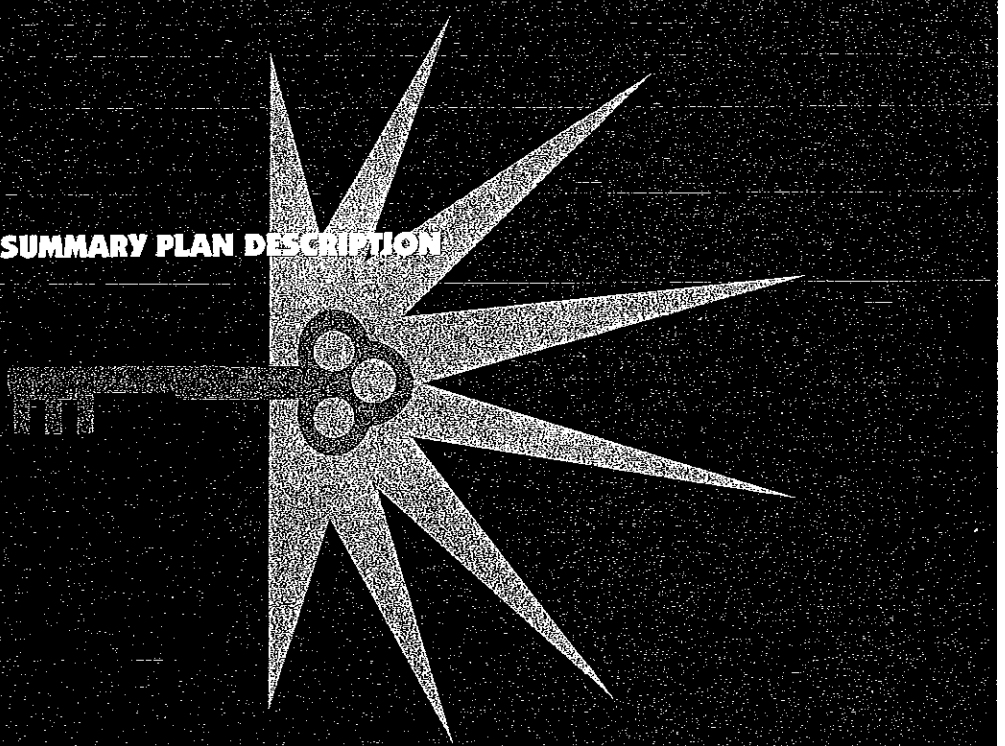
The key to Medical and Vision Benefits

SUMMARY PLAN DESCRIPTION



Key Question

Q WHAT IF I GET SICK OR HURT?

A Most people consider their medical coverage to be the most important employee benefit they have. The company provides you with this key benefit to help keep you healthy and ensure your peace of mind. Not only does the medical plan assist you with the expense of medical bills, it also helps make sure you receive the most appropriate, cost-effective care.

Q WHAT IF I NEED VISION CARE?

A In the face of sudden danger, our first impulse is to protect our eyes. When it comes to maintaining a sound, healthy body, it's plain to see that vision care is a key concern. That's why the company also provides you with vision care benefits as part of your overall health care coverage.

Both your medical and vision care benefits are described in this booklet. Each has a separate section that summarizes what the plan covers and its major provisions.

THE MEDICAL AND VISION CARE PLANS ARE KEYS TO YOUR GOOD HEALTH.

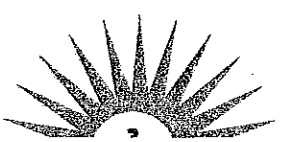
This booklet is a "summary plan description" (SPD) of the company medical and vision care plans for salaried employees.

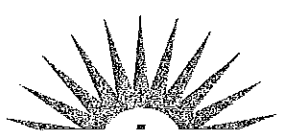
Eligibility for benefits and the actual amount of benefit payments are determined by the legal plan document and laws that govern each benefit plan. This booklet describes the plans in easier-to-read, simplified terms. It cannot cover every detail of the plan. If there is any conflict between the description in this publication and the legal plan document, the plan document will be followed.

The plan administrator, Peabody Holding Company, Inc., maintains the right to interpret the terms of this plan, and its interpretations will be final.

The company intends to maintain these plans for salaried employees, but reserves the right to change or end the plans at any time, within the terms of the plan documents. This booklet is not a guarantee of employment or an employment contract.

Contents





Key Highlights

Medical and vision care coverage

WHO IS ELIGIBLE: All full-time salaried employees and their eligible dependents. You are automatically enrolled for medical and vision care coverage when you are hired. Coverage begins on the date you begin work. You are also eligible for medical coverage after retirement, if certain conditions are met. (See page 7 for more information.)

WHAT IS COVERED: The medical plan covers a wide variety of medical services and supplies. There are special provisions for prescription drugs, home health care, hospice care and treatment of mental illness and substance abuse. (See page 9 for more information.)

