Magnum Coal Company

and Subsidiaries and or Affiliates

Welfare Plan

(Plan Number 501)

Amended and Restated Effective January 1, 2007

This document incorporates by reference one or more specific contracts or documents that describe in more detail certain provisions governing the Magnum Coal Company Welfare Plan.

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ARTICLE I

ESTABLISHMENT OF PLAN

1.1 Purpose

This document constitutes the Magnum Coal Company Welfare Plan (the "Plan"), Plan Number 501. Magnum Coal Company (the "Company") maintains the Plan for the exclusive benefit of its eligible Employees and their spouses and dependents. The Plan provides benefits through the component programs described in Appendix A (the "component programs"). Each of these component programs is described in a contract, certificate or booklet issued by an insurance company, a summary plan description, or another governing document prepared by the Company or vendor for the applicable component programs listed in Appendix A. The documents representing the component programs are incorporated herein by reference. The Plan is created to provide specified health and welfare benefits for the exclusive benefit of Covered Persons, as defined herein; and is intended to satisfy the written document requirements of section 402 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

1.2 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, in its sole discretion and in accordance with the provisions of Article XI may amend, modify or terminate the Plan or any provision or component of the Plan including, but not limited to, the existence and duration of coverage for Employees, Retirees, and Dependents, eligibility and requirements for coverage, the availability, nature and extent of benefits, and the conditions for and method of payment of benefits.

1.3 Participating Plan

The Plan participates in the Company's Premium Only Account Plan which is a cafeteria plan intended to qualify under section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), and which is incorporated herein by reference.

ARTICLE II

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings. Words and phrases not defined in this Article shall have the meaning set forth in an applicable Incorporated Document, and if not defined in an applicable Incorporated Document, then such words and phrases shall have the meaning customarily given them by the applicable insurance company, third party administrator, or other service provider, as the case may be.

2.1 Claims Administrator

Claims Administrator means the person(s) or entity (or entities) authorized and responsible for receiving and reviewing claims for benefits under the Plan; determining what amount, if any, is due and payable; making appropriate disbursements to persons entitled to benefits under the Plan; and reviewing and determining denied claims and appeals.

2.2 COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), as amended, and the regulations issued thereunder.

COBRA applies only to the medical, dental, vision and health care reimbursement plan benefits provided under the Plan.

2.3 Code

Code means the Internal Revenue Code of 1986, as amended, and its regulations.

2.4 Company

Company means Magnum Coal Company, a corporation, and any successor, by merger or otherwise, and its subsidiaries and/or affiliates.

2.5 Covered Person

Covered Person means an Employee, Dependent, or Retiree who has satisfied the eligibility and enrollment provisions of Article III or, if applicable, the provisions of Article VI.

A Covered Person may have Plan coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan and in an applicable Incorporated Document.

2.6 Dependent

Dependent means a legal spouse or dependent of an Employee or a Retiree who is a Covered Person as determined under the applicable Incorporated Document.

2.7 Effective Date

Effective Date means the January 1, 2007, the date of this amended and restated Plan.

2.8 Employee

Employee means a common law employee of the Company. The term Employee does not mean any of the following persons, even if determined retroactively by a court or governmental agency to be a common-law employee:

A. a self-employed individual, as defined in Code section 401(c)(1)(B),

B. a member of the Board of Directors who is not otherwise an Employee,

C. a person the Plan Administrator determines is an independent contractor, or

D. a person the Plan Administrator determines the Company engages as a consultant or advisor on a retainer or fee basis.

A person the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters.

2.9 Employer

Employer means the Company which, with the approval of the Plan Administrator, and subject to such conditions as the Plan Administrator may impose, adopts the Plan. subsidiaries and/or affiliates adopting the Plan are listed on Appendix B.

2.10 ERISA

ERISA means the Employee Retirement Income Security Act of 1974, as amended, and its regulations.

2.11 Incorporated Document

Incorporated Document means an insurance policy, administrative services agreement, plan, trust, summary plan description or other document incorporated by reference in Appendix A, or in other sections of the Plan, together with any exhibits, supplements, addendums or amendments thereto.

2.12 HIPAA

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.13 Plan

Plan means the Magnum Coal Company Welfare Plan as herein set forth and as amended from time to time.

2.14 Plan Administrator

Plan Administrator means the person(s) authorized and responsible for managing and directing the operation and administration of the Plan.

2.15 Plan Year

Plan Year means the 12-month period beginning January 1 and ending December 31.

2.16 Retiree

Retiree means a former Employee who is a Covered Person as determined under the applicable Incorporated Document; provided, however, that except as otherwise provided in an applicable Incorporated Document, employees first hired prior to May 1, 2006 will continue to be eligible for participation in the Retiree Welfare Program provided they otherwise meet the eligibility requirements. Employees first hired on and after May 1, 2006 will not be eligible for participation in the Retiree Welfare Program.

ARTICLE III

ELIGIBILITY, PARTICIPATION, AND COVERAGE

3.1 Eligibility

Employees, Retirees, and Dependents shall be eligible for Plan participation on the later of the Effective Date or the date they meet the eligibility requirements set forth in the applicable Incorporated Document; provided, however, that except as provided in an Incorporated Document, the following Employees shall not be eligible for Plan participation:

A. Employees covered by a collective bargaining agreement where welfare benefits were the subject of good faith bargaining, which does not provide for participation in this Plan;

B. Any temporary Employee with the classification "temporary" meaning any Employee hired to fill a job vacancy for a limited time, as designated by the Plan Administrator;

C. Any intern, as designated by the Plan Administrator;

D. Any seasonal Employee, as designated by the Plan Administrator;

E. Any person who performs service for the Company under an arrangement that the Employer has determined to be a leased employee arrangement; and

F. Any person who performs service for the Company as a contract employee.

Specific eligibility requirements for certain benefits shall be set forth in Article IV or in the applicable Incorporated Documents. Notwithstanding the foregoing, if the eligibility requirements described in an Incorporated Document do not comply with HIPAA or any applicable state law requirements that are not preempted by ERISA, such HIPAA or state law requirements shall supercede the Incorporated Documents.

3.2 Participation

The provisions and requirements describing how and when Employees, Retirees, and Dependents become participants in the Plan and terminate participation in the Plan, and any conditions and limitations to participation in the Plan, shall be as set forth in the applicable Incorporated Document for each applicable component program. For any component program described in an Incorporated Document set forth in Appendix A, the term Covered Persons shall include only individuals eligible to both participate in and receive benefits under said component program.

3.3 Coverage

The provisions and requirements describing when and how Employees and Dependents become Covered Persons, the conditions and limitations to coverage, and the circumstances under which coverage terminates shall be as set forth in the applicable Incorporated Document and the Employer's leave of absence policies.

3.4 Enrollment for Benefits

An eligible Employee or Retiree may enroll for benefits by completing and filing an election form (whether written or electronic, as determined pursuant to the Company's enrollment system in place from year to year) with the Plan Administrator prior to the date of his or her initial eligibility or as otherwise provided by the terms of any Incorporated Document. The election form shall permit an Employee or Retiree to elect benefits for the Plan Year pursuant to an applicable component program described in an Incorporated Document in Appendix A.

3.5 Coverage under the Family and Medical Leave Act and Section 609 of ERISA

A. Family and Medical Leave Act of 1993

If not otherwise provided for herein, the Plan shall provide coverage for a Covered Employee solely to the extent necessary to comply with the Family and Medical Leave Act of 1993 ("FMLA"), and the Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

B. Section 609 of ERISA

The extent provided by applicable law, the Plan Administrator shall extend coverage under the Plan to the person or persons named in a qualified medical child support order under section 609(a) of ERISA, or to an adoptive child or child placed for adoption solely to the extent required by section 609(c) of ERISA. Further, the Plan shall be interpreted and administered as necessary to comply with section 609 of ERISA and the rulings and regulations issued thereunder.

C. Coverage Contingent Upon Contribution

Any coverage provided as a result of this Section shall be conditioned upon payment of applicable contributions by the Employee.

3.6 Uniformed Services Employment and Reemployment Rights Act

Solely to the extent required by the Uniformed Services Employment and Reemployment Rights Act (hereinafter the "Uniformed Services Act"), a Covered Person who is an Employee who enters military service shall have the right to continue coverage under the

Plan for the period prescribed under the Uniformed Services Act. Continuation of coverage shall be conditioned upon payment of any required premiums.

This Section shall be interpreted and applied to give an Employee (and family members who are Covered Persons) only those rights as are prescribed under the Uniformed Services Act and rulings and regulations issued thereunder, and as prescribed under rulings and regulations issued under the Veterans' Housing Opportunity and Benefits Improvement Act signed into law on June 15, 2006 which extends employer health plan continuation and reinstatement rights to reservists entitled to the Department of Defense's TRICARE coverage, even if they don't actually leave employment to perform active military service.

3.7 Coordination with State Medicaid Programs

The fact that a Covered Person is eligible for coverage by, or is covered by, a State Medicaid program shall not affect the Covered Person's eligibility to participate in the Plan or to receive benefits. The payment of benefits under the Plan with respect to any Covered Person shall be made in accordance with any assignment of rights made by or on behalf of the Covered Person of a beneficiary of the Covered Person as required by any State Medicaid program, as provided in section 609(b) of ERISA. To the extent a payment has been made to or with respect to a Covered Person pursuant to a State Medicaid program and the amount so paid is for a medical expense that the Plan has a legal liability to pay, the Plan will pay such expense in accordance with any State law that provides that the State has acquired the right with respect to the Covered Person to receive payment for such expense.

