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Diamond Shamrock Plan
closed group of special employees
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ARCH OF WEST VIRGINIA
A DIVISION OF APOGEE COAL COMPANY
P. O. BOX 156
YOLYN, WEST VIRGINIA 25654

PHONE (304) 792-8200
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copy-Steve FYI. CN

To: Salaried Retirees - Post 4/1/84 - Diamond Shamrock Plan

From: Charlene Necessary *Charlene*

Date: February 14, 1996

Re: **Mandatory Generic Drug Program**

As you are probably aware, a generic prescription is the chemical equivalent of a name-brand drug, but is dispensed under the chemical name rather than the more familiar brand name. The major difference is in packaging and cost. Name-brand drugs can cost as much as 8 or 9 times the generic drug price. Many prescription plans nationwide have implemented mandatory generic reimbursement guidelines as a means of reducing costs while maintaining high levels of coverage. Every plan that we currently provide has mandatory generic requirements, except yours.

Effective April 1, 1996, your prescription plan will have a mandatory generic requirement. This means that when you purchase a prescription that has a generic equivalent, the plan will pay the generic price. You will still have the option to purchase the name-brand prescription but the plan will pay the same amount as it would pay for the generic and you would be responsible for the balance.

In the event your physician believes you have a medical need that precludes you from taking a generic equivalent and you choose to purchase the name brand, you would be responsible for paying the difference between the generic price and the name-brand price and then submitting detailed medical documentation from the prescribing physician as to why a generic equivalent would not be medically appropriate for you. This documentation should be submitted to my attention for review as to medical necessity. If a determination is made that the name brand is medically necessary for you, you will be reimbursed for the difference you paid, and you will not be required to pay the difference in the future.

A brochure concerning generic prescriptions is enclosed. As always, please feel free to contact me should you need additional information.

Enclosure

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facsimile TRANSMITTAL

to: Ilene Knobler
fax #: SL 2961
re: Diamond Shamrock Retirees Benefit Plan
date: May 22, 1996
pages: 24, including cover sheet.

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From the desk of...

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US Permits

YOUR BENEFITS IN RETIREMENT

Your life insurance and medical benefits may continue after retirement if you meet specific requirements.

Eligibility

You are eligible for the medical and life insurance benefits described in this section if you meet two conditions on the date you terminate employment with the Company:

- You have completed ten or more years of service with Diamond Shamrock, and
- You are at least 55 years old.

Not a Contract

This section summarizes the benefits that are currently provided to retirees. It is not a contract with any employee, retiree, or beneficiary. To the full extent permitted by law, Diamond Shamrock reserves the right to terminate or change any provision of this section at any time and for any reason as it applies to current, past, or future retirees and beneficiaries.

Life Insurance

The retired life insurance formula is:

- First Year of Retirement — Your coverage equals 75% of the Company-Paid Life Insurance amount in effect immediately prior to your retirement.
- Second Year of Retirement — Your coverage equals 50% of the Company-Paid Life Insurance amount in effect immediately prior to your retirement.
- Third Year of Retirement — Your coverage equals 25% of the Company-Paid Life Insurance amount in effect immediately prior to your retirement.
- Thereafter and for the remainder of your life — Your coverage equals 10% of the Company-Paid Life Insurance amount in effect immediately prior to your retirement, with a minimum coverage of $10,000.

Since amounts of retired life insurance which exceed $50,000 are now taxable, you can elect to take only $50,000 coverage during the first year of retirement. The second and third year reductions of the $50,000 will be at the same percentages and thereafter the 10% and the $10,000 minimum coverage will apply.

Your Accidental Death and Dismemberment Insurance is terminated on the day immediately preceding your early or normal retirement date.

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During a 31-day period after your retirement, you may elect to convert the difference between your "Active Employee" life insurance coverage and the reduced "retired" coverage; the premium rates will be appropriate to your attained age on the individual policy's effective date. This conversion privilege is available each time your coverage is reduced to the lower percentage. Should you apply for conversion and die within that 31-day period, your beneficiary will receive a benefit equal to the amount of life insurance coverage which might have been issued under the individual policy.

Medical Coverage

As a retiree, you and your eligible dependents are covered under Diamond Shamrock's Medical Plan until you reach age 65, as long as you make the necessary premium contributions. When you become eligible for Medicare benefits at age 65, Medicare becomes your primary coverage and the Diamond Shamrock Medical Plan becomes secondary coverage if you continue to make the required premium contributions.

Termination of Other Employee Benefits

The following benefits are terminated upon your retirement:

- Dental Assistance Plan for you and your dependents
- Accidental Death and Dismemberment Insurance
- Travel Accident Insurance
- Additional Group Life Insurance for you
- Dependent Life Insurance for your family
- Voluntary Group Accident Insurance for you and your family
- Short-Term and Long-Term Disability Plan coverages
- Retirement Plan Service Credits
- Your participation in the Diamond Shamrock Employee Stock Ownership Plan
- Your Employee Shareholding and Investment Plan contributions and the Company's contributions will stop, but you will receive 100% of your participant account, plus the full value of your Corporate account.
- Eligible Resource Account claims may be submitted for reimbursement through the calendar year in which you retire. However, your contributions will stop on your retirement date.

Continuation of Coverage

After termination, you or your covered dependents may have the option to continue coverage under both the Medical Plan and Dental Assistance Plan. This also applies if coverage ends due to divorce, death, or a dependent's reaching the age limitation. See "Continuation of Coverage" in the Termination section on pages T-3 and T-4.

