Patriot Midwest Salaried Employee Guide to

# Medical Benefits

November 2007

This booklet is a “summary plan description” (SPD) and the legal plan document for the medical plan for eligible salaried employees of Patriot Coal Corporation Corp. and certain designated affiliates and subsidiaries in Illinois, Indiana, and Kentucky in effect as of November 2007. A complete list of participating employers may be obtained upon written request to the plan administrator and may be examined at the principal office of the plan administrator and other work sites. This booklet supersedes any booklets previously issued to you.

Eligibility for benefits and the actual amount of benefit payments are determined by this plan document and laws that govern the plan. This booklet describes the plan in easy-to-read, simplified terms.

The plan administrator, Patriot Coal Corporation (“the company”), maintains the right to interpret the terms of this plan, and its interpretations will be final.

The company intends to maintain this plan for eligible employees, but reserves the right to change or end the plan at any time. This booklet is not a guarantee of employment or an employment contract.

If an employee speaks a language other than English, he or she may contact their local human resource office to request help with translating or interpreting the contents of this SPD.

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# Medical Coverage Highlights

**WHO IS ELIGIBLE:** This plan is made available to employees of designated subsidiaries and affiliates of Patriot Coal Corporation. If you are classified by a participating employer as a full-time salaried employee working 35 or more hours per week, or a part-time salaried employee working a regular schedule of 20 or more hours per week year round, and are working in the Kentucky, Illinois or Indiana region, you are eligible to participate in the Patriot Coal Corporation and its Designated Affiliates Welfare Benefit Plan. A complete list of participating employers may be obtained upon written request to the plan administrator and may be examined at the principal office of the plan administrator and other work sites. Temporary and seasonal employees and members of collective bargaining units whose agreements do not provide for their participation in the plan, are not eligible.

**WHAT COVERAGE OPTIONS ARE AVAILABLE**: The medical plan offers three medical options from which to choose. All of the options cover the same services and supplies; the difference between the options lies in the amount of the deductibles, copayments and out-of-pocket limits. In addition, the Consumer Choice Option includes a special company-provided account to help you pay for covered expenses during retirement. (See page 35 for more information.)

**WHAT IS COVERED:** The medical plan covers a wide variety of medical services and supplies. There are special provisions for prescription drugs, home health care, hospice care and treatment of mental illness and substance abuse.

**COST TO YOU**: Your employer pays the majority of the cost of your coverage. However, you may pay a portion of the cost depending on the option you choose. Active employees pay their contributions through before-tax payroll deductions.

You also share in the cost of the treatment you receive by paying deductibles, copayments and a percentage of expenses. Your share depends on the option you have chosen, the kind of care you receive and where you receive it. (See page 10 for more information.)

**MAXIMUM BENEFIT AMOUNT:** The medical plan has a lifetime maximum benefit that is adjusted annually based on the Health Cost Component of the Consumer Price Index. In 2007, the maximum is $2.4 million per covered person. However, additional restrictions apply to hospice care and treatment of mental illness and substance abuse.

**IF YOU LEAVE THE COMPANY:** Your coverage generally ends, although under some circumstances you may be eligible for continued coverage under the federal law known as COBRA. The medical plan also contains special provisions for continuing coverage in the event of retirement, disability, a reduction in the work force or for your surviving dependents in the event of your death. (See page 53 for more information.)

The medical plan may also allow you to convert your coverage to an individual insurance policy if your company-provided coverage ends. (See page 68 for more information.)

**OTHER IMPORTANT POINTS:** You are free to receive your care from any provider you wish, but your share of costs for the medical plan will be less if you use providers that are members of the plan's "participating provider" networks. These networks include hospitals, physicians and pharmacies. (See page 12 for more information.)

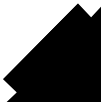
The medical plan includes a Blue Care® Connection program that works with you and your doctor to review your care and avoid unnecessary hospitalization. The purpose of the program is to make sure you receive the most appropriate, cost-effective care for your condition. (See page 13 for more information.)

The medical plan's coverage for a "pre-existing condition"—a condition you had before becoming covered under this plan—may be limited until you have been covered by this plan for a certain number of months. (See page 8 for more information.)

If you are also covered by another medical plan, including Medicare, the company's plan will coordinate with the other plan to avoid duplicate payments of benefits. (See page 49 for more information.)

For disabled and retired employees who are eligible for both Medicare and the company plan, Medicare is the primary plan and the company plan is secondary.

# Eligibility and Enrollment



You are eligible for medical coverage if you are a full-time salaried employee working 35 or more hours per week or a part-time salaried employee working a regular schedule of 20 or more hours per week year-round. Temporary, contractual and seasonal employees are not eligible.

Your coverage will begin on your employment date, provided you enroll within 31 days after your date of employment. If you do not enroll within 31 days, you will have to wait until the next annual enrollment period, unless you have a change in family status. This is explained in the “Changing Your Coverage” section on page 4.

If you are not actively at work for a reason unrelated to your health on the date your coverage would otherwise begin, your coverage becomes effective on the date you are at work.

## Eligibility for Your Dependents

Your eligible dependents become covered by the plan at the same time you do, provided you enroll them within 31 days after your date of employment. Dependents you acquire after your coverage begins—by marriage or birth, for example—will be covered on the date you acquire them, provided they are enrolled within 31 days of that date.

Your eligible dependents include:

- Your spouse.
- Your unmarried children up to the end of the month in which the dependent reaches age 19.
- Your unmarried children up to the end of the moth they attain age 23, if they are full-time students in an educational institution. Proof of full-time student status will be required each spring and fall semester.
- Your unmarried children of any age who are incapable of supporting themselves due to a permanent mental or physical disability and are completely dependent upon you for financial support. The disability must have occurred before age 19. “Supporting” the child also includes having the child live with you or confined to an institution for care or treatment. Proof of incapacity must be provided to the Benefits Department within 30 days of the date coverage would otherwise end due to age. Additional proof may be required to continue coverage thereafter as determined by the company.

Children who are eligible as dependents include:

- Your natural child.

In addition, the following children are also eligible as dependents. The child must reside with you and you must regularly provide at least one-half of his or her annual support.

- Your stepchild.
- Your legally adopted child or a child placed with you for adoption.
- Your grandchildren or other children, who live with you in a regular parent-child relationship, provided you have legal guardianship.

The plan will also cover a child for whom you have been named in a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the plan’s procedures for validating a QMCSO from the Benefits Department.

No eligible employee may be covered as both an employee and a dependent, and no one may be covered as a dependent of more than one employee.

## Enrollment

You may enroll from among several options when you are first hired as an eligible employee or during the plan's annual enrollment period. You may also choose to decline coverage from the company, if you have medical coverage through another source. If you enroll in the plan, you choose the coverage that meets the needs of you and your family. You may choose coverage for:

- Yourself only.
- Yourself plus one dependent.
- Yourself plus two or more dependents.

If you elect dependent coverage, your dependents must be covered under the same medical option as you. For example, you cannot pick Option 250 for yourself and Option 1000 for your dependents.

To enroll for coverage, you must complete an enrollment form and return it to the Benefits Department.

If you do not enroll for medical coverage within 31 days after your hire date, or (for dependent coverage) within 31 days after the date a dependent first becomes eligible, you will not be able to obtain coverage until the next annual enrollment period, unless you have a "change in family status" event that justifies the change. This is explained in the "Changing Your Coverage" below.

## The Cost of Your Coverage

Your cost for coverage depends on the option you select and the number of family members you choose to cover. The cost for each level of coverage is printed on your enrollment form. Your contributions will automatically be deducted in equal installments from your paychecks on a before-tax basis. This means you will not have to pay any federal or state taxes on the amount of your salary that is used to pay your contributions. Should the costs for the plan go up or down in future years, the portion that you pay will reflect these changes in cost.

You may also opt out of medical coverage altogether; in this case, you'll receive an annual cash payment. The amount of the cash payment is reduced if you enroll after January 1. If you leave the company during the year, you will be required to repay a portion of the cash payment depending on the date your employment ended. This also applies if you enroll or increase your coverage during the year because of a qualifying change in family status.

## Changing Your Coverage

All the choices you make when you enroll (or decline to enroll) are binding until the end of the calendar year for which you're enrolling. Except in certain cases as explained in the following sections, you will not be able to enroll, cancel or change them until the next annual enrollment period.

### Changes During the Annual Enrollment Period

An annual enrollment period is conducted in the fall of each year. Changes you make during the annual enrollment period become effective on the following January 1.

During the annual enrollment period, you may make the following changes to your coverage:

- You may switch to any other available coverage option.
- You may cancel coverage for yourself or your dependents if medical coverage is available through another source.
- If you declined medical coverage, you may enroll during a subsequent annual enrollment period. However, your choice for coverage in this situation will be limited to Option 1000. This also applies if you cancel coverage and later decide to re-enroll in a subsequent year.
- You may add a dependent to your coverage.

Here is a summary of the changes you can make during annual enrollment:

| Your Situation | Changes You Can Make |
|---|---|
| During the previous year, you elected medical coverage for yourself and your dependents. | You may elect any of the available medical coverage options, or cancel coverage for yourself or your dependents(s) if medical coverage is available through another source. |
| You declined medical coverage when you were first eligible. | You may enroll for Option 1000 during any subsequent annual enrollment period. This also applies if you cancel coverage and then decide to re-enroll in a subsequent year. |
| You declined coverage for your dependent(s) when the dependent was first eligible. | You may add the dependent(s) to your current coverage option during any subsequent annual enrollment period. |

**Changes During the Year**

You may enroll or cancel coverage for yourself or your dependents only during the annual enrollment period unless you experience a “change in status” event that justifies a change in coverage. The change in coverage must be consistent with the event. Examples of “change in status” events include:

- Marriage, divorce, legal separation or annulment.
- Addition of a child through birth, adoption, placement for adoption, legal guardianship or custody.
- Death of your spouse or dependent.
- Change in employment status of you, your spouse or dependent.
- Change in work schedule, including a reduction or increase in hours of employment by you, your spouse or dependent, including a switch between part-time and full-time, or commencement or return from an unpaid leave of absence.
- Any change in your child’s eligible dependent status.
- A change in the place of residence or worksite of you, your spouse or dependent.
- You and/or your family member become eligible for Medicare.

If you experience a change in family status and wish to change your coverage as a result, you must complete a new enrollment form and return it to the Benefits Department within 31 days after the date of the event.

If you are not actively at work for reasons unrelated to your health on the date coverage would normally begin, coverage will not begin until you return to work. Also, see the “Limitations for Pre-Existing Conditions” section on page 8.

Following is a summary of the changes you can make during the year:

| Your Situation | Changes You Can Make |
|---|---|
| **There is a change in the number of eligible dependents in your family.** | |
| You gain a new dependent through marriage, birth or adoption. | ➘ You may add your new dependent to your current coverage option, or enroll yourself, your spouse and any dependents for coverage under any option.<br>➘ You may drop coverage if you become enrolled for group medical plan coverage under your spouse's plan. |
| You lose a dependent, or your spouse or child loses eligibility for coverage under this plan on account of death, divorce, child reaches the limiting age, etc. | ➘ You must drop coverage for the affected individual. Note: Regardless of your contribution level, the plan does not provide coverage for a family member after the date the person no longer qualifies as an eligible dependent, unless the person is eligible for, enrolls and pays for COBRA coverage. |
| **A court order requires you or your former spouse to provide coverage for a dependent child.** | |
| Your former spouse is required by a court order to provide medical coverage for a child whom you had enrolled for medical coverage. | ➘ You may drop the coverage of the child subject to the order. |
| **You, your spouse or a dependent child becomes eligible for coverage under another plan (including Medicare).** | |
| You become eligible for coverage under another plan because of marriage or a change in your spouse's employment status (e.g., new employment, change from part-time to full-time status). | ➘ You may drop coverage if you become enrolled in group medical plan coverage under your spouse's plan. |
| Your spouse or your dependent child becomes eligible for coverage under another plan due to a change in your spouse's employment status (e.g., new employment, change from part-time to full-time status). | ➘ You may drop coverage for your spouse and/or your dependent if they become enrolled for group medical coverage under your spouse's plan. |
| You become eligible for Medicare. | ➘ You may drop coverage for yourself, your spouse and your dependents upon enrollment for Medicare. |
| Your spouse or dependent becomes eligible for Medicare. | ➘ You may drop coverage for the affected individual upon enrollment for Medicare. |
| The annual enrollment under your spouse's plan occurs while your coverage choices under this plan are in effect. | ➘ You may drop coverage for yourself, your spouse and your dependents if you are enrolled for group medical plan coverage under your spouse's plan.<br>➘ You may keep coverage for yourself but drop coverage for your spouse and your dependents if they are enrolled for group medical plan coverage under your spouse's plan. |

<table>
<tr><td>A coverage change permitted under IRS rules is made under another employer plan (such as the plan of your spouse's employer).</td><td>➘ You may drop coverage for yourself, your spouse and for your dependents if you are enrolled for group medical plan coverage under the other plan.<br>➘ You may keep coverage for yourself but drop coverage for your spouse and/or your dependents if they are enrolled for group medical plan coverage under the other plan.<br>➘ If you declined coverage because you had group medical plan coverage under the other plan and an election change is made to drop that coverage, you may enroll yourself, your spouse and/or your dependents in any option.<br>➘ You may enroll your spouse and/or your dependents in your current coverage if group medical plan coverage under the other plan is dropped pursuant to a permissible election change.</td></tr>
<tr><td colspan="2">You are no longer eligible for coverage under this plan.</td></tr>
<tr><td>You lose coverage under this plan because of a change in employment status that affects eligibility (e.g., change from full-time to part-time, reduction in force, leave of absence).<br>Note: You remain eligible for coverage while on FMLA leave, as long as you continue to pay your required contributions.</td><td>➘ You must drop coverage.</td></tr>
<tr><td colspan="2">You, your spouse or a dependent child loses coverage under another plan (including Medicare).</td></tr>
<tr><td>You lose coverage under another plan because of death, divorce or a change in your spouse's employment that affects eligibility for coverage.</td><td>➘ You may enroll for coverage in any option if you lost group medical plan coverage.</td></tr>
<tr><td>Your spouse or your dependent loses coverage under another plan due to a change in employment status that affects eligibility for coverage.</td><td>➘ You may enroll your spouse and/or your dependent in your current coverage option, or enroll yourself, your spouse and any dependents for coverage under any option.</td></tr>
<tr><td>Your dependent loses coverage under your spouse's plan due to your spouse's death or due to divorce.</td><td>➘ You may enroll your dependent in your current coverage option, or enroll yourself, your spouse and any dependents for coverage under any option.</td></tr>
<tr><td>Your spouse or dependent loses eligibility for Medicare or Medicaid.</td><td>➘ You may enroll the affected individual under your current medical coverage option.</td></tr>
</table>

| | |
|---|---|
| You, your spouse and/or your qualified dependents lose group medical plan coverage sponsored by a governmental or educational institution including a state's children's health insurance program, a medical care program of an Indian Tribal government, the Indian Health Service or tribal organization, a state health benefits risk pool, or a foreign government group health plan. | ➘ If you previously declined coverage because you were enrolled for this coverage, you may enroll yourself, your spouse and/or your dependents for coverage in any option.<br>➘ You may enroll your spouse and/or your dependents in your current coverage option if they lose the other group health coverage. |
| You, your spouse or your dependent lose other group medical coverage because (1) employer contributions toward such coverage are terminated, or (2) the coverage was provided through COBRA and the right to COBRA coverage has been exhausted. | ➘ You may enroll yourself, your spouse and any dependent(s) for coverage under any option. |

## Limitations for Pre-Existing Conditions

Benefits under any option may be limited if you or your dependent has a pre-existing condition.

- A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care or treatment (including prescription drugs) was recommended or received within the six-month period ending on the individual's enrollment date. For this purpose, the term "enrollment date" means, for an employee who enrolls when first eligible, the first day of employment as an eligible employee; in all other cases, the "enrollment date" is the date coverage begins.
- Charges related to a pre-existing condition are not covered during the 12-month period starting on the individual's enrollment date.
- The limit for pre-existing conditions will not apply to pregnancy. It also does not apply to a child who is enrolled within 31 days of birth or placement for adoption, in most cases.

However, this limitation period will be reduced by the amount of time that the covered person had "creditable coverage" from another medical plan before enrolling in this plan. A person receives creditable coverage for prior periods of coverage under other group medical plans, individual medical insurance and certain other state and federal health benefit programs. However, if you or your dependent had a period of 63 consecutive days with no creditable coverage, any periods of creditable coverage that occurred prior to that lapse will not be counted. Note that any period during which you or your dependents were satisfying a group health plan's waiting period is not counted toward the 63-day lapse in creditable coverage.

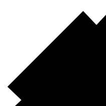
The limitation period will not apply at all to your dependent child if the child was enrolled in creditable coverage within 31 days of birth or placement for adoption and the child has not had a subsequent lapse of creditable coverage for a period of 63 or more days. Coverage that a child had prior to placement for adoption is not taken into account.

You will be required to provide proof of creditable coverage. The limitation on pre-existing conditions will apply unless you can provide this proof when it is requested. You should contact your prior group health plan or health insurer to obtain a Certificate of Creditable Coverage or other appropriate documentation. The certificate may be submitted to the Benefits Department. If you need assistance, contact the Benefits Department at 1-800-633-9005.

## Eligibility for Disabled and Retired Employees

Certain retired and disabled employees are also eligible for medical coverage. Refer to “When You Become Disabled” on page 54 and “When You Retire” on page 59.

# Your Medical Benefits



You can control your medical coverage costs and out-of-pocket costs by choosing one of three medical options. You may choose from among the Consumer Choice Option, Option 250 and Option 1000.

You can also opt out of medical coverage if you have coverage from another source.

To help make your choices easier to understand, the names of two of the options are based on the annual deductible per person for network expenses—Option 250 means a $250 deductible, while Option 1000 means a $1,000 deductible. Otherwise, these options generally work the same and use the same preferred provider organization (PPO) network.

Option 250 provides the highest level of coverage and requires the highest level of monthly contributions.

Option 1000 currently eliminates your monthly contribution altogether if you are full-time, but has the highest level of potential out-of-pocket costs when you receive medical care.

A third option, the Consumer Choice Option, works differently from the other two choices. It is referred to as a consumer-driven health plan. The Consumer Choice Option gives you the opportunity to save for health care during retirement.

These three options are described in more detail starting on page 10.

In addition to the three options, you can choose to opt out of medical coverage altogether if you can show proof of other coverage. If you choose no coverage, you will receive a cash payment each year (not applicable for retirees and disabled employees). Please note, you must show proof of other coverage to receive the cash payment with the no-coverage option.

## Comparing Your Options

The following table compares the main features of the three medical options available. See the following pages for more complete descriptions of covered services, including benefits for non-network expenses.

Although the types of services covered under the Consumer Choice Option are the same as Option 250 and Option 1000, the plans are structured differently. The Consumer Choice Option is referred to as a consumer-driven health plan. This option can be used in conjunction with the retiree medical plan described on page 59 to pay for medical expenses after you retire. The Consumer Choice Option is explained in more detail on page 35.

# Benefits at a Glance

| Feature | Consumer Choice Option | | Option 250 | | Option 1000 | |
|---|---|---|---|---|---|---|
| | Network* | Non-Network | Network* | Non-Network | Network* | Non-Network |
| Preventive Care | The plan pays 100% up to $500 per calendar year (no deductible) | The plan pays 60% | The plan pays 100% up to $500 per calendar year (no deductible) | The plan pays 60% | The plan pays 70% up to $500 per calendar year (no deductible) | The plan pays 50% |
| Primary Deductible | You pay:<br>$250 yourself<br>$500 yourself +1<br>$750 yourself + 2 | You pay:<br>$500 yourself<br>$1,000 yourself +1<br>$1,500 yourself + 2 | You pay:<br>$250 per person<br>$500 per family | You pay:<br>$500 per person<br>$1,000 per family | You pay:<br>$1,000 per person | You pay:<br>$2,000 per person |
| Employee Choice Account | The company provides<br>$750 yourself<br>$1,500 yourself +1<br>$2,250 yourself + 2 | | N/A | N/A | N/A | N/A |
| Secondary Deductible | You pay:<br>$350 yourself<br>$700 yourself +1<br>$1,050 yourself + 2 | You pay:<br>$700 yourself<br>$1,400 yourself +1<br>$2,100 yourself + 2 | N/A | N/A | N/A | N/A |
| Inpatient Hospital, Emergency Room and Other Medical Expenses** | The plan pays 80% | The plan pays 60% | The plan pays 80% | The plan pays 60% | The plan pays 70% | The plan pays 50% |
| Co-payment Maximum (the most you pay each year for your percentage share of covered charges) | $1,100 yourself<br>$1,350 yourself+1<br>$1,600 yourself+2<br>Excludes primary deductible, Employee Choice Account and secondary deductible | $2,200 yourself<br>$2,700 yourself+1<br>$3,200 yourself+2 | N/A | N/A | N/A | N/A |
| Out-of-Pocket Maximum (the most you pay out of your pocket each year for your deductibles and your share of covered expenses) | $1,700 yourself<br>$2,550 yourself+1<br>$3,400 yourself+2<br>Includes primary and secondary deductibles and copayment maximum | $3,400 yourself<br>$5,100 yourself+1<br>$6,800 yourself+2 | $1,500 per person<br>$3,000 per family | $3,000 per person<br>$6,000 per family | $4,500 per person<br>$9,000 per family | $9,000 per person<br>$18,000 per family |
| Lifetime Maximum Benefit | $1 million indexed annually for inflation (in 2007, limit is $2.4 million) | | $1 million indexed annually for inflation (in 2007, limit is $2.4 million) | | $1 million indexed annually for inflation (in 2007, limit is $2.4 million) | |

If emergency services meet the requirements of "urgent or emergency care" as defined by the plan, then the covered charges are treated as if they were from a network provider, whether you go to a network or non-network provider. All hospitalization and certain other types of care must be approved under the Blue Care® Connection program. Benefits may be reduced if you don't comply.

* If you or a covered dependent lives outside the network area, benefits will be paid at network rates. Your eligibility records must be adjusted, however, or all claims will be processed as out-of-network. Contact the Patriot Benefits Call Center at 1-800-633-9005 or e-mail benefits@**patriotcoal.com** for information and forms. ("Out-of-area" does not apply to prescription drugs.)

** Inpatient mental health and substance abuse benefits are limited to 30 days per calendar year and up to 60 days per lifetime. Outpatient mental health and substance abuse benefits are limited to 30 visits per calendar year and do not apply toward the out-of-pocket maximum. Emergency room copayment of $50 is required if care was not for a true emergency.

## Annual Deductible

The annual deductible is the amount of covered expenses you must pay for each covered individual each calendar year before the medical plan will pay benefits.