3.8 Health Insurance Portability and Accountability Act of 1996

Solely to the extent required by the Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA"), an Employee shall be a Covered Person under the Plan no later than such time as required under HIPAA, and the Plan shall be subject to the special enrollment, pre-existing condition limitations, and nondiscrimination in health status provisions of HIPAA. This Section shall be interpreted and applied to give an Employee only those rights as prescribed under HIPAA and the rulings and regulations issued thereunder.

A Covered Person's rights and responsibilities pursuant to the privacy and security rules of HIPAA are set forth in Article XII.

ARTICLE IV

BENEFITS

4.1 Benefits Incorporated by Reference

Each Covered Person may elect to receive coverage under the benefits listed in the Incorporated Documents set forth in Appendix A. The terms, conditions and limitations of benefits offered under this Plan are contained in the Incorporated Documents, which are incorporated herein in full, as amended from time to time. The Plan Administrator, Claims Administrator, insurer, contract number, or funding method of providing certain benefits may change from time to time and shall be reflected in the Incorporated Documents in Appendix A.

ARTICLE V

COORDINATION OF BENEFITS

5.1 Applicability

Except as hereinafter provided, the following Coordination of Benefits ("COB") provisions apply to this Plan, as outlined in this Article V, when a Covered Person has health care coverage under more than one Health Care Arrangement. In addition, when the provisions describing coordination of benefits are set forth in an applicable Incorporated Document, such Incorporated Document shall govern except to the extent the provisions fail to establish order of responsibility, in which case the provisions of this Article V shall govern.

5.2 COB Definitions

A. "Health Care Arrangement" means any of the following coverages which provides benefits or services to the Covered Person for, or because of, medical, surgical or hospital care treatment:

1. Group, blanket or franchise coverage, whether insured or uninsured;
2. Any prepayment coverage on a group basis, including HMOs;
3. Coverage under a labor-management trusteed plan, a union welfare benefit plan, a company organization plan or an employee benefits plan;
4. Coverage under government programs and any other coverage required or provided by law other than Medicare or a state plan under Medicaid;
5. Group or individual automobile coverage including no-fault coverage or uninsured motorist coverage;
6. Individual health care coverage;
7. Any coverage provided through a school or other educational institution;
8. Any benefits received from a law suit or the settlement of a law suit or potential law suit;
9. Other arrangements of insured or self-insured group coverage.

The term Health Care Arrangement shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Health Care Arrangements into consideration in determining its benefits and that portion which does not.

B. "Allowable Expense" means a usual and customary item of expense for health care, when the item of expense is covered at least in part by one or more Health Care Arrangements covering the individual for whom the claim is made.

When a Health Care Arrangement provides benefits in the form of services instead of cash payments, the reasonable cash value of each rendered will be considered both an Allowable Expense and a benefit paid.

C. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which an individual has no coverage under this Plan.

5.3 Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules which applies:

A. COB/Non-COB Provision

The benefits of a Health Care Arrangement which does not contain a COB provision always shall be determined before the benefits of a Health Care Arrangement which does contain a COB provision.

B. Auto Insurance

The benefits of the Health Care Arrangement which covers the person as a beneficiary under an automobile insurance policy, including no-fault or uninsured motorist coverage shall be determined prior to this Plan, even if the policy has been selected as secondary.

C. Non-Dependent/Dependent

The benefits of the Health Care Arrangement which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the Health Care Arrangement which covers the person as a dependent.

D. Dependent Child/Parents not Separated or Divorced

Except as stated in Paragraph (E) below, when this Plan and another Health Care Arrangement cover the same child as a dependent of different persons, called "parents":

1. the benefits of the Health Care Arrangement of the parent whose birthday falls earlier in a year are determined before those of the Health Care Arrangement of the parent whose birthday falls later in that year; but

2. if both parents have the same birthday, the benefits of the Health Care Arrangement which covered the parent longer are determined before those of the Health Care Arrangement which covered the other parent for a shorter period of time.

However, if the other Health Care Arrangement does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Health Care Arrangements do not agree on the order of benefits, the rule in the other Health Care Arrangement will determine the order of benefits.

E. Dependent Child/Separated or Divorced Parents

If two or more Health Care Arrangements cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. first, the Health Care Arrangement of the parent with custody of the child;

2. then, the Health Care Arrangement of the spouse of the parent with custody of the child; and

3. finally, the Health Care Arrangement of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Health Care Arrangements of that parent has actual knowledge of those terms, the benefits of that Health Care Arrangement are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

This Plan will not cover the expenses of any child who does not meet the definition of Dependent as defined herein, except as may be required pursuant to a qualified medical child support order under section 609(a) of ERISA.

F. Active/Inactive Employee

The benefits of a Health Care Arrangement which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Health Care Arrangement which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Health Care Arrangement does not have this rule, and if, as a result, the Health Care Arrangements do not agree on the order of benefits, this rule is ignored.

G. Continuation Coverage

If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:

1. First, the benefits of a plan covering the person as an employee (or as that employee's dependent);

2. Second, the benefits of coverage under the continuation plan.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

H. Longer-Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Health Care Arrangement which covered an employee, member or subscriber longer are determined before those of the Health Care Arrangement which covered that person for the shorter time.

I. Medicare Coordination

1. Employees and/or Spouses Age 65 or Older

   Unless an active Employee age 65 or older gives the Plan written notice waiving his or her right to Plan benefits, the Plan is Primary. With respect to the spouse who is age 65 or older of an active Employee, unless the Employee gives the Plan written notice waiving Plan benefits, the Plan is primary.

2. Medicare Disabled Covered Persons

   If required by law, the Plan is primary with respect to a Covered Person who is also entitled to Medicare because of disability. Otherwise, the Plan is secondary.

3. Covered Persons with End-Stage Renal Disease

   For the period required by law, if any, the Plan is primary with respect to a Covered Person entitled to Medicare because of end-stage renal disease. Otherwise, the Plan is secondary.

5.4 Effect on the Benefits of this Plan

A. When this Section Applies

This Section 5.4 applies when, in accordance with Section 5.3, "Order of Benefit Determination Rules", this Plan is a secondary payor of benefits to one or more other Health Care Arrangements. In that event, the benefits of this Plan may be reduced under this Section. Such other Health Care Arrangement or Arrangements are referred to as "the other Arrangements" in (B) immediately below.

B. Reduction in this Plan's Benefits

The benefits that would be payable under this Plan in the absence of the COB provisions specified in this Article V will be reduced by the benefits payable under the other Arrangements for the expenses covered in whole or in part under this Plan. This applies whether or not claim is made under a Health Care Arrangement.

When a Health Care Arrangement provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

5.5 Limitation of Benefits

In applying this Article's provisions, the Plan does not pay health care benefits in an amount greater than it would have if it were primary. Furthermore, in determining what benefits are paid from this Plan, payments from this Plan shall be limited so that the combined payment from all Plans shall not exceed the amount that this Plan would pay if the primary payor.

5.6 Right to Receive and Release Necessary COB Information

The Company has the right to obtain any information necessary to apply the COB provisions of this Article V. The Company has the right to obtain COB information from or give that information to any other organization or person involved in the administration of the COB provisions of this Plan or any other Health Care Arrangement. The Company need not tell, or get the consent of, any person prior to obtaining that information. Each person claiming benefits under this Plan must give the Company any information it needs to process the claim.

5.7 Facility of Payment

A payment made under another Health Care Arrangement may include an amount which should have been paid under this Plan. If it does, the Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case

"payment made" means reasonable cash value of the benefits provided in the form of services.

5.8 Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under the COB provisions specified in this Article V, it may recover the excess from one or more of:

A. the persons it has paid or for whom it has paid;

B. insurance companies; or

C. other Health Care Arrangements, including Workers' Compensation.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

ARTICLE VI

CONTINUATION COVERAGE

6.1 Eligibility for Continuation Coverage

Except as hereinafter provided, the provisions contained in this Article VI apply only to medical, vision, dental, and health care reimbursement plan benefits provided under the Plan. In addition, when the provisions for COBRA continuation coverage are set forth in an applicable Incorporated Document, such applicable Incorporated Document shall govern except to the extent such language fails to comply with requirements of applicable law or fails to determine the right or liability of the party, in which case the provisions of this Article VI shall govern.

Certain Covered Persons shall have the right to purchase continuation coverage under this Plan in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, Title X (COBRA), provided such individuals were Covered Persons under the Plan on the date immediately preceding the date of a Qualifying Event or become Covered Persons during the continuation period because such Dependent is born to or placed for adoption with the Employee.

6.2 Definitions

For purposes of this Article VI, the following terms have the following meanings:

A. "Employee" means a person who is (or was) covered under the Plan by virtue of the person's performing services for the Company on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage.

B. "Dependent" means, with respect to an Employee as defined in this Section 6.2, any individual who, on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage, is covered under the Plan as (1) the Dependent spouse of such Employee or (2) the Dependent child of such Employee. The term Dependent shall include any child born to or placed for adoption with the Employee during the continuation period.