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MEDICAL PLAN

Your Diamond Shamrock Medical Plan provides comprehensive coverage for medical expenses with several cost-effective outpatient benefits.

Effective Date of Coverage

You and your dependents are eligible for Medical Plan coverage on your date of employment. However, if you are confined either in a hospital or at home on the day your coverage is to begin, coverage for you and your dependents will begin when you return to work. If an eligible dependent is confined on the effective date, the dependent's coverage will begin following his or her medical release from confinement.

You may choose not to participate in the plan, but you should do so only if you have adequate coverage under another medical plan. If you do not elect medical coverage when you and/or a dependent become eligible, you will not have an opportunity to participate again until the following January 1 and you provide evidence of insurability. You may change your coverage without evidence of insurability at other times only in the following situations:

- If you have a change in family status, such as a marriage, divorce, death, birth, or adoption, your dependents become ineligible for the plan, or your spouse has a change in employment, you may adjust your medical coverage to reflect that change.
- If you are transferred from a location in which you had elected a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), you may elect a new HMO/PPO or Medical Plan coverage.

Eligible newborn children are covered from birth. New dependents must be reported within 30 days of birth, marriage, adoption, or other event. Otherwise, you will be required to provide evidence of insurability.

Medical Necessity

Before medical charges will be considered for payment, the charges must first be determined to be reasonably necessary for the medical care of the patient's sickness or injury. In addition, reimbursement will be based on the most cost-effective level of necessary medical care.

Reasonable and Customary

Benefits will be paid under the Medical Plan for eligible charges which are considered "reasonable and customary." Reasonable and customary charges are defined as:

- The provider's usual charge for the service or supply, but not more than the prevailing charge in the area for a like service or supply.

If your medical expenses exceed the "reasonable and customary" charges for similar services, you will have to pay the difference.

Please see the glossary for a more detailed definition of reasonable and customary, as well as other important terminology.

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Cost-Sharing

You and the company share the cost of the Medical Plan. Your share of the cost will be automatically deducted from your pay before federal income taxes are deducted.

Medical Coverage

There are many medical conditions that can mean significant expenses with or without a family member being confined in a hospital. In addition, during or after a hospital confinement, there will be eligible charges for hospitals, doctors, specialists, private nurses, or medical services. It is for these major expenses that the Medical Plan provides substantial financial protection for you and your family.

How the Plan Works

Medical benefits are determined on a calendar-year basis. Once a deductible is satisfied, the applicable benefit percentage is paid for covered expenses incurred during the remainder of the year. Medical expenses in excess of benefits paid under this plan, as well as the deductibles, are your responsibility.

Calendar-Year Deductibles

- Individual — The first $200 of an individual's covered expenses incurred in a calendar year
- Family — The first $600 of covered expenses incurred in a calendar year by you and your eligible dependents. However, no more than $200 of each member's covered expenses may be applied against this "family deductible"
- Common Accident — If two or more eligible family members are injured in the same accident, only one $200 yearly deductible will be required for their combined covered expenses due to the accident

Medical Plan Percentages

- 80% — For all covered expenses incurred after the deductible is satisfied except the following expenses:
- 50% — For all covered expenses, after the deductible is satisfied, for outpatient physicians' services in connection with any mental, psychoneurotic, or personality disorders, unless such expenses are incurred: (a) during a hospital confinement for which room and board charges are made, or (b) for the administration of convulsive therapy. Benefits cannot exceed 50 visits in a calendar year
- 100% — For all covered charges over the out-of-pocket limit
- 100% — For certain outpatient services
- 80% — For hospital confinements for mental disorders. There is a lifetime maximum of 180 days per person in hospital psychiatric care.

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Out-of-Pocket Limits

After you have paid the following out-of-pocket maximums, which include your annual deductible, the plan will pay 100% of eligible expenses for the remainder of the calendar year up to an individual lifetime maximum.

- Individual — $1,200 per calendar year
- Family — $2,400 per calendar year

Individual Lifetime Maximum

Whenever medical benefits are paid, they are charged against an individual's lifetime maximum. The Medical Plan lifetime maximum is $750,000 for you and each of your covered dependents.

Any benefits paid at 100% under the outpatient coverages (see pages M-7 and M-8) do not reduce the lifetime maximums.

Automatic Reinstatement of Lifetime Maximum

Once medical benefits have been charged against a lifetime maximum, up to $2,000 will automatically be reinstated on the first of each year until the full maximum is restored. The maximum can never be restored to an amount which is over $750,000.

The full individual maximum may be reinstated at any time by submitting evidence of the person's good health. The reinstatement shall be effective when the Human Resources representative for the plan determines the evidence to be satisfactory.

Covered Expenses

When ordered by a physician, the following services and supplies are examples of covered medical expenses. (A charge is considered to be incurred on the date of the service or purchase for which the charge is made.)

