GAO

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Fact Sheet for Congressional Requesters

July 1992

EMPLOYEE BENEFITS

Financing Health Benefits of Coal Industry Retirees

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GAO

United States
General Accounting Office
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Human Resources Division

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July 22, 1992

The Honorable Orrin G. Hatch
The Honorable David L. Boren
The Honorable Mitch McConnell
The Honorable David Durenberger
United States Senate

This is in response to your December 11, 1991, request for information relating to proposed legislation regarding health benefits for retirees in the coal industry. There is considerable interest in the legislation because the two trusts that currently provide these benefits have deficits. You asked that we respond to certain questions regarding the two health benefit trusts as well as the two pension trusts. Your questions concerned the characteristics of the trusts' beneficiaries, the benefits provided, and the present and projected financial condition of the trusts. Your questions and our responses are in the body of this fact sheet.

Background

The United Mine Workers of America (UMWA) and the Bituminous Coal Operators' Association, Inc. (BCOA), have established four trusts that provide pension and health benefits for coal industry retirees (coal miners and workers in certain related occupations) and their eligible dependents. Generally, the 1950 Pension Trust and the 1950 Benefit Trust provide benefits to individuals who retired before January 1, 1976. Individuals who retired after this date receive their pension from the 1974 Pension Trust and their health benefits directly from their last employer. However, if their last employer no longer provides them with health benefits, the individuals receive their health benefits from the 1974 Benefit Trust.

The trusts are funded by contributions made by employers (coal companies and noncoal producers, such as coal truckers and processors) that have signed the National Bituminous Coal Wage Agreement—the collective bargaining agreement negotiated between UMWA and BCOA—or similar agreements. The current agreement was effective February 1, 1988, and expires on February 1, 1993.

The benefit trusts first experienced annual operating deficits in fiscal year 1987. As of December 31, 1991, the trusts had a combined estimated accumulated deficit of about $115 million.

On March 12, 1990, the Secretary of Labor appointed a commission to review and make recommendations concerning the financial crisis

confronting the 1950 and 1974 Benefit Trusts. In its November 5, 1990, report, the Commission:

- agreed that, to avoid delays resulting from litigating contractual requirements that former signatories contribute to the health benefit trusts, the requirements should be imposed by statute,
- agreed that the practice of some employers of reneging on their commitments to provide retirees with health care should be prohibited by the Congress,
- supported enactment of statutory authority for using assets from the overfunded 1950 Pension Trust to reduce existing deficits in the health trusts, and
- supported actions to reduce health care costs without the loss of benefits.

A major issue on which the Commission did not reach agreement was who should contribute to fund health benefits for retirees whose former employers were no longer in existence or in the coal business. Some commissioners believed that the entire coal industry should help pay for them, whereas others believed that just former and current signatories should be required to contribute.

Legislation has been proposed to deal with the problems discussed in the Commission's report. On November 19, 1991, Senator Rockefeller and several cosponsors introduced S.1989, and on April 8, 1992, Senator Boren and several cosponsors introduced S.2550.

Scope and Methodology

To respond to your questions, we obtained information from officials of the UMWA Health and Retirement Funds, the organization that administers the four trusts. We also met with officials of UMWA, BCOA, and a consultant employed by the Private Benefits Alliance. We obtained coal production and reserve data for 1990 from the Department of Energy's Energy Information Administration.

We did not independently verify the accuracy of the data provided to us. We did, however, cross-check its internal consistency. Much of the financial data came from audited financial statements of the four trusts. In some cases, data to fully answer the questions were not available or would have taken longer to develop than the time we had available. Additional details of our methodology are discussed in our responses to some of the questions. Our work was performed from January to June 1992 in accordance with generally accepted government auditing standards.

We are providing copies of this fact sheet to Senator Wendell H. Ford, Congressman Harold Rogers, and others who have expressed an interest in this work. We will also make copies available to others upon request.

If you have any questions about the matters discussed in this fact sheet, please call me on (202) 512-7215. Other major contributors are listed in appendix II.

Joseph F. Delfico

Joseph F. Delfico
Director, Income Security Issues

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Abbreviations

BCOA	Bituminous Coal Operators' Association, Inc.
EIA	Energy Information Administration
NBCWA	National Bituminous Coal Wage Agreement
PBA	Private Benefits Alliance
UMWA	United Mine Workers of America

Questions and Responses Related to Financing Health Benefits of Coal Industry Retirees

Question 1

What is the actual size of the current deficit in both the 1950 and 1974 Health/Benefit trusts and when did the deficit first occur in each trust? What will be the expected deficit in both trusts by the end of 1992 and in each successive year for the next five years?

GAO Response

The trusts' audited financial statements for the fiscal year ended June 30, 1991, state that the accumulated deficits were as follows:

- The 1950 Benefit Trust: $79,310,000.
- The 1974 Benefit Trust: $9,667,000.

The trusts' audited financial statements show that the current deficits occurred as follows:

- The 1950 trust experienced its first deficit as the result of fiscal year 1988 operations. The net deficit at the end of that year was $18,068,000, comprised of a gross deficit $21,019,000 from the year's operations and a surplus carryover of $2,951,000 from 1987.
- The 1974 trust experienced its first deficit as the result of fiscal year 1990 operations. The net deficit at the end of that year was $24,806,000, comprised of a gross deficit of $26,368,000 from the year's operations and a surplus carryover of $1,562,000 from 1989.

The trusts estimated that as of December 31, 1991, the deficit was about $99.3 million in the 1950 trust and about $15.0 million in the 1974 trust. The trusts also stated that, unless the contribution rates were increased, they would suspend the payment of health benefit claims in April 1992 because the claims already approved would be equal to the estimated contributions to be received during the remainder of the current BCOA/UMWA contract period.

Therefore, in January 1992 the trusts filed a request for a preliminary injunction with the District of Columbia federal district court for increased contribution rates to cover the current deficit and to fund the estimated benefit claims to be filed through January 31, 1993. The court, however, denied the request and set a trial date for June 1992 on the matter; however, the trial was later rescheduled for January 1993.

In February 1992, beneficiaries filed a request with a Virginia federal district court for a preliminary injunction to prevent the trusts from discontinuing benefit payments in April 1992. The injunction was granted,

and the court also ordered BCOA to raise the contribution rates to $3.07/hour for the 1950 Benefit Trust and to $0.60/hour for the 1974 Benefit Trust. These rates are to be in effect for the remainder of the contract period unless modified by another court.

A projected deficit cannot be computed with any precision because of the many variables involved and the assumptions that need to be made about each. However, a reasonable approximation can be derived of the trusts' costs that would need to be funded by contributions on the basis that the benefits will not be changed from the current contract.

The trusts provided us with (1) actual per capita cost data (net of reimbursements) for four categories of expenses for each benefit trust as of December 31, 1989, and (2) demographic trend estimates for 1990-2001. Based on these data, as adjusted for medical inflation, the total benefit costs of each trust are estimated as follows for 1993-97.

Estimated Annual Net Total Expenses for 1950 and 1974 Benefit Trusts, 1993-97

Year	1950 trust	1974 trust	Total
1993	$214,747,255	$46,768,118	**$261,515,373**
1994	212,989,517	50,620,053	**263,609,570**
1995	211,288,155	54,818,705	**266,106,860**
1996	209,355,483	59,692,474	**269,047,957**
1997	206,914,852	64,968,701	**271,883,553**

Note: Projected expenses net of reimbursements from Medicare and Labor's Black Lung Program adjusted for (1) inflation based on estimates of the consumer price index per alternative II (which assumes moderate economic growth) of the 1992 report of the Board of Trustees of the Federal Old Age and Survivors Insurance and Disability Insurance Trust Funds and the assumption that medical inflation will exceed the consumer price index by 3.5 percentage points and (2) estimated administrative costs which averaged 5.49 percent and 9.44 percent, respectively, of net medical expenses for fiscal years 1988-91 per the 1950 and 1974 trusts' financial statements. (Under alternative I, which assumes low inflation, the trusts' expense range would be about 1 percent lower in 1993 to about 4 percent lower in 1997. Similarly, under alternative III, which assumes more rapid inflation, the trusts' expense range would be about 4 percent greater in 1993 to about 10 percent greater in 2001.)

Question 2

How many retired coal miners and other categories of beneficiaries (e.g., spouses, children) are currently served by each trust? If this figure is expected to rise, what is the estimated number of persons that will be served by each trust over the next five years?

GAO Response

The trusts' officials provided the following data as of January 24, 1992. Data on median age of beneficiaries was not readily available.

	1950 trust		1974 trust	
Category	Beneficiaries	Average age	Beneficiaries	Average age
Retired miners	29,326	77	6,539	66
Retirees' spouses	21,962	70	5,616	61
Retirees' children	1,567	17	1,709	16
Retirees' grandchildren	468	14	120	11
Retirees' parents	10	84	4	80
Retirees' other dependents: disabled children	506	42	65	37
Surviving spouses	44,873	78	1,503	67
Children of surviving spouses	935	18	184	16
Other dependents of surviving spouses: disabled children	874	46	22	35
Total	**100,521**		**15,762**	

The trusts estimate that over the next 5 years (1992-96), the total beneficiaries served by the 1950 trust and the 1974 trust will be as shown below as of the end of each calendar year. The estimates for each trust are based on their attrition and growth experiences, respectively, from 1982 to 1991.

Estimated Populations of the 1950 and 1974 Benefit Trusts, 1992-96

As of December 31	1950 Benefit Trust	1974 Benefit Trust
1992	95,679	16,555
1993	89,176	17,111
1994	82,921	17,586
1995	76,942	18,067
1996	71,215	18,656

Question 3

With respect to current beneficiaries, how many are attributable to present signatories, former signatories, and companies no longer in business? Based on the most recent data available, indicate the proportion of expenditures of the funds attributable to each of these categories of beneficiaries.

GAO Response

At the direction of BCOA/UMWA, the trusts made a census of the status of the last employer of each primary beneficiary[1] as of September 1990. The 1978 BCOA/UMWA contract was used as the basis because it was the first contract to include the "evergreen" clause, which obligates a signatory employer to continue contributing to the trusts even if the employer does not participate in a subsequent contract. The trusts reported the following determinations in April 1991.