C. "Qualified Beneficiary" means an Employee or Dependent as defined in this Section 6.2 but shall not mean Dependents defined in Section 6.7(B), except that the term Qualified Beneficiary shall include Dependents born to or placed for adoption with the Employee during the continuation period.

D. “Qualifying Event” means any of the following, the occurrence of which would result in loss of coverage under the Plan were it not for the right to purchase COBRA continuation coverage:

1. for Employees, termination of employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee;

2. for Dependents:

    a. death of the Employee;

    b. divorce of the Employee and spouse;

    c. legal separation of the Employee and spouse;

    d. reduction in hours worked by the Employee or termination of employment for any reason other than gross misconduct;

    e. entitlement of the Employee to benefits under Title XVIII of the Social Security Act (relating to Medicare); or

    f. ceasing to qualify as a Dependent child under the Plan.

The Qualifying Event shall be deemed to occur on the date of the Qualifying Event — not on the date coverage ends because of the Qualifying Event.

6.3 Loss of Eligibility for Continuation Coverage

A Qualified Beneficiary shall not be eligible for COBRA continuation coverage unless:

A. the Company or Plan Administrator is notified of the election of COBRA continuation coverage, on a form provided for that purpose, within 60 days of the later of:

1. the date the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of an event described in Section 6.2(D); or

2. the date notice of eligibility is sent to the individual in accordance with Section 6.5(C); and

B. the Qualified Beneficiary pays the initial required premium, as set forth in Section 6.8, no later than the date 45 days after the date on which COBRA continuation coverage was elected.

Until expiration of the election period, a Qualified Beneficiary may change or revoke any election. Failure to elect COBRA continuation coverage within the prescribed election period shall result in a waiver of the right to COBRA continuation coverage.

6.4 Termination of COBRA Continuation Coverage

COBRA continuation coverage shall terminate on the date on which the earliest of the following occurs:

A. the last day of the month preceding the date the Qualified Beneficiary fails to pay a subsequent required premium within 30 days of the date it is due;

B. except in the case of certain retirees and widows pursuant to Code section 4980B(g)(1)(D), the date the Qualified Beneficiary first becomes, after the date of making a COBRA election, entitled to Medicare;

C. the date the Qualified Beneficiary first becomes, after the date of election, covered under another group health plan, as defined in Code section 5000(b)(1), not containing a limitation or exclusion as to any pre-existing condition of such individual (other than such an exclusion or limitation which does not apply to, or is satisfied by, such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996);

D. 36 months from the date on which a Qualifying Event described in Sections 6.2(D)(2)(a), 6.2(D)(2)(b), 6.2(D)(2)(c), 6.2(D)(2)(e), or 6.2(D)(2)(f) occurs;

E. 18 months from the date on which a Qualifying Event described in Sections 6.2(D)(1) or 6.2(D)(2)(d) occurs. If a Qualifying Event described in Sections 6.2(D)(2)(a), 6.2(D)(2)(b), 6.2(D)(2)(c), 6.2(D)(2)(e), or 6.2(D)(2)(f) occurs subsequent to a Qualifying Event described in Section 6.2(D)(2)(d), an additional period of coverage shall be allowed for Dependents who have properly and timely elected and paid for COBRA continuation coverage; but, in no event shall the sum of the first and second periods of coverage exceed 36 months from the date of the first Qualifying Event giving rise to the Qualified Beneficiary's eligibility for COBRA continuation coverage;

F. the date the Company terminates all group health plans;

G. in the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled (i) at the time of the Qualifying Event or (ii) at any time during the first 60 days of continuation coverage, the 18-month period set forth in Section 6.4(E) shall be extended to 29 months; provided that such individual notifies the Plan Administrator of such determination in accordance with Section 6.5(D) before the end of such 18-month period; and provided further that if the Qualified Beneficiary does not remain disabled during the extended period, coverage shall cease with the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled;

H. in the case of a Qualifying Event described in Section 6.2(D)(2)(d) that occurs less than 18 months after the date the Employee becomes entitled to Medicare, 36 months from the date the Employee becomes entitled to Medicare; or

I. In the case of the health care reimbursement plan, the last day of the Plan Year in which the Qualifying Event occurs.

6.5 Notice Requirements

A. The Company shall notify the Plan Administrator of the occurrence of an event described in Sections 6.2(D)(1), 6.2(D)(2)(a), 6.2(D)(2)(d), and 6.2(D)(2)(e), within 30 days of the date of the described event.

B. The Qualified Beneficiary shall be responsible for notifying the Plan Administrator of the occurrence of an event described in Sections 6.2(D)(2)(b), 6.2(D)(2)(c), or 6.2(D)(2)(f) within 60 days of the date of the described event.

C. The Plan Administrator shall provide notice to Qualified Beneficiaries of their COBRA continuation coverage rights within 14 days of the date it receives the notice described in Sections 6.5(A) and (B).

D. A Qualified Beneficiary, who is determined under Title II or XVI of the Social Security Act to have been disabled at any time within the first 60 days of the continuation period, shall be responsible for notifying the Plan Administrator of such determination within 60 days after the date of such determination, but in no event later than the end of the 18-month period set forth in Section 6.4(E). Such Qualified Beneficiary further shall be responsible for notifying the Plan Administrator of any final determination under such Title(s) that he or she is no longer disabled, within 30 days of the date of such determination.

E. At the commencement of coverage under the Plan, the Plan Administrator shall provide each Employee or Dependent spouse who is a Covered Person with notice of their rights under COBRA.

6.6 Coverage Available for Continuation

A Qualified Beneficiary may elect to continue receiving the health care coverage (as defined in COBRA regulations) he or she was receiving immediately before the event giving rise to the right to elect COBRA continuation coverage. If coverage provided to similarly situated active Employees is changed or eliminated, COBRA continuation coverage also shall be changed or eliminated. If the Company terminates the Plan but continues to maintain one or more other group health plans, as defined in Code section 5000(b)(l), COBRA continuation coverage recipients may elect coverage under one of those other group health plans. A Qualified Beneficiary may elect to continue to receive coverage for the level of reimbursement, if any, that the individual had in effect under his or her health care reimbursement plan immediately before the Qualifying Event after reflecting debits for health care reimbursements made up to the Qualifying Event.

6.7 Election Rules

A. Scope of Election

Each affected Qualified Beneficiary generally shall have an independent right to elect or reject COBRA continuation coverage under this Article VI; provided, however, that in the event an Employee or his or her spouse makes an election to continue coverage on behalf of the other or on behalf of any other Qualified Beneficiary, such election shall be binding on such other party; and provided further, that in the event the Qualified Beneficiary is a minor or an incapacitated person, the parent or legal guardian of such minor or the legal representative of such incapacitated person shall have the right to elect or reject continuation coverage on behalf of such minor or incapacitated person, and any such election or rejection of coverage shall be binding on such minor or incapacitated person. Each Qualified Beneficiary is entitled to a separate election with respect to any choice of coverages available under the Plan.

B. After Acquired Dependents

A Qualified Beneficiary eligible for COBRA continuation coverage may elect to cover Dependents (as defined in Section 6.2(B)) acquired after the date of eligibility described under Section 6.3 to the same extent as Covered Persons, provided the Company or Plan Administrator is notified of the election to cover such Dependent(s) in the manner and within the time set forth in an applicable document incorporated by reference under the Plan, except that in no event shall notice be required within a period of less than 30 days. Such newly acquired Dependent(s), other than Qualified Beneficiaries defined in Section 6.2(C), shall have no independent right to COBRA continuation coverage. Failure to notify the Company or Plan Administrator within the prescribed time shall result in a waiver of the right to elect COBRA continuation coverage for such newly acquired Dependent(s).

C. Open Enrollment Periods

During an open enrollment period occurring during the COBRA coverage period, a Qualified Beneficiary may elect to cover Dependents not previously covered, subject to the terms and conditions set forth in the applicable document incorporated by reference under the Plan.

6.8 Required Premium

In order to receive COBRA continuation coverage, Qualified Beneficiaries shall agree, on forms furnished by the Plan Administrator, to pay any required premiums to the Plan and shall make such premium payments when and as required. All premiums other than the initial premium shall be due on the first day of the calendar month. The amount of the premium shall be no more than 102 percent of the cost of coverage. In the case of a Qualified Beneficiary who is determined under Title I or XVI of the Social Security Act to have been disabled at any time within the first 60 days of continuation coverage, the cost of coverage for the 19th month through the 29th month of coverage shall be no more than 150 percent of the cost of coverage. Notwithstanding the foregoing, the cost of coverage shall not exceed the maximum, nor be changed more frequently than, permitted by law.

ARTICLE VII

CONTRIBUTIONS, FUNDING AND PLAN ASSETS

7.1 Contributions

A. Employer Contributions

The Employer shall pay, as contributions to the Plan, all or a portion, as determined by the Company, of the cost of the benefits provided under the Plan. The Employer reserves the right to cease payments under the Plan at any time and shall be under no obligation to make any contributions to the Plan after the Plan is terminated.

B. Contributions by Covered Persons

1. Amount

From time to time, the Company shall determine, on a fixed dollar or percentage basis, the amount, if any, of contributions required from Covered Persons who are Employees or Retirees to entitle them and their Dependents, if applicable, to be covered by and receive benefits under the applicable component programs. The amount of such contribution shall be as set forth in any election or enrollment form issued in conjunction with the Plan; as such forms may be changed from time to time. Any such election or enrollment form is hereby incorporated by reference into the Plan as if set forth in full herein.