The annual deductible depends on the option you have chosen and whether your expenses are network or non-network. Deductibles are shown in the Benefits at a Glance chart on page 10. However, there are special features and exceptions:

- The deductible may be satisfied with a combination of network and non-network expenses.
- If two or more covered members of your family are injured in the same accident, you only have to meet one annual deductible for their combined covered expenses for that accident. (This does not apply to the Consumer Choice Option.)
- If you have covered expenses in the last three months of a calendar year that apply toward your deductible, they may be applied to the next year's deductible as well. (This does not apply to the Consumer Choice Option.)
- The deductible also applies to prescription drug coverage under Option 1000.
- No deductible applies to wellness benefits received from network providers, as explained under the "Wellness Benefits" section on page 18.

## Emergency Room Copayment

You will pay an additional $50 copayment for emergency room care that is not medically necessary for a true emergency or urgent situation, as defined by the plan. The copayment is in addition to the annual deductible.

## Out-of-Pocket Maximum

The out-of-pocket maximum provides additional protection for you by putting a cap on the amount you're required to pay in one calendar year for each person's covered expenses. The out-of-pocket maximum varies depending on the option you choose and whether your expenses are network or non-network.

For most types of care, you pay a percentage of the covered expenses (called copayments) after the deductible is met. If the amount you have paid in one year for one person's covered medical expenses reaches the out-of-pocket maximum amount shown in the network columns on the Benefits at a Glance chart (including the deductible and copayments), the plan will pay 100% of any additional covered network expenses incurred by that person for the rest of that year. If the amount you have paid in one year for one person's covered medical expenses reaches the out-of-pocket maximum amount shown in the non-network columns on the chart, the plan will pay 100% of any additional covered expenses (network and non-network) incurred by that person in that calendar year.

For all covered family members combined, the most you will pay out-of-pocket for covered expenses in one calendar year is the family maximum amount shown in the Benefits at a Glance chart on page 10.

The out-of-pocket maximum, however, does not apply to the following:

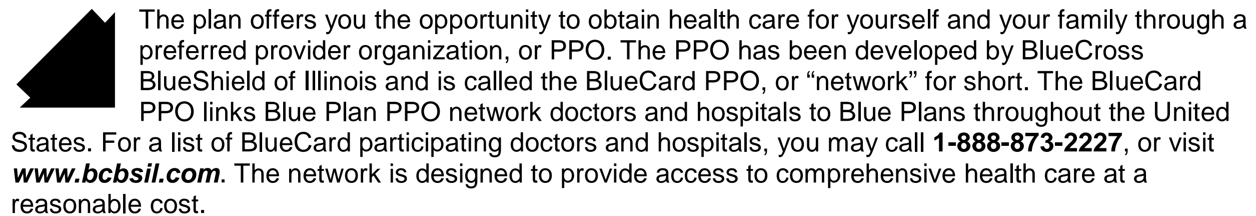
- Expenses that aren't covered by the medical plan.
- Penalties for not complying with the Blue Care® Connection program.
- Emergency room copayments.
- Expenses for prescription drugs under the Consumer Choice Option and Option 250.
- Expenses for outpatient mental illness and substance abuse.
- Expenses that exceed the plan's negotiated rates or other plan maximums.

## Lifetime Maximum Benefit

For all covered expenses, the medical plan pays a lifetime maximum of $1 million for each covered person, as of March 1, 1990. This amount is increased annually by the Health Cost Component of the Consumer Price Index. In 2007, the lifetime maximum is $2.4 million.

For hospice care expenses, there is a $10,000 lifetime maximum per individual. This amount is included in the $2.4 million lifetime maximum for all benefits.

# BlueCard Network



The plan offers you the opportunity to obtain health care for yourself and your family through a preferred provider organization, or PPO. The PPO has been developed by BlueCross BlueShield of Illinois and is called the BlueCard PPO, or “network” for short. The BlueCard PPO links Blue Plan PPO network doctors and hospitals to Blue Plans throughout the United States. For a list of BlueCard participating doctors and hospitals, you may call **1-888-873-2227**, or visit ***www.bcbsil.com***. The network is designed to provide access to comprehensive health care at a reasonable cost.

You aren’t required to use the network to get health care. In fact, the plan still pays benefits when you use non-network doctors and hospitals. But if you do use the network, there are several important advantages:

- If you use a network provider, your share of the cost is less. If you choose a non-network provider, you may pay more out of your own pocket for certain expenses.
- Because the providers who participate in the network have agreed to prearranged fees, you don’t have to worry about being charged more for your medical care than the negotiated rate approved by BlueCross BlueShield. When you get care outside the network and the fee is above what is usual, customary and reasonable, you will have to pay the difference.
- In most cases, you don’t have to fill out claim forms when you use the network. That saves you time and effort. Simply present your health plan ID card when you visit a network provider. Your claims will be filed automatically and BlueCross BlueShield will pay the benefits directly to the provider.

If you go to a network provider and are “balance billed”—meaning you are billed any additional amount beyond the deductible or copayments, or charged the difference between the full amount and the discounted network amount—please call BlueCross BlueShield of Illinois at **1-888-873-2227**. A BlueCross BlueShield representative will contact the provider.

## If You Have an Emergency

If you have an emergency, you should seek medical help immediately—within the network or from a non-network provider.

In either case, if you are admitted to a hospital, you or someone on your behalf must call Blue Care® Connection (BCC) within two working days of your admission, as described on page 13. If BCC is not notified, your benefits will be reduced.

If the emergency visit meets the requirements of “urgent or emergency care” as defined by the plan, then the covered charges are treated as if they were from a network provider, whether you go to a network or non-network provider.

## If You Need Care Your Network Doctor Can't Provide

If there is no network doctor who provides a certain type of service, you may be able to go to a non-network provider and have your covered expenses paid at network levels. To be eligible for this, you must call BlueCross BlueShield of Illinois at **1-888-873-2227**.

## Traveling in the United States

If you need emergency medical attention, go immediately to the nearest medical facility. Then follow standard emergency procedures. (See the "If You Have an Emergency" section on page 12.)

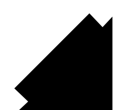
If you are traveling and you need non-emergency medical attention, call BlueCross BlueShield of Illinois at **1-888-873-2227**. The BlueCross BlueShield of Illinois representatives will direct you to a network provider in the area if one is available. If you do not use a network provider when one is available, any covered expenses you have will be paid at non-network levels.

## If You or a Dependent Lives Outside the Network Area

If you or a covered dependent lives outside the network area, benefits will be paid at network rates. Your eligibility records must be adjusted, or all claims will be processed as non-network. Contact the Patriot Benefits Call Center at **1-800-633-9005** for information and forms.

The plan itself does not furnish health care services; it only provides reimbursement for covered services received by covered individuals. For this reason, neither the company nor the claims administrator can guarantee the availability or quality of care, and neither is liable for any act or omission of any provider.

# Blue Care® Connection Program and Hospital Pre-Certification



The Blue Care® Connection (BCC) program is administered by BlueCross BlueShield of Illinois. The program is designed to help you and the company manage costs by reviewing, in advance, the health care services you receive. This allows BCC to "pre-certify" (authorize in advance as being medically necessary) certain types of care and make sure that it is medically necessary.

If you use a network provider, in most cases the provider will handle pre-certification for you. However, it's still ultimately your responsibility to pre-certify by calling BCC at 1-800-325-4705 before receiving care.

If you use a non-network provider, you or your provider must first call BCC.

If you don't call first, you must pay an additional $200 penalty for each procedure that's not pre-certified. This pre-certification penalty is in addition to your annual deductible and out-of-pocket maximum.

Also, if BCC determines that services are not medically necessary, the plan will not pay benefits for your expenses.

Pre-certification is required for all non-emergency hospitalizations and for these outpatient and extended care services:

- Home health care.
- Private-duty nursing.
- Hospice care.
- Skilled nursing facility care.

- Certain surgical procedures. (See "Surgical Charges" on page 19.)
- Residential treatment facilities.

The goal of the BCC program is to ensure that you receive the most appropriate, cost-effective, quality care for your condition.

## Pre-Certification for Inpatient Admissions

To request pre-certification, simply call the BCC pre-certification number given in the "How to Contact BCC" section on page 16. Registered professional nurses will carefully evaluate the proposed hospitalization. If the nurse determines that inpatient hospitalization does not meet the guidelines for medical necessity, a consulting physician will be asked to review the case and make a determination.

If you do not call BCC before you or a family member is admitted for an elective hospitalization, your covered hospital charges will be reduced by an additional $200. This amount does not count toward the annual deductible or your out-of-pocket maximum.

If the hospitalization is for an emergency, you do not have to notify BCC in advance, but must do so within two working days. Otherwise, the same $200 penalty will apply.

To be considered an emergency, the patient must be admitted for a condition or bodily injury that occurs suddenly and requires immediate care because of impending danger to the patient's life.

If BCC does not receive a call requesting pre-certification for inpatient care and later determines that the care was not medically necessary, the medical plan will not pay any charges related to the hospital admission. If BCC determines that the care should have been provided on an outpatient basis, BCC will allow the charges that would have been covered for outpatient care. Any inpatient-related charges, such as charges for room, board and physician visits, will not be eligible for benefits.

## Exceptions for Maternity Admissions

For an admission due to pregnancy, you should call BCC by the end of the third month of pregnancy. However, group health plans generally may not, under federal law, restrict benefits or require a provider to obtain authorization from the plan for prescribing a hospital length of stay in connection with childbirth for the mother or newborn child that does not exceed 48 hours for normal vaginal delivery or 96 hours for a cesarean section (as long as the patient is otherwise covered by the plan and eligible for benefits). The law does not prevent your physician from discharging the mother or newborn before 48 hours (or 96 hours), if after consultation with the mother it is determined that hospital confinement is no longer necessary. However, for inpatient care that continues beyond 48 hours (or 96 hours for a cesarean section), BCC must be notified before the end of this period.

For a non-emergency hospital confinement that is needed during pregnancy but before the admission for delivery, BCC must be notified before the scheduled admission date.

## If You Call for Pre-Certification but BCC Does Not Approve an Inpatient Stay

It might happen that you call to request pre-certification for inpatient care, but BCC determines that care can be received on an outpatient basis. If you receive inpatient care anyway, the plan will only cover those charges that would have been covered if the care had been provided on an outpatient basis.

## Pre-Certification of Outpatient and Extended Care Services

You must call BCC for approval of the outpatient services listed on page 13. You must pre-certify with BCC no later than one day before treatment starts. However, you should pre-certify as soon as you think you might need treatment. To request pre-certification, simply call the BCC pre-certification number given

in the “How to Contact Blue Care® Connection (BCC)” section on page 16. If you don’t call, you will pay an additional $200 for each procedure.

Also, no benefits are provided for these services unless they have been approved as medically necessary by BCC.

## Pre-Certification Alone Does Not Guarantee Coverage

The purpose of pre-certification is to make sure health care services are medically necessary—it is not a guarantee of benefits or payment.

When BCC approves your admission or outpatient care, this does not guarantee that the plan will provide benefits for your expenses. The nurses at BCC check to determine the medical need for an inpatient admission or other care, but they cannot verify each covered person’s benefits or coverage limitations before authorizing the care. This may affect your eligibility for benefits.

For example, the care could be for a cosmetic condition, and the plan may pay only limited benefits or none at all. BCC may not learn that the care was for a cosmetic condition until it later reviews the patient’s medical records. Therefore, please keep in mind that benefits cannot be determined until the patient’s medical records are received.

When you request pre-certification, in most cases your admission will be approved. However, sometimes the reviewing nurse may suggest a less costly alternative, such as having a surgical procedure performed on an outpatient basis or in an ambulatory surgical center.

The reviewer will also try to make sure you aren’t charged for a longer inpatient stay than is necessary, by:

- Suggesting that tests be performed on an outpatient basis before your inpatient admission.
- Discouraging a weekend admission (because much non-emergency testing and treatment is less likely to be performed over the weekend).
- Encouraging admission on the morning that surgery is to be performed.

## Recertification for Extending an Inpatient Stay

When BCC authorizes an inpatient admission, the reviewing nurse may assign the number of days that are commonly needed for inpatient care. If a physician believes it is medically necessary for you to receive inpatient care longer than originally authorized, you are responsible for obtaining approval for the additional days through BCC. (See the “How to Contact Blue Care® Connection (BCC)” section on page 16.)

## If You Do Not Call for Recertification

If BCC approves a specific length of stay, but you stay for a longer period without requesting approval for the additional days, your benefits may be reduced for the additional days you receive care.

- If BCC later determines that the additional days of care were medically necessary, eligible expenses will be covered by the plan.
- If BCC later determines that the additional days of care were not medically necessary, the plan will not provide any benefits for those days.

## If You Call for Recertification but BCC Does Not Approve Additional Days

If BCC receives a call requesting approval of additional days of care, and BCC determines that additional inpatient care is not medically necessary, the plan will not provide any benefits for the extra days.

## Concurrent Review

In many cases, BCC will review the medical necessity of an admission and the need for continued treatment while you are still hospitalized. This is called "concurrent review."

If it is determined that you no longer need inpatient care, BCC may recommend continued care in a less costly alternative setting such as a skilled-nursing facility or at home through a home health agency. BCC may determine that no medical necessity exists for inpatient or outpatient care.

In either case, BCC will issue a letter stating to you and the provider(s) that the current care is no longer necessary. You will be responsible for any charges you incur that begin the day after you receive the notification.

## Retrospective Review

BCC may perform reviews of certain inpatient and outpatient claims after they are paid. This is called a "retrospective review." Retrospective reviews are done to ensure care was medically necessary and to see if any unusual patterns exist in the treatment.

## Managed Second Surgical Opinion

To reduce the risk of unnecessary surgery, the medical plan offers a managed second surgical opinion program as an optional benefit. If your physician recommends surgery, you may call BCC to see whether a second opinion is recommended. BCC will confer with a consulting physician and make a recommendation. Expenses for a second or third surgical opinion are covered by the plan at the same level as other medical services. (See the Benefits at a Glance chart on page 10.)

## Individual Case Management

In many cases, patients suffering from catastrophic or long-term illness do not require continuous acute inpatient hospital care. In fact, such a patient can often benefit from receiving care in a more comfortable setting, including his or her own home. Skilled medical services provided in the home may be more cost-effective than an inpatient hospital stay—so care can be provided longer without depleting your benefits.

BCC can work with you, your physician, social workers and home health agencies, the hospital and your family to provide high-quality, cost-effective treatment options on a voluntary basis. This program of alternative treatment is called "individual case management."

Possible candidates for individual case management may be suggested by BlueCross BlueShield of Illinois, physicians, hospital-discharge planners, other providers of care or even by the patient's family.

To be considered eligible for individual case management, this company medical plan must be your primary coverage.

If the patient is eligible for individual case management and an appropriate alternative treatment plan is developed, the physician and the patient's family must agree to the plan in writing.

Individual case management can provide continued treatment in place of inpatient hospital care. It can also help hold down health care costs and preserve benefits. In some cases, alternative treatment may be provided outside of the plan's standard benefit coverage.

## How to Contact Blue Care® Connection (BCC)

When you need to contact Blue Care® Connection, please call 1-800-325-4705.

If you're calling to request pre-certification, be sure to have the following information:

- Your identification number (from your health plan ID card).

- The name and phone number of the admitting physician.
- The date of admission.
- The name of the hospital or treatment facility.
- The reason for the admission, and how long the doctor expects you to be an inpatient.

If necessary, a professional registered nurse at BCC will contact your physician or hospital to obtain more specific information about your condition.

If possible, the reviewing nurse will give your physician or hospital a verbal decision immediately. However, if the nurse determines the admission is not medically necessary, BCC will ask a consulting physician to review the case. After this consulting physician makes a decision, BCC will notify your physician or treatment facility immediately and send you a letter informing you whether the admission has been approved.

## If You Disagree with BCC's Decision

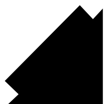
If you or your physician disagrees with any decision made by BCC, an appeal may be submitted in writing within 180 days to:

Blue Care Connection
P.O. Box 1220
Chicago, IL 60690-1220

To file an appeal, you should follow the guidelines outlined in your denial letter, Explanation of Benefits, or other correspondence from BlueCross BlueShield of Illinois. Please refer to page 80 for a complete discussion of your rights to appeal any BCC decision.

The Blue Care® Connection program offers you guidance to help coordinate care. It supports you in obtaining the right treatment in the right setting. BCC also provides educational assistance with health problems or questions. BCC helps you become a wise consumer of health care.

# Blue Access for Members



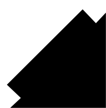
The following information is available to you by logging on to *www.bcbsil.com* and creating an account. You can access the following information:

- Check the status of a claim.
- Confirm your coverage and dependent coverage.
- Receive an e-mail when a claim is finalized.
- Choose to stop receiving paper claim statements.
- Find a doctor or hospital in the network.
- Get information about your health care benefit plan.

You will also find health and wellness information from the Mayo Clinic including:

- Self-management tools to help with low back pain, headaches and other common health problems.
- Interactive tools to help you lose weight, quit smoking and start exercising.
- Information to help you understand medical treatments.

# Covered Medical Expenses



The medical plan will pay benefits only for the services and supplies listed in the following sections. These services and supplies must be prescribed or performed by a physician and, except for wellness benefits, must be for the medically necessary treatment of a non-occupational illness, injury or pregnancy.

The plan provides benefits only for covered expenses that do not exceed the charges negotiated for the BlueCross BlueShield network. Participating providers agree to accept these rates and will not bill you for covered expenses other than the deductible, copayment and your percentage share of expenses. For a non-participating provider, you must pay any amounts that exceed the BlueCross BlueShield negotiated rates in addition to the deductible, copayment and your percentage share of covered expenses.

## Wellness Benefits

The plan provides benefits for certain wellness and preventive care services. For the Consumer Choice Option and Option 250, when the care is received from a network provider, the plan will pay 100% of covered wellness expenses up to $500 per person per calendar year with no deductible. For Option 1000, the plan pays 70% of covered wellness services with no deductible, up to $500 per person per calendar year. For all three options, covered expenses in excess of the $500 annual maximum and covered wellness charges by non-network providers will be subject to the deductible and considered under the benefits or other medical expenses shown on the chart on page 10.

Covered wellness expenses include:

- Routine well-child care for newborns and children under age 6, including routine immunizations.
- Routine physician examinations, except for examinations required for admission to a school or for participation in sports.
- The following routine pediatric immunizations for children up to age 18 as recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices:
  - Hepatitis B.
  - Diphtheria, tetanus, pertussis.
  - *Haemophilus Influenzae* type b.
  - Inactivated polio virus.
  - Measles, mumps, rubella.
  - Varicella.
  - Meningococcal.
  - Pneumococcal.
  - Influenza.
  - Hepatitis A.
  - Rotavirus.
  - HPV (females age 9 through 18).
- The following routine immunizations for individuals ages 19 and older as recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices:
  - Varicella.
  - Influenza.
  - Pneumococcal.
  - Hepatitis A.
  - Hepatitis B.
  - Meningococcal.
  - HPV (females up to age 26).
  - Diphtheria, tetanus, pertussis.

    - Shingles.
    - Measles, mumps, rubella.
- Pap tests, mammograms, screenings for hypertension and diabetes, and examinations for cancer, blindness and deafness, and other screening and diagnostic procedures.

Note that these wellness benefits can be provided only for charges your physician identifies as routine. Services for which a diagnosis is provided or symptom indicated will be paid in accordance with regular plan benefits.

## Hospital Charges

Covered expenses include the following inpatient and outpatient hospital charges. For an inpatient hospital stay, BCC must approve the hospitalization, as explained on page 14.

- Room and board expenses in a semiprivate room, including expenses for intensive care or coronary care units. The cost of a private room may be eligible if medically necessary.
- Special diets.
- General nursing care.
- Use of operating, delivery, recovery and treatment rooms and equipment.
- Emergency room services.
- All FDA-approved and appropriately prescribed drugs and medicines for use in the hospital, and covered drugs or medicines sent home following hospitalization, up to a 30-day supply.
- Dressings, ordinary splints and casts.
- X-ray examinations, X-ray therapy and radiation therapy and treatment.
- Laboratory tests.
- Physical therapy.
- Anesthesia and its administration.
- Blood and blood derivatives, to the extent they are not donated without charge or the hospital's supply are not replaced by or for the patient.
- Processing and administering of blood and blood plasma to the extent it is not donated by the patient.
- Chemotherapy.
- Renal dialysis therapy administered according to Medicare regulations.
- Dental care due to accidental bodily injury or oral dental surgery when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition.

## Surgical Charges

Covered expenses include the following surgical services:

- Surgical procedures, including customary pre-operative and post-operative services, performed by a physician or surgeon. (Voluntary sterilization surgery is covered but reversal of sterilization surgery is not.)
- The necessary services of an assistant surgeon who actively assists the physician in surgery when:
    - You or your covered dependent is hospitalized.
    - The type of surgery requires assistance as determined by BCC.
    - The services of interns, residents or other post-graduate medical personnel are not available.

  - Payment for assistant surgeons will be at 25% of the primary surgeon's negotiated rate or if services are provided by a non-network physician, the usual and customary rate.

- Medical supplies required for surgery in a hospital, a hospital's outpatient department, a physician's office or a freestanding ambulatory surgical facility.

- Administration of anesthesia when administered by a certified nurse anesthetist or a physician other than the surgeon or assistant surgeon.

- When more than one surgical procedure is performed at the same operative session and through the same incision, payment for the secondary procedures will be limited to 50% of the BlueCross BlueShield negotiated rate that would apply if the procedures were performed independently. However, additional charges for "incidental surgery" are not covered. Incidental surgery is a procedure that is usually included in the primary surgery charge.

- Oral dental surgery due to an accident or alveolectomy.

- Surgical benefits for the following procedures may be covered, subject to prior approval by BCC:

  - Surgery for treatment of temporomandibular joint dysfunction (TMJ) if necessary to reorient the joint.
  - Reduction mammoplasty, if medically necessary (not cosmetic).
  - Obesity, if you or your covered dependent meets the medical necessity criteria as determined by BCC, and BCC has given prior authorization for the surgery.
  - Human organ or tissue transplants for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney as follows:
    - If both the donor and recipient have coverage, each will have their benefits paid by their own program.
    - If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, coverage will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
    - If you are the donor for the transplant and no coverage is available to you from any other source, coverage will be provided for you. However, no benefits will be provided for the recipient.
    - Coverage will be provided for inpatient and outpatient covered services related to the transplant surgery; the evaluation, preparation and delivery of the donor organ; the removal of the organ from the donor; the transportation of the donor organ to the location of the transplant surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

- Cosmetic or reconstructive surgery required for:

  - Repair of defects resulting from an accident.
  - Following a mastectomy, reconstruction of the affected breast and reconstruction of the other breast to create a symmetrical appearance, including services required as a result of complications.
  - Replacement of diseased tissue that was surgically removed.
  - Treatment of a birth defect.