	Number of primary beneficiaries		
Employer status	**1950 trust**	**1974 trust**	**Total**
1. Company signed the 1978 or a subsequent BCOA/UMWA contract and is still in business	28,993	4,758	**33,751**
2. Company did not sign the 1978 or a subsequent agreement or is no longer in business	26,320	2,730	**29,050**
3. Company signed the 1978 or a subsequent agreement but business status unknown	1,458	150	**1,608**
4. Company could not be identified	22,434	0	**22,434**
Total	**79,205**	**7,638**	**86,843**

BCOA requested that the trusts revise the table because group #1 included coal companies that (1) are out of business but whose related companies are still in any kind of business, (2) were purchased by a signatory who then shut down their operations, and (3) were signatory subsidiaries whose operations the signatories had shut down. BCOA requested that group #1 include just the companies signatory to the 1978 or subsequent contract that were still in the coal business. This change resulted in a shift to group #3 of nonoperating companies owned by operating signatories. BCOA also requested the trusts to make an extensive search of appropriate publications to redetermine the business status of companies in group #2 whose status had been "out of business" as of April 1991; this resulted in a

[1]A primary beneficiary was defined as either a retired miner or the surviving spouse or the eligible dependent of a retired miner receiving benefits from either the 1950 or the 1974 Benefit Trust.

shift of companies to groups #1 and #3. The table below shows the effect of these changes. The trusts advised us that they did not retain records showing the number of beneficiaries shifted by each change.

The trusts reported the 1950 Benefit Trust revised data to BCOA in July 1991; BCOA did not ask for the revised data for the 1974 trust. The total primary beneficiary population for the trusts is lower because the trusts used as the basis for the revisions the March 1991 beneficiary population, which reflects attrition since September 1990.

	1950 trust beneficiaries		1974 trust beneficiaries	
Employer status	**Primary**	**Total**	**Primary**	**Total**
1. Company signed the 1978 or subsequent BCOA/UMWA contract and is still in business	22,765[a]	34,874	981	**1,938**
2. Company did not sign the 1978 or subsequent agreement or is no longer in business	21,134	30,567	2,758	**5,669**
3. Company signed the 1978 or a subsequent agreement but business status unknown[b]	11,854	17,336	3,867	**7,343**
4. Company could not be identified	21,734	23,682	0	**0**
Total	**77,487**	**106,459**	**7,606**	**14,950**

[a]Comprised of 19,345 identified with companies that signed the 1988 contract and 3,420 with those that did not sign.

[b]Includes nonoperating coal companies owned by operating signatories.

The trusts said that they do not maintain expense data by individual beneficiary. However, based on the per capita average annual costs for each trust, provided in response to question 5, the expenditures in each of the four categories might be approximated as follows per the April 1991 report and the revised data reported in July 1991. For the April 1991 report, the cost is just for primary beneficiaires; there would be additional costs for their dependents. The costs for both primary beneficiaires and dependents are included for the July 1991 report.

Annual Net Health Care Expenses for Benefit Trusts by Beneficiary Group as of April and July 1991 Reports

	Primary beneficairies per April 1991 report[b]		Total beneficiaries as per July 1991 report[b]	
Employer status[a]	**1950 trust**	**1974 trust**	**1950 trust**	**1974 trust**
1. Company signed the 1978 or a subsequent BCOA/UMWA contract and is still in business	$55,753,539	$10,781,628	$67,062,702	$4,391,508
2. Company did not sign the 1978 or a subsequent agreement or is no longer in business	50,613,360	6,186,180	58,780,341	12,845,954
3. Company signed the 1978 or a subsequent agreement but business status unknown	2,803,734	339,900	33,337,128	16,639,238
4. Company could not be identified	43,140,582	0	45,540,486	0
Total	**$152,311,215**	**$17,307,708**	**$204,720,657**	**$33,876,700**

[a]See notes in previous tables for definitions of the status categories.

[b]Net expense is gross expense less reimbursement from Medicare and the Department of Labor's Black Lung Program: $1,923 and $2,266, respectively, per beneficiary for the 1950 and 1974 trusts.

Question 4

Describe the benefits provided to the beneficiaries under the 1950 and 1974 Health Benefit Trusts. To what extent do the benefits provided to the beneficiaries under the 1950 and 1974 Health Benefit Trusts represent the beneficiaries' primary medical benefits? If the latter, what other medical benefits do the beneficiaries receive?

GAO Response

Both trusts provide the same health benefits, which include the following:

- Inpatient hospital benefits.
- Outpatient hospital benefits.
- Physicians' services and other primary care.
- Insulin and prescription drugs and medications.
- Skilled nursing care facility services.
- Home health services and equipment.
- Other benefits. These include, when medically necessary, certain orthopedic and prosthetic devices; physical and speech therapy; hearing aids; ambulance and other transportation; and outpatient mental health, alcoholism and drug addiction testing, counseling, and therapy.

Physician services and visits generally are subject to copayments of $5 per visit, up to a maximum of $100 per each defined 12-month period per

family. Copayments for prescription drugs and insulin are $5 per prescription or refill, up to a $50 maximum per 12-month period. Additionally, a vision care program pays the actual charge, up to a maximum amount (ranging from $10 to $25), for vision exams, each lens, and frames, with certain exclusions and limitations. A copy of the 1950 Benefit Trust plan's benefit provisions is included as appendix I.

The trusts provided data showing that as of December 31, 1991, about 88 percent of the 1950 Benefit Trust beneficiaries and about 56 percent of the 1974 Benefit Trust beneficiaries were Medicare eligible. In addition, the trusts said that as of 1991, 5,414 beneficiaries had some other type of medical insurance coverage exclusive of Medicare. However, this other coverage may be for just certain types of medical care, such as outpatient care, drugs, or vision. In some cases, such coverages are through the spouse's employment.

Question 5

What is the distribution, on a state-by-state basis, of the residence of current beneficiaries and the amount of benefit payments, and the number of signatory, former signatory and non-signatory tons produced?

GAO Response

The following table, based on data provided by the trusts, shows the state-by-state distribution of beneficiaries as of December 1991 and the related benefit costs net of reimbursements by Medicare and the Department of Labor's Black Lung program. The benefit costs are computed based on average annual per capita costs for each trust because the trusts did not have data on actual benefits paid by state.

The table also shows, for 1990, total bituminous coal production data by state, which was obtained from the Department of Energy. Coal production data by signatory status were not readily available.

Estimated Annual Net Costs of Benefit Trusts and Bituminous Coal Production by State

	1950 Benefit Trust[a]		1974 Benefit Trust[b]		
State	Beneficiaries	Net cost	Beneficiaries	Net cost	Coal tons[c]
Alabama	4,501	$8,655,423	664	$1,504,624	28,943
Alaska	20	38,460	0	0	
Arizona	266	511,518	12	27,192	11,304
Arkansas	565	1,086,495	32	72,512	39
California	648	1,246,104	5	11,330	
Colorado	1,396	2,684,508	66	149,556	12,313
Connecticut	49	94,227	0	0	
Washington, D.C.	51	98,073	0	0	
Delaware	97	186,531	2	4,532	
Florida	2,221	4,270,983	138	312,708	
Georgia	228	438,444	23	52,118	
Hawaii	0	0	0	0	
Idaho	25	48,075	4	9,064	
Illinois	4,598	8,841,954	48	108,768	60,393
Indiana	2,531	4,867,113	35	79,310	35,886
Iowa	91	174,993	0	0	381
Kansas	211	405,753	0	0	721
Kentucky	12,890	24,787,470	1,649	3,736,634	172,546
Louisiana	19	36,537	3	6,798	
Maine	8	15,384	0	0	
Maryland	589	1,132,647	6	13,596	3,469
Massachusetts	28	53,844	1	2,266	
Michigan	764	1,469,172	7	15,862	
Minnesota	14	26,922	0	0	
Mississippi	40	76,920	0	0	
Missouri	213	409,599	1	2,266	2,646
Montana	181	348,063	1	2,266	120
Nebraska	11	21,153	0	0	
Nevada	49	94,227	3	6,798	
New Hampshire	10	19,230	0	0	
New Jersey	175	336,525	0	0	
New Mexico	258	496,134	4	9,064	12,879
New York	323	621,129	1	2,266	
North Carolina	635	1,221,105	81	183,546	
North Dakota	4	7,692	0	0	
Ohio	6,966	13,395,618	1,005	2,277,330	35,080

(continued)

State	1950 Benefit Trust[a]		1974 Benefit Trust[b]		Coal tons[c]
	Beneficiaries	Net cost	Beneficiaries	Net cost	
Oklahoma	462	888,426	73	165,418	1,687
Oregon	57	109,611	0	0	
Pennsylvania	20,260	38,959,980	3,704	8,393,264	66,474
Rhode Island	5	9,615	0	0	
South Carolina	210	403,830	24	54,384	
South Dakota	3	5,769	0	0	
Tennessee	2,773	5,332,479	107	242,462	6,103
Texas	226	434,598	8	18,128	355
Utah	991	1,905,693	286	648,076	22,057
Vermont	1	1,923	0	0	
Virginia	7,639	14,689,797	1,272	2,882,352	46,752
Washington	335	644,205	17	38,522	127
West Virginia	26,904	51,736,392	6,463	14,645,158	168,720
Wisconsin	47	90,381	1	2,266	
Wyoming	395	759,585	28	63,448	1,824
Total	**100,983**	**$194,190,309**	**15,774**	**$35,743,884**	**690,819**

[a]Net costs are computed at $1,923 per participant. Gross costs were $3,337 per participant.

[b]Net costs are computed at $2,266 per participant. Gross costs were $3,044 per participant.

[c]Coal tonnage is in thousands of short tons produced in 1990 as reported in the the Energy Information Admininstration's 1990 annual report of coal production.

Question 6

If there were a re-enrollment and recertification of beneficiaries, what percentage, if any, of current beneficiaries would be found ineligible as a result of changes of residence, age or any other reason? What would the savings to the benefit plans be if a re-enrollment and recertification occurred?

GAO Response

BCOA and UMWA officials told us that a reenrollment and recertification of beneficiaries would probably identify some ineligible individuals who were continuing to receive benefits; however, the number would not be significant. The officials also said that the belief that there could be a significant number of ineligible individuals receiving benefits is probably a carryover from the 1970s, when (1) the pension and health benefit programs were a single combined fund and (2) the health benefits for active workers and retirees were paid from the same fund. During this

period, abuses in the use of union cards of active miners were identified, such as ineligible individuals using the health card of an active miner, or an individual who had quit his job still using his card to obtain benefits or someone else using it. Such abuses have not been identified with retirees, however.