2. Payment

As a condition of receiving benefits under the Plan, eligible Employees shall agree, on forms furnished by the Company, to make contributions under the Plan in the amount and in the manner determined under the applicable component program and policies implemented by the Company.

C. Priority in use of Contributions

Benefits shall be deemed to come first from amounts contributed by eligible Employees and Retirees and then from amounts contributed by the Employer.

Administrative expenses of the Plan shall be deemed to come first from amounts contributed by the Employer.

7.2 Funding

A. Funding Policy

The Company shall establish and carry out, and may revise from time to time, the funding policy for the Plan.

B. Funding Mechanism

It is the funding policy of the Plan that all Plan benefits are to be provided under, and in accordance with, the provisions of the insurance contracts, HMO contracts, or other documentation used to administer benefits by a third-party administrator or other vendor listed in Appendix A, which the Employer shall purchase and maintain on behalf of the Plan. Provided, however, that any payments made to or credited to the Employer in accordance with retroactive rate adjustments, experience rating, or demutualization distribution provisions, if any, of the insurance or HMO contracts shall be the separate property of the Employer and shall not constitute Plan assets. Benefits shall be deemed to come first from amounts contributed by Employees or Retirees and then from amounts contributed by the Employer.

The insurance contracts and HMO contracts and other documentation used to administer the benefits listed in Appendix A provide for receipt of premium and other payments from the Employer and, if they provide any benefits on a contributory basis, the premium or other payments shall consist of contributions of the Employer and contributions of the Employees or Retirees covered under the benefit; otherwise the premium payments shall consist of contributions of the Employer only. Whether or not contributions are to be made by the Employees and Retirees and the amount of any such contributions is subject to change by the Employer.

Insurance premiums for eligible Employees and their family members may be paid in part by the Company out of its general assets, and where required by a component program, by Employees and/or Retirees. Contributions for any self-funded component programs may also be made, in part, by the Company out of its general assets and in part by Employees and/or Retirees. The Plan Administrator provides a schedule of the applicable premiums during open enrollment periods and upon request.

7.3 Plan Assets

Subject, in all cases, to the right of the Employer to terminate its obligation hereunder, the Employer shall pay benefit(s) provided for herein, to the extent not:

A. provided for by Employee or Retiree contributions;

B. payable from an insurance policy held under the Plan; or

C. paid by a trust fund established by the Employer.

To the extent an insurance policy provides for payment of premiums directly from the Company, unless the insurance policy states otherwise, payable dividends, retroactive rate adjustments, or experience refunds are not Plan assets. These dividends, retroactive rate adjustments, or experience refunds are Company property, which the Company may retain to the extent they do not exceed the Company's aggregate contributions to Plan cost made from its own funds.

ARTICLE VIII

ADMINISTRATION

8.1 Plan Administrator

The Company shall appoint a company, person, entity or committee to serve as Plan Administrator. In the absence of such appointment, the Company shall be the Plan Administrator. The Plan Administrator shall be the "named fiduciary" for purposes of ERISA.

8.2 Plan Administrator's Duties

Except as to those functions reserved within the Plan to the Company, or an Employer, the Plan Administrator shall have the duty to manage the operation and administration of the Plan. The Plan Administrator shall cause to be maintained such records as may be reasonably necessary or desirable for the proper management and administration of the Plan. The Plan Administrator shall also cause to be maintained for inspection by any individual who participates or is eligible to participate in the Plan, a copy of the document governing the Plan; the latest annual report, summary annual report, and summary plan description; and any amendments or changes to these documents. Upon written request, the Plan Administrator shall provide to such participating or eligible individuals a copy of these documents and may impose a reasonable charge, as permitted by law, for such copies.

8.3 Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Company or an Employer, the Plan Administrator shall have the right to exercise full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

A. require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;

B. make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan;

C. interpret the Plan, prescribe Plan procedures, and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;

D. determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan;

E. determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;

F. delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;

G. engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan;

H. make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Company, including changing the funding arrangement or any other amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies; and

I. pay all reasonable and appropriate expenses in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Persons and all other interested parties.

8.4 Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by the Company, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by the Employer. Unless otherwise determined by the Company or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

8.5 Liability Insurance

The Company may obtain liability coverage at the Company's expense to insure any Employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties.

8.6 Reserved Powers

The Company reserves the powers, among others:

A. to adopt the Plan;

B. to amend and terminate the Plan according to Article XI; and

C. to appoint and remove any Claims Administrator or Plan Administrator.

8.7 Power and Authority of the Insurers, HMOs, third-Party Administrators, and Other Vendors

Certain benefits under the Plan are provided by a contract with an insurer, HMO, third-party administrator, or other vendor listed in the Incorporated Documents in Appendix A. The insurance companies, HMOs, third-party administrators, and other vendors are responsible for the functions assigned to them pursuant to their contract or agreement with the Plan or the Company, including determining eligibility for, and the amount of, any benefits payable under their respective component programs, and prescribing claims procedures to be followed and the claims forms to be used by Employees pursuant to their respective component programs.

ARTICLE IX

PROCEDURES

9.1 General Claims Procedures

A claim for benefits under a component program must be filed in accordance with the claims procedures provided in the applicable document governing such component program. To the extent that any component program does not contain a claims procedure, then the provisions of this Article IX shall apply.

No Plan benefit shall be paid unless a Participant has first submitted a written claim for benefits to the Plan Administrator. Upon receipt of a properly documented claim, the Plan Administrator shall direct payment to or on behalf of the Participant the benefits provided under this Plan as soon as is administratively feasible.

9.2 Claims Administrator

To the extent the claims procedure of this Article IX apply, the Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claims Administrators. A Claims Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claims Administrator.

Claims with respect to benefits provided on an insured basis shall be determined by the insurance company issuing the policy or agreement as Claims Administrator, except that, if the Employer and insurance company so agree in writing, the Plan Administrator shall retain final authority over the disposition of any review pursuant to Section 9.11.

9.3 Claims Administration

The Claims Administrator shall have the duty to receive and review claims for benefits under the Plan; to determine what amount, if any, is due and payable under the terms and conditions of the Plan; to make or authorize appropriate disbursements of benefit payments to persons entitled thereto; to inform the Company or any other third party, as appropriate, of the amount of such benefits; to make claims decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part.

9.4 Claim Forms

To the extent this Article IX applies, the Claims Administrator shall furnish to a claimant, upon request, the form(s) required for filing a claim for benefits under the Plan.

9.5 Deadline for Filing a Claim

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services or supplies received, is received by the Claims Administrator by the deadline listed in the plan specific Summary Plan Description.

9.6 Proof of Claim

As a condition of receiving a Plan benefit and as often as the Claims Administrator determines reasonably necessary, a Covered Person must submit such evidence as the Claims Administrator or Plan Administrator shall require that a claim is reimbursable under the terms of the Plan and shall, if required by the Claims Administrator or Plan Administrator, submit to a paid physical examination by a Plan-selected physician.

9.7 Decision on the Claim

A. Welfare Benefits (Except for short and long-term disability benefits, if any, or health plan benefits, as described in the Plan). Any time an application for benefits, other than disability benefits as described in (B) below, or health benefits described in (C) below, is wholly or partially denied, the Covered Person shall be given written notice of such action within a reasonable period of time but not later than 90 days after the claim is received by the plan, unless special circumstances require an extension of time for processing. If there is an extension, the Covered Person shall be notified of the extension and the reason for the extension within the initial 90-day period. The extension shall not exceed 180 days after the claim is filed.

Such denial notice will indicate the reason for denial, the pertinent provisions of the Plan on which the denial is based, an explanation of the Plan's claims and appeals procedures and time periods, a description of any additional material or information necessary to perfect the claim, an explanation of why such material or information is necessary, and a statement informing the claimant of the right to bring a civil action under ERISA.

B. Disability Benefits. Any time an application for short-term or long-term disability benefits is wholly or partially denied, the Covered Person shall be given written notice of such action within a reasonable period of time, no later than 45 days after the claim is received by the plan, unless the Claims Administrator determines that an extension of up to 30 days is necessary due to matters beyond the Plan's control. If there is an extension, the Covered Person shall be notified, before the initial 45-day period of time expires, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The 30-day extension period is tolled until the Covered Person responds to any information request. A second 30-day extension is also permitted if the Claims Administrator determines that, due to matters beyond the Plan's control, a decision cannot be rendered within the first extension period. In that case, the Covered Person shall be

notified, before the end of the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. Such extension notices shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The claimant shall be afforded at least 45 days within which to provide the specified information.

A denial notice will indicate the reason for denial, the pertinent provisions of the Plan on which the denial is based, an explanation of the Plan's claims and appeals procedures and time periods, a description of any additional material or information necessary to perfect the claim, an explanation of why such material or information is necessary, and a statement informing the claimant of the right to bring a civil action under ERISA. The notice also shall include an explanation of the internal rules or criteria, and scientific or clinical judgment, used as a basis for the denial (or a statement that a copy of such information is available to the claimant free of charge).

C. Health claims

The following rules shall apply to health claims (e.g., medical, vision, dental, employee assistance plan, and health care reimbursement plan) filed under the Plan.

1. Urgent Care Claims – Claims for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician, would subject the patient to severe pain that cannot be adequately managed otherwise.