- Semi-private hospital room and hospital services (limited to 45 days a calendar year for drug- or alcoholism-related confinements)
- Surgeon charges
- Ambulance services for local travel
- Doctors' medical care services — Office, home, and hospital visits
- Private duty nursing by a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN) or a Christian Science nurse listed in the *Christian Science Journal*, other than a close relative, for such period as the attending physician certifies to be necessary for the patient's strictly medical needs
- Speech therapy by a qualified speech therapist, other than a close relative, to restore speech loss, or correct an impairment, due to (a) a congenital defect for which corrective surgery has been performed, or (b) an injury or sickness except a mental, psychoneurotic, or personality disorder

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- Drugs and medicines prescribed by a physician and dispensed by a licensed pharmacist
- X-ray and laboratory examinations
- Surgical dressings
- Blood and blood plasma, if not replaced
- Artificial limbs, eyes, and larynx
- Electronic heart pacemaker
- Casts, splints, trusses, braces, crutches
- Oxygen and rental of equipment for its administration
- Chemotherapy
- Kidney dialysis furnished by a dialysis center. Also, certain expenses for home dialysis, such as dialysate solutions and disposable coils.
- Home health care — Up to 100 visits a calendar year
- Hospice care — When hospital care is not necessary, subject to certain limitations (See Glossary)
- Chiropractors — Limited to 26 visits per calendar year
- Physical therapy services when (a) rendered by a physician in approved facilities, or (b) under the direction of a physician and rendered by a licensed physical therapist, other than a close relative
- Rental of wheel chair, hospital bed, or iron lung
- Room, board, and other services and supplies furnished by a convalescent nursing home (other than personal items and professional services) after a hospital stay of at least three consecutive days, for up to 60 days per related confinement (confinements separated by less than 90 days) and subject to a daily limit equal to 50% of the prior hospital's semi-private room rate
- Services and supplies furnished for the routine medical care of a newborn child who is not ill will be covered during the child's hospital confinement immediately following birth
- Artificial insemination involving the employee and his/her spouse, but not a surrogate donor
- Birthing centers

In the event your physician orders the use of a private room (only for isolation due to a contagious disease or reverse isolation due to severe burns or similar injury), the difference between the semi-private and private room rate is an eligible expense.

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Maternity

Maternity benefits are provided to all female employees and spouses of male employees. Maternity expenses will be payable when the delivery takes place after medical coverages have begun. However, as explained in a subsequent section, payments may be "coordinated" on a secondary basis if maternity benefits are provided by another group medical plan.

Maternity will be treated the same as any illness for the purpose of benefit calculations.

Surgical Benefits

Eligible surgical charges include the following physician's services:

- The immediate pre-operative examination by the doctor performing the surgical procedure
- Performance of the surgical procedure
- Assistance with the surgical procedure where required by the nature of the procedure or by the patient's condition, provided it is not performed in a hospital having available staff physicians qualified to provide such assistance
- Post-operative care required by and directly related to the surgical procedure

It is prudent for you and your doctor to discuss his fees in advance of any treatment. At that time, you may explain that your coverage is for "reasonable and customary" charges. In addition, an operative report may be required for unusual circumstances or medical complications in connection with a particular surgical procedure.

Inpatient surgery is payable after the deductible and subject to the appropriate coinsurance percentage explained earlier. In addition, certain nonemergency elective surgery performed on an inpatient basis in a hospital or in an ambulatory surgical center is subject to an incentive second opinion. If a second opinion is obtained, even if it does not confirm the need for surgery, benefits are payable at the appropriate coinsurance percentage. If no second opinion (or third opinion) is obtained, the gross eligible surgical charges will be reduced by 20%. Contact your Human Resources representative if you have any questions. Also see the Glossary for important definitions.

Home Health Care Benefits

If your physician orders home health care, you can receive benefits for services and supplies provided by a Home Health Care Agency under a Home Health Care Plan including:

- Nursing care provided or supervised by a Registered Nurse (R.N.)
- Home health aide services
- Physical, occupational, speech, or respiratory therapy by a qualified therapist

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- Nutrition counseling provided or supervised by a registered dietician
- Medical supplies, laboratory services, drugs, and medications prescribed by a physician

Benefits will be provided for the continuous period during which inpatient confinement would be required in a convalescent nursing home or skilled nursing facility if home health care weren't provided.

Not more than 100 visits will be included as eligible expenses for any one person in a calendar year. Each visit by a member of a home health care team is counted as one visit.

Hospice Benefits

When a person is terminally ill, the program will pay for certain expenses as outlined below. See the Glossary for a definition of a hospice. Eligible charges include:

- Outpatient benefit — $2,000 maximum
- Daily hospice limit — Up to $150 per day
- Inpatient benefit — $3,000 maximum Lifetime
- Bereavement benefit — For counseling services for the family unit, if ordered and received under the Hospice Care Program, up to $200 maximum

Medical Emergency Benefits

Outpatient emergency room charges, excluding physicians' fees, may be payable in full for an illness which is considered a medical emergency. A medical emergency is defined as a sudden onset of one of the following conditions with severe symptoms requiring immediate care:

- Acute appendicitis
- Asthma attack or severe respiratory distress
- Convulsive seizures
- Coronary
- Diabetic coma or insulin reaction
- Frostbite
- Hemorrhage
- Renal colic
- Severe allergic reaction
- Shock
- Stroke
- Sunstroke
- Unconsciousness

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Other illnesses may qualify as a medical emergency if the attending physician submits a written statement which documents the need for emergency treatment.

Outpatient Benefits

Outpatient benefits are designed to provide you and your family with a cost-effective alternative to inpatient care. Use these benefits where appropriate and where medically there is no need for a confinement to provide quality care.

Outpatient Surgical Benefits

Reasonable and customary surgical charges are covered **in full** for you and your dependents if the eligible surgery is performed on an **outpatient** basis. Surgical benefits are determined through the use of computer profiles maintained by the Prudential Insurance Company of America. These profiles are derived from surgical fee data for like procedures in a given area, and they are updated on a periodic basis.