  The surgery must be performed within 12 months following the date of the accident, removal of diseased tissue or birth, or if surgery must be delayed because of the patient's physical condition, it is performed as soon as medically necessary and appropriate based on the patient's physical condition.

## Important Information About Coverage for Reconstructive Surgery Following Mastectomies

Under federal law, group health plans that provide medical and surgical benefits for mastectomies must also provide coverage for the following services, which are to be provided in a manner determined in consultation with the attending physician and the patient:

- Reconstruction of the breast on which the mastectomy has been performed.

- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

- Prostheses and physical complications in all stages of the mastectomy, including lymphedemas.

As with other covered services, the usual deductibles, copayments or percentage share of expense you are required to pay will apply.

## Home Health Care

Covered expenses include home health care if approved in advance through BCC. (See the “How to Contact Blue Care® Connection (BCC)” section on page 16.) The home health care must be a necessary alternative to hospitalization.

Eligible expenses from an authorized home health care agency include:

- Part-time or intermittent nursing services.
- Physical, occupational or speech therapy.
- Medical and surgical supplies that would also be covered as a hospital inpatient expense.
- Prescription drugs for IV infusion therapy or injections.

However, the following coverage limitations apply:

- The home health care must be provided according to a plan of treatment established by the patient’s physician and approved through BCC.
- The patient must be homebound for health reasons, but the patient may leave home occasionally to obtain outpatient hospital care that cannot be provided at home, or to obtain care from a licensed health care professional.

Benefits for home health care are not provided for:

- Private-duty nursing.
- Dietary services or food.
- Homemaker services (housecleaning, preparation of meals, etc.).
- Convalescent, custodial, maintenance or domiciliary care.
- Purchase or rental of dialysis equipment except for peritoneal dialysis if approved by BCC.
- Care for mental illness, alcoholism or drug addiction.

## Hospice Care

Hospice care means care that relieves pain and meets the basic life-supporting needs of a covered person who is terminally ill and has a life expectancy of six months or less. The purpose of the service is to provide care for the patient without attempting to prolong his or her life.

A hospice provider is a hospital, home health care agency or other provider that may legally provide hospice care.

The following special limitations apply to hospice care:

- All hospice care benefits are limited to a lifetime maximum of $10,000.
- The care must be provided according to a physician’s written treatment plan that has been approved in advance by BCC. (See the “How to Contact Blue Care® Connection (BCC)” section on page 16.)
- Counseling for the family is covered up to a maximum of $200.

Benefits for hospice care are not provided for:

- Care given by volunteers who do not usually charge for their services.

- Pastoral services.
- Homemaker services (housecleaning, preparation of meals, etc.).
- Food or home-delivered meals.
- Care to prolong life.
- Expenses incurred by family members for temporary relief away from the patient (respite care).
- Funeral expenses.

## Skilled Nursing Facility

Covered expenses include care from an approved skilled-nursing facility, subject to the following limitations:

- The care must be provided according to a physician's treatment plan and approved in advance by BCC. (See "How to Contact Blue Care® Connection (BCC)" section on page16.)
- The care must likely result in a significant improvement in the patient's condition. (Custodial care is not covered.)
- The degree of care must be more than can be given in the patient's home, but not so much as to require acute hospitalization.

## Other Medical Services

The following expenses are eligible for benefits:

- Expenses you incur at your home, a hospital, a clinic or your physician's office for the professional services of a physician or surgeon, including consultations by a qualified specialist.
- Expenses you incur for the services of a physician's assistant or nurse practitioner.
- Expenses incurred for the services of a registered nurse (RN) or licensed practical nurse (LPN), when the skills of an RN or LPN are required.
- The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye.
- The fitting of diaphragms or the insertion or removal of an IUD.
- Artificial insemination, when medically diagnosed as an appropriate treatment for infertility. However, the plan will cover artificial insemination for only one of the following, after which the plan will no longer pay benefits:
  - No more than three times within three consecutive cycles.
  - No more than a total of four attempts within a six-month period.

  In vitro fertilization and gamete-transfer procedures are not covered.
- Laboratory tests, radium therapy, X-rays and microscopic tests including the services of radiologist or pathologist.
- Diabetes education, limited to one per lifetime.
- Diabetic supplies, including insulin.
- Services by a licensed chiropractor, limited to $1,000 per calendar year. Care will be reviewed for medical necessity after 20 visits.
- Professional local ambulance services for transportation to a clinic, medical center, hospital, physician's office or skilled-nursing facility, when medically necessary.
- Air ambulance charges are also covered for:

    - Medically necessary transportation from a remote area to the first, nearest hospital where treatment can be given.
    - Transportation to a hospital in the event of a life-threatening accidental injury or sudden, life-threatening illness.

- Prosthetic appliances to replace missing or nonfunctioning parts of the body. Covered prosthetic appliances include:

    - Breast prostheses, internal and external (including two surgical brassieres per year), for reconstruction after a mastectomy.
    - Cardiac pacemakers, atomic or electronic.
    - Extraocular and intraocular lenses to replace either surgically removed or congenitally absent crystalline lenses of the eye.
    - Penile prostheses in men suffering impotency resulting from an organic disease or injury.
    - Artificial eyes.
    - Artificial limbs.
    - Colostomy supplies and other equipment directly related to ostomy care.
    - Electronic speech aids after a laryngectomy.
    - Urinary collection and retention systems (Foley catheters, tubes, bags and so forth) in cases of permanent urinary incontinence.

  Coverage also includes supplies needed to effectively use a covered prosthesis (for example, batteries for an artificial larynx or stump socks needed to use on an artificial limb), as well as adjustments, repairs and replacement of the device.

  Covered expenses for an electronic prosthetic limb are limited to the cost allowed for a covered standard mechanical prosthesis to replace the same body part.

- Orthopedic devices, including:

    - Braces and trusses.
    - Custom-made and molded supportive orthotic appliances for the feet, when prescribed by a physician.
    - Custom-made shoes when prescribed by a physician.
    - Up to two pairs of surgical stockings per prescription in a six-month period, when prescribed by a medical physician for such conditions as thrombophlebitis or conditions resulting from surgery.

- Rental of durable medical equipment for home use, up to its purchase price. In some cases, BCC may instead approve the outright purchase of the equipment if it is for long-term use.

- Home oxygen equipment, including stationary and portable oxygen systems, will be eligible for coverage according to Medicare guidelines up to the purchase price.

- Services of an inhalation therapist in the patient's home, under the orders of the attending physician.

- Physical therapy by a licensed physical therapist that is expected to produce significant improvement within a two-month period. Benefits will no longer be paid when care has become maintenance. When the therapeutic goals of the treatment plan have been achieved and/or when no more measurable progress is expected, benefits will cease. Physical therapy coverage for temporomandibular joint syndrome (TMJ) follows the same guidelines.

- Speech therapy, by a licensed speech therapist, to restore speech that has been impaired as a result of illness, surgery or injury. Speech therapy will also be covered after surgery to correct birth defects. Developmental delays in learning to talk, the perfection of speech and educational services are not covered.

- Occupational therapy for a physical or severe mental disability to restore the ability to perform ordinary tasks of daily living. Benefits will end when the therapeutic goals of a treatment plan have been achieved or when no more measurable progress is expected. Occupational therapy is not covered for most mental and chemical-dependency conditions.

- Cardiac rehabilitation to restore health as much as possible, through exercise, education of the patient and reducing risk factors. To be eligible for benefits, cardiac rehabilitation must be provided within 12 months after one of the following:
  - An acute myocardial infarction (heart attack).
  - Coronary bypass surgery.
  - Stable angina pectoris (heart-related chest pains).
- Biofeedback therapy, when reasonable and necessary for muscle re-education of specific muscle groups or for treating specific muscle abnormalities. This is not covered for treatment of ordinary muscle tension or for psychosomatic conditions.
- Treatment of temporomandibular joint syndrome (TMJ) to realign the joint, and removable appliances and splints when medically necessary. Services or supplies in connection with crowning, wiring or repositioning the teeth, such as orthodontia, are not covered.
- Dental care for the initial repair of an accidental injury to sound natural teeth only if the services are received within 12 months after the date of the accident.
- Services of a Navajo medicine man who is certified by the office of Native Healing Services and the Navajo Health Authority, or the services of a Northern Cheyenne or Crow medicine man, up to $400 per covered individual per calendar year.

## Pregnancy

Necessary treatment of pregnancy is covered in the same way as an illness or injury for you or (if covered) your spouse with the following exceptions:

- The pre-existing conditions limitation does not apply to pregnancy.
- Pre-certification is not required for a hospital stay that does not exceed 48 hours for a normal delivery or 96 hours for a cesarean section (see the "Blue Care® Connection Program and Hospital Pre-certification" section on page 13 for more information).

Termination of a pregnancy is covered when necessary to save the life of the mother.

Charges incurred by a newborn child for the hospital nursery and physician visits while both the mother and the child are in the hospital will be paid as part of the mother's claim. The baby's other charges will be subject to the annual deductible and all other plan provisions.

No benefits are provided for the pregnancy of a dependent child.

## Maternity Stays

Federal law requires medical plans to cover maternity hospital stays of at least 48 hours for the normal delivery of a baby, and at least 96 hours for a cesarean section. This coverage applies to both the mother and the newborn.

Of course, mothers may go home sooner if they choose, their doctors approve, and it is safe to do so.

## Mental Illness and Substance Abuse

After you meet the annual deductible, the medical plan pays the following benefits for covered mental illness and substance abuse expenses described in this section.

**Inpatient Mental Illness and Substance Abuse**

The medical plan covers inpatient mental illness and substance abuse programs for up to 30 days per individual per year, not to exceed 60 days per lifetime. After the annual deductible is met, covered expenses are paid at the level shown for inpatient hospital expenses in the Benefits at a Glance chart on

page 10. Also, the inpatient care must be approved by the Blue Care® Connection program, as explained on page 14.

**Outpatient Mental Illness and Substance Abuse**

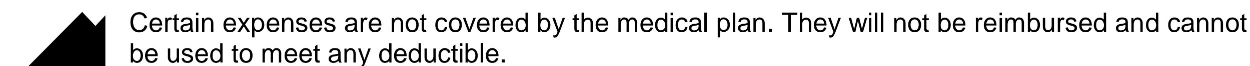
The plan covers outpatient treatment of mental illness and substance abuse for up to 30 visits per calendar year. After you've met the annual deductible, covered expenses are paid at the level shown for other medical expenses in the Benefits at a Glance chart on page 10. Your share of these expenses does not count toward the out-of-pocket maximum.

**Covered Services**

- Treatment by a registered psychologist, psychiatrist or licensed social worker who is under the supervision of a psychiatrist or psychologist.
- Psychotherapy, psychological testing, counseling, group therapy and Medicare-approved alcoholism or drug rehabilitation programs that are medically necessary, if sources of free care are not available.
- Treatment for alcoholism and drug abuse for emergency detoxification or any medical treatment required following detoxification.

Drugs and medicines requiring the written prescription of a physician and dispensed by a licensed pharmacist will be covered under the prescription drug benefit, and are not subject to the limitations that apply to other treatment of mental illness and substance abuse.

# Exclusions



Certain expenses are not covered by the medical plan. They will not be reimbursed and cannot be used to meet any deductible.

The medical plan does not pay benefits for any of the following:

- Convalescent care, custodial, domiciliary or sanitarium care or rest cures.
- Travel expenses.
- Expenses for any services you have no legal obligation to pay or for which no charge would be made if you had no medical coverage.
- Expenses in excess of the rates negotiated by BlueCross BlueShield for network providers.
- Expenses for the plan's penalties for failure to pre-certify a hospital admission or for hospitalizations that exceed the length of stay approved by the Blue Care® Connection program.
- Institutional care when the covered individual does not have to be an inpatient to receive medically effective care.
- Services or supplies in connection with treatment that the claims administrator determines to be experimental or investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational if any of the following applies:
  - There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.
  - When required by the FDA, approval has not been granted for marketing.
  - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.
  - The written protocol or written informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

However, this exclusion will not apply if the claims administrator determines that both of the following apply:

- The disease can reasonably be expected to cause death within one year in the absence of effective treatment, and all other, more conventional methods of treatment have been exhausted.
- The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the claims administrator will take into account the results of a review by a panel of independent medical professionals, selected by the claims administrator.

Final decisions regarding coverage will be at the sole discretion of the plan administrator.

- Any expenses that are not medically necessary for the treatment of an illness or injury (except as described for wellness benefits under the "Covered Medical Expenses" section on page 18).
- Procedures that are not needed when performed with other procedures or that are unlikely to provide a physician with additional information when used repeatedly.
- Any services provided before the effective date of coverage or after coverage ends.
- Services in connection with transsexual surgery.
- Accidental bodily injury or illness caused by war or any act of war, whether or not declared, including armed aggression, participation in a riot or attempted felony or assault.
- Accidental bodily injury or illness that is covered by any workers' compensation or occupational disease law.
- Except as required by law, expenses from a U.S. government hospital or any other hospital operated by a government unit, unless there is an expense that the covered individual is legally required to pay.
- Services in connection with any treatment of the teeth, gums or alveolar process, except:
  - Dental care for the initial repair of an accidental injury to sound natural teeth provided the care is received within 12 months following the date of the accident.
  - Hospital expenses when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition.
- Surgery for the purpose of fitting or wearing dentures or dental implants.
- Any medical observation or diagnostic study that is not medically necessary. This limitation does not apply to wellness benefits listed under the "Covered Medical Expenses" section on page 18.
- Hearing aids or their prescription or fitting.
- Vision training, eyeglasses and contact lenses or examinations for their prescription or fitting, except:
  - The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye.
  - Contact lenses, as long as the contacts are for the replacement of the eye's lenses.
  - Vision training following eye surgery.

  See your vision care summary plan description to see how vision exams, contact lenses and eyeglasses are covered by the optional vision plan.
- Eye surgery for a condition that could be corrected with lenses instead, including, but not limited to, radial keratotomy, Lasik and PRK—unless it's the plan administrator's opinion that no other treatment is medically acceptable and the plan administrator determines that the surgery is a generally approved procedure in the medical community as a whole.
- Physical and speech therapy that is educational in nature.
- Supervised exercise programs that are not traditionally medical in nature, such as swimming, horseback riding, etc.
- Cosmetic treatment, except:

  - To repair defects resulting from an accident.
  - Replacement of diseased tissue that was surgically removed.
  - Treatment of a birth defect.
  - Following a mastectomy covered by the plan, reconstruction of the affected breast and reconstruction of the other breast to create a symmetrical appearance, including services required as a result of complications.

  The surgery must be performed within 12 months following the date of the accident, removal of diseased tissue or birth, or if surgery must be delayed because of the patient's physical condition, it is performed as soon as medically necessary and appropriate based on the patient's physical condition.

- Actual or attempted impregnation or fertilization that involves the covered individual as a surrogate or donor, or the pregnancy of a surrogate mother.
- Expenses in connection with assisted reproductive technology or "ART." ART means any combination of chemical or mechanical means of obtaining gametes and placing them in a medium (whether internal or external to the human body) to improve the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer or pronuclear state tubal transfer. Artificial insemination is covered by the plan, subject to the limitations described under the "Covered Medical Expenses" section on page 18.
- Expenses for reversals of sterilization procedures.
- Home obstetrical delivery.
- Expenses for abortion, unless medically necessary to save the life of the mother.
- Charges for more than one ultrasound test for a normal, uncomplicated pregnancy.
- Adoption expenses.
- Charges incurred as a result of a pregnancy of a dependent child.
- Hypnosis and acupuncture.
- Naturopathic or holistic services.
- Massage therapy or rolfing.
- Treatment, instructions or activities for control or reduction of weight, except medical treatment approved by BCC or surgery for morbid obesity as described under the "Surgical Charges" section on page 19.
- Expenses for telephone conversations with a physician in the place of an office visit, for writing a prescription or for medical summaries and preparing medical invoices.
- Marriage counseling, encounter or self-improvement group therapy and school-related behavioral problems.
- Treatment received from a person who is your close relative or ordinarily resides with the patient. A "close relative" means you, your spouse or a person related to you or your spouse as a brother, sister or parent.
- Any care that does not require the services of a specifically trained medical professional.
- Routine foot care, including, but not limited to, treatment of corns and calluses, and non-surgical treatment of bunions.
- Expenses for an autopsy or postmortem surgery.
- Transportation for delivery of home health care.
- Dentures, replacement of teeth or structures directly supporting teeth.
- Electrical continence aids, anal or urethral.

- Wigs or hairpieces.
- Implants for cosmetic purposes.
- Penile prostheses for psychogenic impotence.
- Personal comfort or service items for use during confinement in a hospital, including, but not limited to, a radio, television, telephone and guest meals.
- Services or supplies not specifically listed under the “Covered Medical Expenses” section on page 18 including, but not limited to:
  - Air conditioners, humidifiers, dehumidifiers, purifiers or tanning booths.
  - Over-the-counter orthopedic or corrective shoes.
  - Exercise equipment.
- Medical care, services or supplies for any injury that may have been caused by the act or omission of a third party, unless the covered individual has fully complied with the plan’s subrogation provision. (See “The Plan’s Right to Recover Payment from Third Parties and Subrogation” section on page 51.)
- Services or supplies related to a pre-existing condition, as explained in the “Limitations for Pre-Existing Conditions” section on page 8.
- Claims received more than 12 months after the date the services or supplies were received.

The plan reserves the right to limit or exclude expenses for other services or supplies.

# Prescription Drug Benefits

The table below shows what the various plans pay toward the cost of prescription drugs. The Consumer Choice Option and Option 250 both have the same prescription drug coverage. If you choose the Consumer Choice Option, you cannot use your Employee Choice Account to pay for prescription drugs. Under both the Consumer Choice Option and Option 250, your copayments do not count toward the annual deductible or the out-of-pocket maximum.

| | Consumer Choice Option | | Option 250 | | Option 1000 | |
|---|---|---|---|---|---|---|
| | Network | Non-Network | Network | Non-Network | Network | Non-Network |
| | Paid Through Prescription Solutions (no deductible or out-of-pocket maximum | | Paid Through Prescription Solutions (no deductible or out-of-pocket maximum) | | Paid Through BlueCross BlueShield of Illinois (1) (annual deductible and out-of-pocket maximum apply) | |
| Retail Generic Drugs (30-day supply) | 85% (2)(4) $10 minimum copay | 70% (2)(4) $10 minimum copay | 85% $10 minimum copay | 70% $10 minimum copay | 70% after deductible | |
| Retail Preferred Brand-Name Drugs (4) (30-day supply) | 70% (2)(3)(4) $20 minimum copay $75 maximum | 60% (2)(3)(4) $20 minimum copay $100 maximum | 85% (3) $20 minimum copay $80 maximum | 70%(3) $20 minimum copay $105 maximum | 70% after deductible | |
| Retail Non-Preferred Brand-Name Drugs (30-day supply) | 50% (2)(3)(4) $40 minimum copay $150 maximum | 40% (2)(3)(4) $40 minimum copay $200 maximum | 70% (3) $30 minimum copay $120 maximum | 60%(3) $30 minimum copay $170 maximum | 70% after deductible | |
| Mail Service Pharmacy Generic Drugs (up to a 90-day supply) | 85%(4) $10 minimum copay | N/A | 85% $20 minimum copay | N/A | N/A | |
| Mail Service Pharmacy Preferred Brand Name Drugs (up to a 90-day supply) | 70% (3)(4) $50 minimum copay $200 maximum | N/A | 85% (3) $40 minimum copay $160 maximum | N/A | N/A | |
| Mail Service Pharmacy Non-Preferred Brand-Name Drugs (up to a 90-day supply) | 50% (3)(4) $100 minimum copay $400 maximum | N/A | 70% (3) $60 minimum copay $240 maximum | N/A | N/A | |

(1) If your prescriptions are filled at a participating BlueScript pharmacy, you will receive discounts, and the pharmacy will file your claims for you. After you meet your annual deductible, BlueCross BlueShield of Illinois will reimburse 70% of the cost of each prescription for the rest of the calendar year (or 100% after you have met the annual out-of-pocket maximum). If you use a non-participating provider, you receive the same level of benefits, but you must file a claim for reimbursement with BlueCross BlueShield of Illinois.

(2) If you receive a maintenance drug from a retail pharmacy instead of using the Prescription Solutions Mail Service pharmacy, you will pay a $10 surcharge in addition to your regular percentage of the cost.

(3) If you or your doctor requests a brand-name drug when a generic equivalent is available, you will pay the generic copayment plus the difference in cost.

(4) Minimum and maximum copays will be indexed for annual Patriot prescription drug inflation.

## Participating Provider Pharmacy Program

Prescription drug benefits under the Consumer Choice Option and Option 250 are administered by Prescription Solutions. Persons covered by the Consumer Choice Option or Option 250 will receive discounts from retail pharmacies that participate in the Prescription Solutions retail pharmacy network. In addition to the discounts, the Consumer Choice Option and Option 250 pay higher benefits for prescriptions purchased from a Prescription Solutions participating pharmacy, and you generally do not have to file a claim.

If you purchase prescriptions from a pharmacy that is not a member of the network, you will have to pay the full cost of the drug up front and file a claim for reimbursement through Prescription Solutions.

If you are enrolled in Option 1000, prescription drugs are covered in the same way as other medical expenses and will be processed by BlueCross BlueShield of Illinois. Pharmacies participating in the BlueScript program will provide discounts and will file your claim for reimbursement from BlueCross BlueShield of Illinois.

## Consumer Choice Option and Option 250 Prescription Drug Benefits

The following section explains the provisions of the prescription drug coverage for the Consumer Choice Option and Option 250. Option 1000 prescription drug benefits are described on page 33.

You can access much of the information about your plan by creating an account at ***www.rxsolutions.com***. You will need your Prescription Solutions insurance card number as well as your date of birth. You will then be asked to create a username as well as a password.

### Generic Substitution

When you have a prescription filled, the copayment you pay is based on whether you receive a generic, preferred brand or non-preferred brand-name drug. You will pay the lowest amount for generic drugs. Generic drugs have the same chemical make-up and produce the same effect on the body as their brand-name equivalents, but they usually cost less. If you or your physician requests a brand-name drug when a generic is available, you will pay the difference in cost, in addition to your regular generic copayment.

### Brand-Name

Brand-name drugs are divided into two categories: “preferred brand” and “non-preferred brand.”

- Preferred brand-name drugs are those that appear on the plan’s preferred drug list. Your copayment for a preferred brand-name will be higher than a generic, but lower than a non-preferred brand-name.
- Non-preferred brand-name drugs are those for which there are less expensive but effective alternatives. These drugs, therefore, have the highest copayment. The drug you choose is up to you and your doctor, but your costs and the company’s costs will be higher if you use non-preferred brand-name drugs.