   The Claims Administrator shall notify the claimant of the Plan's determination not later than 72 hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but no later than 48 hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded the claimant to provide the specified additional information.

2. Pre-service Claims – Claims which must be decided before a patient will be afforded access to health care (e.g., preauthorization requests).

   The Claims Administrator shall notify the claimant of the Plan's determination not later than 15 days after receipt of the claim. This period may be extended by 15 days, provided the Claims Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If such an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. If the claim is improperly filed, the Claims Administrator shall notify the claimant as soon as possible, but not later than five (5) days after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

3. Post-service Claims – Claims involving the payment or reimbursement of costs for medical care which has already been provided.

   For non-urgent post-service health claims, the Plan has up to 30 days, to evaluate and process claims for benefits covered by ERISA. The 30-day period begins on the date the claim is first filed. This period may be extended by 15 days provided the Claims Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

4. Concurrent Care Claims – Claims where the Plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments.

   Concurrent care claims may fall under any of the other three categories, depending on when the appeal is made. However, the Plan must give the claimant sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

5. Provisions applicable to all health claims

An "adverse benefit determination" is a denial, reduction or termination of a benefit, failure to provide or pay for (in whole or in part) a benefit, a denial to participate in the Plan, or a claim denial on the grounds that the treatment is experimental, investigational or not medically necessary. This also includes concurrent care determinations. In the event of an adverse benefit determination, the claimant will receive notice of the determination.

A denial notice will indicate the reason for denial, the pertinent provisions of the Plan on which the denial is based, an explanation of the Plan's claims and appeals procedures and time periods, a description of any additional material or information necessary to perfect the claim, an explanation of why such material or information is necessary, and a statement informing the claimant of the right to bring a civil action under ERISA. The notice also shall include an explanation of the internal rules or criteria, and scientific or clinical judgment, used as a basis for the denial (or a statement that a copy of such information is available to the claimant free of charge). For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, the notice will also include an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request. For adverse determinations involving urgent care, the notice will also include a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

9.8 Right to Appeal

A claimant whose claim for benefits under the Plan has been denied, in whole or in part, shall have the right to appeal the denial.

A. Welfare Benefits (Except for short and long-term disability benefits, if any, or health benefits, as described in the Plan). A Covered Person who has had a claim for benefits, other than the disability benefits as described in (B) below, or health benefits as described in (C) below, denied by the Claims Administrator or is otherwise adversely affected by action of the Claims Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 60 days after such claimant is advised of the Claims Administrator's action. The requested review must take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. If written request for review is not made within the 60-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant

information and submit issues, comments, documents, records, and other information in writing.

The Claims Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It may hold a hearing if it deems it necessary and shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than 60 days after receipt of the written request for review, unless the Plan Administrator determines that special circumstances, such as a hearing, require an extension. The claimant shall be notified in writing of any such extension within 60 days following the request for review, and such extension shall not exceed 60 days from the end of the initial period.

A copy of the review determination shall be furnished to the claimant. If the claimant's claim is denied, the review determination notice shall set forth the specific reason or reasons for the adverse determination, reference to the specific Plan provisions on which the determination is based, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all relevant information, a statement informing the claimant about the right to bring a civil action under ERISA, and a description of any voluntary appeals procedure offered by the Plan, if any.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

B. Disability Benefits. A Covered Person who has had a claim for short-term or long-term disability benefits wholly or partially denied by the Claims Administrator or is otherwise adversely affected by action of the Claims Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 180 days after such claimant is advised of the Claims Administrator's action. If written request for review is not made within the 180-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues and comments in writing.

The Claims Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than 45 days after receipt of the written request for review, or an additional 45 days if the Plan Administrator determines that special circumstances require an extension. The claimant shall be notified in writing of any such extension before the initial period of time expires, and such notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the

determination on review. The extension period is tolled until the claimant responds to any information request.

A copy of the review determination shall be furnished to the claimant. If the claimant's claim is denied, the review determination notice shall set forth the specific reason or reasons for the adverse determination, reference to the specific Plan provisions on which the benefit determination is based, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all relevant information, a statement informing the claimant about the right to bring a civil action under ERISA, and a description of any voluntary appeal procedures offered by the Plan, if any. The notice also shall include an explanation of the internal rules or criteria, and scientific or clinical judgment, used as a basis for the denial (or a statement that a copy of such information is available to the claimant free of charge), a statement that the claimant has the right to obtain information about the voluntary appeals process, if any, and information as to how the claimant may obtain information about a voluntary alternative dispute resolution options from the Department of Labor or state regulators. The Plan will provide for the identification of experts whose advice was obtained on behalf of Plan in connection with an adverse determination, without regard to whether the advice was relied on in making determination.

In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appear nor the subordinate of any such individual. In deciding an appeal, no deference will be afforded to the initial adverse benefit determination and the review of the appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

C. Health claims

The following rules shall apply to health claims (e.g., medical, vision, dental, employee assistance plan, and health care reimbursement plan) filed under the Plan.

A Covered Person who has had a health claim for benefits wholly or partially denied by the Claims Administrator or is otherwise adversely affected by action of the Claims Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 180 days after such claimant is

advised of the Claims Administrator's action. If written request for review is not made within the 180-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues and comments in writing.

The Claims Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than:

1. for urgent health claims, as soon as possible considering the medical situation, but no later than 72 hours,

2. for pre-service claims, within a reasonable period of time given the medical situation, but no later than 30 days (or 15 days following each appeal if there are two mandatory appeals),

3. for post-service claims, within a reasonable period of time, but not later than sixty (60) days after receipt of the request for review (or 30 days following each appeal if there are two mandatory appeals).

In certain cases, the Claims Administrator may obtain a limited extension of time if the Plan Administrator determines that special circumstances require an extension. The claimant shall be notified in writing of any such extension before the initial period of time expires, and such notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review. The extension period is tolled until the claimant responds to any information request.

A copy of the review determination shall be furnished to the claimant. If the claimant's claim is denied, the review determination notice shall set forth the specific reason or reasons for the adverse determination, reference to the specific Plan provisions on which the benefit determination is based, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all relevant information, a statement informing the claimant about the right to bring a civil action under ERISA, and a description of any voluntary appeal procedures offered by the Plan, if any. The notice also shall include an explanation of the internal rules or criteria, and scientific or clinical judgment, used as a basis for the denial (or a statement that a copy of such information is available to the claimant free of charge), a statement that the claimant has the right to obtain information about the voluntary appeals process, if any, and information as to how the claimant may obtain information about a voluntary alternative dispute resolution options from the Department of Labor or state regulators. The Plan will provide for the identification of experts whose advice was obtained on behalf of Plan in connection with an adverse determination, without regard to whether the advice was relied on in making determination.

In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appear nor the subordinate of any such individual. In deciding an appeal, no deference shall be afforded to the initial adverse benefit determination and the review of the appeal shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

D. Non-ERISA Benefits Claims. A claim for benefits under a Benefit Program that is not an ERISA Benefit Program must be filed in accordance with the claims procedures provided in the Summary Plan Description of the underlying Benefit Program, or if the Benefit Program does not contain a claims procedure, the claims procedure established by the Plan Administrator shall apply.

9.9 Legal Remedy

Before pursuing a legal remedy, a claimant shall first exhaust all claims, review, and appeals procedures required under the Plan.

9.10 Third Party Liability Claims – Subrogation and Reimbursement

When the provisions describing Subrogation are set forth in an applicable Incorporated Document, such Incorporated Document shall govern.

A. Conditions for Payment of Benefits

Prior to payment of a benefit by the Plan to a Covered Person or his or her assignee for any expense or loss for which there may be a claim against a third party, the Covered Person (or if a minor, his or her parent or legal guardian) shall:

1. provide proof, satisfactory to the Plan Administrator, that no right, claim, interest or cause of action against a third party has been, or will be, discharged or released without the written consent of the Plan Administrator;

2. execute a written agreement assigning to the Plan all rights, claims, interests, and causes of action that the Covered Person has against a third party in connection with the claim;

3. authorize the Plan, in writing, to sue, compromise or settle, in the Covered Person's name or otherwise, all rights, claims, interests, or causes of action to the extent of benefits paid and shall do nothing to prejudice the rights given to the Plan under this Article; and

4. agree, in writing, to assist the Plan in prosecuting any rights, interests, claims, or causes of action that have been assigned to the Plan against a third party, including, if requested by the Plan Administrator, the institution of a legal proceeding against a third party.

B. Plan's Right of Recovery

The Plan shall have the right to recover payments made to a Covered Person or his or her assignee for expenses or damages paid by a third party to the Covered Person and without applying the "make whole" doctrine that would otherwise allow the Covered Person to retain damages recovered from third parties.

C. Plan's Right to Reimbursement

A Covered Person who recovers payment from a third party shall reimburse the Plan, in full and without reduction for attorney's fees or costs, from the proceeds received from the third party, regardless of whether the proceeds are paid by way of settlement, judgment, or otherwise. The Plan shall have an equitable interest in the amount recovered, or to be recovered, by the Covered Person for the entire amount paid by the Plan for the claim.

D. Claimant's Failure to Reimburse

Should it be necessary for the Plan to institute legal action against the Covered Person for failure to reimburse the Plan, in full, or to honor the equitable interest in the amount recovered from a third party, the Covered Person shall be liable for all costs of collection, including reasonable attorney's fees.