The vision plan covers a vision exam and new lenses (if needed due to a significant prescription change) and frames once every 24 months. (See page 32 for more information.)

COST TO YOU: You pay no premiums—currently the company provides you with vision and medical coverage with no premium contributions from you.

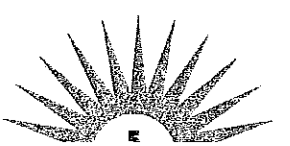
However, you do share in the cost of the treatment you receive by paying deductibles, copayments and a percentage of expenses. What you pay depends on the type of care you receive and where you receive it. (See page 9 for more information.)

The medical plan has a cap, or out-of-pocket maximum, on the amount you pay for most covered expenses. This maximum is $1,250 for one person in one calendar year, and $3,000 combined for all covered family members per calendar year. (See page 15 for more information.)

The vision plan pays up to a specified amount for covered expenses. You pay any remainder. (See page 32 for more information.)

MAXIMUM BENEFIT AMOUNT: In general, the medical plan pays a lifetime maximum benefit of $1 million per covered person as of March 1, 1990. (This is adjusted annually based on the Health Cost Component of the Consumer Price Index. In 1994, the maximum was $1,350,000.) However, additional restrictions apply to hospice care and treatment of mental illness and substance abuse. (See page 16 for more information.)

Maximum benefits for the vision plan are listed on page 32.



IF YOU LEAVE THE COMPANY: Your coverage generally ends, although under some circumstances you may be eligible for continued coverage under the federal law known as COBRA. The medical plan (but not the vision plan) also contains special provisions for continuing coverage in the event of a reduction in the work force, or for your surviving dependents in the event of your death. (See page 40 for more information.) The medical plan (but not the vision plan) may also allow you to convert your coverage to an individual insurance policy if your company-provided coverage ends. (See page 43 for more information.)

OTHER KEY POINTS: You are free to receive your care from any provider you wish, but your share of costs for the medical plan will be less if you use providers that are members of the plan's "participating provider" networks. These networks include hospitals, physicians and pharmacies. (See page 10 for more information.)

The medical plan includes a Coordinated Care Options program that works with you and your doctor to review your care and avoid unnecessary hospitalization. The purpose of the program is to make sure you receive the most appropriate, cost-effective care for your condition. (See page 11 for more information.)

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

If you are also covered by another medical or vision care plan, the company's plan will coordinate with the other plan to avoid duplicate payments of benefits. (See page 36 for more information.)

Eligibility and Enrollment

If you are a full-time salaried employee, you are eligible for medical and vision care coverage as of your date of employment. If you are not at work on your date of employment, your coverage becomes effective on the date you are at work.

You are automatically enrolled for medical and vision care benefits. The plan currently requires no contributions.

Special provisions for medical coverage only: If you are not actively working but you are receiving company-paid continuation of your salary, or benefits from the company's long-term disability plan for salaried employees, you remain eligible for medical coverage.

When you retire, you and your dependents may remain eligible for medical coverage if, on the date you retire, you are at least age 55 and have completed at least 10 years of service. To be eligible for coverage as a retiree, you must choose to begin receiving retirement benefits from the company's retirement plan within 31 days following the date you stop working for the company.

ELIGIBILITY FOR YOUR DEPENDENTS

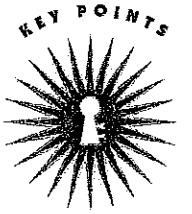
Your eligible dependents become covered by the plan at the same time you do. Dependents you acquire after you have been eligible—by marriage or birth, for example—will be covered on the date you acquire them, provided they are enrolled within 31 days of that date. However, if a dependent is hospitalized on his or her eligibility date, coverage for that person does not become effective until the day after he or she is discharged from the hospital. (This provision does not apply to a newborn or adopted child who becomes eligible and is enrolled after you are already covered.)

Your eligible dependents include:

- Your spouse.
- Your unmarried children under age 19.
- Your unmarried children up to the day they attain age 23, if they are full-time students.
- Your unmarried children of any age who are incapable of supporting themselves due to a mental or physical disability and are completely dependent upon you for financial support. The disability must have occurred before age 19 (or age 23 if a full-time student) while the child met the definition of a dependent child. "Supporting" the child also includes having the child live with you or confined to an institution for care or treatment.

Children who are eligible as dependents include:

- Your natural child.



Full-time salaried employees are eligible for medical and vision care coverage.

Coverage begins when you begin work.

You may also cover your eligible dependents.

Benefits from the medical plan may be limited for a pre-existing condition.

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

The child must normally reside with you and you must regularly provide one-half of his or her annual support. However, the plan will also cover a child for whom you have been named in a qualified medical child support order.