*The preferred drug list may change from time to time due to new drugs coming on the market, older drugs becoming available in generic form, etc. Log on to your account at* ***www.rxsolutions.com*** *for an up-to-date list. (Click on the Health Tools tab.)*

### Using Prescription Solutions Network Pharmacies

Pharmacies participating in the Prescription Solutions network have agreed to provide discounts for participants in the Consumer Choice Option and Option 250. When you fill a prescription at a network pharmacy, the plan will pay the benefits as shown in the chart on page 29 for up to a 30-day supply of each prescription. Note that you will be required to pay the minimum copayment shown on the chart or a percentage of the cost, whichever is greater. For example, if you have chosen Option 250, you will pay the greater of $10 (the minimum copayment) or 15% of the cost for a 30-day supply of a generic drug. If the actual charge for the drug is less than the minimum copayment, you will pay the full cost of the drug.

You will also pay the difference in cost if you or your physician requests a brand-name drug when a generic equivalent is available.

In general, you will not have to file a claim when using a network pharmacy. With the Consumer Choice Option and Option 250, the network pharmacy will usually file the claim directly with the plan for reimbursement. Simply show your prescription plan ID card to the pharmacist, and you will pay only your percentage share of the cost or copayment that applies to the discounted price for the drug.

To locate a network pharmacy near you, contact Prescription Solutions at **1-888-306-3243** or log on to your account at ***www.rxsolutions.com.*** (Click on the Drugstore tab.) To access the 800 number, you will need to enter your Prescription Solutions member number from your prescription plan ID card.

**Non-Network Pharmacies**

If you purchase prescriptions from a pharmacy that is not a member of the network, you will have to pay the full cost of the drug up front and file a claim for reimbursement through Prescription Solutions.

The plan will pay the benefits as shown in the chart on page 29 for up to a 30-day supply of each prescription. The discussion in the previous section regarding the minimum copayment and generic drug substitution also applies to prescriptions filled at a non-network pharmacy.

You can obtain prescription drug claim forms by logging on to your account at ***www.rxsolutions.com.*** (Click on the Help Topics tab and select Most Used Forms.) You may also call Prescription Solutions at **1-888-306-3243**.

**Mail Service**

If you have enrolled in the Consumer Choice Option or Option 250, you may use the Prescription Solutions Mail Service Pharmacy for prescription drugs. These would normally be medications you take for periods of 30 days or longer for chronic health conditions such as diabetes, asthma, arthritis, high blood pressure and heart disease.

Using the mail service allows you to receive up to a 90-day supply of your maintenance medication for a percentage of the cost or a minimum copayment, whichever is greater. If the actual charge for the medication is less than the minimum copayment, you will pay the full cost of the medication. Copayments are shown in the chart on page 29.

To use the mail service program, you should ask your physician to write a prescription for up to a 90-day supply of your maintenance drug. Complete the order form; then mail the prescription, order form and your payment in the pre-addressed envelope. You may obtain an order form and instructions by logging on to your account at ***www.rxsolutions.com.*** (Click on the Drugstore tab and select Order a New Prescription.) You may also call Prescription Solutions at **1-888-306-3243**. Or ask your doctor to call that number for instructions on how to fax the prescription.

Like the retail program, if a brand-name drug is dispensed when a generic drug is available, you will be required to pay the generic copayment plus the difference in cost between the generic and brand-name drug. Also, you will pay more for a non-preferred brand-name drug than a preferred brand-name drug.

Your prescription will be reviewed by a pharmacist, checked for adverse drug interactions, and verified by quality-control personnel before it is sent to your home by first-class mail or UPS. You should allow 14 days from the date you mail your order for delivery, although you may pay an additional charge if overnight delivery is requested. Overnight delivery charges are not covered by the plan. If you need medication immediately, ask your physician to write two prescriptions, one for a 30-day supply and the other for a 90-day supply. Take the first 30-day prescription to a local network retail pharmacy for medication for your immediate use until your first mail order arrives.

After your initial order, you can request a refill of the same prescription by logging on to your account at ***www.rxsolutions.com.*** (Click on the Drugstore tab and select Refill a Prescription.) You may also call **1-888-306-3243**. To use this service, you'll need your Prescription Solutions member number from your prescription plan ID card and your credit card number.

**Maintenance Medications**

For certain maintenance medications (drugs prescribed for periods of 30-days or longer for chronic conditions) you will be required to pay a $10 surcharge in addition to your regular copayment if you do not use the Prescription Solutions Mail Service Pharmacy to obtain your medications. This $10 surcharge will be applied if you receive more than two fills of a listed maintenance medication at a retail pharmacy. The list contains both preferred and non-preferred medications. To obtain a copy of the most current maintenance medication list, contact the Patriot Benefits Call Center at **1-800-633-9005**.

**Prior Authorization**

The plan requires that certain medications meet medical necessity criteria and be approved in advance. These include but are not limited to the following drug categories. Please note that not all drugs in the categories listed below require prior authorization.

- Acne therapy medication for participants over the age of 35.
- ADHD agents.
- Anorexients (after180 days).
- Asthma/COPD preparations.
- Antiulcer/GERD agents.
- Hypertension/heart failure agents.
- Impotency drugs.
- Insulin prefilled pens and pen devices.
- Narcotic analgesics.
- Non-narcotic/arthritis analgesics.
- Self injectables (other than insulin).

Keep in mind the above list is not all inclusive and may change from time to time. Log on to your account at ***www.rxsolutions.com*** for a current list of medications requiring prior authorization. (Click on Health Tools and select Prior Authorization.) To determine if your medication requires a prior authorization you may also contact Prescription Solutions at **1-888-306-3243**.

If your doctor prescribes a drug that requires prior authorization, the following will occur:

- Your physician must contact the Prescription Solutions prior authorization department to request approval; otherwise the drug will not be covered under the plan. You may still purchase the medication by paying 100% of the cost.
- Prescription Solutions will verify your medical condition with your physician to ensure that the medication is appropriate.
- You will be notified in writing if the medication is not approved for payment under the plan. Once your physician provides the required information, the prior authorization process usually takes less than 48 hours.

To request prior authorization, have your physician call **1-800-711-4555** or fax a request to **1-800-527-0531**.

You can check the status of a prior authorization request at any time by calling the Prescription Solutions Member Services department at **1-888-306-3243**.

In some cases, you may need to follow a "step therapy program" before the plan will provide benefits for the prescribed medication. This approach may require you to try more traditional and proven medications first, before trying the newest, more costly medications. Or, continued medications beyond a certain period may require review and approval by the plan.

**Glucose Monitor Program**

Special rules apply to diabetic supplies for Option 250 and the Consumer Choice Option.

For patients with diabetes, you have a choice of two blood glucose meters at no cost: Accu-Chek® brand products by Roche Diagnostics and OneTouch® brand products by LifeScan, Inc., a Johnson & Johnson company. Test strips that fit these monitors are on the plan's preferred drug list, making testing more affordable. You may contact Roche at **1-800-533-4368** or LifeScan at **1-800-227-8862** for details*. Other types of glucose monitors are not covered under the prescription drug program.*

**Diabetes supplies for active employees and dependents,** You may purchase diabetes supplies, including test strips, insulin, syringes, etc. (but not glucose monitors) through the prescription drug program. Simply present your ID card at a participating pharmacy.

**Diabetes supplies for individuals for whom Medicare is the primary payer.** Diabetes supplies, including glucose test monitors, blood glucose test strips, lancing devices, lancets, insulin pumps and control solution are covered by Medicare, which is the primary plan for all diabetes supplies. The company plan will pay second. However, to receive coverage under Medicare, you must purchase supplies from a provider who is authorized to bill Medicare directly. You should use a Medicare-approved provider or ask if your local pharmacy is Medicare-approved.

Because Medicare is primary, your claim for diabetic supplies must be sent to Medicare first. Then this plan will pay the balance of the cost not covered by Medicare—up to the amount the company plan would have paid in the absence of Medicare.

## Option 1000 Prescription Drug Benefits

If you are enrolled in Option 1000, covered prescription drugs are administered by the medical claims administrator and are reimbursed at 70% after you have met the medical plan deductible each year.

Here's how you receive benefits for prescription drugs:

- When you have a prescription filled, you will be required to pay the full cost of the drug up front. If you are using a BlueScript retail or mail order participating pharmacy, your cost will be discounted. Then, the participating pharmacy will file your claim with BlueCross BlueShield of Illinois.
- If you use a non-participating pharmacy, you will not receive the BlueScript discounts and you must file a claim with BlueCross BlueShield of Illinois. BlueCross BlueShield of Illinois will then reimburse you.
- BlueCross BlueShield of Illinois will credit the amount you have paid for covered prescriptions, along with your other covered medical expenses, toward your annual medical plan deductible and send you a check in the amount of the benefits payable for your expenses. After you have met the deductible, you will be reimbursed at 70% for all covered prescription drugs for the rest of the calendar year. (If your overall medical costs reach the out-of-pocket maximum in a calendar year, the plan will then pay 100% of eligible prescription drugs for the rest of that year.)
- You will receive an explanation of benefits from BlueCross BlueShield of Illinois showing the amount that was applied to your deductible and how your benefits were determined.

## Covered Drugs

Coverage is limited to medications and drugs requiring a written prescription from a physician and dispensed by a licensed pharmacist—plus insulin and diabetic supplies such as syringes, lancets and glucose sticks. Dispensing limits may apply.

## Drugs Not Covered by the Plan

Under all options (the Consumer Choice Option, Option 250 and Option 1000), the plan does not cover expenses for:

- Cosmetic products (such as Rogaine, Minoxidil or topical applications for treatment of acne or wrinkles). If a drug such as Retin-A is prescribed for a person over age 35, you will be required to furnish proof of medical necessity.
- Any drug that is experimental or investigational, or one that is being used for a treatment that has not received final approval from the FDA.
- Any drug covered by workers' compensation.
- Refills before 75% of the prescription is used.
- Smoking cessation prescriptions in excess of a 180-day program within any 12-month period (over the counter products are not eligible).
- Drugs that have an over-the-counter equivalent – except for physician prescribed over-the-counter Prilosec.

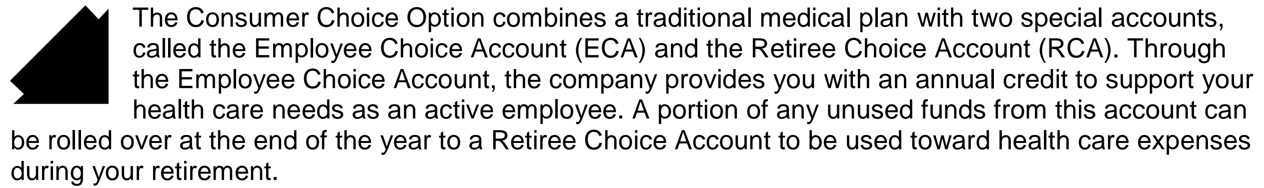
## More Information About Prescription Drugs

You also may obtain educational information about your prescription drugs by visiting the Prescription Solutions or BlueCross BlueShield of Illinois Web sites. If you have other group health coverage for prescription drugs—through your spouse's employer, for example—refer to the "Claims Procedures" section on page 47 for information about how to submit your claims.

## Resources for Prescription Coverage Information

| | **Consumer Choice Option and Option 250** | **Option 1000** |
|---|---|---|
| **Member Services** | Phone: 1-888-306-3243 | BlueCross BlueShield of Illinois:<br>Phone: 1-888-873-2227 |
| **Mail Service Pharmacy** | Phone: 1-888-306-3243<br>Fax: 1-800-527-0531 | N/A |
| **Web site** | www.rxsolutions.com | www.bcbsil.com |
| **Prior authorization** | Providers call:<br>Phone: 1-800-711-4555<br>Fax: 1-800-527-0531<br>www.rxsolutions.com<br>Members call:<br>Phone: 1-888-306-3243 | BlueCross BlueShield of Illinois:<br>Phone: 1-888-873-2227 |

# Consumer Choice Option

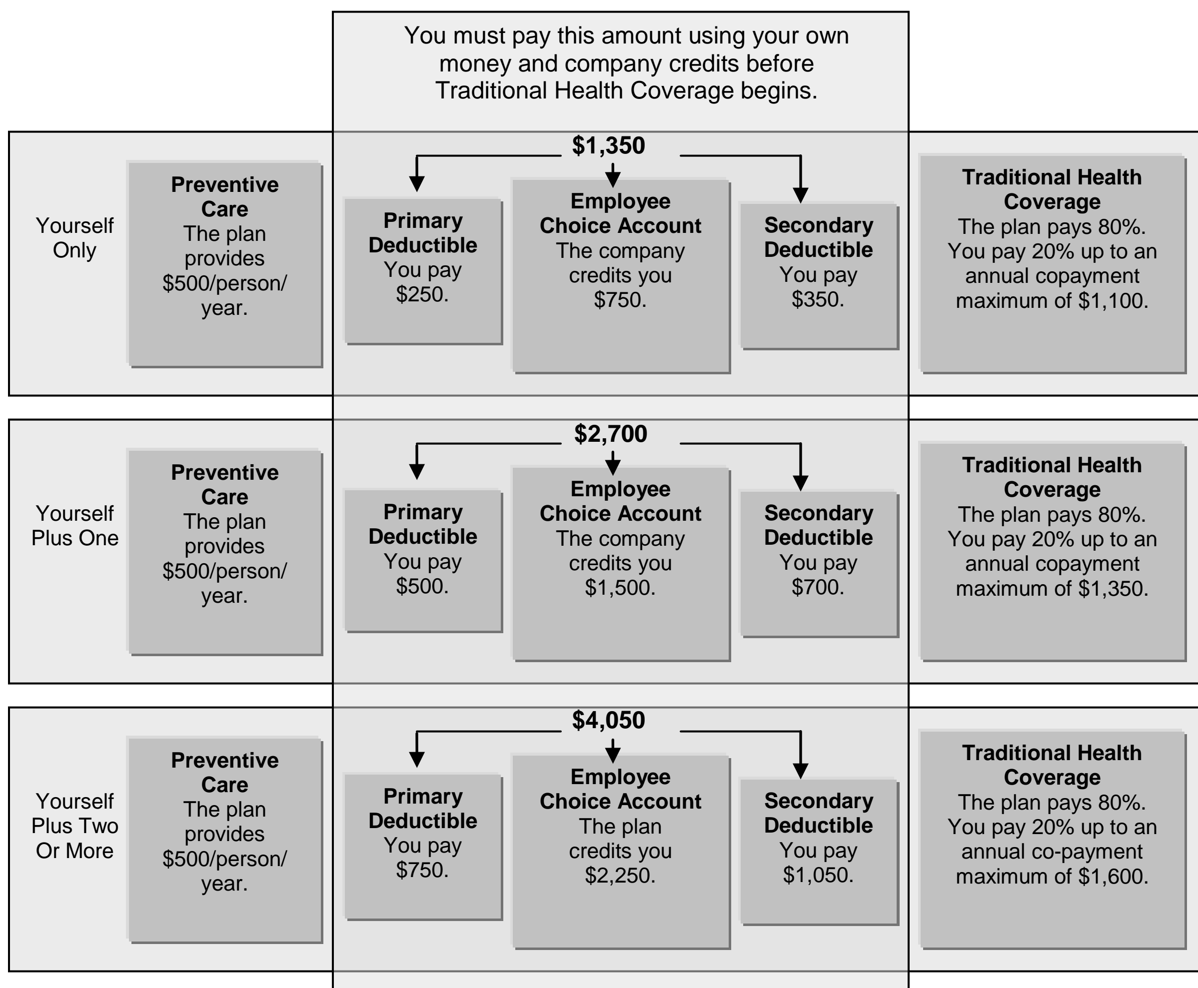


The Consumer Choice Option combines a traditional medical plan with two special accounts, called the Employee Choice Account (ECA) and the Retiree Choice Account (RCA). Through the Employee Choice Account, the company provides you with an annual credit to support your health care needs as an active employee. A portion of any unused funds from this account can be rolled over at the end of the year to a Retiree Choice Account to be used toward health care expenses during your retirement.

## Highlights of the Consumer Choice Option

The diagram below summarizes how the Consumer Choice Option works:

### Consumer Choice Option Coverage Levels




(Amounts listed are for network services. See page 10 for non-network amounts.)

## How the Consumer Choice Option Works

**Primary Deductible:** You must pay a primary deductible before your Employee Choice Account (credited by the company) is available to you. The amount of your primary deductible depends on how many people you are covering, and whether you are using network or non-network providers (see chart on page 10). The primary deductible can be met with a combination of expenses from any or all family members. This is different from Option 250, which requires a separate deductible for each covered person.

**Employee Choice Account:** After you have met your primary deductible, you gain access to your Employee Choice Account. This account gives you the opportunity to choose how and when the dollars in your account are spent to pay for eligible medical expenses. The amount of credit the company provides each year varies based on how many dependents you are covering (see chart on page 35). The Employee Choice Account gives you the option to save money for the future if you do not need or want to use the money now ("save"). You also have the option to pay for medical needs now ("spend"). Here's a brief summary of how these two paths—"save" vs. "spend" differ.

| "Save" | "Spend" |
|---|---|
| If you choose to save all or a portion of your Employee Choice Account, the plan allows you to roll over the money to the following year, up to plan limits. The excess amount beyond these limits can be invested in an interest-bearing Retiree Choice Account to pay for health expenses during your retirement. See "How to 'Save'" later in this section. | If you choose to spend your account value, you may use the value of your account to pay claims. If you use the entire amount during the year, you then pay for your additional medical expenses out of your pocket until you have met the secondary deductible (see below). See "How to 'Spend'" later in this section. |

The two paths are described separately above to help you understand the difference. But keep in mind, many people may end up spending part of their account and saving the rest.

**Secondary Deductible:** After you meet your primary deductible and "spend" the money in your Employee Choice Account (or "save" by choosing to use your own money for medical expenses that would have been paid from your Employee Choice Account), you are responsible for paying any additional health care expenses you have until you meet the secondary deductible.

**Traditional Health Coverage:** After you've met the secondary deductible, the plan will provide coverage for any further expenses, just like a traditional health plan. The plan will pay for 80% of the cost of eligible services received from a network provider. You pay the other 20%, up to an annual "copayment maximum." The annual maximum you pay for your share of expenses depends on how many people you are covering, and whether you are using network or non-network providers (see chart on page 10). The primary deductible, secondary deductible, and amounts paid out of the Employee Choice Account do not count toward the copayment maximum.

## How to "Save"

If you do not use all the money in your Employee Choice Account in a year, you can roll over a certain amount of it into your Employee Choice Account for next year. This rollover amount will be used to pay for part of your secondary deductible for the following year (you must pay the primary deductible every year, even if you have an existing balance in your Employee Choice Account).

The maximum amount you can roll over from one year's Employee Choice Account to the next is:

- $250 if you have "yourself only" coverage.
- $500 if you have "yourself plus one" coverage.
- $750 if you have "yourself plus two or more" coverage.

Any amounts remaining in your Employee Choice Account that are less than these amounts will remain in the account and be applied toward the next year's secondary deductible—they cannot be transferred to a Retiree Choice Account, described below.

## Investing in a Retiree Choice Account

If you carry over the maximum toward the next year's secondary deductible, the remaining amount in your Employee Choice Account will transfer to your Retiree Choice Account. You can use money from your Retiree Choice Account to reimburse yourself for medical expenses you incur during your retirement. Interest will be credited to your Retiree Choice Account based on the rate of interest earned by one-year U.S. Treasury bills. (This rate is subject to change based on business conditions.) See more details about the Retiree Choice Account on page 43.

## Building Up Your Employee Choice Account

Each year that you elect coverage under the Consumer Choice Option, the company will credit the full annual amount to your Employee Choice Account. In other words, you will receive a credit of $750 if you have "yourself only" coverage, $1,500 if you have "yourself plus one" coverage, or $2,250 if you have "yourself plus two or more" coverage.

Keep in mind that the limits on the amount you can roll over each year mean that your secondary deductible for the following year will never be completely covered. There will be a small "gap" before the traditional coverage steps in. The amount of the gap depends on the coverage level you have chosen: $100 for "yourself only" coverage, $200 if you have "yourself plus one" coverage, or $300 if you have "yourself plus two or more" coverage.

If you enroll in the Consumer Choice Option and then switch to another option in a future enrollment period, you will forfeit any money that remains in your Employee Choice Account (but you will not lose any money that has already been transferred to your Retiree Choice Account.)

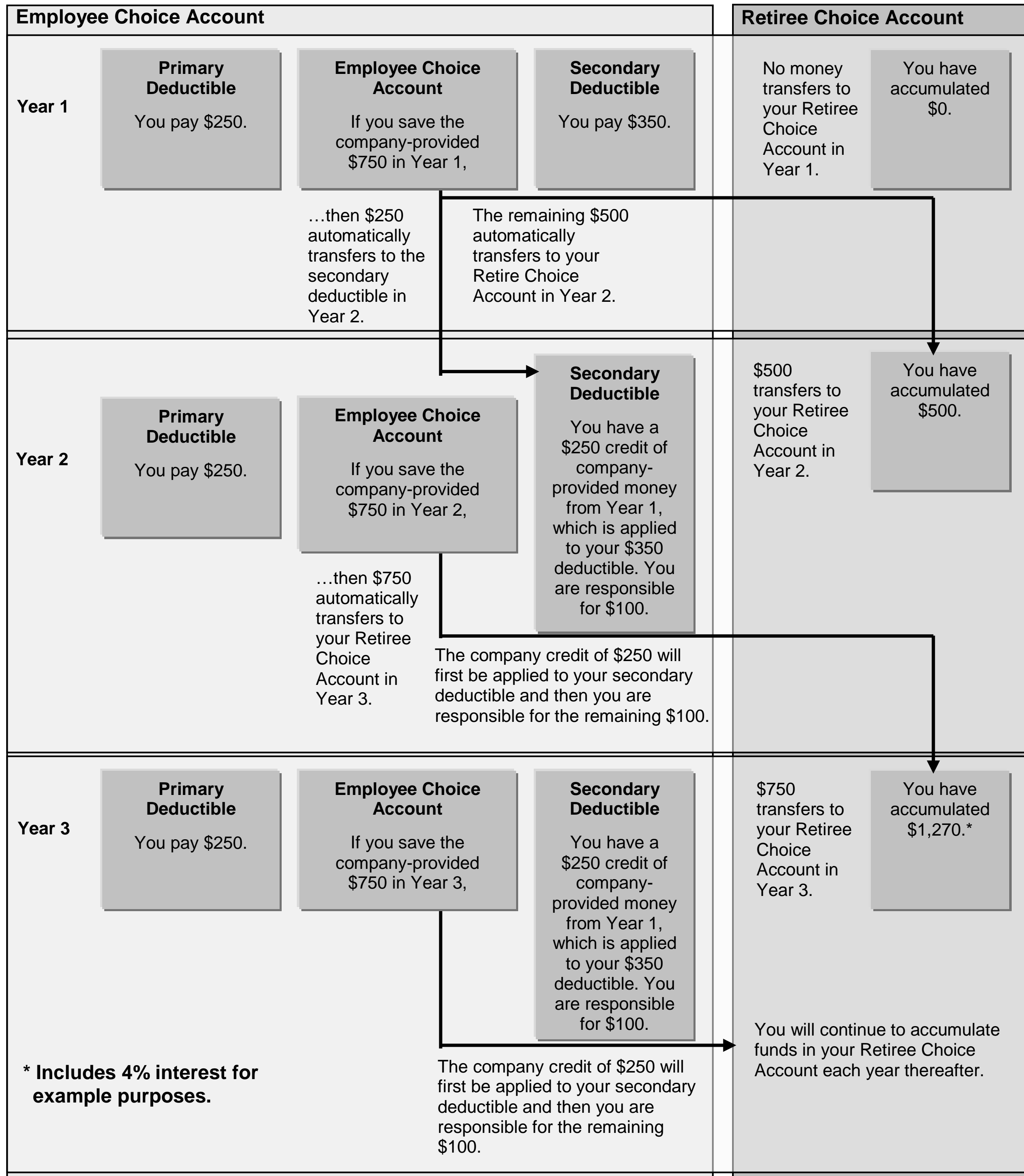
## Spending Before-Tax or After-Tax

If you "save" the money in your company-provided Employee Choice Account, this means you will be paying the full deductible out of your pocket. This full deductible includes the primary deductible, the amount of your Employee Choice Account and the secondary deductible. When you pay "out of pocket" in this manner, you have a choice to spend before-tax or after-tax dollars:

- **Spending before-tax dollars** means you can pay for eligible expenses using tax-free money. To do this, you must elect to contribute to a health care flexible spending account. The health care flexible spending account is described in a separate summary plan description. If you use a health care flexible spending account along with the Employee Choice Account, there are several plan rules you'll need to understand. These are explained in more detail on page 41.
- **Spending after-tax dollars** simply means using your own cash. In exchange, you have the opportunity to save the company-provided account for your retirement health care needs.