E. Right to Withhold Future Benefits

The Plan shall have the right to withhold future benefits to which a claimant or a Covered Person through whom the claimant derives his or her claim may be entitled until the amount otherwise due the Plan from a third party, plus interest, has been satisfied.

9.11 Payment Procedures

A. Payment of Claim

Subject to Section 8.3, benefits shall be payable to the claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber,

or charge any benefit payable under the Plan, voluntarily or involuntarily, the Claims Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such claimant as the Claims Administrator deems appropriate.

B. Facility of Payment

If a claimant dies before all amounts payable under the Plan have been paid, or if the Claims Administrator determines that the claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the claimant may be paid to any other person or institution reasonably determined by the Claims Administrator to be entitled equitably thereto and without prejudice therefore. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

ARTICLE X

MISCELLANEOUS

10.1 No Employment Rights

Employment rights of an Employee participant shall not be deemed to be enlarged or diminished by reason of the establishment of the Plan, and the participant shall not have any right to be retained in the service of the Employer that he would not otherwise have. The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer, the Company, or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

10.2 No Property Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested. No individual has any right, title, or interest in the property of the Company or the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

10.3 No Assignment of Benefits

Except as provided in Section 9.12, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. Notwithstanding the foregoing, a Covered Person may direct, in writing, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized, to a provider of medical or dental services or supplies furnished or to be furnished to him or her, or to a person or entity that has provided or paid for, or agreed to provide or pay for, any benefits payable under the Plan. The Plan reserves the right to make payment directly to the Covered Person. No payment by the Plan pursuant to such direction and assignment shall be considered as recognition by the Plan of a duty or obligation to pay a provider of medical or dental services or supplies except to the extent the Plan actually chooses to do so.

10.4 Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

10.5 Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

10.6 Misrepresentation or Fraud

A Covered Person who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis, and at its discretion, may choose to deny such individual future eligibility under the Plan.

10.7 Legal Action

No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth in Article IX or if so provided in the applicable component program, nor shall an action be brought at all unless within 36 months after the date a claim is incurred under the Plan.

10.8 Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law and, to the extent not preempted, the laws of the State of West Virginia.

10.9 Governing Instrument

This document, together with the documentation incorporated by reference into it, is the legal instrument governing the Plan. In case of conflict between this document and any other writing or evidence, the terms of this document shall govern.

10.10 Savings Clause

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

10.11 Captions and Headings

The captions and headings of an Article, Section, or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

10.12 Notices

No notice or communication in connection with the Plan made by a claimant, an Employee, or a Covered Person shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

10.13 Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing wavier unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

10.14 Parties' Reliance

The Board of Directors, the Company, the Employer, the Claims Administrator, the Plan Administrator and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Company, the Employer or their employees, except for willful misconduct or willful breach of duty to the Plan.

10.15 Disclaimer

The Company makes no assertion or warranty about:

A. health care services and supplies that Covered Persons obtain reimbursement for as Plan benefits, or

B. whether Plan benefits will be excludable from a Covered Person's gross income for federal or state income tax purposes.

10.16 Expenses

All expenses of the Plan shall be paid from Employer contribution to the extent made available by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

10.17 Indemnification

The Employer, to the extent permitted by law, shall indemnify and hold harmless the Board of Directors, and any employee, officer, or shareholder of the Company or the Employer from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Company.

10.18 Fiscal Records

The fiscal records of the Plan are to be maintained on the basis of the Plan Year provided, however, that records for a component program shall be maintained in accordance with the contract or other document governing the component program listed as an Incorporated Document in Appendix A.

ARTICLE XI

AMENDMENT, TERMINATION OR MERGER OF PLAN

11.1 Right to Amend the Plan

Except as provided in Section 11.3, the Company reserves the unlimited right to amend the Plan or any provision or component of the Plan in any way. No Covered Person by virtue of attaining any eligibility status shall be considered vested in any benefits provided under this Plan that cannot be modified by amendment. Any amendment to the Plan shall be in writing and shall be adopted by resolution of the Company's Board of Directors or by resolution of any committee or individual duly authorized and appointed by the Board of Directors.

11.2 Right to Terminate or Merge the Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Company reserves the unlimited right to terminate or merge the Plan or any provision or component of the Plan. Any amendment to the Plan shall be in writing and shall be adopted by resolution of the Company's Board of Directors or by resolution of any committee or individual duly authorized and appointed by the Board of Directors or in accordance with the procedures provided in the applicable component program. Any decision to terminate or merge the Plan shall be in writing and shall be adopted by the Company in accordance with its normal procedures.

11.3 Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Plan shall be effective at such date as the Company shall determine and as set forth in the applicable adopting resolution except that no amendment, termination or merger shall reduce benefits payable for covered expenses incurred prior to the later of the date the amendment, termination or merger is effective or adopted, except as required or permitted by law.

11.4 Change in Funding Mechanism

The Company reserves the unlimited right to change, modify, cancel or otherwise terminate any of the funding arrangements available under Section 7.2(B), including, by way of example and not by way of limitation, the right to change insurance carriers and the right to provide previously insured benefits on a partially insured or fully uninsured basis.

ARTICLE XII

HIPAA PRIVACY AND SECURITY

12.1 Purpose

Under the privacy and security rules of HIPAA, and the regulations issued thereunder at 45 CFR Parts 160 and 164, a group health plan must: (i) restrict the use and disclosure of protected health information ("PHI"), (ii) ensure the confidentiality, integrity, and availability of all electronic protected health information ("e-PHI") the plan creates, receives, maintains, or transmits, (iii) protect against any reasonably anticipated threats or hazards to the security and integrity of such information, (iv) protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the HIPAA privacy rules set forth in 45 CFR Part 164, Subpart E, and (v) ensure compliance with the HIPAA security rules set forth in 45 CFR Part 164, Subpart C by its workforce.

12.2 Effective Date

Except as otherwise stated herein, the provisions of this Article XII and Section 12.5 shall be effective as of **January 1, 2007.**

12.3 Uses and Disclosures of PHI

The Plan and the Employer may disclose a Plan participant's PHI to the Employer (or to Employer's agent) for the Plan administration functions under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations.

12.4 Restriction on Plan Disclosure to the Employer

Neither the Plan nor any of its business associates, health insurance issuers, or HMOs, will disclose PHI to the Employer except upon the Plan's receipt of the Employer certification that the Plan has been amended to incorporate the agreements of the Employer under Section 12.5, except as otherwise permitted or required by law.

12.5 Privacy Agreements of the Employer

As a condition for obtaining PHI from the Plan, it's Business Associates, Insurers, and HMOs, Employer agrees it will:

A. Not use or further disclose such PHI other than as permitted by Section 12.3, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

B. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to Employer with respect to such information;

C. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Employer;

D. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which Employer becomes aware;

E. Make the PHI of a particular participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;

F. Make the PHI of a particular participant available for purposes of required accounting of disclosures by Employer pursuant to the participant's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

G. Make Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

H. If feasible, return or destroy all PHI received from the Plan that Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, Employer agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

I. Ensure that there is adequate separation between the Plan and Employer by implementing the terms of subparagraphs (1) through (3), below:

1. Employees With Access to PHI: The following employees or other individuals under the control of Employer are the only individuals that may access PHI received from the Plan:

   Human Resource personnel and legal are the only Magnum Coal employees who will have access to your health information for plan administration functions. NOTE: Human Resource is vague and could include:

   - HR employees with responsibility for <u>investigating appeals and recommending decisions</u> to the Committee.
   - HR employees responsible for <u>investigating questions and recommending decisions</u>.
   - HR employees responsible for <u>Plan management and quality assessment activities</u>.

- Audit personnel

Members of the workforce who require specialized training due to their particular job function, rank, exposure to PHI or discipline, will be trained accordingly. The following job descriptions will require specialized training:

- HR personnel;
- Information Systems;
- Internal audit;
- Legal personnel

2. Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (1), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Employer for the Plan.

3. Mechanism for Resolving Noncompliance. If Employer or any other person(s) responsible for monitoring compliance determines that any person described in (1), above, has violated any of the restrictions of this Article, then such individual shall be disciplined in accordance with the policies of Employer established for purposes of privacy compliance, up to and including dismissal from employment. Employer shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

12.6 Security Agreements of Employer

As a condition for obtaining e-PHI from the Plan, its business associates, insurers, and HMOs, Employer agrees it will:

A. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

B. Ensure that the adequate separation between the Plan and Employer as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

C. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

D. Report to the Plan any Security Incident of which it becomes aware. For purposes of this Section 12.6, "Security Incident" shall mean successful unauthorized access to, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

E. Upon request from the Plan, Employer agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to Employer.

12.7 PHI not Subject to this Article XII

Notwithstanding the foregoing, the terms of this Article XII (other than Section 12.6) shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504 (f)(l)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

12.8 Definitions

All capitalized terms within this Article XII not otherwise defined by the provisions herein shall have the meaning given them in the respective Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA.

APPENDIX A

MAGNUM COAL COMPANY WELFARE PLAN

INCORPORATED DOCUMENTS

The benefits provided under the Plan shall be those self-insured and/or insured benefits as shall be made available to Covered Persons from time to time, as such benefits may be amended or terminated in the future. The terms, conditions and limitations of the benefits are set forth in the Plan and the underlying Incorporated Documents referenced herein. Certain documents are incorporated by reference in this Appendix A, including any written document pursuant to which the applicable benefit is provided under the Plan (e.g., written plans, vendor contracts, insurance policies, coverage certificates, summary plan descriptions, or other materials describing benefits provided there under).