Hospital Pre-Admission Testing Benefits

When a physician schedules you or your dependents for admission to the hospital, outpatient X-rays or laboratory examinations may be covered in **full**. To be payable, the testing must:

- Take place within ten days of the hospital confinement, and
- Be directly related to the sickness or injury requiring the subsequent confinement.

Supplemental Accident Benefits

Medical care benefits may be provided for you or your dependents when accidental injury necessitates emergency treatment at the hospital or in a physician's office. The treatment must take place within 72 hours of the accident and must be provided on an outpatient basis.

Eligible charges are payable in full on a reasonable and customary basis, and include such items as:

- Emergency room charges and necessary medical supplies
- Physician services for surgery and other medical care
- X-rays and laboratory examinations
- Drugs and medicines requiring the written prescription of a physician, and dispensed by a licensed pharmacist
- Ambulance service to the hospital and, if certified by a physician as medically necessary, transfer to another hospital equipped to furnish special treatment incident to the injury
- Surgical dressings, casts, splints, braces, and crutches

The 72-hour limit does not apply to X-rays due to accidental injury.

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Outpatient Diagnostic Benefits

When a physician does not require hospital admittance for diagnostic tests, covered X-rays or laboratory examinations are payable in full. The services must be ordered by your physician; in addition, they must be related directly to, and necessary for, the diagnosis of any illness or injury. Some examples of other covered services are:

- EEGs, EKGs, and brain/body scans
- Blood tests, urine analyses, etc.
- Routine PAP smear (one in a continuous twelve-month period)

Examples of services which are not covered under this benefit are:

- X-rays and laboratory tests in connection with routine physical examinations
- Dental X-rays, except in cases of accidental injury to the teeth occurring while covered by the plan

Outpatient Radiotherapy/Chemotherapy Benefits

Outpatient radium, X-ray, and chemotherapy treatments are payable in full, if ordered by a physician. This benefit does not include:

- Treatment for cosmetic purposes, unless the condition is due to an accidental injury which occurred while covered by the plan
- X-ray examinations for diagnostic purposes

Medical Plan Exclusions

Although our plan protects you and your dependents against most medical expenses, certain health care services are not covered by the Medical Plan. Generally, only medical services and supplies which are medically necessary to treat an injury, illness, or pregnancy are covered. Excluded are routine medical care expenses and services for which coverage is provided under other benefit programs.

For example, your Medical Plan does not cover:

- Any expenses incurred before coverage under Diamond Shamrock's plan begins
- Charges in excess of amounts which are "reasonable and customary"
- Expenses for a work-related disability entitling you or a dependent to benefits from worker's compensation laws, occupational disease law, or similar legislation
- Charges for conditions for which others are responsible, which are in excess of $1,000 (charges to the extent of a payment or payments as a result of judgment, settlement, or otherwise by any person or persons considered responsible for the condition giving rise to the charges, or by their insurers)
- Cosmetic surgery or treatment, except that necessitated by accidental injury occurring while a covered employee

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- Eyeglasses, contact lenses, and hearing aids; examinations to determine the need for an adjustment of these items
- Hospital confinements for weekend admissions (Friday or Saturday), if not medically necessary (See definitions.)
- Hospital charges to the extent they can be allocated to scholastic education or vocational training
- Routine physical, including screening and research studies, premarital, or pre-employment examinations not reasonably necessary or required for the diagnosis of sickness or injury
- Rest cures or custodial care
- Expenses for care or treatment ordinarily received free, such as care received in a government hospital
- Expenses for care or treatment to the extent any benefits are provided by any law or government program under which you or one of your dependents are or could be covered
- Charges for physician's services or X-ray examination for mouth conditions caused by periodontal or periapical disease or any condition involving teeth, surrounding tissue or structure, the alveolar process or the gingival tissue, except for treatment or removal of malignant tumors. However, this exclusion does not apply to treatment of accidental injury to natural teeth within 12 months of the accident occurring while covered (including replacement of such teeth within that period)
- Physician's services for (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations, (b) corns, calluses or toenails, except removing nail roots or care prescribed by an M.D. or D.O. treating metabolic or peripheral-vascular disease
- Treatment for disease or injury due to war or any act of war while covered under this program ("war" means declared or undeclared war and includes resistance to armed aggression)
- Charges in connection with abortion unless the life of the mother would be endangered if the fetus were carried to term, or a physician certifies that the fetus most likely has been damaged or deformed
- Routine immunizations
- Pregnancy charges for dependent daughters
- Charges in connection with organ transplants, unless the recipient is covered by the plan, the donor and recipient are both covered by the plan, or the donor is a covered by the plan and the recipient is an immediate family member (a parent, brother, sister, or child)
- Charges for the reversal of a tubal ligation or vasectomy, unless medically necessary

Claim Payment Examples

The following examples show how the medical benefits are calculated when you have medical expenses due to injury or illness.