# Consumer Choice Option—How the Money Transfers Year After Year

If you think you are likely to follow a “save” strategy for your Employee Choice Account, it’s important to understand how the dollars will flow from year to year. The diagrams below show how the transfers can work from Year 1 through Year 3, assuming “yourself only” coverage.



## How to “Spend”

If you use your company-provided Employee Choice Account to pay for current medical expenses, you’ll be following the “spend” option.

Once you meet your annual primary deductible, you can use money from your Employee Choice Account to pay for eligible medical expenses covered under the medical plan. If you use the entire amount in your Employee Choice Account during the year, you then pay for your additional medical expenses by meeting a secondary deductible. After that, traditional health coverage steps in, and you pay only your copayment (20% of charges for network services) until you reach your annual copayment maximum (see chart on page 10).

You may use all of your annual Employee Choice Account credit. When you enroll again for the following year, you will receive another credit to replenish your account. But you could also have some money leftover. If so, you may still “save” a portion for the next year as described under “How to Save” on page 36. With the Employee Choice Account each year, keep in mind you can only roll over or “save” up to $250 if you have “yourself only” coverage, up to $500 if you have “yourself plus one” coverage, or up to $750 if you have “yourself plus two or more” coverage. Any amounts in excess of these limits will automatically be transferred to a Retiree Choice Account to reimburse yourself for medical expenses during retirement (see details on page 43).

## Consumer Choice Option vs. Option 250: How The Approaches Compare

| | CONSUMER CHOICE OPTION | OPTION 250 |
|---|---|---|
| Focus | The company provides a fixed amount each year, which you can choose to spend or save. This focuses attention on the full cost of health care coverage. It encourages you to seek preventive care and play an active role in managing your spending and/or savings. | After you meet an annual deductible, you pay a share of the cost. This focuses more on the portion of the expense you must pay. This plan also encourages you to seek preventive care. |
| Philosophy | This option lets you treat plan benefits like they are your own money. Unused amounts in your Employee Choice Account (ECA) can be rolled over to the next year’s plan, up to certain limits. Beyond these limits, the extra amount can be shifted to a Retiree Choice Account for use during retirement. In combination with the Medical Premium Reimbursement Program, your savings can help provide health security during retirement. | Many people regret paying for “insurance” they never use. With traditional coverage if you do not use the plan, you receive no benefit – you cannot build up cash value over time. |

| | | |
|---|---|---|
| Health Care for Retirement | In combination with the retirement benefits described on page 59, your savings can help provide more health security during retirement. You can use up to $5,000 per calendar year to pay for deductibles and copayments. You can also use it to purchase an individual health insurance policy. | You still have access to the retireement benefits described on page 59, but that only covers purchase of a policy, not out-of-pocket expenses for health care. |
| Deductibles | Although the plan has a high deductible before traditional health coverage steps in, you have an employer-provided ECA to cover a portion of that deductible (if you choose to spend it). The deductible can be met with a combination of expenses from any or all family members. | The annual deductible is more modest, but it is completely your responsibility. What's more, each covered person meets an individual deductible before the plan pays a percentage of covered charges. |
| Copayment (Your percentage share of covered expenses) | If you spend your ECA for current health expenses, you will have 100% coverage for eligible charges while you are spending your ECA credit. After your credit is used up and you have met the secondary deductible, the plan pays a percentage of covered charges, the same as Option 250. | Until you reach your out-of-pocket maximum, Option 250 will never pay 100% of any expense (except wellness care). You will always have to pay a portion of the covered charge. |
| Out-of-Pocket Expenses | Traditional health coverage begins after you meet the full deductible (primary + ECA + secondary deductible). After the deductible, both the Consumer Choice Option and the Option 250 pay 80% of covered network expenses while you pay 20%. Your 20% share is capped at a certain level, depending on how many people you are covering. This copayment maximum can be met with a combination of expenses from any or all family members. Both plans protect you from runaway health costs with an annual out-of-pocket maximum. See the chart on page 10. | Option 250 coverage begins after you meet an annual deductible per person. After the deductible, both plans pay 80% of covered network expenses while you pay 20%. Both plans protect you from runaway health costs with an annual out-of-pocket maximum. See the chart on page 10. |

| Cash Flow | If you choose to “save” your ECA and later have a large health care expense, such as for the birth of a baby or because of a serious accident, you may have to pay the full deductible (primary + ECA + secondary deductible) all at once before the traditional coverage steps in. However, if unexpected expenses arise, you always have the option of changing your mind and spending your ECA instead of saving it. When you are spending your ECA, you have 100% coverage for eligible charges covered by your ECA credit. | Under Option 250, if you have a large health care expense, such as for the birth of a baby or because of a serious accident, you will have to pay the full deductible for each person before the traditional coverage steps in for that person. However, the smaller deductible required may make it easier to manage for your family’s budget. |
|---|---|---|

## Prescription Drug Benefits and the Consumer Choice Option

When you choose coverage under the Consumer Choice Option, prescription drugs are covered, but they are treated a little differently than other eligible health care expenses. Prescription drugs are covered exactly the same way as under Option 250. For covered drugs, the plan pays a certain percentage, and you pay a certain percentage, subject to a minimum and maximum copayment. You do not pay a deductible for prescription drugs.

You cannot use the Employee Choice Account to pay for prescriptions, and the amounts you pay for prescription drugs do not count toward your primary or secondary deductible, or toward the copayment maximum.

## Eligible Expenses for the Employee Choice Account

Under the Consumer Choice Option, you can use the Employee Choice Account to pay for expenses covered under the medical plan, except for prescription drugs as previously explained.

In addition to the exclusion for prescription drugs, you cannot use the Employee Choice Account to pay for expenses that are not covered under the medical plan, such as cosmetic surgery.

See page 18 for a listing of covered medical expenses and page 25 for expenses that are excluded.

You cannot use the Employee Choice Account to reimburse yourself for your primary deductible.

## The Consumer Choice Option and the Health Care Flexible Spending Account

The health care flexible spending account, described in a separate summary plan description booklet, is a special account that lets you pay yourself back with tax-free money for many out-of-pocket health care expenses.

You can choose to use both the Consumer Choice Option’s Employee Choice Account and a health care flexible spending account, if you wish. However, you should be aware of some rules that apply if you use them together.

- You can use a health care flexible spending account to reimburse yourself for all or any portion of your full Consumer Choice Option deductible (primary deductible + Employee Choice Account + secondary deductible).

- If you elect the Consumer Choice Option and you contribute to the company's health care flexible spending account, you must first use the money in your flexible spending account to pay eligible claims before you can use the Employee Choice Account. This is because the flexible spending account money will be lost if not used by the end of the year (due to IRS rules), while the Employee Choice Account credit can be rolled over to the next year.

## Timing Your Claims if You Participate in the Health Care Flexible Spending Account

If you want to use the health care flexible spending account to pay for expenses that are not eligible under the Consumer Choice plan—such as Lasik surgery or over-the-counter medications—you will have to plan carefully. To ensure that you can pay for these expenses with before-tax dollars, you must submit these specific claims (which are not eligible under the medical plan) for reimbursement prior to submitting the claims that are eligible for reimbursement from the Employee Choice Account.

For example, let's assume that an employee elects coverage under the Consumer Choice Option. She also sets aside money in her health care flexible spending account to pay for the portion of her children's orthodontia expenses that aren't covered by the dental plan. Then she has an unexpected medical expense for a leg injury before the orthodontia expense is incurred. In this case, her medical expense would be paid out of the health care flexible spending account first. To avoid this and save her flexible spending account money for its original intended purpose, she would need to delay filing her claim for the leg injury until after she had submitted the claim for uncovered orthodontia expenses.

## Filing a Claim for the Employee Choice Account

If you are choosing to "spend" your Employee Choice Account, here's how to receive reimbursement:

1. You or your health care provider must first submit a claim to BlueCross BlueShield of Illinois (BCBSIL) using the process described on page 47. You are generally not required to pay the charge until BCBSIL has issued an Explanation of Benefits (EOB) form telling you how much of the claim is your responsibility.
2. To file a claim for reimbursement from your Employee Choice Account, you must provide the Explanation of Benefits (EOB) form from BCBSIL showing it has processed an eligible claim. Until you have met your full Consumer Choice Option deductible (primary deductible + Employee Choice Account + secondary deductible) each year, your EOB's will show that the full amount of your claim is "patient responsibility."
3. If you have already met the primary deductible, complete an Employee Choice Account claim form and submit it to BeneFLEX. The claim form is available through the BeneFLEX Web site at *www.beneflexhr.net*. See the box on the next page for more details.
4. Submit both the EOB and the Employee Choice Account claim form to BeneFLEX at the address or fax number on the claim form.
5. Once your claim has been approved, BeneFLEX will mail a reimbursement check to your home. This process usually takes approximately one week. For your convenience, you may request direct deposit of your reimbursement by logging on to *www.beneflexhr.net*.

All claims for the Employee Choice Account incurred in a given calendar year must be submitted no later than December 31 of the following calendar year.

Remember that if you are using the health care flexible spending account, you must use up the money in that account before using the Employee Choice Account. For further information on filing a claim under your flexible spending account, refer to the Flexible Spending Account summary plan description.

**MORE ABOUT BENEFLEX AND CLAIM FORMS**

If you have any questions about filing claims for the Employee Choice Account, you may call BeneFLEX HR Resources, Inc. (BeneFLEX) at 1-800-631-3539 and ask to speak with a claims representative. Identify yourself as a Patriot employee, state the assistance you need, and your call will be forwarded to the appropriate representative.

All claim forms, including direct deposit forms, may be printed from the BeneFLEX website at *http://employee.beneflexhr.net*.

All forms require your signature and date as indicated on the bottom of the form. An explanation of benefits substantiating your claim must be attached to the claim form.

To submit the completed forms to BeneFLEX, you can mail them to:

BeneFLEX HR Resources, Inc.
3660 S. Geyer Road, Suite 340
St. Louis, MO 63127

Claim forms may be faxed to 314-909-6983.

## Retiree Choice Account

If you enroll in the Consumer Choice Option for medical coverage, you also have access to a tool to help you save for future medical expenses after you retire—the Retiree Choice Account.

## Who Is Eligible for the Retiree Choice Account

If you are an employee enrolled in the Consumer Choice Option, you are eligible for the Retiree Choice Account. You do not have to be a certain age for money to be put into the account for your retirement.

However, if you leave the company before retirement, you must be at least age 55 before you can take money out of the Retiree Choice Account. You must also have at least five years of service when you leave the company to receive the full amount of your account. If you have less than one year of service when you leave the company, you will forfeit any money you have in your Retiree Choice Account. This is explained more fully under “If You Leave The Company Before Retirement” on page 44.

## How the Retiree Choice Account Works

As explained on page 35, if you are enrolled in the Consumer Choice Option for medical coverage, that option includes a company-provided Employee Choice Account you can use to pay for eligible expenses. If you don’t use the entire amount in your Employee Choice Account by the end of the year, you can roll what remains—up to certain limits—into your Employee Choice Account for the following year.

To recap, the maximum amount you can roll over from one year to the next in the Employee Choice Account is $250 if you have “yourself only” coverage, $500 if you have “yourself plus one” coverage, or $750 if you have “yourself plus two or more” coverage.

If you exceed any of these limits, then the excess amount is transferred into your Retiree Choice Account.

## Earning Interest on Your Retiree Choice Account

Amounts you transfer into your Retiree Choice Account will earn interest. The rate of interest your account earns will equal that paid on current one-year U.S. Treasury bills on January 1 of each year. The simple interest will be calculated and applied on December 31 of the year following each plan year and will be applied after all claims have been processed for the prior plan year. The tax-free interest will be automatically placed in your Retiree Choice Account. The rate of interest is subject to change based on business conditions and is not guaranteed.

## Eligible Expenses for the Retiree Choice Account

You can use the Retiree Choice Account to purchase your own health care policy when you retire. This can be another employer's group health plan, an individual policy, or Patriot Coal Corporation's Catastrophic Medical Plan (see page 61 for eligibility requirements) or Medicare.

You can also use up to $5,000 per year from your Retiree Choice Account to pay for the deductibles or copayments of the health care plan that you purchase.

You can begin taking money out of the Retiree Choice Account after you are age 55 and are no longer an active employee. You may not take money out of the account until you meet both these requirements.

## If You Leave The Company Before Retirement

If you leave the company and have less than one year of service, you will forfeit any money in your Retiree Choice Account. (Remember that all the money in your account originally was contributed by the company.)

If you leave the company with at least five years of service, you will be entitled to the full amount in your Retiree Choice Account when you reach age 55. If you leave the company with one to four years of service with the company, you are entitled to a percentage of the money from your Retiree Choice Account when you reach age 55, as summarized in the following table:

| Years of Service | Percentage of Retiree Choice Account You Are Eligible For |
|---|---|
| Less than 1 year | 0% |
| 1 year | 20% |
| 2 years | 40% |
| 3 years | 60% |
| 4 years | 80% |
| 5 or more years | 100% |

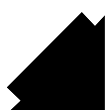
## Additional Details of the Employee Choice Account and Retiree Choice Account

| | |
|---|---|
| **Type of account** | The Employee Choice Account and Retiree Choice Account are technically known as health reimbursement arrangements (HRAs). Money in an HRA can be used to reimburse the eligible medical expenses of you and any other family members you have covered, in any combination.<br><br>The Employee Choice Account and the Retiree Choice Account represent an "unfunded" plan as defined by federal law. This means the money will be paid out of the company's general assets and has not been placed in a trust or special account. Money in the Employee Choice Account does not earn interest, unless it is transferred to the Retiree Choice Account.<br><br>The money in your Retiree Choice Account can be used to purchase a health care policy after you retire. You can also use the account (up to $5,000 per year) to pay the deductibles and copayments of the health care plan that you purchase. Money in this account earns interest based on the rate of interest earned by one-year U.S. Treasury bills. |

| | |
|---|---|
| **Transfers to the Retiree Choice Account** | Amounts over the maximum balance allowed in the Employee Choice Account will be transferred to the Retiree Choice Account on January 1 of the following calendar year. |
| **Time limit for filing claims** | Claims for a given year can be reimbursed up to December 31 of the following calendar year. Claims will not be reimbursed after that limit. If part of your Employee Choice Account is transferred to your Retiree Choice Account before December 31 of the current year (for example, as a result of a change in your family status), or if any of your Employee Choice Account is forfeited before December 31 of the current year, you have 12 months from the date of that event to make a reimbursement claim against the amount being transferred or forfeited. |
| **If you choose a different medical option during the next annual enrollment period** | Any amount left unspent in your Employee Choice Account (after eligible transfers to your Retiree Choice Account) will be forfeited, although you will have until December 31 of the following year to submit claims against the amount to be forfeited. (Whatever amount you have transferred to your Retiree Choice Account stays there, subject to the plan's eligibility rules.) |
| **If you are hired (or become eligible for coverage) between annual enrollment periods** | When you first enroll in the plan, you receive the entire annual credit that the company normally puts in the Employee Choice Account for the year. At the end of the year, the amount you can roll over into your secondary deductible for the next year (or into your Retiree Choice Account) is reduced based on when you enrolled in the plan. If you joined in the first quarter of the year, your remaining account balance is reduced by 25%; in the second quarter, 50%; in the third quarter, 75%. If you join in the fourth quarter, you will not be able to roll money into your Employee Choice Account for the following year. |
| **If the number of people you cover under the plan changes before the next annual enrollment period** | If the change is because a dependent is no longer eligible, the annual credit from the company, and the limits on the amount you can roll over or build up in your Employee Choice Account, will be reduced and will be effective immediately. If the amount you have in your Employee Choice Account exceeds the limits, the excess will be transferred to your Retiree Choice Account. If the change is because you are adding a dependent(s), your coverage level will increase, as appropriate, on the date of the change and an additional amount will be credited to your Employee Choice Account. |
| **If you switch from another medical coverage option to the Consumer Choice Option before the next enrollment period because of a qualifying change in family status** | The same rules apply as if you were newly hired or newly eligible for the plan, as described above. |
| **If you switch from the Consumer Choice Option to another medical coverage option before the next enrollment period because of a qualifying change in family status** | The same rules apply as if you terminated employment with the company (described below). |

| | |
|---|---|
| **If you terminate employment with the company (for any reason)** | If you choose to continue coverage under the provisions of the law known as COBRA, the plan continues as usual. After COBRA coverage ends, or if you don't elect COBRA continuation, any remaining balance in your Employee Choice Account is forfeited (except for reimbursements you receive for claims filed before the end of the filing time limit). If you have a balance in the Retiree Choice Account, your right to the money in that account is subject to the Retiree Choice Account's rules based on years of service (see page 44). |
| **If your covered dependent elects individual coverage under COBRA** | The dependent is then treated the same as a new hire. |
| **If you become divorced** | Unless there is a court order, divorce decree or other legal instruction stating otherwise, you as the employee have all rights to your Employee Choice Account and/or Retiree Choice Account balances. If there is a change in the number of people you cover, change in family status rules will apply. |
| **If you die while an active employee** | If your surviving covered dependents choose to continue coverage under COBRA, the plan continues as usual. After COBRA coverage ends, or if your dependents don't elect COBRA continuation, any remaining balance in your Employee Choice Account is transferred to your Retiree Choice Account. Your surviving dependents may use your Retiree Choice Account immediately, subject to the account's rules based on your years of service (see page 44). |
| **If you take a leave that is covered under the Family and Medical Leave Act** | You continue to participate in the plan as if you were actively at work. |
| **When you retire** | When you retire, the remaining amount in your Employee Choice Account transfers to your Retiree Choice Account. Your Retiree Choice Account becomes available to you, subject to that account's rules based on years of service (see page 44). The Retiree Choice Account is completely separate from the Retiree Medical Plan (which requires you to be at least age 55 and have 10 years of service), as described starting on page 59. |
| **If you die after you retire** | The Retiree Choice Account is immediately available for use by your surviving dependents for eligible expenses, subject to the account's rules based on your years of service (see page 44). If you have no dependents, the Retiree Choice Account is forfeited after all claims have been received within the time limits for filing them. |
| **If you become disabled and receive benefits from the short-term disability plan** | You continue to participate in the plan as if you were actively at work. |
| **If you become disabled and receive benefits from the long-term disability plan** | You will no longer be eligible for the Consumer Choice Option and you will need to make a new medical election. Your entire Employee Choice Account will roll over into a Retiree Choice Account. |
| **Hardship withdrawal** | No withdrawals from the Retiree Choice Account prior to age 55 are permitted. |

# Filing Claims



You must file claims for medical expenses and prescription drugs using the process outlined below. You must submit the claim within one year of the date you incur an expense. BlueCross BlueShield participating providers and Prescription Solutions participating pharmacies will file their claims directly with the appropriate claims administrator. For all other providers, you must file a claim using this process. If you also have coverage through another plan that is your primary plan (as described in the Coordination of Benefits section), you may also claim secondary benefits using this process.

1. Obtain a BlueCross BlueShield of Illinois (BCBSIL) claim form from your Benefits Department or log on to *www.bcbsil.com/member/pp/medical_coverage.htm* and select "Download a Claim Form". Claims for prescription drugs under the Consumer Choice Option and Option 250 must be filed using the Prescription Solutions claim form. You can obtain prescription drug claim forms by logging on to your account at ***www.rxsolutions.com.*** (Click on the Help Topics tab and select Most Used Forms.) You may also call Prescription Solutions at **1-888-306-3243**. Claims for prescription drugs under Option 1000 must be filed using the BCBSIL claim form.
2. Securely attach your itemized bills and/or prescriptions to the claim form. Check your bills to make sure the information on the bill includes the:
   - Patient's name.
   - Diagnosis (for medical claims).
   - Date and type of service.
   - Itemized charges.
   - Name of the provider, provider tax identification number and address.

   Do not send cash register receipts, balance-due statements, proof-of-payment receipts or canceled checks in place of an itemized bill.
3. Be sure to sign the claim form and complete all the sections that apply.
4. If you or your dependents are also covered by another medical plan (including Medicare) that is the primary payer, you must attach a copy of the other plan's explanation of benefits to your bill before submitting it. Refer to the "Coordination of Benefits" section on page 49 for more information. Remember, you should keep a copy of all bills you submit.
5. Submit medical and prescription drug claims to the address shown on the appropriate BlueCross BlueShield of Illinois or Prescription Solutions claim form.

If any part of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things you can do to appeal the decision. Most of your medical claims questions can be answered quickly and efficiently by either calling the claims administrator or submitting a written request for review to:

**For medical claims under the Consumer Choice Option and Option 250:**

BlueCross BlueShield of Illinois
2001 Fox Drive
Champaign, Illinois 61820-7331
1-888-873-2227

**For prescription drug claims under the Consumer Choice Option and Option 250:**

Prescription Solutions
3515 Harbor Blvd.
M/S LC07 – 286
Costa Mesa, California 92626
1-800-562-6223

**For medical and prescription drug claims under Option 1000:**

BlueCross BlueShield of Illinois
2001 Fox Drive
Champaign, Illinois 61820-7331
1-888-873-2227

## Payment of Benefits

If you use a BlueCross BlueShield participating provider, the benefit payment will be made directly to the provider.