As of January 1, 2008, the Plan benefits consist of the following:

The Magnum Coal Company Group Medical Plan (active and retiree)
The current service providers are:
Fiserv Health Harrington Benefit Services
Aetna Life Insurance Company
Systemed/Medco

The Magnum Coal Company Dental Plan
The current service provider is:
Delta Dental of West Virginia

The Magnum Coal Company Vision Plan
The current service provider is:
Fiserv Health Harrington Benefit Services

The Magnum Coal Company Basic Life and AD&D Plans (active and retiree) Dependent Basic Life and AD&D Plans Optional Employee and Dependent Life and AD&D Plans
The current service provider is:
MetLife Group

The Magnum Coal Company Retiree Welfare Benefit Program (retiree medical coverage and retiree life insurance)
The current service provider is:
Fiserv Health Harrington Benefit Services
MetLife Group
Benefits Administrator Services, Inc. (BAS)

The Magnum Coal Company Business Travel Accident Plan
The current service provider is:
Hartford Insurance Company

The Magnum Coal Company Long Term Disability Plan
The current service provider is:
CIGNA

The Magnum Coal Company Short Term Disability Plan
The current service provider is:
CIGNA

The Magnum Coal Company Sickness and Accident Plan
The current service provider is:
CIGNA

The Magnum Coal Company Cafeteria Premium Only Account Plan
Health Care Reimbursement Account Plan
Dependent Care Reimbursement Account Plan
The current service provider is:
Fiserv Health Harrington Benefit Services

The Magnum Coal Company Severance Plan
The current service provider is:
Magnum Coal Company

This Appendix is considered a part of the Plan and may be amended by the Company at any time for any reason without consent of any person except as otherwise provided by Applicable Law.

APPENDIX B

MAGNUM COAL COMPANY WELFARE PLAN

ADOPTING SUBSIDIARIES AND OR AFFILIATES

Name of Subsidiary	Effective Date of Adoption
Apogee Coal Company, LLC	January 1, 2006
Hobet Mining, LLC	January 1, 2006
Catenary Coal Company, LLC	January 1, 2006
Speed Mining, LLC	January 1, 2007
Coal Clean, LLC	January 1, 2007
Infinity Coal Sales, LLC	January 1, 2007
Little Creek, LLC	January 1, 2007
Remington, LLC	January 1, 2007
Dakota, LLC	January 1, 2007
Day, LLC	January 1, 2007
Highwall Mining, LLC	January 1, 2007
IO Coal, LLC	January 1, 2007
Thunderhill Coal, LLC	January 1, 2007
Pond Fork Processing, LLC	January 1, 2007
Weatherby Processing, LLC	January 1, 2007
Coyote Coal Company LLC	January 12, 2007
Midland Trail Energy LLC	January 1, 2008

AMENDMENT TO THE
MAGNUM COAL COMPANY
RETIREE WELFARE BENEFIT PROGRAM

Effective January 1, 2008, the Magnum Coal Company Retiree Welfare Benefit Program (the "Plan") shall be amended as follows:

I. The eligibility provisions of the Plan shall be amended to add the following eligible location and eligible employees:

"Midland Trail Energy LLC shall be an eligible location. A non-union hourly employee of Midland Trail Energy LLC is eligible to participate in the Plan if: (i) the employee was employed by Catenary Coal Company, LLC as of February 17, 2008, (ii) was eligible for retiree medical coverage under the Plan as of February 17, 2008, (iii) became employed by Midland Trail Energy LLC on February 18, 2008, and (iv) continues employment with an "eligible location" until the occurrence of a "qualifying event". Provided, however, that if the employee terminates employment with Midland Trail Energy LLC after February 18, 2008, and is later rehired by the Employer or another "eligible location" the employee shall not be eligible to participate in the Plan.

A salaried employee of Midland Trail Energy LLC is eligible to participate in the Plan if: (i) the employee was employed by Catenary Coal Company, LLC as of February 27, 2008, (ii) was eligible for retiree medical coverage under the Plan as of February 27, 2008, (iii) became employed by Midland Trail Energy LLC on February 28, 2008, and (iv) continues employment with an "eligible location" until the occurrence of a "qualifying event"." Provided, however, that if the employee terminates employment with Midland Trail Energy LLC after February 18, 2008, and is later rehired by the Employer or another "eligible location" the employee shall not be eligible to participate in the Plan.

II. In all other respects, the Plan shall remain unchanged.

Executed this 1st day of January, 2008.

MAGNUM COAL COMPANY

By: Dale Lucha

Title: VP - HR
Chairperson - Benefits Committee

AMENDMENT NUMBER ONE
TO THE
MAGNUM COAL COMPANY WELFARE PLAN

Effective as set forth below, the Magnum Coal Company Welfare Plan (the "Plan") shall be amended as follows:

I. Effective January 1, 2008, Appendix A to the Plan shall be amended to reflect CIGNA as the service provider for the Short-Term Disability Plan, the Long-Term Disability Plan and Accident and Sickness Plan.

II. Effective January 1, 2008, Appendix B to the Plan shall be amended to reflect Midland Trail Energy LLC as a participating employer in the Plan.

III. In other respects, the Plan shall remain unchanged.

Executed this 25th day of March, 2008.

MAGNUM COAL COMPANY

By: Dale Lucha

Its: VP-HR
Chairperson-
Benefits Committee

AMENDMENT NUMBER FIVE
TO THE
MAGNUM COAL COMPANY
DEFINED CONTRIBUTION RETIREMENT PLAN

I. Effective January 1, 2008 , the attachment to Section 4 of the Adoption Agreement, shall be amended to provide the following language to the end thereof:

"A non-union hourly employee of Midland Trail Energy LLC is eligible to participate in the Plan if: (i) the employee was employed by Catenary Coal Company, LLC as of February 17, 2008, (ii) was eligible to participate in the Plan as of February 17, 2008 and (iii) became employed by Midland Trail Energy LLC on February 18, 2008. Provided, however, if the employee terminates employment with Midland Trail Energy LLC after February 18, 2008 and is later rehired by the Employer or another "eligible location" the employee shall not be eligible to participate in the Plan.

A salaried employee of Midland Trail Energy LLC is eligible to participate in the Plan if: (i) the employee was employed by Catenary Coal Company, LLC as of February 27, 2008, (ii) was eligible to participate in the Plan as of February 27, 2008 and (iii) became employed by Midland Trail Energy LLC on February 28, 2008. Provided, however, if the employee terminates employment with Midland Trail Energy LLC after February 28, 2008 and is later rehired by the Employer or another "eligible location" the employee shall not be eligible to participate in the Plan."

II. In all other respects, the Plan shall remain unchanged.

Executed this 1st day of January, 2008.

MAGNUM COAL COMPANY

By: Dale Lucha

Title: VP - HR
Chairperson - Benefits Committee

MEMORANDUM

To: All Salaried and Non-Union Hourly Employees

From: Debra L. Campbell DLC

Date: April 28, 2008

Subject: **Magnum 401(k) Plan Summary Material Modification**

The attached serves as a Summary of Material Modification (SMM), as required by the Employee Retirement Income Security Act (ERISA). This SMM should be keep with Your Benefits Summary notebook.

If you have any questions, please contact your local Human Resources representative.

Attachment

500 Lee Street, Suite 900, Charleston, WV 25301 Phone (304) 380-0200 Fax (304) 380-0359

SUMMARY OF MATERIAL MODIFICATIONS
TO
THE MAGNUM COAL COMPANY 401(k) PLAN

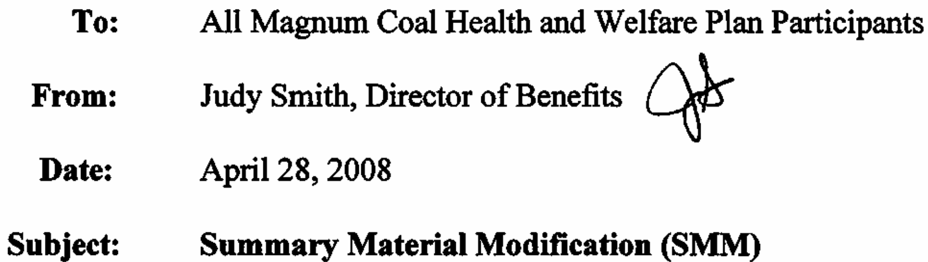
This Summary of Material Modifications to the Magnum Coal Company 401(k) Plan (the "Plan") describes the changes to the Plan, as set forth below.

1. Effective as of January 1, 2008, the Plan is amended to provide that Participants are no longer permitted to take loans under the Plan.

2. The following is certain identifying information in connection with the Plan:

Plan Name:	Magnum Coal Company 401(k) Plan
Plan Number:	001
Employer ID Number:	20-3678373
Plan Administrator:	The Magnum Coal Company Benefit Committee Magnum Coal Company 500 Lee Street East Suite 900 Charleston, WV 25103 (304) 380-0304

MEMORANDUM



To: All Magnum Coal Health and Welfare Plan Participants

From: Judy Smith, Director of Benefits

Date: April 28, 2008

Subject: **Summary Material Modification (SMM)**

The attached serves as a Summary of Material Modification (SMM), as required by the Employee Retirement Income Security Act (ERISA). This SMM should be keep with Your Benefits Summary notebook.