Trust officials said that they have established procedures to verify the eligibility of beneficiaries in the 1950 and 1974 Benefit Trusts on an ongoing basis, as follows:

- The entire primary beneficiary population (that is, the retired miners, surviving spouses or dependents) is divided into 24 groups. A different group is sent a status questionnaire each month, which results in a 2-year cycle for contacting each of them. The questionnaire asks for data on each primary beneficiary dependent's employment, marital status, and residence.
- A follow-up questionnaire is sent to any nonrespondents and, if there is no response, the trusts' field service office attempts to contact the individual. If such attempts are unsuccessful, the beneficiary is removed from the eligibility list.
- Returned questionnaires are reviewed to determine dependents' continued eligibility per the benefit plan documents. Those found to be ineligible will be terminated from the program. The health benefits of about 265 individuals are terminated annually through this process.

Also, health benefits for beneficiaries who are children are terminated automatically as of the last day of the month in which they become 22 years of age. In addition, the trusts identify deceased beneficiaries as a result of a returned pension check by either the post office or family members; the filing of a death benefit claim; and information obtained from the Health Care Financing Administration on a monthly basis on accretions and deletions of individuals eligible for Medicare benefits.

Question 7

Describe the funding formula for each Health/Benefit and Pension Trust.

GAO Response

Under the 1988 UMWA/BCOA agreement (effective Feb. 1, 1988), the health benefit and pension trusts were to be funded based on hours worked by each employer's employees, as follows:

Trust	Hourly rate	Period covered
1950 pension	$0.0	Feb. 1, 1988 - Jan. 31, 1993
1950 benefit	1.83	Feb. 1, 1988 - Jan. 31, 1989
	1.84	Feb. 1, 1989 - Jan. 31, 1990
	1.85	Feb. 1, 1990 - Jan. 31, 1993
1974 pension	0.47	Feb. 1, 1988 - Jan. 31, 1989
	0.595	Feb. 1, 1989 - Jan. 31, 1990
	0.71	Feb. 1, 1990 - Jan. 31, 1993
1974 benefit	0.08	Feb. 1, 1988 - Jan. 31, 1993

The agreement provides for additional contributions by these employers for every ton of coal purchased by them from other operators on which contributions have not been made, as follows:

Trust	Tonnage rate	Period covered
1950 pension	$0.0	Feb. 1, 1988 - Jan. 31, 1993
1950 benefit	0.704	Feb. 1, 1988 - Jan. 31, 1989
	0.708	Feb. 1, 1989 - Jan. 31, 1990
	0.712	Feb. 1, 1990 - Jan. 31, 1993
1974 pension	0.181	Feb. 1, 1988 - Jan. 31, 1989
	0.229	Feb. 1, 1989 - Jan. 31, 1990
	0.273	Feb. 1, 1990 - Jan. 31, 1993
1974 benefit	0.031	Feb. 1, 1988 - Jan. 31, 1993

However, the agreement also provides that employers may increase the contribution rates as necessary to fund the benefits provided by the trusts. Consequently, in response to the benefit trusts' increased costs and suits brought by the trusts against BCOA for increased contributions to cover deficits incurred, the actual contribution rates for the two benefit trusts were generally greater than the contract rates, as follows.

Trust	Hourly rate	Period covered
1950 benefit	$1.83	Feb. 1, 1988 - June 30, 1988
	2.00	July 1, 1988 - Apr. 30, 1989
	2.17	May 1, 1989 - Aug. 31, 1990
	2.92	Sept. 1, 1990 -Dec. 31, 1990
	2.43	Jan. 1, 1991 - Feb. 28, 1991
	2.65	Mar. 1, 1991 - Mar. 31, 1991
	2.85	Apr. 1, 1991 - Apr. 30, 1991
	2.17	May 1, 1991 - Mar. 31, 1992
	3.07	Apr. 1, 1992 - present
1974 benefit	$0.08	Feb. 1, 1988 - June 30, 1990
	0.79	July 1, 1990 - July 31, 1990
	0.33	Aug. 1, 1990 - Nov. 30, 1990
	0.08	Dec. 1, 1990 - Dec. 31, 1990
	0.82	Jan. 1, 1991 - Feb. 28, 1991
	0.60	Mar. 1, 1991 - Mar. 31, 1991
	0.40	Apr. 1, 1991 - Apr. 30, 1991
	0.33	May 1, 1991 - Mar. 31, 1992
	0.60	Apr. 1, 1992 - present

During the last 2 months of the 1984 BCOA/UMWA agreement, the contribution rates in effect were the following.

Trust	Rate	
1950 benefit (contract rate was $0.64/ton)[a]	$0.800	per ton for coal produced, purchased signatory and reclaimed coal, and purchased nonsignatory coal
	0.000	per hour for truckers, nonproducing processors, and mine construction projects
1950 pension (contract rate was $1.11/ton)[a]	0.950	per ton of coal produced, purchased signatory and reclaimed coal, and purchased nonsignatory coal
	0.000	per hour for truckers, nonproducing processors, and mine construction projects
1974 benefit	0.000	per ton of coal produced, purchased signatory and reclaimed coal, and purchased nonsignatory coal
	0.000	per hour for truckers, nonproducing processors, and mine construction projects
1974 pension	0.066	per ton of coal produced, purchased signatory and reclaimed coal
	0.508	per ton for purchased nonsignatory coal
	1.020	per hour for truckers, nonproducing processors, and mine construction
	1.020	per hour for coal produced, purchased signatory and reclaimed coal

[a]The rates shown are not the contract rates. BCOA officials said that for the last 2 months, BCOA voluntarily reprogrammed 16 cents/ton from the 1950 Pension Trust contribution to the 1950 Benefit Trust contribution because the trust had forecast a deficit if additional funds were not received.

Question 8

Provide a breakdown of all employer contributions to each health benefit trust in 1991. For example, how much did the members of BCOA contribute to each trust? How much did employers who have so-called "me too" agreements with the United Mine Workers contribute to each trust in 1991? Are there any other categories of employers who contribute to the trusts? What is the expected contribution level for each of these categories of employers over the next five years?

GAO Response

The trusts provided us data showing the following contributions breakdown for the fiscal year ended June 30, 1991, for the 1950 and 1974 Health Benefit Trusts. Generally, all the non-BCOA signatories are referred

to as the "me too" contributors. There are no other categories of contributors to the trusts.

Contributions to 1950 and 1974 Benefit Trusts for 1991

	1950 trust	1974 trust	Total
BCOA members	$115,711,000	$19,886,000	**$135,597,000**
Other signatories:			
Standard[a]	99,991,000	17,313,000	**117,304,000**
Nonstandard[b]	1,699,000	2,072,000	**3,771,000**
Total	**$217,401,000**	**$39,271,000**	**$256,672,000**

[a]Signatories that are contributing to both benefit trusts at the BCOA rates.

[b]Signatories that are contributing to the benefit trusts at either the BCOA rate or at some other rate as negotiated by the union with the company. From the contribution amounts, it appears that most of these signatories are contributing only to the 1974 trust.

It is not possible to derive a meaningful estimate of what the contributions might be over the next 5 years for each group of current contributors because contributions are dependent on the existence of a BCOA/UMWA contract. If a contract is negotiated, there is no reliable way to estimate what the contribution rates might be, who would be signatory to such a contract, and whether they would be in BCOA. For example, a substantial number of signatories to the 1984 contract did not sign the 1988 contract, many because they went out of business.

The contribution question, however, can be approached with some precision from the expense perspective, which essentially provides an estimate of the contributions necessary to fund the benefits, assuming the benefits remain unchanged (see response to question 1).

Question 9

If both the contribution formula and the contribution rates paid by BCOA members prior to the 1988 contract revision had been continued through 1991, what would the size of the deficit in each trust be today?

GAO Response

The question is not relevant for the 1974 Benefit Trust because it was funded on an hours basis (except for purchased coal) since it was reconstituted to provide benefits just for the retired so-called "orphan"

miners[2] and their eligible dependents as a result of the 1978 contract negotiations. During its first few years of operation, the 1974 trust built up a substantial surplus, and the contribution rate was zero under both the 1981 and 1984 BCOA/UMWA contracts. The surplus absorbed the annual operating deficits that the 1974 trust incurred in 1987, 1988, and 1989. Therefore, what actually happened to the 1974 Benefit Trust under the current contract is what would have happened under the question's scenario.

The question is relevant for the 1950 Benefit Trust since its funding basis was tonnage through the 1984 contract. The 1950 trust incurred its first operating deficit in fiscal year 1987, but its existing surplus absorbed that deficit so that an overall deficit did not occur until fiscal year 1988.

We estimated the contributions that would have been made to the 1950 Benefit Trust under a tonnage-based formula for workers covered by standard contracts who were engaged in the production of coal (coal production hours). We did not include (1) contributions on coal acquired from others who had not made contributions to the trust (purchased nonsignatory coal), since signatory contributions on such coal were already on a tonnage basis, and (2) contributions for employees of coal producers covered by nonstandard contracts. Employers with nonstandard contracts contribute to the 1974 Benefit Trust and some contribute to the 1950 Benefit Trust at either the normal rate or a rate that they have negotiated with UMWA. The trusts did not have data readily available detailing the nonstandard arrangements and the extent to which employers with nonstandard contracts contributed to the 1950 trust. Overall, nonstandard hours were only a small percentage of the total hours worked under the contract.

We analyzed the impact of the change from tons to hours on the trust's year-end deficits rather than restating the trust's assets and liabilities because (1) we analyzed only contributions where the change from tons to hours made a difference, rather than all contributions, (2) changing the contribution method does not directly affect liabilities, and (3) we had no basis for estimating when or to what extent any increased contributions would have reduced liabilities.

We did not make estimates for 1991 because the trust's actual operations resulted in a surplus for the year due to the extra contributions made

[2]These are retired miners who are receiving their pensions from the 1974 Pension Trust and whose last employer no longer provides them health benefits.

pursuant to a preliminary injunction obtained by the trust. Under a tonnage basis, it is likely that a similar injunction would have been sought by the trust since deficits, although smaller, apparently would still have occurred.

We had to estimate coal production because the trust ceased receiving such data when hours worked, rather than tons produced, became the basis for contributions under the 1988 contract, which was effective February 1, 1988. We converted the hours reported for contribution purposes for workers covered by standard contracts who were engaged in the production of coal to tons of coal produced using estimated productivity rates. For February to June 1988, we computed our own productivity estimate using the ratio of aggregate tons and hours shown in the trust's contribution receipts data for July 1987-January 1988. For other years we noted that (1) productivity estimates had been made by the trusts, BCOA, and a consultant for the Private Benefits Alliance (PBA, which represents a number of coal companies that are not signatories to the BCOA/UMWA agreement) and (2) these estimates were all very close to each other. We used the lowest of these productivity estimates in our calculations for fiscal years 1989 and 1990. Had we used a higher estimate, tons produced and the contributions on such tons would have been higher.