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Hospitalized

John's wife underwent surgery to correct an ulcer problem. Her bills were covered in the following manner:

	Total Bills	Covered By: Outpatient Benefits 100% Coverage	Covered By: Inpatient Benefits 80% Coverage
Semi-private hospital Room and board at $190 per day for 14 days	$2,660	-0-	$2,660
Extra hospital services (X-ray, anesthesia, tests)	1,950	-0-	1,950
Surgeon's fee	1,100	-0-	1,100
Drugs in hospital	150	-0-	150
at home	210	-0-	210
Television, phone rental	50	-0-	-0-
TOTALS	**$6,120**	**-0-**	**$6,070**

John paid the hospital $50 for the television and telephone. He then satisfied his $200 medical deductible and received 80% of the next $5,000 and 100% of the remaining eligible expenses. The benefits program paid $4,870 of the $6,120 total bill for his wife's operation. John paid $1,250.

Not Hospitalized

This example shows how your bills would be paid if you were not hospitalized. James has a severe allergy problem which requires frequent, regular treatments from his doctor. In addition, during the year James visited the doctor for an accidental fall and a couple of nonemergency sicknesses. Here's the financial assistance the benefits program provided for him.

	Total Bills	Covered By: Outpatient Benefits 100% Coverage	Covered By: Medical Benefits 80% Coverage
Doctor's visits (nonemergency)	$500	-0-	$500
Laboratory tests	175	$175	-0-
X-rays	125	125	-0-
Drugs and medicines	250	-0-	250
Rental of special equipment	100	-0-	100
Doctor's visits (accident)	50	50	-0-
TOTALS	**$1,200**	**$350**	**$850**

The Outpatient Diagnostic Laboratory and X-ray coverage paid $300 and Supplemental Accident Benefits covered $50 of James' expenses. After James paid $200 of the remaining bills, which satisfied the $200 medical deductible, the Medical Plan paid 80% of the remaining bills —$520. In all, the Medical Plan paid $870 of the total $1,200 in bills. James paid $330.

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Coordination of Benefits (Non-Duplication)

Increasingly, as both husband and wife are employed, family members are covered by more than one group medical plan. Your Diamond Shamrock Medical Plan is "coordinated" with group insurance and government medical programs to prevent duplication of benefits for the same dollar of medical expenses. This means that your combined benefits for all defined plans will pay up to — but not more than — your allowable Diamond Shamrock Medical Plan benefits. "Allowable" expenses are any necessary, reasonable and customary medical services covered, at least in part, by one of the coordinating plans.

The following types of plans are coordinated with our Medical Plan:

- Group insurance plans, whether on an insured or uninsured basis, including prepayment coverages, group practices, or individual practice coverages
- Governmental benefit programs, other than Medicare, and other coverages required or provided by law
- Any student medical coverages sponsored by or provided through schools or other education institutions.

The coordination provision does not apply to an individual, private insurance policy, except "no-fault" coverage for medical or dental care required in policies or contracts to meet motor vehicle insurance laws or other legislation.

When a member of your family also is covered by one of the above programs, the primary plan pays its benefits first, without regard to the other plan(s). A plan without a Coordination of Benefits provision is always the primary plan. If all plans have coordination clauses, then benefits are determined in the following manner:

- A plan is primary if it covers the individual as an employee, and it is the secondary plan if the covered individual is a dependent.
- If a child is covered under both parents' plans, benefits for the child are paid first from the plan of the parent whose birthday falls earliest in the year.
- When the parents are separated or divorced, their plans pay in this order: (a) if a court decree has established financial responsibility for the child's health care expenses, the plan of the parent with this responsibility; (b) the plan of the parent with custody of the child; (c) the plan of the stepparent married to the parent with custody of the child; (d) the plan of the parent not having custody of the child.
- If a retired employee returns to active work with a new employer, the active plan is primary over the retired plan.
- When a determination cannot be made under the above rules, the primary plan is the one which has covered the individual for the longest period of time.

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Our Medical Plan will pay the benefits explained in this booklet when it is the primary plan. When secondary, it will only pay any difference between the primary plan benefits and our plan benefits. No plan will pay more than it would have paid without a Coordination of Benefits provision.

Medicare

If you reach age 65 and continue to be actively employed by Diamond Shamrock, you have two choices. You may continue your Diamond Shamrock Medical Plan with Medicare acting as secondary coverage, or you may choose Medicare as your only coverage. If you choose Medicare as your primary coverage, your benefits from the Diamond Shamrock Medical Plan will be terminated. The cost of Medicare coverage is always employee paid. Your covered spouse has the same choice once your spouse reaches age 65.

Claims and Claim Handling

Send your Medical Plan claims directly to the Prudential Insurance Company. To discuss payment of your medical claims, you may call Prudential toll-free at 1-800-542-3131. You should take the necessary claim form to the hospital or physician's office. When this is not possible in emergency situations, you should present your plan identification card to the hospital or attending physician and, if necessary, request them to call Prudential at the indicated number for verification of coverage.

Before a medical benefit claim can be processed for payment, the following forms must be completed and forwarded with other medical service receipts and bills:

- Medical Benefit Program Claim Form — This must be completely filled out by the employee per the specific instructions provided within the form. Write N/A in those spaces which do not apply to the claim.
- Hospital Bill (if hospitalized) — This must be an itemized bill. No payment can be made on balance due statements.
- Other Medical Service Bills — These include eligible charges for laboratory services, prescription drugs, registered nurses, medical equipment, and other out-of-hospital type professional charges. All submitted bills must include the following information:
  - — Patient's name
  - — Date and type of medical service received
  - — Diagnosis of the illness or injury
  - — Itemized charges
  - — Name of physician who prescribed the medical services or supplies
  - — Prescription numbers (Original drug store receipts or labels from containers are acceptable. However, special prescription claim forms are available through your Human Resources representative.)