If you use a non-participating provider, the benefit payment will be made to you.

The plan will not pay more than it would usually pay because you have indicated that it should pay the provider directly. Once the plan has made a payment in good faith, it is no longer obligated for payment of that claim, even if it turns out the payment was sent to the wrong person or organization.

## Recovery of Excess Payments

If the plan pays more than necessary under the plan provisions, then the plan has the right to deduct the excess amount from future payments, or to require that it be repaid by the person or organization that received it.

## The Plan's Right to Receive and Release Necessary Information

To determine the benefits for your claim, the plan may require additional information such as itemized bills, a statement from your provider, medical records of anyone making a claim, a medical examination, and so forth.

By participating in this plan, you (and your covered dependents) agree that the plan may provide or obtain any information necessary to carry out the plan's provisions without having to give any person notice or obtain anyone's agreement. When you submit a claim for benefits, you must provide all the information needed to carry out the plan's provisions.

## Payment of Benefits to Persons Other Than You

Under normal conditions, benefits are paid to you or to the provider of services. Under conditions where you would normally receive a payment but are incapable of handling your affairs, the plan may pay benefits to any individual or organization that has assumed the costs of your care or financial support.

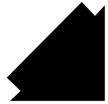
In the event of your death, the plan may also continue to honor decisions you made about payment of benefits.

Once the plan has made its payments under this provision, the plan is no longer liable to you for benefits.

## Right to Audit

The company reserves the right to inspect and analyze, for audit purposes, the claim files held by the claims administrator.

# Coordination of Benefits



Like most group health plans, your medical plan includes a coordination of benefits (COB) provision. This provision applies if you or your dependents are covered by more than one group plan.

Under COB, one plan is considered "primary" and the other "secondary." The plan that is primary pays first and usually pays its normal plan benefits.

The primary plan is determined as follows:

- Any plan that does not contain a coordination of benefits provision is primary.
- If a plan covers the patient as an employee, that plan is primary and any plan covering the patient as a dependent is secondary.
- If the patient is a dependent child whose parents are not divorced or legally separated, the plan of the parent whose birthday is earlier in the calendar year is primary.
- If the patient is a dependent child whose parents are divorced or legally separated, the following rules apply:
  - A plan is primary if it covers a child as a dependent of a parent who is required by a court decree to provide health coverage.
  - If there is no court decree that requires one parent to provide health coverage to a dependent child, the plan of the parent who has custody of the child is primary. (The plan of the custodial parent's spouse is secondary and the plan of the other natural parent is third.)
- If a plan covers a person as an active employee, that plan is primary, and any plan that covers that person as a retired or former employee is secondary. If a plan covers a person as a dependent of an active employee, that plan is primary, and any plan that covers that person as a dependent of a retired or former employee is secondary.
- If a plan covers a person because of federal or state continuation-of-coverage laws, that plan is secondary to a plan that covers the person on any other basis.
- If none of the above rules applies, the plan that has covered the individual the longest period of time is primary.

However, if the person is a Medicare eligible beneficiary, see the sections "Primary Coverage for Active Employees Who Are Eligible for Medicare" and "Effect of Medicare on Benefits for Disabled and Retired Employees" on page 50.

When another plan is primary, the benefits paid by our company plan will be reduced by the amount of the other plan's payment.

In other words, if the primary plan's payments are equal to or greater than the amount the company plan would pay for the same expenses, then the company plan will pay nothing for that claim. On the other hand, if the primary plan's benefits are less than what the company plan would normally pay, then the company plan will pay the difference. For example:

- If your other plan's benefit for a claim is $500, and the company plan would pay $500 for the same claim, then the company plan will pay nothing.
- If your other plan's benefit is $400, and the company plan would pay $500 for the same claim, then the company plan will pay $100.

These rules apply only when another plan is primary and the company plan is secondary. If the company plan is primary, its benefits are determined as if no other plan is involved; however, a secondary plan may pay additional benefits.

To make sure you receive the benefits to which you are entitled under both plans, it is important to submit your claims properly. For example, when you file a claim for your spouse, be sure to file under his or her plan first. After you have received payment from that plan, then you can submit for payment to our company plan. When you submit a claim to the second plan, be sure to include the explanation of benefits from the primary plan, as well as another copy of the itemized bill.

## Primary Coverage for Active Employees Who Are Eligible for Medicare

This plan assumes all actively working employees and their eligible dependents will be provided with primary coverage under this company plan, with secondary coverage provided by Medicare. This applies to active employees and their dependents over age 65, as well as disabled dependents of an active employee.

While you are working, you should submit your claims to this company plan first, then to Medicare. (If you or your spouse chooses in writing to have Medicare provide primary coverage, then coverage from the company plan will end.)

For active employees entitled to Medicare because of end-stage renal disease, after 30 months of coverage this company plan will be secondary and Medicare will be primary.

## Effect of Medicare on Benefits for Disabled and Retired Employees

For disabled and retired employees and their dependents who are eligible for both Medicare and the company plan, Medicare is the primary plan and the company plan is secondary. Medicare must first process medical claims. Then, the company's third party administrator will process medical claims as secondary payer.

In order for the company plan to process medical claims as a secondary payer, disabled and retired employees who are eligible for Medicare are required to enroll in all available Medicare products – Parts A, B, and Part D or in Medicare Advantage (previously known as Medicare Part C). As new Medicare options become available, the company will coordinate all Medicare plan options with the Company welfare benefit plans as allowed by law.

If you or any of your dependents are enrolled in Parts A, B and D of Medicare, benefits under this company plan will be reduced by the amount of benefits paid by Medicare in the same way that the plan coordinates with other group health plans that are primary, as explained at the beginning of the "Coordination of Benefits" section on page 49. If you and your dependents are eligible to receive benefits under Medicare and do not enroll, the company plan will not pay benefits. For this reason, disabled and retired employees should enroll for coverage under all Medicare options as soon as they are eligible. *Medicare provides a special enrollment period for employees who are covered by an employer-sponsored group health plan when they stop working. Contact your Social Security office for more information. You and your covered dependents are responsible for all Medicare premiums.*

When you receive the Medicare statement showing what Medicare has paid, you should submit a copy of the statement to the company plan, along with copies of your bills and a properly completed claim form covering the same medical expenses.

*If you enroll in Medicare Advantage, an alternative to traditional Medicare, your benefits under the company plan will be reduced by the amount of benefits that would have been payable under the Medicare Advantage Plan if you had followed all applicable rules to obtain benefits.*

Plan participants eligible to receive benefits under Medicare are not required to access PPO providers or to obtain pre-certification as outlined in the "Blue Care® Connection Program and Hospital Pre-Certification" section on page 13.

For disabled and retired employees entitled to Medicare because of end-stage renal disease, after 30 months of coverage this company plan will be secondary and Medicare will be primary.

## The Plan's Right to Necessary Information

To carry out the plan's provisions for coordination of benefits, the plan administrator may provide or obtain any information it considers necessary. This information can be given to or obtained from any insurance company or other organization or person, and the claims administrator does not have to give any person notice or obtain anyone's agreement. Any person enrolled in the company plan automatically agrees to this provision.

## The Plan's Right to Make Payments to Other Organizations

If any other plan makes a payment that should have been made by the company plan, the company plan has the right to pay the other plan any amount necessary to satisfy the terms of the provision for coordination of benefits.

These amounts the company plan pays will be considered benefits paid under the plan (for example, they will count toward benefit maximums). Once the payment is made, the plan will no longer be liable for payment for that claim.

## The Plan's Right to Recover Payment from Third Parties and Subrogation

If you or a dependent have medical expenses as a result of an injury or accident, a third party may be liable for those expenses. In this case, the plan may advance payments for the medical expenses that are covered charges under the plan. These advance benefit payments are conditional, however, because they are subject to the plan's "right of recovery" provisions. For purposes of this provision, a "third party" includes, but is not limited to, any person, insurance company or other entity that is in any way responsible for the illness or injury, or is in any way responsible for providing compensation, indemnification, or benefits for the illness or injury; any law or policy of insurance or accidental benefit plan providing no-fault, uninsured, underinsured or general group or individual liability coverage; any medical reimbursement insurance whether or not purchased by you or your dependents who are submitting the claim or on behalf of the person submitting the claim; any specific risk accident or health coverage or insurance, including without limitation premises or homeowners medical reimbursement coverage, and student, student-athletic or student-team coverage or insurance.

The plan has the right to recover the conditional benefit payments out of the proceeds of any settlement or judgment that you or your dependent receives from the liable third party, or from the third party's insurer, or from any insurer providing you or your dependent with indemnity against the acts of third parties before any other amounts are deducted from the recovery (first lien). If you or your dependents receive settlement or judgment proceeds, then the plan may recover its conditional benefit payments directly from you or your dependent. This is the plan's right of reimbursement and it means that you or your dependents must reimburse the plan for the benefits previously provided.

In addition, the plan has the right to recover the conditional benefit payments directly from the liable third party or insurers. The plan pursues this right of recovery directly against the third party or insurers as your subrogee. This means that the plan is subrogated (substituted) to all of your or your dependent's claims, demands, actions against the liable third parties and insurers to the full extent of the plan's right of recovery for the benefits it previously provided plus the attorney's fees and costs the plan incurs pursuing the claim against the third party or insurers. The plan may assert its claim against any third party even if you or your dependents do not, or the plan may join any action you or your dependents bring against a

third party. The plan does not waive any of its rights to reimbursement by not independently asserting its claim against any third party or by not joining in any action brought by you or your dependents against any third party.

The plan does not recognize the “make whole” doctrine and may recover the conditional benefit payment amounts owed to it regardless of the description or characterization of any recovery or whether: (a) the settlement or judgment or other recovery specifically includes medical expenses; (b) you or your dependent have been fully indemnified for your losses; or (c) the plan’s recovery results in you or your dependent receiving only a partial recovery (or no recovery) for damages.

**Example:** Suppose you are injured in an automobile accident that was the other driver’s fault. The plan pays most of the cost of your hospital bills. Later, the other driver’s insurance company also pays you for your medical bills. So now you have essentially been paid twice for your medical bills as a result of this accident—once from the plan and once from the other driver. The “right of recovery” provisions now come into play, and the plan is entitled to a refund of the benefits paid. The plan may also pursue recovery directly from the third party.

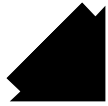
The following applies under the right of recovery provisions and relates to plan benefits and plan benefit payments for medical expenses incurred as a result of the accident or injury:

- You and your dependents must notify the plan, in writing, whenever plan benefits may be subject to the plan’s rights of recovery.
- The plan is not obligated to pay benefits for any medical expenses incurred until you or your dependents promise in writing to include the expenses in any claim you or your dependents are making, to reimburse the plan if you recover the medical expenses or any other proceeds related to your losses or damages, and to cooperate fully with the plan in its attempts to recover the conditional benefit payments from liable third parties and insurers.
- You must cooperate fully with any reasonable requests made by the plan in connection with its rights of reimbursement and subrogation. If you do not fulfill these obligations, then the plan is not obligated for any benefits or covered expenses incurred by you or your dependents.
- You must inform the plan in advance of any settlement proposals advanced or agreed to by any liable third parties or insurers and obtain written consent from the plan prior to settling any claim to which this plan is subrogated.
- You must provide the plan with notice if you or your dependents assert a claim or claims against any third party and keep the plan informed as to the status of such claim or claims.
- You must notify the plan of any compensation you or your dependents receive from any third party in connection with the injury or illness and immediately reimburse the plan upon receipt of such compensation.
- You must take no actions to compromise or impair the plan’s rights to recovery.
- In the event you or your dependents fail or refuse to provide whatever assignment, form or document is requested by the plan or its claims administrator, the plan will be relieved of all legal, equitable or contractual obligations contained in this plan for any benefits or covered expenses incurred by you or your dependents.
- If you or your dependents receive any settlement or judgment proceeds, then within 30 days of the recovery you must fully reimburse the plan for any conditional benefit payments it previously provided. If this reimbursement is not timely made, then the plan is not obligated to pay benefits for any future medical expenses incurred by you or your dependents.

Further, the plan may sue you or your dependents, or as applicable, your heirs, guardians, executor or other representative in order to recover the amount due the plan under these provisions. Where the plan is successful, in whole, or in part, the plan shall also be entitled to reimbursement from you or your dependents all costs of collection, including reasonable attorney’s fees. The plan’s obligation will resume when both of the following have occurred: (a) the plan receives full reimbursement for any conditional

benefit payments previously provided; and (b) arrangements satisfactory to the plan have been made with regard to its rights of recovery for future covered medical expenses.

# When Coverage Ends



Your coverage will end on the date the earliest of the following occurs:

- The plan is terminated.
- You no longer meet the definition of an eligible employee. Medical coverage will be continued if you are an eligible disabled employee or an eligible retired employee, as explained on page 54 and page 59.
- You elect to terminate your coverage because of a change in family status. You elect to terminate your coverage during the annual enrollment period. In this case, coverage will end on December 31 following the annual enrollment period.
- You fail to pay the required contribution for coverage.

Coverage for your dependents will end on the date the earliest of the following occurs:

- Your dependents are no longer eligible (for example, your child reaches the limiting age or marries). Coverage will terminate at the end of the month of the 19th or 23rd birthday.
- You elect to terminate your dependent's coverage because of a change in family status.
- You elect to terminate your dependent's coverage during the annual enrollment period. In this case, coverage will end on December 31.
- Your coverage ends.
- You die (except as provided under "For Surviving Spouses and Dependent Children" section on page 54).
- You fail to pay the required contribution for coverage.

The following sections describe continuation provisions that may apply in certain circumstances.

## Coverage While on Leave of Absence

Your medical coverage will be continued while you are on an approved leave of absence under the Family and Medical Leave Act or an approved unpaid leave under the Patriot Coal Corporation Unpaid Leave Policy provided you pay the required contributions for coverage. If you choose not to continue your coverage, it will be reinstated without restrictions on the date you return to work from a leave.

If you fail to return to work at the end of your leave, you may be required to pay back the company for its cost for providing coverage during your leave. However, you will not be required to repay the company if the reason you don't return is due to a serious health condition that would entitle you to leave under the Family and Medical Leave Act.

You may also continue medical coverage for yourself and your covered dependents during a leave protected by the Uniformed Services Employment and Reemployment Rights Act of 1994, provided you pay any required contributions. Assuming you pay your contributions when due, your right to continue coverage under this provision will end 24 months after you begin your protected military leave or when you fail to return to work within the time period prescribed by the Act, whichever is earlier. If your coverage is canceled while you are on a protected leave, it will be reinstated on the date you return from the leave, provided that date is within the period prescribed by the Act. You will not be required to satisfy any pre-existing conditions limitation period to the extent that this period was satisfied before the start of your protected leave.

For any other leave of absence, your coverage will end during the leave unless you elect coverage under COBRA, or you are eligible for coverage as a disabled or retired employee, as defined on pages 54 and 59.

## If There Is a Reduction in the Work Force

If your employment ends because of a reduction in the work force, you may continue your medical coverage according to company policy for three calendar months after the end of the last month in which the reduction in work force occurs, provided you pay the required premiums.

The coverage provided under this provision will reduce the maximum period of continuation of coverage available under COBRA as described on page 62.

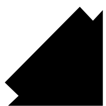
## For Surviving Spouses and Dependent Children

In the event of your death, your surviving spouse and eligible dependent children may continue their medical coverage for the rest of the month of your death plus six additional months, provided they pay the required premiums. Thereafter, coverage may be continued only if one of the following applies:

- If you are an active employee or disabled employee and on the date of your death you would have met the definition of a retired employee, your surviving spouse's coverage may continue under the plan that would have been available to you if you had retired on the date of your death. This coverage may be continued until his or her death or remarriage.
- If you are an eligible retired employee, your surviving spouse may continue the coverage you had as a retiree on the date of your death, if your spouse was already enrolled in your coverage on that date. If your spouse is not enrolled in your coverage because he or she had coverage under another health plan, your spouse may enroll in your coverage if he or she later loses coverage under the other plan.
- Dependent children are eligible for as long as the surviving spouse is eligible, and they continue to meet the plan's definition of a dependent child. If there is no surviving spouse at the time of your death, coverage for your dependent children will end.

The coverage provided under this provision will reduce the maximum period of continuation of coverage available under COBRA as described on page 62.

# When You Become Disabled



You remain eligible for coverage while you are receiving short-term disability benefits. Thereafter, you may remain eligible as described below.

The coverage provided under this provision will reduce the maximum period of continuation of coverage available under COBRA as described on page 62.

If you became disabled on or after January 1, 2006, you may elect to continue your medical coverage under the plan offered to active employees for a maximum period of 36 months as described below:

- If you are receiving short-term disability (STD) benefits, you will remain eligible for medical coverage up to a maximum period of 180 days (6 months). Contributions will continue to be deducted on a pay period basis.
- If you are receiving long-term disability (LTD) benefits, you may elect to continue your medical coverage for a maximum period of 30 months, provided you pay the required contributions.
- Coverage will end prior to the 36 month maximum if you are no longer receiving LTD benefits.

**Retiree Medical – If you are less than age 55 at the end of 36 months**

If you are less than age 55 at the end of your 36 months of medical coverage, you may be immediately eligible to receive a retiree medical allowance which provides a benefit to help you purchase medical coverage.

To be eligible to access your retiree medical allowance prior to retirement age, you must meet the following requirement at the end of your 36 months of medical coverage.

- You had 5 or more years of service before your disability began.
- You continue to be eligible for long-term disability benefits under the Patriot sponsored Disability Plan.

If you are eligible for retiree coverage under another Patriot group health plan, you are not eligible for the coverage described in this section.

Under the retiree medical plan, the company will provide an allowance toward the purchase of medical coverage for employees who became disabled on or after January 1, 2006. The dollar amount will be based on your years of service, as defined below, with Patriot Coal Corporation and selected subsidiaries and affiliates (company).

Years of service means the number of days of full-time or part-time employment with the company, divided by 365. That number is then rounded up to the next full year to determine the maximum amount you can be reimbursed from the plan.

For purposes of measuring years of service, the following are included:

- Years of full-time or part-time employment. Full-time employment means performance of active work on a full-time basis (35 hours or more per week). Part-time employment means working a regular schedule of 20 or more hours per week year round. It does not include temporary employment or employment that is not year-round. It does, however, include certain absences from work, including:
  - Absence due to a military leave protected by the Uniformed Services Employment and Reemployment Act, if you return to work within the time period provided in the act.
  - Absence due to termination of employment, if you are reemployed within 90 days.
  - Absence covered under the Family and Medical Leave Act.
  - Absence due to short-term disability benefits if you are receiving benefits under the company disability plan for a maximum of 180 days.
  - Absence due to long-term disability if you are receiving benefits under the company disability plan to a maximum of 30 months if all of the following apply:
    - Your disability began on or after January 1, 2006.
    - You had five years of service at the time you became eligible for long-term disability.
  - Absence due to disability if you are receiving long-term disability (LTD) benefits from the company disability plan and you return to work within 24 months after LTD benefits begin.
- Years of service are generally based on the continuous period of full-time or part-time employment with the company immediately prior to termination. However, the following exceptions will apply:
  - If you leave the company and are reemployed, you will receive credit for the prior period of employment if you return to work before a "break in service" occurs.
  - "Break in service" means a period of 90 consecutive days during which you were not employed by the company.
    - If you have a break in service and then return to work, you will receive credit for the period of employment prior to the break in service if (a) you had five years of service prior to the break (10 years for breaks prior to 1989), or (b) the break did not exceed the number of years and months of service you had before the break.

Your allowance will be based on your age and years of service with the company (with years of service rounded up to the next full year) as shown in the table below.

| | Medical Coverage Allowance | |
|---|---|---|
| For Service | Full-time Employee | Part-time Employee |
| Prior to age 50 | $2,700 x Years of Service, plus | $1,350 x Years of Service, plus |
| From age 50-54 | $8,100 x Years of Service, plus | $4,050 x Years of Service, plus |
| At age 55 and beyond | $13,500 x Years of Service | $6,750 x Years of Service |

The allowance multiplier will be adjusted for inflation each January while you are on long term disability and eligible for medical coverage under this plan as a disabled employee. The adjustment will be based on the medical component of the Consumer Price Index (CPI), not to exceed 5%.

You can use the tax-free allowance immediately at the end of your 36 months of medical coverage eligibility or at any time in the future. You may request reimbursement for any premiums you pay for medical, dental, or vision insurance for you and your eligible dependents (as defined by the plan). Such plans may include:

- Individual health insurance policies.
- Medicare and Medicare supplement plans.

Your allowance at the end of your 36 months of medical coverage is a lifetime maximum – it is not reinstated each year or at any other time in the future. Once your maximum allowance is exhausted, you will no longer be eligible for any reimbursement of your medical premiums from the company.

If you should die before your maximum allowance is used, your surviving spouse and his or her eligible dependents may continue to be reimbursed for such premiums until the allowance is exhausted. If your spouse dies or remarries, the remaining balance will be forfeited. You will not be eligible to receive a lump-sum cash payment. If there is no surviving spouse eligible for benefits, the balance of your allowance remaining at the time of your death will be forfeited.

Please note that this retiree medical plan is an "unfunded" plan as defined by federal law. This means the money will be paid out of the company's general assets and has not been placed in a trust or special account.

Also, please note, retiree medical plan benefits are not considered taxable income.

***Claims for Reimbursement***

The retiree medical plan is administered by BeneFLEX HR Resources, Inc. (BeneFLEX), a third-party administrator located in St. Louis, Missouri. For reimbursement of premiums other than the Patriot Catastrophic Medical Plan, you will need to send proof of your paid medical premiums to BeneFLEX. Reimbursements will be made once a month for the current month or past month premium payments. Payments will not be made for future dates of coverage.

**Retiree Medical – If you are age 55 or greater at the end of 36 months**

If you are at least age 55 at the end of your 36 months of medical coverage, you may be immediately eligible to receive a retiree medical allowance which provides a benefit to help you purchase medical coverage.

To be immediately eligible for a retiree medical allowance, you must meet the following requirement at the end of your 36 months of medical coverage.

- You must be at least age 55 at the end of the 36 months of disability medical coverage.
- You had 5 or more years of service before your disability began.

If you are eligible for retiree coverage under another Patriot group health plan, you are not eligible for the coverage described in this section.

Under the retiree medical plan, the company will provide an allowance toward the purchase of medical coverage for employees who became disabled on or after January 1, 2006. The dollar amount will be based on your years of service, as defined below, with Patriot Coal Corporation and selected subsidiaries and affiliates (company).