In addition to estimates of production, we made assumptions about the tonnage contribution rates we used. The current agreement sets an initial contribution rate of $0.704 per ton for purchased nonsignatory coal that was intended to be equivalent to the initial rate of $1.83 per hour set for signatory coal, based on productivity of 2.6 tons per hour. The agreement specifically provided for only a very slight increase in contribution rates (two $.01 per hour increases over the life of the agreement), even though productivity had been increasing, thus reducing the number of hours required for a given level of production. However, under the agreement's guarantee clause, if contributions are insufficient to cover benefits, the contributions should be increased, and BCOA had raised the contribution rate several times. One instance was for the last 2 months of the 1984 contract, pursuant to the trust's notification that a deficit would occur if contributions were not increased. Another instance was in July 1988 for the current contract because Pittston Coal did not sign the contract and BCOA realized that a higher contribution rate was needed to fund benefits in light of the deficit the trust had incurred in 1988. A third instance was in May 1989 as a result of a review of the trust's financial data for the previous 10 to 12 months, which showed that deficits were continuing.

In estimating what contributions would have been on a production basis, we used the agreement's rate per ton for purchased coal that was in effect during February 1988-June 1988. This assumed that the parties to the agreement would have set the same per ton rate for signatory coal as they set for purchased nonsignatory coal. Beginning in July 1988, we increased the rate per ton by the same percentage that BCOA had increased the hourly rate. We assumed that, had contributions to the trust been on a tonnage basis, BCOA would have raised the rate per ton to make up for Pittston's withdrawal and the 1988 deficit. We did not revise the rate per ton to reflect BCOA's May 1989 increase because, if contributions had been on a tonnage basis, the deficit which led to BCOA's decision that an increase was required would have been less.

The following table shows our estimate of the contributions that would have been received by the 1950 Benefit Trust under a tonnage-based formula and their effect on the trust's deficits for fiscal years 1988-90.

Estimated Effect of Tonnage-Based Contributions Under Current Contract for Fiscal Years 1988-90

Dollars in thousands

Fiscal Year	Additional contributions on tonnage basis	Contributions from non-coal producers	Cumulative deficit	
			Actual	Estimated
1988	$14,184	$ 4,683	$18,068	$ 8,567
1989	32,196	12,279	45,178	15,759
1990	28,678	12,291	84,701	39,566
Total	**$75,059**	**$29,253**		

In arriving at the estimated deficit, we subtracted the contributions that the trust received under the current contract from truckers and coal processors. Truckers and coal processors do not produce coal and, therefore, did not contribute to the 1950 Benefit Trust under the prior contract when contributions were on a tonnage basis. A trusts official said that their data system does not identify the contributions made to individual trusts by truckers and coal processors. However, the official also said that a special analysis of these employers' contributions for July 1991-May 1992 showed that contributions were made to the 1950 Benefit Trust on about 80 percent of the hours they reported. Accordingly, we computed the additional contributions that the trust received from these employers under the current contract by considering that contributions were made to the 1950 Benefit Trust for 80 percent of the hours they reported.

The tables on the following pages show the details of our calculations for these 3 years.

Comparison of Contributions for the Last 5 Months of FY 1988 on Hourly and Tonnage Bases for Coal Companies for 1950 Benefit Trust

Hourly based contributions		
Total coal production hours reported for Feb. 1988-June 1988	36,595,650 hrs.	
Contract contribution rate	x $1.83/hr.	
Total contributions for mined signatory coal		$66,970,040
Tonnage based contributions		
Total coal production hours reported for Feb. 1988-June 1988	36,595,650 hrs.	
Estimated productivity rate[a]	x 3.15	
Estimated coal production	115,276,298 tons	
Tonnage contribution rate per contract[b]	x $0.704/ton	
Estimated contributions		81,154,513
Excess of tonnage over hourly base		$14,184,474
Additional contributions received on hourly basis from truckers and coal processors: 80% of 3,199,000 hours at $1.83 per hour		$4,683,336

[a]Actual average productivity rate for July 1987-January 1988 based on 207,319,000 tons and 65,873,000 hours.

[b]The 1988 BCOA/UMWA contract provided that the contribution rate for purchased coal on which contributions had not been made at the time of acquisition was to be $0.704/ton from Feb. 1988 to Jan. 1989, which was equivalent to the initial hourly rate of $1.83.

Comparison of Contributions for FY 1989 on Hourly and Tonnage Bases for Coal Companies for 1950 Benefit Trust

Hourly based contributions		
Contributions for first 10 months of year:		
Total coal production hours reported for July 1988-April 1989	68,586,094	
Actual contribution rate	x $2.00/hr.	
Total contributions for mined signatory coal for period		$137,172,188
Contributions for last 2 months of year:		
Total coal production hours reported for May-June 1989	12,795,048	
Actual contribution rate	x $2.17/hr.	
Total contributions for mined signatory coal for period		27,765,254
Total contributions on hourly basis		164,937,442
Tonnage based contributions		
Total coal production hours reported for fiscal year 1989	81,381,142 hr.	
Estimated productivity rate[a]	x 3.15 tons/hr.	
Estimated coal production	256,350,597 tons	
Contribution rate[b]	x $0.769/ton	
Estimated contributions for year		197,133,609
Excess of tonnage over hourly base		$32,196,167
Additional contributions received on hourly basis from truckers and coal processors: 80% of 6,395,000 hours at $2.00/hour, and 80% of 1,179,000 hours at $2.17/hour		$12,278,744

[a]Trust estimated productivity for 1989 at 3.15 tons/hour. PBA estimated it as 3.16 tons/hour, while BCOA estimated it as 3.23 tons/hour. The trust rate is used on the basis of conservatism.

[b]Reflects a 9.29-percent increase in the contract rate of $0.704/ton for consistency with hourly rate increase from $1.83 to $2.00 as of July 1988.

Comparison of Contributions for FY 1990 on Hourly and Tonnage Bases for Coal Companies for 1950 Benefit Trust

Hourly based contributions		
Total coal production hours reported by signatories for FY 1990	79,658,376	
Actual contribution rate for year	x $2.17/hr.	
Total contributions for mined signatory coal for period		$172,858,676
Tonnage based contributions		
Total coal production hours reported by signatories for FY 1990	79,658,376 hr.	
Estimated productivity rate[a]	x 3.29 tons/hr.	
Estimated coal production	262,076,057 tons	
Contribution rate	x $0.769/ton	
Estimated contributions for period		201,536,488
Excess of tonnage over hourly base		$28,677,812
Additional contributions received on hourly basis from truckers and coal processors: 80% of 7,466,000 hours at $2.17/hour		$12,960,976

[a]Trust estimated productivity for 1990 at 3.29 tons/hour. PBA estimated it as 3.41 tons/hour, while BCOA estimated it as 3.35 tons/hour. The trust rate is used on the basis of conservatism.

Question 10

At the beginning of 1991 the 1950 Pension Plan was overfunded by approximately $250 million, what is the amount of overfunding as of January 1, 1992? To the extent that the surplus has decreased, how was the money spent allocated in 1991 and what is the reason for this decline? Indicate the amounts of employer contributions to both pension plans since 1984.

GAO Response

The annual actuarial valuations for the 1950 Pension Plan of the United Mine Workers of America show its funded status as of July 1, 1989, through July 1, 1991, as follows.

UMWA 1950 Pension Plan Funded Status, 1989-91

Dollars in thousands

As of July 1	Assets at market	Actuarial accrued liability	Actuarial surplus	
			Amount	Percent
1989	$1,759,234	$1,558,275	$200,959	12.9
1990	1,659,530	1,422,654	236,876	16.7
1991	1,572,444	1,391,973	180,471	13.0

The change in the actuarial surplus from one year to the next reflects changes in four major factors that affect the actuarial valuation: plan benefits; the actuarial assumptions used, such as for interest to be earned; plan contributions received; and the plan's actual experience compared to expected experience during the year in such areas as beneficiary mortality. The following table shows these changes for 1989-90 and 1990-91.

UMWA 1950 Pension Plan Changes in Factors Affecting Actuarial Surplus, 1989-91

Dollars in thousands

Period	Surplus increase or (decrease) from				Net change in surplus
	Increase in benefits	Actuarial assumptions	Contributions	Experience	
1989-90	$ 0	$36,214	$14,924	(15,221)	$35,917
1990-91	(129,588)	2,603	7,908	62,672	(56,405)

The plan had no benefit changes during 1990. However, during 1991 benefits were increased via an amendment to the February 1, 1988, BCOA/UMWA agreement as follows.

- Death benefits were increased and transferred from the Benefit Trust to the Pension Trust. The death benefit payable (1) to widows/dependents was increased from $3,500 to $5,000 and (2) to the nearest survivor was increased from $3,000 to $4,000. As of July 1, 1991, these death benefits were valued at $87,757,000.
- One-time lump-sum payments totaling $41,831,000 were made from the Pension Trust to pensioners and widows in pay status as of February 1, 1991, as follows: (1) regular pensioners received $500, (2) disabled pensioners received $290, and (3) widows received $375.

The employer contributions to both pension plans for fiscal years 1984-91 have been as follows.

Contributions to 1950 and 1974 Pension Trusts, Fiscal Years 1984-91

Fiscal Year	Total contributions to 1950 plan	Total contributions to 1974 plan	Total
1984	$360,590,000	$190,569,000	**$551,159,000**
1985	351,560,000	176,154,000	**527,714,000**
1986	353,664,000	156,915,000	**510,579,000**
1987	321,068,000	131,372,000	**452,440,000**
1988	170,192,000	96,041,000	**266,233,000**
1989	7,878,000	53,584,000	**61,462,000**
1990	12,436,000	65,866,000	**78,302,000**
1991	6,298,000	61,395,000	**67,693,000**
Total	**$1,583,686,000**	**$931,896,000**	**$2,515,582,000**

Question 11

What is the amount of the current, aggregate withdrawal liability of BCOA members for the health benefit trusts upon termination of the current UMWA/BCOA agreement?

GAO Response

The current BCOA/UMWA contract was effective February 1, 1988, and expires February 1, 1993. The contract provides the following with regard to withdrawal liability for each benefit trust:

"...in the event that an individual employer ceases, for whatever reason,...to have an obligation to contribute to the [1950 and/or 1974] Benefit Trust, that Employer shall be considered to be in Withdrawal, and shall be liable to the...Benefit Plan and Trust for Withdrawal Liability.

"Such Withdrawal Liability shall arise whether Withdrawal is caused by a cessation of covered operations by the Employer, the Employer's bankruptcy, failure of the Employer to execute a successor agreement following the expiration of this or any successor agreement, or for any other reason.