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When one of the above items is improperly completed or missing, the processing of your medical bills can be delayed. In addition, you should check with your doctor and/or hospital to ensure that they promptly send in their required forms. A significant portion of delayed claim payments are due to doctors and hospitals not submitting their forms on a timely basis.

Benefits are paid directly to hospitals, clinics, laboratories, emergency room groups, and similar providers of medical services. For physician expenses, payments are made to you or the physician to whom you have assigned benefits. If you must pay a charge which otherwise would be assigned, be sure to clearly indicate on the submitted bill that it has been paid.

If your spouse is employed and covered under another group plan as previously defined, both insurance offices must receive copies of all medical claim forms and bills. "Coordinated" claims normally require more processing time. Therefore, it is essential that you submit all statements to both offices as soon as possible.

Limitations

The Medical Plan has limitations; it is not intended to cover every expense completely. The plan is designed to provide protection where medically necessary expenses could be financially disastrous to your family.

Termination of Coverage

Medical Plan coverage will end for you and your dependents when:

- You terminate employment with Diamond Shamrock;
- You transfer out of the eligible classes; or
- The Medical Plan coverage terminates.

In addition, dependent coverages are cancelled:

- The date an eligible dependent ceases to qualify as such for any reason, i.e., age, graduation from college, marriage, entrance into military service, divorce, legal separation, etc. However, when an eligible child reaches age nineteen, medical coverages are continued through the end of that calendar year. If a dependent is enrolled as a full-time student in an accredited college, university, or institution of learning, medical coverage continues until the dependent's twenty-third birthday.

When you retire, Medical Plan coverages continue for you and your eligible dependents. Refer to Your Benefits in Retirement section for further details of benefits in retirement.

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Full Medical Plan coverages are continued for the eligible dependents of a deceased regular employee for three calendar months following the employee's death, subject to any other provisions relating to termination of dependents' insurance. Your eligible dependents must pay the employee premiums to receive this coverage. At the end of this period, they may continue coverage for the remaining 33-month period by paying the full premium plus 2%, as described under "Continuation of Coverage" in the Termination section on pages T-3 and T-4.

After termination, you or your covered dependents may have the option to continue coverage under both the Medical Plan and the Dental Assistance Plan. This applies also if coverage ends due to divorce, death, or a dependent's reaching the age limitation. See "Continuation of Coverage" in the Termination section on pages T-3 and T-4.

Note: If you become totally and permanently disabled and you have not chosen to be covered under the Diamond Shamrock Long-Term Disability Plan, your company service ends when your Salary Continuation Plan benefits end. That means that you (and any eligible, covered dependents) lose your Medical Plan protection.

Conversion Privilege

If your coverage under this plan is terminated, you may convert to an individual policy if you reside or maintain permanent residency in the United States. Conversions to an individual policy also are available to dependents when they no longer are eligible for coverage under the Medical Plan. However, conversion privileges are not provided for individuals eligible for Medicare because of age.

You need not undergo a medical examination if you make application for the individual policy within the 31-day period immediately following the date on which your Medical Plan coverages are terminated. Your Human Resources representative will provide the necessary conversion forms and assist you in the application process. (See the Additional Information section for details.)

HMO/PPO Options

A Health Maintenance Organization (HMO) is an organized system of health care, providing a comprehensive package of services on a fixed, pre-paid basis. The care is provided by a group of physicians, or a number of groups practicing together, sharing facilities, medical equipment, records, and personnel. HMOs are located in defined geographic areas.

One or more HMOs may be available in certain locations. If HMO coverage is available at your location, you can enroll in that coverage rather than the Medical Plan described in this section. Your premium costs for HMO coverage are also deducted automatically from your pay before federal income tax is deducted.

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A Preferred Provider Organization (PPO) is a group of physicians, hospitals, and other health care providers who agree to charge certain rates for health care. These rates are typically less than those charged by other providers. Therefore, you and the plan save money if you use these providers. If a PPO is available in your location, you will receive information on it with enrollment materials.

For more information, see your Human Resources representative.

The Prudential Patient Advisory Support Services (PruPASS) Program

The PruPASS Program is a combination of three health care plan services: (1) Pre-Admission and Concurrent Review Service; (2) Second Surgical Opinion Program; and (3) the Support Specialist. The program is designed to evaluate all inpatient hospital admissions and nonemergency elective surgical procedures that you or your dependents may require. The purpose of the program is to make sure that you understand the length of hospital stay and elective surgical procedures that will be considered necessary under your health care plan before you incur the expense.

To receive the benefits of the PruPASS Program, you or your dependent must call the PruPASS toll-free number, 1-800-245-2653, **before** scheduling surgery or entering the hospital. A Support Specialist will then be assigned to assist you.

The Support Specialist, under the supervision of a PruPASS medical professional and together with your doctor, will evaluate your medical condition or that of your dependent. The Support Specialist will approve a hospital length of stay that will be fully eligible under your Medical Plan. However, this approval does not guarantee either the payment of benefits or the amount of benefits.