Years of service means the number of days of full-time or part-time employment with the company, divided by 365. That number is then rounded up to the next full year to determine the maximum amount you can be reimbursed from the plan.

For purposes of measuring years of service, the following are included:

- Years of full-time or part-time employment. Full-time employment means performance of active work on a full-time basis (35 hours or more per week). Part-time employment means working a regular schedule of 20 or more hours per week year round. It does not include temporary employment or employment that is not year-round. It does, however, include certain absences from work, including:
  - Absence due to a military leave protected by the Uniformed Services Employment and Reemployment Act, if you return to work within the time period provided in the act.
  - Absence due to termination of employment, if you are reemployed within 90 days.
  - Absence covered under the Family and Medical Leave Act.
  - Absence due to short-term disability benefits if you are receiving benefits under the company disability plan for a maximum of 180 days.
  - Absence due to long-term disability if you are receiving benefits under the company disability plan to a maximum of 30 months if all of the following apply:
    - Your disability began on or after January 1, 2006.
    - You had five years of service at the time you became eligible for long-term disability.
  - Absence due to disability if you are receiving long-term disability (LTD) benefits from the company disability plan and you return to work within 24 months after LTD benefits begin.
- Years of service are generally based on the continuous period of full-time or part-time employment with the company immediately prior to termination. However, the following exceptions will apply:
  - If you leave the company and are reemployed, you will receive credit for the prior period of employment if you return to work before a "break in service" occurs.
  - "Break in service" means a period of 90 consecutive days during which you were not employed by the company.
    - If you have a break in service and then return to work, you will receive credit for the period of employment prior to the break in service if (a) you had five years of service prior to the break (10 years for breaks prior to 1989), or (b) the break did not exceed the number of years and months of service you had before the break.

Your allowance will be based on your age and years of service with the company (with years of service rounded up to the next full year) as shown in the table below.

| | Medical Coverage Allowance | |
|---|---|---|
| For Service | Full-time Employee | Part-time Employee |
| Prior to age 50 | $2,700 x Years of Service, plus | $1,350 x Years of Service, plus |
| From age 50-54 | $8,100 x Years of Service, plus | $4,050 x Years of Service, plus |
| At age 55 and beyond | $13,500 x Years of Service | $6,750 x Years of Service |

The allowance multiplier will be adjusted for inflation each January while you are on long term disability and eligible for medical coverage under this plan as a disabled employee. The adjustment will be based on the medical component of the Consumer Price Index (CPI), not to exceed 5%.

You can use the tax-free allowance immediately at the end of your 36 months of medical coverage eligibility or at any time in the future. You may request reimbursement for any premiums you pay for

medical, dental, or vision insurance for you and your eligible dependents (as defined by the plan). Such plans may include:

- Patriot Catastrophic Medical Plan.
- Individual health insurance policies.
- Medicare and Medicare supplement plans.

Your allowance at the end of your 36 months of medical coverage is a lifetime maximum – it is not reinstated each year or at any other time in the future. Once your maximum allowance is exhausted, you will no longer be eligible for any reimbursement of your medical premiums from the company.

If you should die before your maximum allowance is used, your surviving spouse and his or her eligible dependents may continue to be reimbursed for such premiums until the allowance is exhausted. If your spouse dies or remarries, the remaining balance will be forfeited. You will not be eligible to receive a lump-sum cash payment. If there is no surviving spouse eligible for benefits, the balance of your allowance remaining at the time of your death will be forfeited.

Please note that this retiree medical plan is an “unfunded” plan as defined by federal law. This means the money will be paid out of the company’s general assets and has not been placed in a trust or special account.

Also, please note, retiree medical plan benefits are not considered taxable income.

***Claims for Reimbursement***

The retiree medical plan is administered by BeneFLEX HR Resources, Inc. (BeneFLEX), a third-party administrator located in St. Louis, Missouri. For reimbursement of premiums other than the Patriot Catastrophic Medical Plan, you will need to send proof of your paid medical premiums to BeneFLEX. Reimbursements will be made once a month for the current month or past month premium payments. Payments will not be made for future dates of coverage.

***Patriot Catastrophic Medical Insurance***

Eligible retirees may elect coverage under Patriot’s Catastrophic Medical Plan. The plan benefits are identical to the Option 1000 plan design that is described earlier.

***Who Is Eligible for Catastrophic Coverage***

The eligibility rules are different than the retiree medical plan described previously, although the two benefits can work together. To be eligible to participate in the Catastrophic Medical Plan, you must meet all of the following requirements:

- You are at least age 55 at the time you exhaust your 36 months medical coverage as a disabled employee.
- You have 5 or more years of service as defined by the plan. (Ten years of service for employees who retired prior to July 1, 2007.)
- You must enroll within 31 days after you exhaust your 36 months of eligibility for medical coverage as a disabled employee.

***Important Plan Provisions***

If you have coverage through another employer-sponsored group plan (such as through your spouse's employment), you may delay your participation in the Catastrophic Medical Plan. If such employment begins after you lose coverage as a disabled employee, you may temporarily suspend participation under the Catastrophic Medical Plan. If you later lose that coverage, you may elect coverage under the Catastrophic Medical Plan as long as you provide proof that you lost the other coverage. This proof must be provided within 31 days of the date coverage was lost, and participation in the Catastrophic Medical Plan must begin immediately thereafter. If you were not a participant in the company medical plan as an disabled employee because you had coverage through another employer-sponsored group plan, you may

elect coverage under the Catastrophic Medical Plan when your other coverage ends. You must provide proof of your other coverage at the time of your election. You may contact the Patriot Benefits Call Center at 1-800-633-9005 for an enrollment form.

Only eligible dependents at the time you have while covered as a disabled employee can be covered under the Catastrophic Medical Plan; new dependents cannot be added at a later date. If you have a dependent who is covered under another group health plan at the time you elect coverage under the Catastrophic Medical Plan and that dependent later loses the coverage, that dependent can be added within 31 days of the loss of coverage provided they continue to meet the eligibility rules under the plan.

In the event of your death while covered under the Catastrophic Medical Plan, your surviving dependents may continue coverage as long as they remain eligible as defined on page 54.

***The Cost of Coverage***

An enrollment form for the Catastrophic Medical Plan coverage will be available at the end of your 36 months of medical coverage as a disabled employee if you meet the eligibility requirements. The form will include the applicable monthly rates for coverage. You will be responsible for the full cost of the plan.

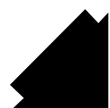
Once enrolled, you may use your retiree medical plan allowance to offset the cost of Catastrophic Medical Plan coverage.

## If You Are Enrolled in the Consumer Choice Option

**If you become disabled and receive benefits from the short-term disability plan:** You continue to participate in the plan as if you were actively at work.

**If you become disabled and receive benefits from the long-term disability plan:** You will no longer be eligible for the Consumer Choice Option and you will need to make a new medical election. Your entire Employee Choice Account will roll over into a Retiree Choice Account.

# When You Retire



Effective January 1, 2006, when you terminate employment with the company after becoming eligible for retirement, your eligibility for benefits under the options described in this summary plan description end, except to the extent to which coverage may be continued under COBRA. You will be eligible for retiree medical benefits as described below.

Your retiree medical plan provides a benefit to help you purchase medical coverage after retirement. Under the plan, the company will provide an allowance toward the purchase of medical coverage for those leaving the company on or after January 1, 2003. The dollar amount will be based on your years of service, as defined by the plan, with Patriot Coal Corporation and selected subsidiaries and affiliates (company).

## Who Is Eligible for Retiree Medical

To be eligible for retiree medical, you must meet all of the following requirements on your last day of employment with the company.

- You retire after January 1, 2006.
- You are at least age 55.
- You have 5 or more years of service as defined by the plan. (Ten years for employees who retired prior to July 1, 2007.)

If you are eligible for retiree coverage under another Patriot group health plan, you are not eligible for the coverage described in this section.

## How the Plan Works

When you end your employment with the company, your allowance will be based on your age and years of service with the company (with years of service rounded up to the next full year) as shown in the table below:

| | Retiree Medical Coverage Allowance | |
|---|---|---|
| For Service | Full-time Employee | Part-time Employee |
| Prior to age 50 | $2,700 x Years of Service, plus | $1,350 x Years of Service, plus |
| From age 50-54 | $8,100 x Years of Service, plus | $4,050 x Years of Service, plus |
| At age 55 and beyond | $13,500 x Years of Service | $6,750 x Years of Service |

The allowance multiplier will be adjusted for inflation each January while you are an active employee. The adjustment will be based on the medical component of the Consumer Price Index (CPI), not to exceed 5%.

You can use the allowance at any time in the future to request reimbursement for any premiums you pay for medical, dental, or vision insurance for you and your eligible dependents (as defined by the plan). Such plans may include:

- Patriot's Catastrophic Medical Plan.
- Individual health insurance policies.
- Another employer’s group health plan.
- Medicare and Medicare supplement plans.
- COBRA continuation coverage while you are eligible for COBRA as described on page 62.

Your allowance at retirement is a lifetime maximum – it is not reinstated each year or at any other time in the future nor will the amount be indexed after you retire. Once your maximum allowance is exhausted, you will no longer be eligible for any reimbursement of your medical premiums from the company.

If you should die before your maximum allowance is used, your surviving spouse and her eligible dependents may continue to be reimbursed for such premiums until the allowance is exhausted. If your spouse dies or remarries, the remaining balance will be forfeited. You will not be eligible to receive a lump-sum cash payment. If there is no surviving spouse eligible for benefits, the balance of your allowance remaining at the time of your death will be forfeited.

Please note that this retiree medical plan is an “unfunded” plan as defined by federal law. This means the money will be paid out of the company’s general assets and has not been placed in a trust or special account.

Also, please note that retiree medical plan benefits are not considered taxable income.

## Years of Service

Years of service means the number of days of full-time or part-time employment with the company, divided by 365. That number is then rounded up to the next full year to determine the maximum amount you can be reimbursed from the plan.

For purposes of measuring years of service, the following are included:

- Years of full-time or part-time employment. Full-time employment means performance of active work on a full-time basis (35 hours or more per week). Part-time employment means working a regular

schedule of 20 or more hours per week year round. It does not include temporary employment or employment that is not year-round. It does, however, include certain absences from work, including:

- Absence due to a military leave protected by the Uniformed Services Employment and Reemployment Act, if you return to work within the time period provided in the act.
- Absence due to termination of employment, if you are reemployed within 90 days.
- Absence covered under the Family and Medical Leave Act.
- Absence due to short-term disability benefits if you are receiving benefits under the company disability plan for a maximum of 180 days.
- Absence due to disability if you are receiving long-term disability (LTD) benefits from the company disability plan and you return to work within 24 months after LTD benefits begin.

- Years of service are generally based on the continuous period of full-time or part-time employment with the company immediately prior to termination. However, the following exceptions will apply:
  - If you leave the company and are reemployed, you will receive credit for the prior period of employment if you return to work before a “break in service” occurs.
  - “Break in service” means a period of 90 consecutive days during which you were not employed by the company.
    - If you have a break in service and then return to work, you will receive credit for the period of employment prior to the break in service if (a) you had five years of service prior to the break (10 years for breaks prior to 1989), or (b) the break did not exceed the number of years and months of service you had before the break.

## Claims for Reimbursement

The retiree medical plan is administered by BeneFLEX HR Resources, Inc. (BeneFLEX), a third-party administrator located in St. Louis, Missouri. For reimbursement of premiums other than the Patriot Catastrophic Medical Plan, you will need to send proof of your paid medical premiums to BeneFLEX. Reimbursements will be made once a month for the current month or past month premium payments. Payments will not be made for future dates of coverage.

If you elect coverage under the Catastrophic Medical Plan as described in the following section, you may elect to have your premium payments automatically deducted from your retiree medical allowance.

## Patriot Catastrophic Medical Insurance

Eligible retirees may elect coverage under Patriot’s Catastrophic Medical Plan. The plan benefits are identical to the Option 1000 plan design that is described earlier.

## Who Is Eligible for Catastrophic Coverage

To be eligible to participate in the Catastrophic Medical Plan, you must meet all of the following requirements:

- You retire after January 1, 2006.
- You are at least age 55.
- You have 5 or more years of service as defined by the plan. (Ten years for employees who retired prior to July 1, 2007.)
- You must enroll within 31 days from the date you end your employment unless you elect COBRA coverage or are eligible for coverage through another employer as described in the next section.

## Important Plan Provisions

If you have coverage through another employer-sponsored group plan at the time you end your employment or obtain other employer-sponsored group coverage after you end your employment, you may delay your participation in the Catastrophic Medical Plan. If such employment begins after you retire, you may temporarily suspend participation under the Catastrophic Medical Plan. If you later lose that coverage, you may elect coverage under the Catastrophic Medical Plan as long as you provide proof that you lost the other coverage. This proof must be provided within 31 days of the date coverage was lost, and participation in the Catastrophic Medical Plan must begin immediately thereafter. If you were not a participant in the company medical plan as an active employee because you had coverage through another employer-sponsored group plan, you may elect coverage under the Catastrophic Medical Plan when you end your employment. You must provide proof of your other coverage at the time of your election. You may contact the Patriot Benefits Call Center at 1-800-633-9005 for an enrollment form.

Only eligible dependents at the time you end your employment can be covered under the Catastrophic Medical Plan; new dependents cannot be added at a later date. If you have a dependent who is covered under another group health plan at the time you elect coverage under the Catastrophic Medical Plan and that dependent later loses the coverage, that dependent can be added within 31 days of the loss of coverage provided they continue to meet the eligibility rules under the plan.

In the event of your death while covered under the Catastrophic Medical Plan, your surviving dependents may continue coverage as long as they remain eligible as defined on page 54.

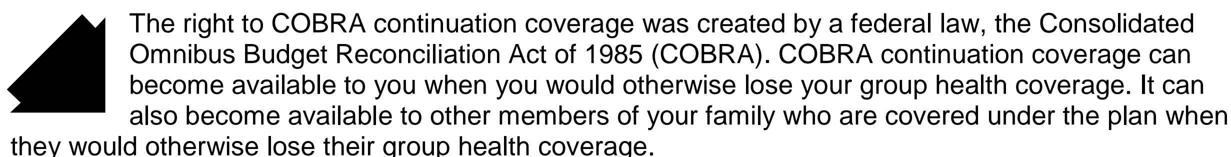
When you end your employment, you may elect COBRA continuation under the Patriot medical plan you are participating in at the time of you end your employment. At the end of your COBRA continuation period, you may then elect coverage under the Catastrophic Medical Plan.

## The Cost of Coverage

An enrollment form for the Catastrophic Medical Plan coverage will be available when you terminate employment and meet the eligibility requirements. The form will include the applicable monthly rates for coverage. You and other participants will be responsible for the full cost of the plan.

Once enrolled, you may use your retiree medical plan allowance to offset the cost of Catastrophic Medical Plan coverage.

# Continuation Coverage Rights Under COBRA



The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage.

## What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage under the plan when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event.

If you are an *employee*, you will become a qualified beneficiary if you lose your coverage under the company-sponsored group health plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

If you are the *spouse* of an employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events occurs:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).
- You become divorced or legally separated from your spouse.

An employee's *dependent children* will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events occurs:

- The employee dies.
- The employee's hours of employment are reduced.
- The employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated.
- The child stops being eligible for coverage under the plan as a "dependent child".

## When Is COBRA Continuation Coverage Available?

Qualified beneficiaries will be offered COBRA continuation coverage only after the Benefits Department has been notified that a qualifying event has occurred.

## You Must Give Notice of Some Events

When the qualifying event is divorce or legal separation of the employee and spouse, a dependent child's losing eligibility for coverage as a dependent child, or a determination of disability by the Social Security Administration, you or your eligible dependent must notify the Benefits Department in writing within 60 days after the event. Notice is also required if a person has previously notified the Benefits Department of a determination of disability, and the Social Security Administration later determines the person is no longer disabled. This notice must be in writing and should be sent to:

> Benefits Administration
> Patriot Investments Corp.
> 12312 Olive Boulevard, Suite 400
> St. Louis, Missouri 63141

The notification must include the employee's name and Social Security number, the name of the spouse and/or dependent child, the nature of the qualifying event (for example, divorce, legal separation or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or legal separation or the date the dependent child reached the plan's limiting age, married or lost full-time student status).

In the case of a divorce or legal separation, when notifying the Benefits Department, the qualifying individual should also include the first and last page of either the divorce decree or the legal separation court approval.

A notice mailed to the plan will be deemed provided on the date of mailing.

*Failure to provide notice during this 60-day notice period will result in the loss of the opportunity to elect COBRA continuation coverage.*

## Electing COBRA Continuation Coverage

Once the Benefits Department receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. You and/or your spouse and dependent children will have 60 days in which to elect COBRA continuation coverage. This 60-day election period begins on the later of:

- The date coverage would end because of the qualifying event.
- The date the Benefits Department provides notice of the right to elect COBRA.

A COBRA election mailed to the Benefits Department will be considered made on the date of mailing.

*If COBRA continuation coverage is not elected during the 60-day election period, the right to elect continuation coverage will be lost.*

You and/or your spouse and dependent children may elect COBRA continuation coverage for all qualifying family members. However, each qualified beneficiary has an independent right to elect continuation coverage. Thus, both you and your spouse may elect continuation coverage, or only one of you may do so. You may also elect to continue coverage on behalf of your dependent children only.

## Employees Eligible for Trade Adjustment Assistance

You may be eligible for a second COBRA election period if you did not elect COBRA continuation coverage after your termination of your employment and you later become eligible for trade adjustment assistance. In this event, you must elect COBRA during the 60-day period that begins on the first day of the month in which you are determined to be eligible for trade adjustment assistance and no more than six months after you initially lost your coverage. Contact the Benefits Department if you want more information about this special election period.

Coverage elected during this second election period will end 18 months from the first day of the second COBRA election period and not the date your coverage ended. The time beyond the loss of coverage and the date you became eligible for trade adjustment assistance will be not counted for purposes of determining whether you have had a 63-day break in coverage or purposes of any pre-existing condition limitation or exclusion.

## Paying for COBRA Continuation Coverage

You must pay the full cost of COBRA continuation coverage. Your first payment must be made within 45 days of the date that the COBRA election was made. If payment is not received within this 45-day period, your coverage will be terminated retroactively to the beginning of the maximum coverage period.

After the initial premium payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30-day grace period. A premium payment that is mailed will be considered made on the date of mailing. If the full amount of the premium is not paid by the due date or within the 30-day grace period, COBRA continuation coverage will be canceled retroactively to the first day of the month with no possibility of reinstatement.

Generally, the amount of the premium for COBRA continuation coverage will not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. In the case of an extension of COBRA continuation coverage due to a disability, the amount of the premium will not exceed 150 percent of the cost of coverage.

The Trade Adjustment Assistance Reform Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA coverage. For more information, call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at *www.doleta.gov/tradeact/2002act_index.cfm*.

## Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. The duration of the coverage depends on the nature of the qualifying event:

- When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or a dependent child's losing eligibility as a dependent child, coverage under COBRA may be continued for up to 36 months from the date of the qualifying event.
- When the qualifying event is the end of employment or reduction of the employee's hours of employment, coverage under COBRA may be continued for up to 18 months from the date of the qualifying event.
- There are three ways in which the 18-month period of COBRA continuation coverage can be extended.

1. **Employee's entitlement to Medicare within 18 months of the qualifying event.**
   An employee who becomes entitled to Medicare benefits less than 18 months before the end of employment or reduction of the employee's hours of employment is entitled to 18 months of COBRA continuation coverage as described above. However, COBRA continuation coverage for qualified beneficiaries other than the employee may last up to 36 months after the date of the employee's Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before employment terminates, COBRA continuation coverage for the spouse and children can last up to 36 months after the date of Medicare entitlement, which would be 28 months after the date of the qualifying event (36 months minus eight months).
2. **Disability extension of 18-month period of continuation coverage.**
   If the Social Security Administration (SSA) determines that you or a family member covered under the plan is disabled and the Benefits Department receives timely notice of that determination, you and your other family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months of COBRA coverage. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA continuation coverage. In order for the extension to be available, the Benefits Department must receive a copy of the SSA's determination during the first 18 months of COBRA continuation coverage and no more than 60 days after the latest of: (1) the date of the SSA determination, (2) the date of the qualifying event or (3) the date coverage would end on account of the qualifying event.
3. **Second qualifying event extension of 18-month period of continuation coverage.**
   If your family experiences a second qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months of COBRA coverage. This extension may be available if the employee or former employee dies, is divorced or legally separated, or if a child no longer qualifies as a dependent child under the terms of the plan, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. Coverage will be extended only if you or your family

members provide notice of the second qualifying event to the Benefits Department no more than 60 days after the event occurs.

## When COBRA Continuation Coverage Ends

A qualified beneficiary's COBRA continuation coverage will end upon occurrence of any of the following events:

- The maximum COBRA coverage period expires.
- The premium for coverage is not paid for in a timely manner.
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have.
- After electing COBRA, the qualified beneficiary enrolls for Medicare.
- If coverage is extended on account of disability, the Social Security Administration makes a determination that the individual is no longer disabled.
- The company no longer provides group health coverage to any of its employees.

## Special Rules for Retirees

If the retiree loses coverage within one year before or after the company files for bankruptcy under Title 11, the retiree is entitled to coverage for life. The retiree's surviving spouse and covered dependents are entitled to coverage for the life of the retiree, and if they survive the retiree, to an additional 36 months of coverage after the retiree's death. If the retiree is not living at the time of the qualifying event but the retiree's spouse has coverage, the surviving spouse is entitled to coverage for life.

The company will provide notification of COBRA eligibility in the event of a bankruptcy proceeding in accordance with the law.

## If You Have Questions

Questions concerning the plan or your COBRA continuation coverage rights should be addressed to the Benefits Department as indicated below. For more information about your rights under ERISA including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at *www.dol.gov/ebsa*. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.).

## Keep the Company Informed of Address Changes

In order to protect your family's rights, you should keep the Benefits Department informed of any changes in the addresses of family members. If you have a qualifying event, you should also keep a copy of any notices you send to the Benefits Department for your records.

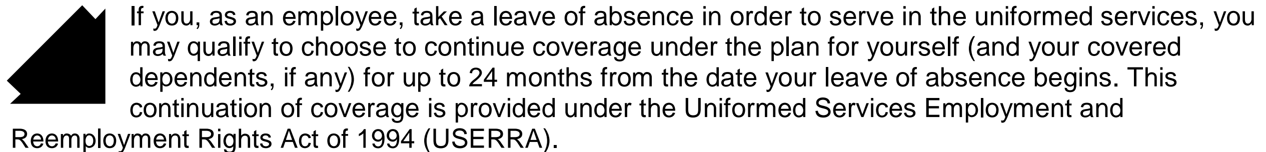
## How to Contact the Benefits Department

All required notices should be mailed to the Benefits Department at the following address:

Benefits Administration<br>
Patriot Investments Corp.<br>
12312 Olive Boulevard, Suite 400<br>
St. Louis, MO 63141

You can also call the Patriot Benefits Department at 1-800-633-9005 if you have any other questions about COBRA continuation coverage.