"...The amount of Withdrawal Liability shall be the product of:

"(i) The hourly contribution rate applicable to the ...Benefit Plan at the time of the Employer's Withdrawal, and

"(ii) The total number of hours reported...to the...Benefit or Pension Plans for contribution purposes for the 60-month period immediately preceding the Employer's Withdrawal."

The issue of whether the withdrawal liability would apply upon termination of the current contract is in dispute. One view holds that the withdrawal liability would expire with the contract and that there would be no such liability after February 1, 1993, unless there is a follow-on contract providing for health benefit contributions. Under this view, an employer would not withdraw during the remaining months of the contract, but would wait for its expiration, and thus avoid the liability. The opposing view is that the instance of the contract's termination, with the lack of a follow-on contract providing for benefit plan contributions, is included in the language of the withdrawal provision and the liability provision would, therefore, apply after February 1, 1993; the employers would be deemed to have withdrawn as of that date.

The trusts estimated that BCOA members will have reported 233,059,001 hours for each Benefit Trust as of January 31, 1993. It is not possible to determine with precision what the withdrawal liability would be on January 31, 1993, because we do not know what contribution rates will be in effect. Shown below are what the estimated withdrawal liabilities would be under the (1) contract contribution rates for January 1993, (2) the actual contribution rates in effect from May 1991-March 1992, and (3) the court-ordered rates in effect beginning April 1992. The contract rates can be viewed as providing the minimum amount of the liability since the contract provides that BCOA cannot reduce the contribution rates below the rates stated in the contract. The March 1992 actual rates can be viewed as providing a mid-range approximation, and the April 1992 rate can be considered as the maximum that might be due if those rates are in effect for January 1993.[3]

[3]Because the court-ordered rate was not intended to eliminate the entire deficit, it is possible that an even higher rate would be in effect near the end of the agreement.

1. Withdrawal liability using contract contribution rates for January 1993 of:	
$1.85 for 1950 trust	$431,159,151
$0.08 for 1974 trust	18,644,720
Total	**$449,803,871**

2. Withdrawal liability using March 1992 contribution rates of:	
$2.17/hr for 1950 trust	$505,738,032
$0.33/hr for 1974 trust	76,909,470
Total	**$582,647,502**

3. Withdrawal liability using April 1992 contribution rates of:	
$3.07/hr for 1950 trust	$715,491,133
$0.60/hr for 1974 trust	139,835,401
Total	**$855,326,534**

Therefore, if the total hours reported by BCOA members through January 31, 1993, equate to the trusts' estimates, the withdrawal liability on that date for BCOA members could be at least $449.8 million and as much as $855.3 million.

Question 12

How much nonsignatory operating tonnage and reserve tonnage is held by each signatory company?

GAO Response

The Department of Energy's Energy Information Administration (EIA) obtains data on coal production and reserves from annual reports submitted by coal mining companies. These reports include the number that the Mine Safety and Health Administration has assigned to each mine. The most recent period for which these data are available is 1990. The trusts' contributions data base also contained these mine numbers but it did not have the numbers for all contributing mines.

A comparison of EIA's and the trusts' data showed that nonsignatory mines (mines for which contributions were not made to the trusts) operated by signatory companies (companies that had signed the 1988 UMWA/BCOA contract) or their contractors produced about 66 million tons of coal

during 1990 and had recoverable reserves of about 2.25 billion tons at the end of that year. These data are understated to the extent that we were unable to identify all companies controlled by a signatory company. In addition, reserves in areas not being mined or no longer mined are not included, since coal reserves are reported only for producing mines.

Health Benefit Provisions of 1950 Benefit Trust

Notwithstanding any other provisions of this Plan, no contributions accruing to the 1950 Benefit Trust on or after February 1, 1988, shall be used for the purpose of paying or otherwise funding any benefit expenses which were accrued by said Trust for any period of time prior to February 1, 1988.

Covered services shall be limited to those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury and which are given at the appropriate level of care or are otherwise provided for in the Plan. The fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary or that it is covered under this Plan. In determining questions of reasonableness and necessity, due consideration will be given to the customary practices of physicians in the community where the service is provided. Services which are not reasonable and necessary shall include, but are not limited to the following: procedures which are of unproven value or of questionable current usefulness; procedures which tend to be redundant when performed in combination with other procedures; diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly; procedures which are not ordered by a physician or which are not documented in timely fashion in the patient's medical records; procedures which can be performed with equal efficiency at a lower level of care. Covered services that are medically necessary will continue to be provided, and accordingly this paragraph shall not be construed to detract from plan coverage or eligibility as described in this Article III.

1950 BENEFIT PLAN

A. Health Benefits

(1) Inpatient Hospital Benefits

(a) Semi-Private Room

When a Beneficiary is admitted by a licensed physician (hereinafter "physician") for treatment as an inpatient to an Accredited Hospital* which is a Participating Hospital (hereinafter "hospital"), benefits will be provided for semi-private room accommodations (including special diets and general nursing care) and all medically necessary services provided by the hospital as set out below for the diagnosis and treatment of the Beneficiary's condition.

A Participating Hospital is an Accredited Hospital which has been designated by the Trustees as a hospital approved as a primary provider of hospital care and treatment.

*Accredited Hospital is a hospital which is operated primarily for the purpose of rendering inpatient therapy for the several classifications of medical and surgical cases and which is approved by the Joint Commission on Accreditation of Hospitals or, for purposes of this Plan, is approved by the Trustees. Determination by the Trustees shall be conclusive.

The criteria to be used by the Trustees in designating Participating Hospitals shall include, but shall not be limited to, the following: (1) availability of hospital to a substantial number of beneficiaries, (2) quality of care provided, (3) number of participating physicians on the hospital staff, (4) reasonableness of hospital costs and charges, (5) bed capacity and (6) willingness to accommodate Trustees' policies. In determining reasonableness of costs and charges, the Trustees shall compare other hospital costs and charges which offer comparable services to comparable population groups.

If a Beneficiary is admitted to a Non-Participating Hospital** by a physician the Plan will pay for care only if the admission is specifically authorized by the Trustees.***

Medically necessary services provided in a hospital include the following:

Operating, recovery, and other treatment rooms
Laboratory tests and x-rays
Diagnostic or therapy items and services
Drugs and medication (including take-home drugs which are limited to a 30-day supply)
Radiation therapy
Chemotherapy
Physical therapy
Anesthesia services
Oxygen and its administration
Intravenous injections and solutions
Administration of blood and blood plasma
Blood, if it cannot be replaced by or on behalf of the Beneficiary

(b) Intensive Care Unit - Coronary Care Unit

Benefits will also be provided for treatment rendered in an Intensive Care or Coronary Care Unit of the hospital, if such treatment is certified as medically necessary by the attending physician.

**A Non-Participating Hospital is an Accredited Hospital, which has not been designated by the Trustees as a Participating Hospital.

***For purposes of Article III A, "Trustees" refers to the Plan Administrator and designated representatives of the Plan Administrator.

(c) Private Room

For confinement in a private room, benefits will be provided for the hospital's most common charge for semi-private room accommodations and the Beneficiary shall be responsible for any excess over such charge except that private room rates will be paid when (i) the Beneficiary's condition requires him to be isolated for his own health or that of others, or (ii) the hospital has semi-private or less accommodations but they are occupied and the Beneficiary's condition requires immediate hospitalization. Semi-private room rates, not private rates, will be paid beyond the date a semi-private room first becomes available and the Beneficiary's condition permits transfer to those accommodations.

(d) Renal Dialysis

Benefits will be provided for renal dialysis provided that the renal dialysis therapy is administered in accordance with Federal Medicare regulations as in effect from time to time.

(e) Mental Illness

Benefits are provided for up to a maximum of 30 days for a Beneficiary who is confined for mental illness in a hospital by a licensed psychiatrist. Subject to the approval by the Trustees, hospitalization may be extended for a maximum of 30 additional days for confinements for an acute (short-term) mental illness, per episode of acute illness. (More than 90 days of confinement for mental illness over a two-year period (dating from the first day of hospital confinement, even if this first day of confinement occurred during a prior Wage Agreement) is deemed for purposes of this Plan to be a chronic (long-term) mental problem for which the Trustees will not provide inpatient hospital benefits.)

(f) Alcoholism & Drug Abuse

Benefits are provided for a Beneficiary who requires emergency detoxification hospital care for the treatment of alcoholism or emergency treatment for drug abuse. Such treatment is limited to 7 calendar days per inpatient hospital admission.

If treatment of a medical or mental condition is necessary following detoxification or emergency treatment for drug abuse, benefits may be provided under other provisions of this Plan and are subject to any requirements or limitations in such provisions.

(See paragraph (7)(f) for information concerning services related to treatment of alcoholism and drug abuse.)

(g) Oral Surgical/Dental Procedures

Upon approval by the Trustees, benefits are provided for a Beneficiary who is admitted to a hospital for the oral surgical procedures described in paragraph (3)(e) provided hospitalization is medically necessary.

Benefits are also provided for a Beneficiary admitted to a hospital for dental procedures only if hospitalization is necessary due to a pre-existing medical condition and prior approval is received from the Trustees.

(h) Maternity Benefits

Benefits are provided for a female Beneficiary who is confined in a hospital for pregnancy. Such benefits will also be available for services pertaining to termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or surgeon.

(i) General

In the event that a Beneficiary is in an area in which Participating Hospitals are not located and such Beneficiary requires emergency hospital services rendered in an Accredited Hospital, such services will be considered to have been rendered in a Participating Hospital.

(2) Outpatient Hospital Benefits

(a) Emergency Medical and Accident Cases

Benefits are provided for a Beneficiary who receives emergency medical treatment or medical treatment of an injury as the result of an accident, provided such emergency medical treatment is rendered within 48 hours following the onset of acute medical symptoms or the occurrence of the accident.

(b) Surgical Cases

Benefits are provided for a Beneficiary who receives surgical treatment in the outpatient department of a hospital.

(c) Laboratory Tests and X-rays

Benefits are provided for laboratory tests and x-ray services performed in the outpatient department of a hospital which provides such services and when they have been ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

(d) Chemotherapy and Radiation Therapy

Benefits are provided for chemotherapy treatments of a malignant disease or radiation treatments performed in the outpatient department of a hospital.

(e) Physiotherapy

Benefits are provided for physiotherapy treatments performed in the outpatient department of a hospital. Such therapy must be prescribed and supervised by a physician.

(f) Renal Dialysis

Benefits are provided for outpatient renal dialysis treatments rendered in accordance with Federal Medicare regulations as in effect from time to time.