When your doctor recommends nonemergency elective surgery, the Support Specialist will arrange for a second opinion examination, at no cost to you or your dependent. If the second opinion doctor does not confirm the need for the proposed surgery, then a third opinion may be arranged, again, at no cost to you or your dependent. If a second opinion is not obtained, your eligible charges will be reduced. **If you have been admitted to a hospital because of an emergency, PruPASS must be called within two working days of admission.**

Maximum benefits are available under the plan only if you or your dependents use the PruPASS Program. If you do not use the PruPASS Program for a scheduled hospitalization, or if the stay in the hospital is beyond the approved number of days, **your gross eligible hospital expenses, that would otherwise have been covered, will be reduced by 20%.**

Likewise, if you or your dependents undergo elective surgery without obtaining the second opinion required by the PruPASS Program, **gross eligible surgical charges, that would otherwise have been paid, will be reduced by 20%.**

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To receive maximum hospital and surgical benefits under your health care plan, call the PruPass Support Specialist at 1-800-245-2653.

It is possible to extend the number of days of Inpatient Hospital Confinement that Prudential approved as needed for medical care of the patient's condition. A call must be made requesting the extension of stay by the patient or a member of the patient's family or the doctor before the previously approved length of stay is over.

When the request is made, the Support Specialist will make a new Determination of Need on the basis of information given by the doctor. The doctor will be told how many days, if any, that Prudential approves as needed for medical care of the patient's condition. This will be confirmed by written notice sent to you, to the doctor, and to the hospital.

Medical Plan Glossary

Birthing center — A birthing (for birth) center is a facility that offers maternity care in a homelike atmosphere under the direction of trained medical personnel, such as state licensed certified nurse midwives (CNM).

Calendar year — January 1 through December 31

Close relative — The employee, spouse and a child, brother, sister, or parent of the employee or spouse.

Convalescent nursing home — Only an institution meeting the following requirements:

- It is operated pursuant to law and is primarily engaged in providing, for compensation from its patients, the following services for persons convalescing from sickness or injury — room, board, and 24-hour-a-day nursing service by one or more professional nurses and other nursing personnel needed to provide adequate medical care.
- It provides services under the full-time supervision of a proprietor or employee who is a physician or a registered graduate nurse (R.N.).
- It maintains adequate medical records and has available the services of a physician under an established agreement if not supervised by a physician.

The term "convalescent nursing home" does not include any institution or part thereof which is used principally as a rest facility or a facility for the aged or for the care of drug addicts or alcoholics.

Counseling services — Counseling services are supportive services provided, after the death of the terminally ill person, by members of the hospice team in counseling sessions with the family unit.

Custodial care — Care not requiring continuous medical and nursing services in hospitals or convalescent nursing homes.

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Determination of need — A determination by Prudential, under the terms of the insurance, that approves or disapproves a day or days of inpatient hospital confinement (including hospital services and supplies) as needed for medical care of a diagnosed sickness or injury.

Eligible expenses — These are the expenses that may be used as the basis for a claim under the terms of the insurance.

Emergency admission — A hospital admission for an inpatient hospital confinement for a condition which, unless promptly treated on an inpatient basis, would:

(1) Put the patient's life in danger; or

(2) Cause serious damage to a bodily function of the patient.

Home health care agency — Any of the following: (1) a hospital, as defined above, which provides a program of home health care, or (2) a home health agency as defined for Medicare, or (3) an organization which is certified by the patient's physician as an appropriate provider of home health services, is licensed or certified as a home health care agency if the state or local jurisdiction in which it is located requires such licensing or certification, has a full-time administrator, keeps written records of services provided to the patient, and has at least one registered nurse (R.N.) or one's nursing care available.

Home health care plan — A written program submitted by the physician in charge of the patient. It must be a written program for care and treatment of a sickness or injury in the patient's home and certification that inpatient confinement in a hospital, convalescent nursing home or skilled nursing facility would be required if the home care were not provided.

Hospice — A hospice is a facility which provides short periods of stay for a terminally ill person in a home-like setting for either direct care or respite. This facility may be either free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program.

Hospital — The term "hospital" has three possible meanings for the purposes of the Medical Plan. They are:

- An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals
- Any other institution which is operated pursuant to law, under the supervision of a staff of physicians with 24-hour-a-day nursing service, and which is primarily engaged in providing:

  (1) General inpatient medical care and treatment for sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or under its control, or

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(2) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities except that, solely as to expense incurred in connection with the treatment of mental, psychoneurotic, and personality disorders when such treatment is legally performed, by or under the supervision of a physician, the term "hospital" shall include a mental health treatment facility of mental, psychoneurotic, and personality disorders which does not satisfy the requirement above, but is: .

(i) Affiliated with a hospital under a contractual agreement with an established system of patient referral, or

(ii) Licensed, certified, or approved as a mental health treatment center by the appropriate agency of the state in which it is located, or

(iii) Accredited as such in a facility by the Joint Commission on Accreditation of Hospitals.

- A Christian Science sanitarium accredited by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts. Treatment given to a patient in accordance with healing practices of Christian Science will be considered as if given for medical care.

In no event shall the term "hospital" include a convalescent nursing home or include an institution or part thereof which:

(i) Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged, or

(ii) Furnishes primarily domiciliary or custodial care, including training in the routines of daily living, or

(iii) Is operated primarily as a school.

Hospital confinement (weekends) — If an individual is admitted to the hospital on a Friday or Saturday, no benefits are payable for hospital-related expenses incurred during that first weekend (Friday or Saturday). However, all eligible plan benefits would be paid if the admission is required because of an "emergency" or if surgery is performed that weekend. An "emergency" means sudden, unexpected medical condition that without immediate medical attention could result in death or cause impairment to bodily functions.