# Continuing Coverage While On Military Leave



If you, as an employee, take a leave of absence in order to serve in the uniformed services, you may qualify to choose to continue coverage under the plan for yourself (and your covered dependents, if any) for up to 24 months from the date your leave of absence begins. This continuation of coverage is provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Your USERRA continuation coverage will end as soon as any of the following events occurs:

- You fail to pay any required premium for coverage within the required time.
- You lose your USERRA rights due to a dishonorable discharge or other conduct specified in USERRA.
- You complete your military service but fail to report to work or to apply for reemployment within the time required by USERRA, as described in the following chart.

| The Length of Your Period of Uniformed Service | When You Must Report-to-Work or Submit an Application for Reemployment |
|---|---|
| No more than 30 days (or if your absence is for the purpose of undergoing an examination to determine your fitness to perform uniformed services) | No later than the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period—or, if that is unreasonable or impossible through no fault of your own, as soon as possible.* |
| 31 to 180 days | No later than 14 days after completion of your military service—or, if that is unreasonable or impossible through no fault of your own, as soon as possible.* |
| 181 days or more | No later than 90 days after completion of your service* |

*If you are hospitalized for or are convalescing from an injury or illness incurred or worsened as a result of your service, the applicable time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. The maximum period for recovery generally is two years from completion of service.

## USERRA and COBRA

USERRA continuation coverage is separate from COBRA continuation coverage, although they may run concurrently, which means that they begin at the same time. However, COBRA coverage can continue for up to 18 months (and for longer periods under certain circumstances), while as noted on the previous page, USERRA coverage can continue for up to 24 months. In addition, COBRA coverage may be ended for additional reasons that do not apply to USERRA coverage. For more information about COBRA continuation coverage see page 62.

## Paying for USERRA Continuation Coverage

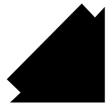
If your period of uniformed service period is less than 31 days, you are not required to pay more for USERRA coverage than the amount that you pay for such coverage as an active employee.

For longer periods, if you choose to continue health coverage under USERRA, your cost is the same as for COBRA continuation coverage—102% of the full cost to the plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving USERRA continuation coverage.

## For More Information

If you leave employment to enter military service, you should contact the Benefits Department to determine whether you also have the right to continue your health care coverage under USERRA.

# Converting Medical Coverage to an Individual Policy



After your (or your dependent's) coverage ends, you (or a previously covered dependent) can ask to convert your medical coverage to an individual insurance policy. (This conversion privilege is not available if your coverage ended because the company terminated the plan or you failed to make required contributions.)

Dependents cannot be added to the individual policy if they were not covered by the plan at the time your coverage ended.

Furthermore, the benefits available under an individual insurance policy are not necessarily the same as the benefits offered under the company's medical plan. You should examine the new individual policy carefully.

To convert coverage, you must submit a written application and the first premium payment to the designated insurance company within 31 days of the date your coverage ends. You or your covered dependents do not have to provide proof of good health. The policy will be effective on the day after your plan coverage ends.

# Terms and Definitions

## Ambulatory Surgical Facility

An institution, either freestanding or as part of a hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures for which a patient is admitted and discharged within a brief period.

## Claims Administrator

The organization retained by the company for granting or denying claims and providing pre-certification, currently BlueCross BlueShield of Illinois and Prescription Solutions for the Consumer Choice Option and Option 250 prescription drug claims.

## Company

Patriot Coal Corporation and its subsidiaries and affiliates.

## Custodial Care

Care provided primarily for the convenience of the patient or his or her family, the maintenance of the patient, or to help the patient carry out the activities of daily living, rather than primarily for therapeutic value in the treatment of a condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, supervising the self-administration of medications not requiring the constant attention of trained medical personnel, or acting as a companion or sitter.

## Disabled Employee

Any employee who is receiving short-term or long-term disability benefits under the company's disability plan.

## Durable Medical Equipment

Equipment that meets all of the following conditions:

- It can withstand repeated use.
- It is primarily and customarily used in the therapeutic treatment of sickness or injury.
- It is generally not useful to a person in the absence of a sickness or injury.
- It is appropriate for use in the home.
- It is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature.
- It is not primarily for the convenience of the person caring for the patient.
- It is not used for exercise or training.

## Educational Institution

Any state-accredited high school, college or university, including other recognized educational institutions such as nursing schools, trade schools and so forth, with full-time curriculums. Correspondence schools, night schools or schools requiring less than full-time attendance are not included.

## Eligible Retired Employee

A former salaried employee who has stopped working for the company, and who, on the date he or she stopped working, is at least 55 with 10 or more years of service.

## Emergency or Urgent Care

A serious medical condition resulting from injury or sickness that arises suddenly and requires immediate medical care to avoid serious physical impairment or loss of life, and for which you seek medical attention after the onset.

## Employee

Any full-time (working 35 or more hours per week) or part-time employee of the company who is regularly scheduled to work at least 20 hours per week year-round, or is considered to be a full-time employee while on vacation and who is not a disabled employee or retired employee.

This definition does not include any temporary or seasonal employees, or any person who is a non-resident alien and who receives no income from the company that constitutes income from sources within the United States as defined by the Internal Revenue Code.

## Home Health Care

Services provided by either:

- A hospital-based home health care agency that is licensed by the state and approved by the Joint Commission on Accreditation of Healthcare Organizations.
- A community home health care agency approved by Medicare.

## Home Health Care Agency

A home health care agency is a federally certified public or private organization that meets all the following conditions:

- It is primarily engaged in providing skilled-nursing and other therapeutic services.
- It has policies established by associated professional personnel, including at least one physician and one RN, which govern the services provided under the supervision of the physician or nurse.
- It maintains medical records on all patients.
- It is licensed and approved by state or local law.
- It is a hospital certified by the state public health law to provide home health services.

## Hospital

An institution that meets all of the following conditions:

- It is primarily engaged in providing diagnostic and therapeutic facilities for compensation on an inpatient basis for surgical and medical diagnosis under the supervision of a staff of physicians.
- It provides 24-hour nursing services by registered nurses.
- It is not a rest home, home for the aged, facility to treat drug or alcohol addiction, nursing home, hotel or similar institution.
- It is licensed by the state and approved by, or under the waiting period for accreditation by, the Joint Commission on Accreditation of Healthcare Organizations.

For purposes of mental illness and substance abuse benefits, the definition of a hospital also includes:

- A facility approved by the claims administrator for inpatient or outpatient treatment of chemical abuse.
- Psychiatric hospitals classified and accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- A residential treatment facility, if approved by the Blue Care® Connection program when necessary treatment cannot be provided while the patient is living at home.

## Illness

Any disease or disorder of the body, or pregnancy. Pregnancy includes normal delivery, cesarean section, miscarriage, complications resulting from pregnancy or termination of pregnancy if medically necessary, certified and performed by a physician.

## Injury

An accidental bodily injury caused directly and exclusively by sudden and violent means.

## Medically Necessary

A service or supply that is ordered by a physician and which the plan administrator (or a person or organization designated by the plan administrator) determines as meeting all the following conditions:

- It is provided for the diagnosis or direct treatment of an injury or illness.
- It is appropriate and consistent with the diagnosis and treatment of the injury or illness.
- It is provided in accordance with generally accepted medical practice on a national basis at the time it is provided.
- It is the most appropriate supply or level of service that can be provided on a cost-effective basis.
- It is not provided in connection with medical or other research.
- It is not experimental, educational or investigational.

The fact that a physician prescribes services or supplies does not automatically mean such services or supplies are medically necessary and covered by the plan. The treatment must also meet the plan's other provisions.

## Medicare

The health insurance program for aged and disabled persons under Title XVIII of the Social Security Act, as amended and currently in effect.

## Mental Illness

A psychotic disorder, a psychophysiological autonomic or visceral disorder, a psychoneurotic disorder, a personality disorder, or any other mental, emotional or functional nervous disorder classified as a mental disorder in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

## Physician or Surgeon

An individual licensed to diagnose and treat illnesses, prescribe and administer drugs and medicines, or perform surgery. The definition also includes:

- A licensed dentist who is operating within the scope of his or her license to provide dental work or treatment that is covered under the medical plan.
- A podiatrist operating within the scope of his or her license for certain covered podiatry services that are common to both medicine and podiatry.
- A certified, registered psychologist providing diagnosis or treatment of a mental and nervous condition.

## Qualified Medical Child Support Order

As defined in Section 609(a) of ERISA, added by the Omnibus Budget Reconciliation Act of 1993, effective August 10, 1993. This describes a court order naming you as being responsible for the costs of a child's health care.

## Registered Psychologist

A person providing registered psychological services for diagnosis or treatment of mental, psychoneurotic or personality disorders. The psychologist must qualify, in the jurisdiction in which he or she is practicing, in the following ways:

- If state licensing or certification exists, he or she must hold a valid license or certificate as a psychologist.
- If state licensing or certification does not exist, he or she must hold a valid, non-statutory (professional) certification established by that area's recognized psychological association.
- If neither statutory or non-statutory licensing nor certification exists, the psychologist must hold a statement of qualification by a committee established by that area's psychological association. If no committee exists, he or she must hold a diploma in the appropriate specialty from the American Board of Examiners in Professional Psychology.

## Skilled Nursing Facility

A facility that is qualified to participate in and receive payments from Medicare. In addition, the facility must do all the following:

- Operate legally in the area it is located.
- Be accredited as a skilled-nursing facility by the Joint Commission on Accreditation of Healthcare Organizations.
- Regularly provide room and board.
- Provide 24-hour-a-day skilled-nursing care.
- Maintain a daily medical record of each patient under the care of a physician.
- Be authorized to administer medications ordered by a physician.

## Spouse

Your legal partner in marriage by a civil or religious ceremony. Common-law marriage is not recognized by the plan. Also, domestic partners are not recognized by this plan.

## Step Therapy Program

An approach that requires you to try more traditional and proven medications before trying the newest, most costly medications.

## Surviving Spouse

Your spouse surviving after your death, who at the time of your death was living with you or supported by you.

## Termination of Employment

Includes any of the following:

- You voluntarily end your employment with the company.
- The company ends your employment.
- Retirement.
- Death.

# Plan Administration Information

**Plan Name**
The Patriot Coal Corporation and Affiliates Welfare Benefit Plan

**Type of Plan**
Life insurance, accidental death and dismemberment, medical, dental, vision care, flexible spending accounts and disability benefits. Life insurance, accidental death and dismemberment, dental, vision care, flexible spending accounts and disability benefits are described in separate booklets.

**Employer Identification Number**
The employer identification number assigned to the company by the Internal Revenue Service is 20-0480084.

**Plan Number**
501

**Effective Date**
June 1, 1985

**Plan Fiscal Year**

January 1 to December 31

**Plan Sponsor**
Patriot Coal Corporation

You may direct correspondence to:

Patriot Coal Corporation
12312 Olive Boulevard, Suite 400
St. Louis, Missouri 63141

**Plan Administrator**
Patriot Coal Corporation
12312 Olive Boulevard, Suite 400
St. Louis, Missouri 63141

**Agent for Service of Legal Process**
The agent for service of legal process varies by state. To determine the appropriate agent for your location, you may contact:

Patriot Coal Corporation
12312 Olive Boulevard, Suite 400
St. Louis, Missouri 63141

Service of legal process may also be made upon the plan administrator.

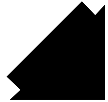
**Funding and Disbursements**
The plan is funded by contributions from Patriot Coal Corporation and its subsidiaries and affiliates and/or participating employees. Disbursements are made by the applicable claims administrator in accordance with the terms of the plan.

Medical and prescription drug benefits are self-insured by Patriot Coal Corporation and its affiliates and are not guaranteed under a policy or contract of insurance.

**Participating Provider Arrangements**
Some of BlueCross BlueShield contracts with providers and administrators allow for additional discounts or allowances to be paid to or retained by the claims administrator or another BlueCross BlueShield organization. However, all claims submitted will have the copayments and deductibles that are your responsibility calculated without regard to such discounts and allowances.

In addition, the plan's contract with the prescription drug benefits administrator may provide for the sharing in manufacturers' rebates. These rebates may be shared between the administrator and the plan. However, the copayments, which are your responsibility, will be calculated without regard to such rebates.

# Your ERISA Rights



As a participant in this 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, all documents governing the plan, including insurance contracts, 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 Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. 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

In addition, if you are a participant in a group health plan, you have the right to:

- 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 for information concerning your COBRA continuation coverage rights.
- Receive a copy of the plan's Qualified Medical Child Support procedures without charge upon request.
- A reduction or elimination of exclusionary periods of coverage for pre-existing 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 elect COBRA continuation coverage, or when your COBRA continuation coverage ceases if you request it within 24 months after losing coverage and you have creditable coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion or limitation, as described in the summary plan description.

## Prudent Actions 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 plan participants and beneficiaries. No one, including your employer 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 relating to the decision without charge, and to appeal any denial, all within certain time schedules.

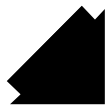
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator 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 that 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 a 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 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# Claims Procedures and Review



There are three types of claims for medical benefits, each of which is subject to different rules.

## Types of Claims

- *Pre-service claim:* A claim for a benefit that requires prior approval under the terms of the plan, such as inpatient admission pre-certification.
- *Urgent care claim:* A type of pre-service claim which, if the regular time periods for handling pre-service claims were followed: (1) could seriously jeopardize your life or health or your ability to regain maximum function, or (2) would, in the opinion of a health care provider with knowledge of your condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.
- *Post-service claim:* A claim for a benefit that does not require prior approval under the terms of the plan. A post-service claim involves a claim for payment or reimbursement for medical care or supplies that have already been received.

## Submitting claims

- *Pre-service and urgent care claims.* A pre-service claim, including an urgent care claim, will be considered submitted when a request for prior approval is received by BCC or other organization authorized to pre-certify certain types of medical care on behalf of the plan. In a situation involving a request for prior approval of a prescription drug, a pre-service claim, including an urgent care claim, will be considered submitted when a request for prior approval of a prescription drug is received by Prescription Solutions. Prior authorization may be requested as described on page 32.

- *Incorrectly submitted claims.* If you do not follow the plan's procedures for filing a pre-service claim, you will be notified of the appropriate procedures if: (1) the request for prior approval was received by someone who customarily is responsible for handling benefit matters and (2) the communication identifies the claimant, the specific treatment, service or product for which approval is requested and the medical basis for the request. Notice of an incorrectly submitted claim will be provided no more than 24 hours (for urgent care claims) or five calendar days (for all other pre-service claims) after the incorrectly submitted claim is received. This notice may be oral unless you request written notification.
- *Post-service claims.* Network providers will generally submit their claims for payment directly to the claims administrator. If you obtain services from a non-network provider, you must pay for the services and submit a claim for reimbursement as described starting page 47. Participating pharmacies will generally submit their claims for payment directly to Prescription Solutions. If you obtain services from a non-participating pharmacy, or if you not present your identification card with your prescription, you must pay the full cost of the drug and then submit a claim for reimbursement. The amount of the reimbursement will be reduced by the amount of any applicable copayments. The procedures for submitting a claim for reimbursement are described on page 47.

Claim forms are available from your Benefits Department. A claim will be considered submitted when it is received by the claims administrator.

# Initial Claims Determinations

The timeframes for making the initial decision regarding a claim and the procedures for notifying you about that decision depend on the type of claim.

- *Urgent care claims.* You will be notified whether your urgent care claim (including a request for prior approval of a prescription drug) has been approved or denied as soon as possible, but in no event later than 72 hours after the claim is received. If more information is needed in order for a determination to be made, you will be advised of the specific information necessary to complete the claim within 24 hours after receipt of the claim. You will be allowed at least 48 hours to provide the necessary information. You will be notified of the determination within 48 hours after the earlier of: (1) the plan's receipt of the requested information or (2) the end of the period you were given in which to provide the information. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.
- *Pre-service claims.* You will be notified whether your pre-service claim (including a request for prior approval of a prescription drug) has been approved or denied within a reasonable period of time appropriate to the medical circumstances involved, but in no event more than 15 days after the claim is received. The 15-day period may be extended an additional 15 days if the extension is necessary due to matters beyond the control of the plan and you are notified of the extension before the initial 15-day period expires. If the extension is required because you failed to submit information necessary to decide the claim, the extension notice will specifically describe the information needed to complete the claim. You will be given at least 45 days from the time you receive the notice to provide the requested information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

### Previously-Approved Medical Treatments

- If BCC previously approved an ongoing course of medical treatment that was to be provided over a period of time or that involved a specified number of treatments and you wish to extend the course of treatment beyond that which had been approved, you may request an extension. If the claim involves urgent care, you will be notified whether the extension has been approved or denied no more than 24 hours after your request for the extension is received, provided that you make such request at least 24 hours before the end of the previously approved period of time or before you received all of the

previously approved treatments. If the request for an extension is made less than 24 hours before the expiration of the prescribed period of time or number of treatments, the request will be treated as a new urgent care claim and decided under the general timeframe applicable to urgent care claims. If the claim does not involve urgent care, the extension request will be treated as a new pre-service claim and will be decided within the timeframe applicable to pre-service claims as described above.

- If BCC previously approved an ongoing course of treatment that was to be provided over a period of time or that involved a specified number of treatments, any decision by the plan to reduce or terminate that course of treatment (other than by plan amendment or termination) before the end of such period of time or before all approved treatments have been received will be considered a benefit denial. You will be notified sufficiently in advance of such reduction or termination to allow you to appeal and obtain a determination on the appeal before the benefit is reduced or terminated.
- *Post-service claims*, including claims involving prescription drugs. The appropriate claims administrator will decide a post-service claim within a reasonable period of time, but not later than 30 days after the claim is received. This time period may be extended for an additional 15 days when necessary due to matters beyond the control of the plan or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period and a determination will be made no more than 45 days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will specifically describe the information needed to complete the claim and you will be allowed 45 days from receipt of the notice to provide the information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

## If Your Claim Is Denied

If your claim is denied in whole or in part, you will receive a written notice that will provide:

- The specific reasons for the denial.
- A reference to the specific plan provision on which the determination was based.
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
  - Your right to submit written comments and have them considered.
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.
- If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
  - A description of the specific rule, guideline, protocol or criterion relied on.
  - A statement that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request.
- If the basis for the denial was medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your circumstances.
  - A statement that such an explanation will be provided free of charge upon request.
- In the case of a denial of an urgent care claim, a description of the expedited review process applicable to such claim.

## Review of Denied Claims

You have 180 calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal the determination. Appeals of claims involving pre-service, urgent care claims, or post-service claims should be submitted to the appropriate claims administrator. Except in the case of an appeal involving an urgent care claim, your appeal must be in writing. *If you do not file an appeal within this 180-day period, you will lose the right to appeal the determination.*

**Expedited procedures for urgent care claims:** You may request an expedited appeal of a denial involving an urgent care claim. This request may be oral or in writing. Under these expedited procedures, all necessary information, including the determination on appeal, may be transmitted to and from BCC or Prescription Solutions, if applicable, by telephone, facsimile or other available similarly expeditious method.

Your appeal should set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim. You may also request the plan to identify any medical or vocational expert from whom it received advice in connection with the benefit determination, regardless of whether it relied on such advice in making the initial benefit determination.

## Determinations on Appeal

The timeframe for making a decision on the appeal depends on the type of claim:

**Urgent care claims**. In the case of an urgent care claim, you will be notified of the determination on appeal as soon as possible, taking into account the medical urgency of the situation, but in no event more than 72 hours after your appeal is received by the plan.

**Pre-service claims.** You will be notified of the determination on appeal within a reasonable period of time but no longer than 15 days after it is submitted. If you are not satisfied with the decision, you have the right to file a second level appeal with the plan administrator. This appeal should be submitted to:

Director, Benefits Administration
Patriot Coal Corporation
12312 Boulevard, Suite 400
St. Louis, Missouri 63141

Your second level appeal request must be submitted within 60 days of receipt of first level appeal decision. The plan administrator will make a determination on your appeal no more than 15 days after your second level appeal is submitted.

**Post-service claims.** The claims administrator will review and decide your appeal within a reasonable period of time but no longer than 30 days after it is submitted. If you are not satisfied with the decision of the claims administrator, you have the right to file a second level appeal with the plan administrator. This appeal should be submitted to:

Director, Benefits Administration
Patriot Coal Corporation
12312 Olive Boulevard, Suite 400
St. Louis, Missouri 63141

Your second level appeal request must be submitted within 60 days of receipt of first level appeal decision.

The plan administrator will make a determination on your appeal no more than 30 days after your second level appeal is submitted.

The review at each level of appeal will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was

submitted or considered in the initial benefit determination or at a lower level of appeal. The review will not give deference to the initial denial or to the decision at a lower level of appeal. In addition, the individual who decides your appeal will not be the same individual who initially decided your claim or made a decision at a lower level of appeal and will not be that individual's subordinate.

A health professional may be consulted in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the initial benefit determination or at a lower level of appeal nor be a subordinate of the health professional who was involved.

Except in instances in which notice is provided pursuant to the expedited procedures for urgent care claims described above, you will be notified in writing of the decision on appeal. If the decision upholds the denial of your claim, the notification will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- If the denial was based on medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:
    - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your circumstances, or
    - A statement that such an explanation will be provided free of charge upon request.
- If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
    - A description of the specific rule, guideline, protocol or criterion relied on, or
    - A statement that a copy of such a rule, guideline, protocol or criterion will be provided free of charge upon request.
- A statement of your right to bring a civil action under Section 502 of ERISA.

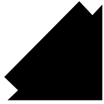
The decision of the plan administrator (or the claims administrator in the case of urgent care claims) shall be final and binding on all individuals dealing with or claiming benefits under the plan.

## Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. Generally, this authorization must be in writing and signed by you; however, in the case of an urgent care claim, a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law and who has knowledge of your medical condition will be acknowledged as your authorized representative even if no written designation is submitted. Any reference in these claims procedures to "you" is intended to include your authorized representative.

An assignment to a health care provider for purposes of payment does not constitute appointment of an authorized representative under these claims procedures.

# Amending the Plan



The plan is adopted with the intention that it will be continued for the benefit of present and future employees and retired employees of the company. However, the company reserves the right to terminate the plan, change required contributions or modify this plan in whole or in part at any time or for any reason, including changes in any and all of the benefits provided.

This may cause employees and retired employees to lose all or a portion of their benefits under the plan, but will not affect the right of any employee or retiree to be reimbursed for any covered expense that has already been incurred.

This means that an employee or a retiree cannot have a lifetime right to any plan benefit or to the continuation of this plan simply because this plan or a specific benefit is in existence at any time during the employee's employment or retirement. This plan will comply with all requirements of the law and will be changed, if necessary, in order to meet any such requirements.