(3) Physicians' Services and Other Primary Care

(a) Surgical Benefits

Benefits are provided for surgical services essential to a Beneficiary's care consisting of operative and cutting procedures (including the usual and necessary post-operative care) for the treatment of illnesses, injuries, fractures or dislocations, which are performed either in or out of a hospital by a physician.

When surgical services consist of necessary major surgery (primary) and the physician performs surgery additional to the primary surgery (incidental surgery), benefits payment for the incidental surgery will be provided but at a rate 50% lower than the physician's normal charge had he performed only the incidental surgery.

(b) Assistant Surgeons

If the Beneficiary is an inpatient in a hospital, benefits will also be provided for the services of a physician who actively assists the operating physician in the performance of such surgical services when the condition of the Beneficiary and type of surgical service requires such assistance.

(c) Obstetrical Delivery Services

Benefits are provided for a female Beneficiary for obstetrical delivery services (including pre- and post-natal care) performed by a physician. Benefits will also be provided if such delivery is performed by a midwife certified by the American College of Nurse Midwifery and licensed where such licensure is required.

Such benefits will also be provided for termination of pregnancy but only if medically necessary and is so certified to and such services are performed by a licensed gynecologist or a surgeon.

(d) Anesthesia Services

Benefits are provided for the administration of anesthetics provided either in or out of the hospital in surgical or obstetrical cases, when administered and billed by a physician, other than the operating surgeon or his assistant, who is not an employee of, nor compensated by, a hospital, laboratory or other institution.

(e) Oral Surgery

Benefits are not provided for dental services. However, benefits are provided for the following limited oral surgical procedures if performed by a dental surgeon or general surgeon:

Tumors of the jaw (maxilla and mandible)
Fractures of the jaw, including reduction and wiring
Fractures of the facial bones
Frenulectomy when related only to ankyloglossia (tongue tie)
Temporomandibular Joint Dysfunction, only when medically necessary and related to an oral orthopedic problem
Biopsy of the oral cavity
Dental services required as the direct result of an accident

(f) Surgical Service Requiring Prior Approval by Trustees

Benefits are not provided for certain surgical services without prior approval of the Trustees. Such surgical procedures include, but are not limited to, the following:

Plastic surgery, including mammoplasty
Reduction mammoplasty
Intestinal bypass for obesity
Gastric bypass for obesity
Cerebellar implant
Dorsal stimulator implants
Prosthesis for cleft palate if not covered by crippled children services
Organ transplants

(g) Inhospital Physicians' Visits

If a beneficiary is confined as an inpatient in a hospital (or with approval of the Trustees in a Non-Participating Hospital) because of an illness or injury benefits are provided for inhospital visits by the physician in charge of the case. Such benefits will also be provided concurrently with benefits for surgical, obstetrical and radiation therapy services when the beneficiary has a separate and complicated condition, the treatment of which requires skills not possessed by the physician who is rendering the surgical, obstetrical or radiation therapy services.

(h) Home, Clinic and Office Visits

Benefits are provided for services rendered to a beneficiary at home, in a clinic (including the outpatient department of a hospital), or in the physician's office for the treatment of illnesses or injuries, if provided by a physician.

(i) Emergency Treatment

When provided by a physician, benefits are provided for a Beneficiary who receives outpatient emergency medical treatment or emergency medical treatment as the result of an accident, provided such emergency medical treatment is rendered within 48 hours following the onset of acute medical symptoms or the occurrence of the accident.

(j) Laboratory Tests and X-rays

Benefits will be provided for laboratory tests and x-rays performed in a licensed laboratory when ordered by a physician for diagnosis or treatment of a definite condition, illness or injury.

Such benefits will not cover laboratory tests and x-rays ordered in connection with a routine physical examination, unless the examination is considered medically necessary by a physician.

(k) Radiation and Chemotherapy Benefits

Benefits are provided for treatment by x-ray, radium, external radiation or radioactive isotope (including the cost of materials unless supplied by a hospital), provided in or out of a hospital, when performed and billed by a physician.

When a Beneficiary's condition requires radiation therapy services in conjunction with medical, surgical or obstetrical services, benefits will be provided for such radiation therapy in addition to the payment for such other types of covered services if the physician performing the radiation therapy services is not the same physician who performs the medical, surgical or obstetrical services.

Benefits are provided for treatment of malignant diseases by chemotherapy provided in or out of the hospital when prescribed and billed by a physician.

(l) Medical Consultation

Benefits are provided for services rendered, at the request of the physician in charge of the case, by a physician who is qualified in a medical specialty necessary in connection with medical treatment required by a Beneficiary.

(m) Specialist Care

Benefits will be provided for treatment prescribed or administered by a specialist if the treatment is for illness or injury which falls within the specialist's area of medical competence.

(n) Primary Care - Podiatrists' Services

Benefits are provided for minor surgery rendered by a qualified licensed podiatrist. Routine care of the feet such as trimming of nails, the treatment of corns, bunions (except capsular or bone surgery therefor) and calluses is excluded.

Covered minor surgery includes surgery for ingrown nails and surgery in connection with the treatment of flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

Benefits for major surgical procedures rendered by a licensed podiatrist are not provided, except if such surgery is rendered in a hospital and has received the prior approval of the Trustees.

(o) Primary Medical Care - Miscellaneous

1. Benefits are provided for care of newborn babies and routine medical care of children prior to attaining age 6.

2. Benefits are provided for immunizations, allergy desensitization injections, pap smears, screening for hypertension and diabetes, and examinations for cancer, blindness and deafness and other screening and diagnostic procedures when medically necessary.

3. Benefits are provided for physical examinations when certified as medically necessary by a physician. Medically necessary will mean that a Beneficiary (i) has an existing medical condition under treatment by a physician, (ii) has attained age 55, (iii) is undergoing an annual or semi-annual routine examination by a gynecologist or (iv) is undergoing a routine examination precribed by a specialist as part of such specialist's care of a medical condition.

4. Benefits are provided for "physician extender" care or medical treatment administered by nurse practitioners, physician's assistants or other certified or licensed health personnel when such service is rendered under the direct supervision of a physician.

5. Benefits are provided for a nominal fee covering instruction in preparation for natural childbirth, if rendered in a hospital or clinic.

6. Benefits are provided for family planning counseling when rendered by a physician or other appropriately trained and supervised health care professionals.

7. Benefits are provided covering artificial insemination if the service is provided by a licensed gynecologist.

8. Benefits are provided for sterilization procedures if such procedures are performed by a physician.

9. Birth control services and medications are not covered under the Plan, except that benefits are provided for physician services rendered in connection with the prescription of oral contraceptives, the fitting of a diaphragm or the insertion or removal of an IUD.

(p) Services Not Covered

1. Services rendered by a chiropractor or naturopathic services.
2. Acupuncture therapy.
3. Home obstetrical delivery.
4. Telephone conversations with a physician in lieu of an office visit.
5. Charges for writing a prescription.
6. Medications dispensed by other than a licensed pharmacist.
7. Charges for medical summaries and medical invoice preparation.
8. Services of any practitioner who is not legally licensed to practice medicine, surgery, or counseling as specifically provided herein.
9. Cosmetic surgery, unless pertaining to surgical scars or to correct results of an accidental injury or birth defects.
10. Physical examinations, except as specifically provided herein.
11. Removal of tonsils, or adenoids, unless medically necessary.

(4) Drugs and Medications

(a) Benefits Provided

Benefits are provided for insulin and prescription drugs (only those drugs which by Federal or state law require a prescription) dispensed by a licensed pharmacist and prescribed by a (i) physician for treatment or control of an illness or a nonoccupational accident or (ii) licensed dentist for treatment following the performance of those oral surgical services set forth in (3)(e). The initial amount dispensed shall not exceed a 30-day supply. Any original prescription may be refilled for up to six months as directed by the physician. The first such refill may be for an amount up to, but no more than, a 60-day supply. The second such refill may be up for an amount up to, but no more than, a 90-day supply. Benefits for refills beyond the initial six months require a new prescription by the physician.

Reasonable charges for prescription drugs or insulin are covered benefits. Reasonable charges will consist of the lesser of:

(1) The amount actually billed per prescription or refill,

(2) The average wholesale price plus 25%, to be not less than $2.50 above nor more than $10.00 above the average wholesale price per prescription or refill, or

(3) The current price paid to pharmacies participating in the Trustee-established prescription drug program.

The Trustees may determine average wholesale price from either the American Druggist Blue Book, the Drugtopics Redbook, or the Medi-Span Prescription Pricing Guide.

(b) Benefits Excluded

Benefits shall not be provided under paragraph (4)(a) for the following:

1. Medication dispensed in a hospital (including take-home drugs), skilled nursing facility or physician's office. (See Article III, A(1)(a) and (5)(a) for benefits provided for drugs and medications during inpatient confinement in a hospital or skilled nursing care facility.)

2. Birth control prescriptions.

3. Prescriptions dispensed by other than a licensed pharmacist.

4. Any medication not specifically provided for in (a) above.

(5) Skilled Nursing Care and Extended Care Units

(a) Skilled Nursing Care Facility

Subject to prior approval by the Trustees and upon determination by the attending physician that confinement in a participating skilled nursing care facility* is medically necessary, to the extent that benefits are not available from Medicare or other State or Federal programs, benefits will be provided for:

1. skilled nursing care provided by or under the supervision of a registered nurse;

2. room and board

3. physical, occupational, inhalation and speech therapy, either provided or arranged for by the facility;

4. medical social services;

5. drugs, immunizations, supplies, appliances and equipment ordinarily furnished by the facility for the care and treatment of inpatients;

6. medical services, including services provided by interns or residents in an approved, hospital-run training program, as well as other diagnostic and therapeutic services provided by the hospital; and

7. other health services usually provided by skilled nursing care facilities.

The Plan will not pay for services in a nursing care facility:

1. that is not licensed or approved in accordance with state laws or regulations;

2. that does not provide care of a quality judged acceptable by the Trustees;

*Participating skilled nursing care facility is limited to a skilled nursing care facility which is licensed and approved by Federal Medicare.

3. unless the service is provided by or under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results.

Exclusions:

Telephone, T.V., radio, visitor's meals, private room or private nursing (unless necessary to preserve life), custodial care, services not usually provided in a skilled nursing facility.

(b) Extended Care Units

Approval may be given by the Trustees for up to two weeks to provide specialized medical services and daily treatments by licensed personnel in extended care units. If a physician requests an extension to the two-week period of treatments, such extension requires prior approval from the Trustees

The Plan will not pay for services in an extended care unit unless, in the case of a Medicare patient, such extended care has prior approval of Medicare.