Inpatient hospital confinement — A hospital confinement for which a room and board charge is made by the hospital.

Medical necessity or medically necessary — These terms apply to those charges for any services or supplies which are reasonably necessary for the medical care of the patient's sickness or injury.

Nonemergency admission — A hospital admission which is for an inpatient hospital confinement but is not an emergency admission.

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Physician — As used in the Medical Plan, physician means:

- A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Surgical Chiropody (D.S.C.), Doctor of Podiatry (D.P.M.), or a Chiropractor (D.C.), who is legally licensed and legally qualified to practice medicine and perform surgery at the time and place services are furnished or rendered.
- Treatment by a Christian Science practitioner listed in the *Christian Science Journal*, including treatment customarily referred to as "absent treatment," will be considered treatment by a physician, and such practitioner will be considered a physician.

In addition, a clinical psychologist is included when the individual is licensed or certified by the appropriate governmental authority to provide clinical psychological services in connection with the diagnosis or treatment of mental, psychoneurotic, or personality disorders.

The term physician does not include: social workers, occupational therapists, educational psychologists, marriage counselors, etc.

Reasonable and customary charges — The reasonable and customary charge for any service or supply is the usual charge of the provider for the service or supply in the absence of coverage under the plan, but not more than the prevailing charge in the area for a like service or supply. A like service is of the same nature and duration, requiring the same skill, and is performed by a provider of similar training and experience. A like supply is one which is identical or substantially equivalent. "Area" means the municipality (or, in the case of a large city, the subdivision thereof) in which the service or supply is actually provided or such greater area as is necessary to obtain a representative cross-section of charges for a like service or supply.

Related confinements — All confinements are considered related unless separated by at least ninety days.

Room charges — Expenses for a hospital room may be:

- **Semi-Private** — Plan will pay up to the highest semi-private room rate for a hospital, or
- **Private** — Plan will pay up to the highest semi-private room rate as an eligible charge (if hospital has no semi-private rooms, plan will pay 90% of the lowest private room rate).

Second opinion surgery — Several definitions apply to seeking a second surgical opinion.

- **Elective surgical procedure** — A nonemergency surgical procedure scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions and is performed while the patient is confined in a hospital as an inpatient or in an ambulatory surgical center.

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Some examples of the more common elective surgical procedures:

— Cardiac bypass graft
— Nonemergency cesarean section
— Joint surgery
— Submucous resection of nose (non-cosmetic)
— Tubes and ovaries (non-sterilization procedures only)
— Tympanotomy
— Varicose vein ligation
— Pacemaker insertion (permanent)
— Herniorrhaphy (pediatric umbilical)
— Intervertebral disc or spinal surgery
— Hysterectomy
— Tonsillectomy and Adenoidectomy
— Prostatectomy
— Cataract removal
— Hemorrhoidectomy
— Gastroplasty

Of course any procedure (even those listed) will not be considered elective if the operation is of an emergency nature (that is, must be performed without delay), as determined by the patient's surgeon.

- Ambulatory surgical center — A public or private institution that is:

— Established, equipped, and operated primarily as a facility for performance of surgical procedures and meets the following requirements: (a) is operated under the supervision of a staff of doctors, maintains adequate medical records, and provides for periodic review of the facility and its operation by a committee composed of doctors other than those owning or supervising the facility; (b) permits a surgical procedure to be performed only by a doctor privileged to perform such procedure in a hospital in its area and requires that a licensed anesthesiologist administer the anesthetics and be present during the surgical procedure, unless only local infiltration anesthetics are used; (c) provides no overnight accommodations for patients, has at least two operating rooms, one post-anesthesia recovery room and full-time services of registered nurses (RN) in all operating and post-anesthesia recovery rooms; (d) is equipped to perform diagnostic X-ray and laboratory examinations and has the necessary equipment and trained personnel to handle foreseeable emergencies, including a defibrillator for cardiac arrest, a tracheotomy set for airway obstruction, and a blood bank or other supply for hemorrhaging; (e) maintains written agreements with hospitals in its area for immediate acceptance of patients who develop complications or require post-operative confinement; or

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— Licensed as an ambulatory surgical center by the state in which the center is located.

- Second Surgical Opinion — An opinion of a board-certified specialist, based on his examination of the patient, of the advisability of an elective surgical procedure after another doctor, licensed to practice medicine and perform surgery, has proposed to perform surgery, but prior to the performance of the surgery.
- Third Surgical Opinion — An opinion of a board-certified specialist of the advisability of an elective surgical procedure, based on his examination of the patient, after the second surgical opinion of another board-certified specialist indicated that the proposed elective surgical procedure is not medically advisable.
- Affirmative Second or Third Surgical Opinion — A second surgical opinion or a third surgical opinion that confirms the advisability of the proposed elective surgical procedure.
- Board-Certified Specialist — A doctor, designated by Prudential, who holds the rank of Diplomate of an American Board (M.D.) or Certified Specialist (D.O.).

Support specialist — The person who will review the need and/or length of inpatient hospital confinement.

Surgical procedure — Cutting, suturing, treatment of burns, correction of fracture, reduction of dislocation, manipulation of joint under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, or injection of sclerosing solution.

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Not subject to deed:

√ outpt surg facility
√ accidents w/I 72 hrs
√ ER
√ ER doc
diagnostics
√ pre-admin testing
√ Otpt surg √ related chgs
√ 2nd opinion
√ pap smear

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