipment is not covered by the plan. Equipment you use in a skilled nursing facility or while you are a patient admitted to and staying overnight at a hospital may be provided by that facility or hospital instead of a DME network provider.

### ***3. Supplies***

The plan will cover the cost of medical supplies when they are medically necessary and prescribed by a physician. You may purchase these supplies from a store but you are encouraged to obtain your supplies from a DME network provider.

### ***4. Oxygen***

The plan covers oxygen and related equipment if you have been referred to a pulmonary consultant for testing and the consultant's report is submitted with the bill for the oxygen. The plan may also cover services of an inhalation therapist who visits your home if your physician orders the treatment.

### ***5. Coal Miners Respiratory Disease Program***

The plan covers services or treatment provided in your home by the Coal Miners Respiratory Disease Program if ordered or requested by a physician. Such services are subject to prior approval and will be covered by the plan only if similar services cannot be obtained under a government program for which you are or would be eligible.

## **DRUGS AND MEDICATIONS**

The plan covers reasonable charges for insulin and drugs which by law require a prescription. See pages 7 and 17 for an explanation of the required copayments.

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

The plan covers drugs prescribed by a physician for treatment or control of an illness or nonoccupational injury when they are dispensed by a pharmacy or hospital outpatient clinic. The plan does not cover drugs dispensed from a physician's office (except allergens), or medications prescribed for birth control.

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

Copayments are not required for drugs and medications administered during your stay in an inpatient facility. You will, however, be required to make a copayment for each ninety-day supply or less of a drug or medication furnished on an outpatient basis as well as for take-home supplies of drugs following a hospital stay.

In the absence of proof of medical necessity, you will be required to pay, in addition to the required copayment, for the additional cost of a brand name drug over the cost of the generic substitute and/or for certain drugs that fall in eight selected categories that are included as "preferred" drugs in the plan's Preferred Product Program.

Refer to page 18 of this booklet for more information about the generic drug substitution program and preferred product program.

### **ROUTINE VISION CARE**

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

<i>Benefit</i>	<i>Maximum Amount</i>	<i>Maximum Amount (Effective January 1, 2005)</i>
Vision Examination	\$29.04 per exam	\$31.94 per exam
Per Lens (maximum of 2)		
Single vision lens	\$14.52	\$15.97
Bifocal lens	\$21.78	\$23.96
Trifocals	\$29.04	\$31.94
Lenticular lens	\$36.30	\$39.93
Contact lens	\$21.78	\$23.96
Eyeglasses frames	\$20.57 per set	\$22.63 per set

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

## **OTHER BENEFITS**

### ***1. Prosthetic Devices***

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

### ***2. Orthopedic Appliances***

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

### ***3. Orthopedic Shoes***

The plan covers the cost of specially-built orthopedic shoes and shoes which must be modified to be attached to a brace, provided that the shoes are prescribed by an orthopedist. When prescribed by an orthopedist, podiatrist, family practitioner, or pediatrician, the cost of adding orthopedic modifications to ordinary shoes may also be covered; however, the cost of the shoes themselves will not be covered.

### ***4. Physical Therapy***

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

### ***5. Speech Therapy***

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

### ***6. Hearing Aids***

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

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

### ***7. Ambulance and Other Transportation***

The plan will pay for ambulance transportation to or from a hospital, clinic, physician's office, or skilled nursing care facility provided that the ambulance is considered medically necessary by a physician. With prior approval, the plan provides coverage for the cost of frequent transportation to a hospital or clinic for essential treatment, such as radiation or physical therapy, if hospitalization would be the only feasible alternative to the transportation coverage in order for the participant to receive the needed treatment. Under certain, limited circumstances, the plan may also cover the services of an escort.

For more complete information about the plan's coverage of transportation for medical services, please contact the Funds' field service office in your area. That office will also give you details on the procedures which you must follow to be reimbursed for transportation expenses and on the level of reimbursement which will be provided.

# FUNDS ADDRESSES AND PHONE NUMBERS

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## **Central Office**

UMWA Health and Retirement Funds  
2121 K Street, N.W., Suite 350  
Washington, D.C. 20037  
Telephone: (202) 521-2200

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

## ***CLAIMS SUBMISSIONS***

### **PRESCRIPTION DRUGS**

UMWA Health and Retirement Funds  
c/o AdvancePCS  
P.O. Box 853901  
Richardson, TX 75085-3901  
Toll Free: 1-800-294-4741

### **MEDICAL SERVICES, SUPPLIES AND VISION CARE**

UMWA Health and Retirement Funds  
P.O. Box 389  
Ephraim, UT 84627-0361  
Toll Free: 1-888-865-5290

# PRIOR APPROVAL AND MANAGED CARE PROGRAMS

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