Exclusions:

1. Services, drugs or other items which are not covered for hospital inpatients;

2. Custodial care.

(6) Home Health Services & Equipment

(a) General Provisions

Benefits are provided for home health services, including nursing visits by registered nurses and home health aides, and various kinds of rehabilitation therapy, subject to the following conditions and approval of the Trustees:

1. The Beneficiary must be under the care of a physician.

2. The Beneficiary's medical condition must require skilled nursing care, physical therapy, or speech therapy at least once in a 60-day period.

3. The physician must initiate a treatment plan and specify a diagnosis, the Beneficiary's functional limitations and the type and frequency of skilled services to be rendered.

4. The Beneficiary must be confined to his home. The services must be provided by a certified home health agency.

(b) Physical and Speech Therapy

Benefits are provided for physical and speech therapy services at home when prescribed by a physican to restore functions lost or reduced by illness or injury. Such services must be performed by qualified personnel. When the Beneficiary has reached his or her restoration potential, the services required to maintain this level do not constitute covered care.

(c) Skilled Nursing

Benefits are provided for skilled nursing care rendered by a registered nurse as a home health service when a Beneficiary's condition has not stabilized and a physician has concluded that the Beneficiary must be carefully evaluated and observed by a registered nurse. The Trustees may request an evaluation visit to the Beneficiary's home.

(d) Medical Equipment

Benefits are provided for rental or, where appropriate, purchase of medical equipment suitable for home use when determined to be medically necessary by a physician.

(e) Oxygen

Benefits are provided for oxygen supplied to a Beneficiary subject to the following conditions when ordered by the attending physician and approved by the Trustees:

1. The patient is referred to a designated pulmonary consultant for testing;

2. Such consultant's report is submitted to the Funds with the order for oxygen.

Benefits are also provided for services of inhalation therapists in the home with the attending physician's order.

(f) Coal Miners Respiratory Disease Program

Benefits are provided for services or treatments administered by personnel employed by the Coal Miners Respiratory Disease Program to a Beneficiary in such Beneficiary's home when ordered or requested by a physician, subject to approval by the Trustees prior to the rendering of such service or treatment, except where such benefits are available under a governmental program and such Beneficiary is eligible, or upon application would be eligible under such programs.

(7) Other Benefits

(a) Orthopedic and Prosthetic Devices

Benefits are provided for orthopedic and prosthetic devices prescribed by a physician when medically necessary. The following types of equipment are covered:

1. Prosthetic devices which serve as replacement for internal or external body parts, other than dental;

These include artificial eyes, noses, hands (or hooks), feet, arms, legs and ostomy bags and supplies;

2. Prosthesis following breast removal;

3. Leg, arm, back, and neck braces;

4. Trusses;

5. Stump stockings and harnesses when these devices are essential for the effective use of an artificial limb. These devices all require prior approval by the Trustees. An examination and recommendation is required by an orthopedic physician.

Note: Benefits are provided for repairs and adjustments for braces, trusses, stump stockings and harnesses as well as replacement of any of those devices which have been worn out and can no longer be repaired. Benefits will be provided for replacements for usable appliances and artificial limbs if they are needed because of a change in the Beneficiary's condition. Benefits will also be provided to cover repair and adjustment cost for appliances and artifical limbs.

If replacement of a prosthesis is required, the Beneficiary should in all cases be reevaluated by an orthopedic physician.

6. Surgical stockings (up to two pairs per prescription with no refills) when prescribed by a physician for surgical or medical conditions. The Plan will not pay Beneficiaries for support hose, garter belts, etc.;

7. Orthopedic shoes when specifically prescribed by a physician or licensed podiatrist for a Beneficiary according to orthopedist specifications, including orthopedic shoes attached to a brace that have to be modified to accomodate the brace. Benefits will not be provided for stock orthopedic shoes;

8. Orthopedic corrections added to ordinary shoes by a physician or licensed podiatrist. Benefits are provided for only the correction to the shoe.

(b) Physical Therapy

Benefits are provided for physical therapy in a hospital, skilled nursing facility, treatment center, or in the Beneficiary's home. Such therapy must be prescribed and supervised by a physician and administered by a licensed therapist approved by the Trustees. The physical therapy treatment is subject to limitations by the Trustees based on the diagnosis, medical recommendation and attainment of maximum restoration.

(c) Speech Therapy

Benefits are provided for speech therapy rendered by a Trustee approved, qualified licensed speech therapist if the Beneficiary is a stroke patient or has had conditions including ruptured aneurysm, brain tumors or autism and needs special instruction to restore technique of sound and to phonate, and needs direction in letter or word exercises in order to express basic needs. Benefits are also provided for speech therapy for child Beneficiaries with a speech impediment from a qualified speech therapist provided that the child cannot receive speech therapy through the public schools.

(d) Hearing Aids

Benefits are provided for hearing aids recommended by a participating otologist or otolaryngologist and a certified clinical audiologist. Such hearing aids must be purchased from a participating vendor. Unless the Beneficiary receives prior approval from the Trustees, the Funds will pay for a hearing aid for only one ear. Benefits for necessary repairs and maintenance, except the replacement of batteries, will be provided after the expiration of the warranty period. Benefits will be provided for replacement hearing aids only if a new aid is needed because of a change in the Beneficiary's condition, or if the aid no longer functions properly. Benefits will not be provided for any fees for incorporating hearing aids into eyeglasses.

(e) Ambulance and Other Transportation

Benefits are provided for ambulance transportation to or from a hospital, clinic, medical center, physician's office, or skilled nursing care facility, when considered medically necessary by a physician.

With prior approval from the Trustees, benefits will also be provided for other transportation subject to the following conditions:

1. If the needed medical care is not available near the Beneficiary's home and the Beneficiary must be taken to an out-of-area medical center;

2. If the Beneficiary requires frequent transportation between the Beneficiary's home and a hospital or clinic for such types of treatment as radiation or physical therapy or other special treatment which would otherwise require hospitalization, benefits will be provided for such transportation only when the Beneficiary cannot receive the needed care without such transportation.

3. If the Beneficiary requires an escort during transportation, the attending Physician must submit satisfactory evidence as to why the Beneficiary needs an escort.

(f) Outpatient Mental Health, Alcoholism and Drug Addiction

Benefits are provided for:

Psychotherapy, psychological testing, counseling, group therapy and alcoholism or drug rehabilitative programs where free care sources are not available when determined to be medically required by a physician.

Benefits are not provided for:

1. Encounter and self-improvement group therapy;

2. Custodial care related to mental retardation and other mental deficiencies;

3. School related behavioral problems;

4. Services by private teachers;

5. Alcoholism and drug rehabilitation if an advance determination has not been made by the rehabilitation team that the Beneficiary is a good candidate for rehabilitation;

6. Alcoholism and drug rehabilitation programs that do not have prior approval of the Trustees.

(8) Co-payments

Certain benefits provided in this Article III shall be subject to the co-payments set forth below and such co-payments shall be the responsibility of the Beneficiary. The Trustees shall implement such procedures as they deem appropriate to achieve the intent of these co-payments. Beneficiaries and providers shall provide such information as the Trustees may require to effectively administer these co-payments, or such Beneficiares or providers shall not be eligible for benefits or payments under this Plan. Any over-payments made to a provider who overcharges the Plan in lieu of collecting the applicable co-payment from a Participant or Beneficiary shall be repaid to the 1950 Benefit Trust by such provider. Co-payments for covered Health Benefits are established as follows:

Benefit	Co-Payment
(a) Physician services as an out-patient as set forth in section A(2) and physician visits in connection with the benefits as set forth in section A(3), paragraph (c) but only for pre- and post-natal visits if the physician charges separately for such visits in addition to the charge for delivery, and paragraphs (g) through (m), paragraph (n) except inpatient surgery, paragraph (o) and section A(7) paragraph (f).	$5 per visit up to a maximum of $100 per 12-month period(*) per family.
(b) Prescription drugs and insulin as set forth in section A(4) and take-home drugs following a hospital confinement as set forth in section A(1)(a).	$5 per prescription or refill up to $50 maximum per 12-month period(*) per family. For purposes of this co-payment provision, a prescription or refill shall be deemed to be each 30 days (or fraction thereof) supply.

*The 12-month periods shall begin on the following dates: March 27, 1988, March 27, 1989, March 27, 1990, March 27, 1991, and March 27, 1992.

(9) Vision Care Program

(a) Benefits	Actual Charge Up To Maximum Amount	Frequency Limits
Vision Examination	$20	Once every 24 months
Per Lens (Maximum = 2)		Once every 24 months
- Single Vision	10	
- Bifocal	15	
- Trifocal	20	
- Lenticular	25	
- Contact	15	
Frames	14	Once every 24 months

Note: The 24-month period shall be measured from the date the examination is performed or from the date the lenses or frames are ordered, respectively, even if the last examination occurred during a prior Wage Agreement.

(b) Lenses will not be covered unless the new prescription differs from the most recent one by an axis change of 20 degress or .50 diopter sphere or cylinder change and the lenses must improve visual acuity by at least one line on the standard chart.

(c) Exclusions include:

1. sunglasses (other than Tints #1 or #2);

2. extra charges for photosensitive or anti-reflective lenses;

3. drugs or medication (other than for vision examination), medical or surgical treatment of eyes;

4. special procedures, such as orthoptics, vision training, sub-normal vision aids, aniseikonic lenses and tonography;

5. experimental services or supplies;

6. replacement of lost or broken lenses and/or frames unless replacement is eligible under the frequency and prescription limitations;

7. services or supplies not prescribed as necessary by a licensed physician, optometrist or optician;

8. services or supplies for which the insured person is entitled to benefits under any other provision of the Plan or as provided under a mine safety glass program;

9. any services which are covered by any worker's compensation laws or employer's liability laws, or services which the Employer is required by law to furnish in whole or in part;

10. services or supplies which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any federal, state, municipal or other governmental body;

11. charges for services or supplies for which no charge is made that the Beneficiary is legally obligated to pay or for which no charge would be made in the absence of vision care coverage.

(d) The exclusions in (c) above shall not be read to limit or exclude coverage that may be contained elsewhere in the Plan.

(10) General Provisions

(a) HMO Election

Any Beneficiary as described in Article II, sections A and D may elect coverage by a certified health maintenance organization (HMO) in lieu of the health benefits provided under this Plan, in accordance with Federal or State laws governing HMO's; provided, however, that all Beneficiaries in a family shall be governed by an HMO election and all elections must be approved by the Trustees.