If you have any questions, please contact your local Human Resources representative.

Attachment

500 Lee Street, Suite 900, Charleston, WV 25301 Phone (304) 380-0200 Fax (304) 380-0359

SUMMARY OF MATERIAL MODIFICATIONS
TO
THE MAGNUM COAL COMPANY WELFARE PLAN

This Summary of Material Modifications to the Magnum Coal Company Welfare Plan (the "Plan") describes the changes to the Plan, as set forth below.

1. Effective as of January 1, 2008, the Plan is amended to provide that CIGNA is the new carrier for the Short-Term Disability Plan, the Long-Term Disability Plan and Accident and Sickness Plan. The address for CIGNA is: 12225 Greenville Ave., Suite 1000, Dallas, TX 75243. The phone number is 1-800-352-0611.

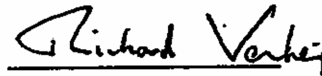
2. The following is certain identifying information in connection with the Plan:

Plan Name:	Magnum Coal Company Welfare Plan
Plan Number:	501
Employer ID Number:	20-3678373
Plan Administrator:	VP, Human Resources Magnum Coal Company 500 Lee Street East Charleston, WV 25301 (304) 380-0304

NOW THEREFORE BE IT RESOLVED, that, effective December 6, 2007, the Benefits Committee is established and that Dale Lucha, John Marcum and Michael Day are appointed as its members; and

FURTHER RESOLVED, that the Benefit Committee is hereby authorized to do the following: (a) oversee the day-to-day administration of the Plans in accordance with the terms of each Plan document; (b) appoint an investment advisor for appropriate plans; (c) amend, modify or otherwise change each Plan's investment funds, vehicles or platforms, including, but not limited to, changing each Plan's investment provider; and (d) amend, modify or terminate any Plan or any component of any Plan in accordance with the terms of each Plan document to facilitate administration of the Plans and comply with certain tax law changes; and

FURTHER RESOLVED, that the President of the Company and/or his designees are hereby authorized to take all appropriate actions to implement the intent of these resolutions.



Secretary

SUGGESTED RESOLUTIONS
TO BE ADOPTED BY
MAGNUM COAL COMPANY BENEFITS COMMITTEE

WHEREAS, Magnum Coal Company ("Magnum") maintains the Magnum Coal Company Welfare Plan (the "Plan") for the benefit of certain of its employees and the employees of its affiliates or subsidiaries; and

WHEREAS, Magnum delegated administrative duties to the Benefits Committee; and

WHEREAS, effective January 1, 2008, the service provider for the Short-Term Disability Plan, the Long-Term Disability Plan and Accident and Sickness Plan was changed from Aetna to CIGNA; and

WHEREAS, it is necessary to amend Appendix A to the Plan to reflect this change and to amend Appendix B to reflect Midland Trail Energy LLC as a participating employer;

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2008, the Appendix A of the Plan is amended to reflect CIGNA as the service provider to the Short-Term Disability Plan , the Long-Term Disability Plan and Accident and Sickness Plan; and

FURTHER RESOLVED, that effective January 1, 2008, Appendix B of the Plan is amended to reflect Midland Trail Energy LLC as a participating employer in the Plan; and

FURTHER RESOLVED, that Committee or its designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement or amendment.

Dale Lucha
VP- HR
Chairperson-Benefits Committee
3-25-08

MIDLAND TRAIL ENERGY LLC
CONSENT

The undersigned being the sole Member of Midland Trail Energy LLC (the ***Company***) does hereby take the following actions without written consent.

WHEREAS, effective January 1, 2008, Company is an indirect subsidiary of Magnum Coal Company (***Magnum***); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries; and

WHEREAS, effective January 1, 2008, Magnum has determined it is in its best interests to allow the Company to participate in the Magnum Coal Company 401(k) Plan, the Magnum Coal Company Defined Contribution Retirement Plan and the Magnum Coal Company Welfare Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Plan is comprised of certain plans including the following plans to which the employees of the Companies may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Disability Plan for Salaried Employees, and (vii) the Magnum Coal Company Benefits After Retirement Plan; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2008, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

REMINGTON II LLC

By: ______________________
Richard Verheij,
Senior Vice President and Secretary

COYOTE COAL COMPANY LLC
CONSENT

The undersigned, being the sole Member of Coyote Coal Company LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

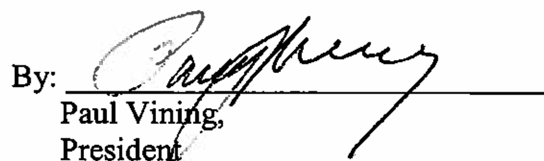
WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

MAGNUM COAL COMPANY

By: 
Paul Vining,
President

COAL CLEAN LLC
CONSENT

The undersigned, being the sole Member of Coal Clean LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

INFINITY COAL SALES, LLC

By: ______________________
Richard Verheij,
Senior Vice President and Secretary

1381591v1

DAKOTA LLC
CONSENT

The undersigned, being the sole Member of Dakota LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

NEW TROUT COAL HOLDINGS II, LLC

By: [signature]
Richard Verheij,
Senior Vice President and Secretary

DAY LLC
CONSENT

The undersigned, being the sole Member of Day LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

NEW TROUT COAL HOLDINGS II, LLC

By:
Richard Verheij,
Senior Vice President and Secretary

1381591v1

HIGHWALL MINING LLC
CONSENT

The undersigned, being the sole Member of Highwall Mining LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

INFINITY COAL SALES, LLC

By: Richard Verheij
Richard Verheij,
Senior Vice President and Secretary

1381591v1

INFINITY COAL SALES, LLC
CONSENT

The undersigned, being the sole Member of Infinity Coal Sales, LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

BROOK TROUT COAL, LLC

By: [signature]
Richard Verheij,
Senior Vice President and Secretary

IO COAL LLC
CONSENT

The undersigned, being the sole Member of IO Coal LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

INFINITY COAL SALES, LLC

By: Richard Verheij
Richard Verheij,
Senior Vice President and Secretary

1381591v1

LITTLE CREEK LLC
CONSENT

The undersigned, being the sole Member of Little Creek LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

BROOK TROUT COAL, LLC

By: Richard Verheij
Richard Verheij,
Senior Vice President and Secretary

1381591v1

POND FORK PROCESSING LLC
CONSENT

The undersigned, being the sole Member of Pond Fork Processing LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

INFINITY COAL SALES, LLC

By: ______________________
Richard Verheij,
Senior Vice President and Secretary

1381591v1

REMINGTON LLC
CONSENT

The undersigned, being the sole Member of Remington LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

REMINGTON HOLDINGS LLC

By: ____________________
Richard Verheij,
Senior Vice President and Secretary

SPEED MINING LLC
CONSENT

The undersigned, being the sole Member of Speed Mining LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

INFINITY COAL SALES, LLC

By: Richard Verheij
Richard Verheij,
Senior Vice President and Secretary

1381591v1

THUNDERHILL COAL LLC
CONSENT

The undersigned, being the sole Member of Thunderhill Coal LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

INFINITY COAL SALES, LLC

By: [signature]
Richard Verheij,
Senior Vice President and Secretary

1381591v1

WEATHERBY PROCESSING LLC
CONSENT

The undersigned, being the sole Member of Weatherby Processing LLC (the ***Company***), does hereby take the following actions by written consent:

WHEREAS, the Company is an indirect subsidiary of Magnum Coal Company ("Magnum"); and

WHEREAS, Magnum maintains certain benefit plans for the benefit of certain of its employees and the employees of its affiliates or subsidiaries that adopt the plan; and

WHEREAS, effective January 1, 2007 the Company has determined it is in its best interests to participate in the Magnum Coal Company 401(k) Plan and the Magnum Coal Company Welfare Benefit Plan (collectively referred to as the "Plans"); and

WHEREAS, the Magnum Coal Company Welfare Benefit Plan is comprised of certain plans including the following plans to which the employees of the Company may be eligible to participate: (i) the Magnum Coal Company Group Medical Plan, (ii) the Magnum Coal Company Vision Plan, (iii) the Magnum Coal Company Dental Plan, (iv) the Magnum Coal Company Flexible Benefit Plan, (v) the Magnum Coal Company Life Insurance Plan for Salaried Employees, (vi) the Magnum Coal Company Life Insurance Plan for Non-Union Hourly Employees, (vii) the Magnum Coal Company Disability Plan for Salaried Employees, and (viii) the Magnum Coal Company Disability Plan for Non-Union Hourly Employees; and

WHEREAS, the Company agrees to be bound by the terms, conditions and policies of each Plan.

NOW, THEREFORE, BE IT RESOLVED, that effective as of January 1, 2007, the Company shall be a participating employer in the Plans; and

FURTHER RESOLVED, that the Company shall be bound by the terms, conditions and policies of each Plan; and

FURTHER RESOLVED, that the President of the Company or his designees are hereby authorized and directed to take all appropriate actions to implement the intent of these resolutions, including, but not limited to, the execution of any agreement reflecting the Company's participation in the Plans.

INFINITY COAL SALES, LLC

By: [signature]
Richard Verheij,
Senior Vice President and Secretary

1381591v1