The Trustees shall pay to the HMO the amount charged by the HMO for coverage of Beneficiaries who elect such coverage but such payment shall not exceed the cost of the health benefits provided under this Plan. Any charges by the HMO in excess of such payment shall be paid by the Beneficiaries.

The Trustees shall not make any payments to any HMO other than as specifically set forth above.

(b) Payment Methods

All benefits under this Plan for services rendered to Beneficiaries by participating clinics are limited to the benefits described in the Plan and shall be paid for on a fee-for-service basis except where demonstrated to the satisfaction of the parties that an alternative payment method is preferable. In their discretion, the Trustees may also provide health services through payments pursuant to a contract with a carrier which agrees to reimburse physicians and other providers of medical services for rendering authorized health services and benefits. Notwithstanding the above, for the term of the

1988 Wage Agreement, the benefits of this Plan shall be processed and provided either through insurance policies or insurance contracts issued by duly licensed insurance carriers, or through payments pursuant to a full administrative services contract with an insurance carrier or other professional contract administrator.

(c) Purpose

The overall purpose of the Plan is to provide Beneficiaries with quality health care and the Trustees will be responsible for constantly reviewing and improving the effectiveness of the administration of the Plan.

(d) Administration

The Trustees are authorized to promulgate rules and regulations to implement the Plan, and those rules and regulations shall be binding upon all persons dealing with and Beneficiaries claiming benefits under the Plan.

(e) Services Rendered Outside the United States

Benefits are provided for health care rendered outside of the United States on the same basis as if such care had been rendered in the United States. (The Beneficiary in such a case will be required to make payment of the expenses and file a claim with the Trustees for reimbursement.)

(f) Medicare

The benefits provided under Article III will not be paid to any Beneficiary otherwise eligible under Article II if such Beneficiary is eligible for Hospital Insurance coverage (Part A) of Medicare for which a premium is not required and/or Medical Insurance coverage (Part B) of Medicare unless such Beneficiary is enrolled for each part of Medicare for which such Beneficiary is eligible. Any such Beneficiary who is enrolled in a Medicare program shall receive the benefits provided under Article III only to the extent such benefits are not provided for under Medicare. The Trustees shall notify each Beneficiary of the obligation to enroll. Failure to notify shall not remove the obligation to enroll.

(g) Subrogation

The 1950 Benefit Trust does not assume primary responsibility for covered medical expenses which another party is obligated to pay or which an insurance policy or other medical plan covers. Where there is a dispute between the Plan and such other party, the Plan shall, subject to provisions 1 and 2 immediately below, pay for such covered expenses only as a convenience to the Beneficiary eligible for benefits under Article II and only upon receipt of an appropriate indemnification or subrogation agreement; but the primary and ultimate responsibility for payment shall remain with the other party.

The Benefit Trust's obligations to pay benefits on behalf of any Beneficiary shall be conditioned:

1. upon such Beneficiary taking all steps necessary or desirable to recover the costs thereof from any third party who may be obligated therefor, and

2. upon such Beneficiary executing such documents as are reasonably required by the 1950 Benefit Trust, including, but not limited to, an assignment of rights to receive such third party payments, in order to protect and perfect the Trust's right to reimbursement from any such third party.

(h) Nonduplication

The health benefits provided under Article III A are subject to a nonduplication provision as follows:

1. Benefits set forth in section A of Article III will be reduced by benefits provided under any other group plan, including a plan of another Employer signatory to the Wage Agreement, if the other plan:

(i) does not include a coordination of benefits or nonduplication provision, or

(ii) includes a coordination of benefits or nonduplication provision and is the primary plan as compared to this Plan.

2. In determining whether this Plan or another group plan is primary, the following will apply:

(i) The plan covering the patient other than as a dependent will be the primary plan.

(ii) Where both plans cover the patient as a dependent child, the plan covering the patient as a dependent child of a male will be the primary plan.

(iii) Where the determination cannot be made in accordance with (i) or (ii) above, the plan which has covered the patient the longer period of time will be the primary plan.

(iv) In the event a Pensioner or surviving spouse is covered under another group plan by reason of his or her employment, the other group plan shall be the primary plan for such Pensioner or surviving spouse and their eligible dependents.

3. As used herein, "group plan" means (i) any plan covering the individuals as members of a group and providing hospital or medical care benefits or services through group insurance or a group prepayment arrangement, or (ii) any plan covering individuals as employees of an employer and providing such benefits or services, whether on an insured prepayment or uninsured basis.

4. If it is determined that benefits under this Plan should have been reduced because of benefits provided under another group plan, the Trustees shall have the right to recover any payment already made which is in excess of the Plan's liability. Similarly, whenever benefits which are payable under the Plan have been provided under another group plan, the Trustees may make reimbursement directly to the insurance company or other organization providing benefits under the other plan.

5. For the purpose of this provision, the Trustees may, without consent of or notice to any Beneficiary, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expenses and benefits.

6. Any Beneficiary claiming benefits under this Plan must furnish the Trustees such information as may be necessary for the purpose of administering this provision.

(i) Explanation of Benefits (EOB), Cost Containment and Hold Harmless

1. Each Beneficiary shall receive an explanation of billing and payment rendered on behalf of such Beneficiary. Should full payment for a service be denied because of a charge that has been determined by the Trustees to be in excess of the reasonable and customary charge, a copy of such EOB shall be forwarded to the UMWA (International Headquarters, Attention: Benefits Department).

2. (i) Regarding health care cost containment, designed to control health care costs and to improve the quality of care without any reduction of plan coverage or benefits, the Trustees are authorized to establish programs of optional in-patient hospital pre-admission and length of stay review, optional second surgical opinions, and case management and quality care programs, and are to establish industry-wide reasonable and customary schedules for reimbursement of medical services at the 85th percentile (except when actual charges are less), and other cost containment programs that result in no loss or reduction of benefits to participants. The Trustees are authorized to take steps to contain prescription drug costs, including but not limited to, paying only the current average wholesale price, encouraging the use of generic drugs instead of brand name drugs where medically appropriate, and encouraging the use of mail order drug programs when advantageous.

(ii) The Trustees shall make available to the individual employer plans maintained pursuant to Article XX (c)(3)(i) of the Wage Agreement any special cost containment arrangements that they make with outside vendors and/or providers. Further, the plan administrators of such plans may "piggyback" the cost containment programs adopted by the Trustees.

(iii) Consistent with Article XX (12) of the 1984 and 1988 Wage Agreements, this Section in no way authorizes or implies a reduction of benefits or additional costs for covered services provided.

(iv) The Trustees shall make available to the individual employer plans ~~the available to the individual employer~~ plans the industry-wide reasonable and customary schedules established pursuant to subsection (i) above.

3. The Employers and the UMWA agree that excessive charges and escalating health costs are a joint problem requiring a mutual effort for solution. In any case in which a provider attempts to collect excessive charges or charges for services not medically necessary, as defined in the Plan, from a Beneficiary, the Trustees or their agent shall, with the written consent of the Beneficiary, attempt to resolve the matter, either by negotiating a resolution or defending any legal action commenced by the provider. Whether the Trustees or their agent negotiates a resolution of a matter or defends a legal action on a Beneficiary's behalf, the Beneficiary shall not be responsible for any legal fees, settlements, judgments or other expenses in connection with the case, but

may be liable for any services of the provider which are not provided under the Plan. The Trustees or their agent shall have sole control over the conduct of the defense, including the determination of whether the claim should be settled or an adverse determination should be appealed.

(11) General Exclusions

(a) In addition to the specific exclusions otherwise contained in the Plan, benefits are also not provided for the following:

1. Cases covered by workers' compensation laws or employer's liability acts or services for which an employer is required by law to furnish in whole or in part.

2. Services rendered (i) prior to the effective date of a Beneficiary's eligibility under the Plan or, (ii) subsequent to the period after which a Beneficiary is no longer eligible for benefits under the Plan or (iii) in a non-accredited hospital, other than for emergency services as set forth in section A(2)(a) and (3)(i).

3. Services furnished by any governmental agency, including benefits provided under Medicaid, Federal Medicare and Federal and State Black Lung legislation for which a Beneficiary is eligible or, upon proper application, would be eligible. There shall be a one-time exception to this exclusion with respect to those Beneficiaries who failed to make proper application by December 31, 1980, for medical benefits under Section 11 of the Black Lung Reform Act of 1977.

4. Services furnished by tax-supported or voluntary agencies.

5. Immunizations provided by local health agencies.

6. Evaluation procedures, such as x-rays and pulmonary function tests in connection with applications for black lung benefits or required by Federal or State Black Lung legislation.

7. Private duty nursing. If necessary to preserve life and certified as medically necessary by the attending physician and an Intensive Care Unit is unavailable, such private duty nursing services may be approved by the Trustees for up to 72 hours per inpatient hospital admission. In no event will payment be made for private duty nursing during a period of confinement in a Hospital Intensive Care Unit.

8. Custodial care, convalescent or rest cures.

9. Personal services such as barber services, guest meals and cots, telephone or rental of radio or television and personal comfort items not necessary to the treatment of an illness or injury.

10. Charges for private room confinement, except as specifically described in the Plan.

11. Services for which a Beneficiary is not required to make payment.

12. Excessive charges as determined solely by the Trustees.

13. Charges related to sex transformation.

14. Charges for reversal of sterilization procedures.

15. Charges in connection with a general physical examination, other than as specifed in the Plan.

16. Inpatient confinements solely for diagnostic evaluations which can be provided on an outpatient basis.

17. Charges for medical services for inpatient or outpatient treatment for mental retardation and other deficiencies.

18. Finance charges in connection with a medical bill.

19. Dental services.

20. Birth control devices and medications.

21. Abortion, except as specifically described in the Plan.

22. Eyeglasses or lenses, except when medically required because of surgically caused refractive errors or as otherwise provided in section A(9).

23. Exercise equipment.

24. Charges for treatment with new technological medical devices and therapy except with the approval of the Trustees.

25. Charges for treatment of obesity, except for pathological, morbid forms of severe obesity (200% or more of desirable weight) when prior approval is obtained from the Trustees.

26. Charges for an autopsy or post mortem surgery.

27. Any types of services, supplies or treatments not specifically provided.

B. Death Benefits

For a participant whose death occurs on or after February 1, 1988, and who is (1) receiving pension payments under the 1950 Pension Trust and is eligible for health benefits or (2) has made application for and is eligible to receive such payments and benefits, death benefits shall be paid in a lump sum for the following amounts: (i) $3000 for such participant with dependents at the time of his death, and (ii) $2500 for such participant without dependents at the time of his death. Beginning February 1, 1990, the lump sum death benefits shall be incresed by $500.

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