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

LIMITATIONS FOR PRE-EXISTING CONDITIONS

Benefits from the medical plan may be limited for a pre-existing condition. A pre-existing condition is an injury, pregnancy or illness, whether or not diagnosed, for which consultation or treatment (including prescribed drugs or medicine) was received during the three months before the effective date of your medical coverage.

If you or your covered dependents have a pre-existing condition, benefits for that condition or any related conditions will be limited to $1,000 per condition until one of the following occurs:

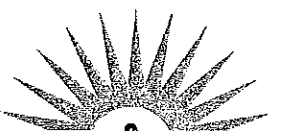
- *For a dependent:* The individual has been continuously covered by the plan for 12 consecutive months.
- *If you have the pre-existing condition and are an active employee:* You have been continuously and actively at work and covered by the plan for six consecutive months.

These limitations do not apply to the vision care plan.

Your Medical Benefits

BENEFITS AT A GLANCE

DEDUCTIBLES YOU PAY	
ANNUAL DEDUCTIBLE	$250
ANNUAL DEDUCTIBLE FAMILY MAXIMUM	$500
HOSPITAL COPAYMENT	
PARTICIPATING NETWORK HOSPITAL	$50
NONPARTICIPATING HOSPITAL	$150
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE AND HOSPITAL COPAYMENT	
INPATIENT HOSPITAL	100%
FOR INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE	100% UP TO 30 DAYS PER CALENDAR YEAR UP TO $20,000 ANNUAL MAXIMUM
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE	
SPECIAL OUTPATIENT BENEFITS *(for same-day surgery, accidents treated within five days, emergency medical care if admitted to the hospital or pre-admission testing)*	100%
SURGERY	100%
HOME HEALTH CARE OR HOSPICE CARE (UP TO PLAN LIMITS)	100%
OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE	80% OF THE FIRST $1,000 50% OF THE NEXT $1,500 (NO COVERAGE FOR EXPENSES AFTER $2,500)
MOST OTHER MEDICAL EXPENSES	80%
ANNUAL OUT-OF-POCKET MAXIMUM YOU PAY *(includes deductible, hospital copayment and 20% coinsurance you pay for most covered expenses)*	
ANNUAL OUT-OF-POCKET MAXIMUM PER INDIVIDUAL	$1,250
ANNUAL OUT-OF-POCKET MAXIMUM PER FAMILY	$3,000



The plan offers you the opportunity to reduce your cost for medical expenses through three participating provider arrangements. If you receive care or supplies from certain providers, your cost will be less.

PRESCRIPTION DRUGS, AMOUNT THE PLAN PAYS *(no deductible or out-of-pocket maximum)*	
PARTICIPATING PROVIDER PHARMACY	85% BRAND NAME 90% GENERIC
NONPARTICIPATING PROVIDER PHARMACY	80%
LIFETIME MAXIMUM BENEFIT THE PLAN PAYS	$1,000,000 INDEXED ANNUALLY FOR INFLATION (IN 1994, LIMIT WAS $1,350,000) (NO MORE THAN $50,000 FOR MENTAL HEALTH AND SUBSTANCE ABUSE)

Participating Blue Cross and Blue Shield physicians and hospitals agree to accept a special rate. Coverage for other providers is limited to reasonable and customary expenses. See the section called Participating providers *on this page.*

All hospitalization and certain other types of care must be approved under a Coordinated Care Options program. Benefits may be reduced if you don't comply. See the section called Coordinated Care Options (CCO) program and hospital precertification *on page 11.*

Benefits for prescription drugs are provided through a separate program administered by PCS Health Systems, Inc. See the section called Prescription drug benefits *on page 19.*

PARTICIPATING PROVIDERS

The plan offers you the opportunity to reduce your cost for medical expenses through three participating provider arrangements.

The preferred hospital program

Certain hospitals have agreed to provide their services under terms that reduce costs for both you and the company. You may go to any hospital you choose to receive medical care, but when you use a hospital on the preferred hospital list, you will pay a lower hospital copayment. Your hospital copayment will be $50 for preferred hospitals, and $150 for other hospitals. The preferred network includes most Blue Cross participating hospitals. Contact your benefits department for a list of preferred hospitals.

Blue Cross and Blue Shield participating physicians

Blue Cross and Blue Shield has contracted with physicians that have agreed to file your claims for you, and to charge fees that Blue Cross and Blue Shield has determined to be "usual, customary and reasonable." This means that for covered services, the provider will file the claims directly with the plan, and bill you only for the deductible and your percentage share of expenses.

Participating provider pharmacy program

Prescription drug benefits are provided through the participating provider pharmacy program. Pharmacies participating in the network have agreed to provide discounts for employees covered by the company medical plan. In addition, the plan pays higher benefits for prescriptions purchased from a participating pharmacy, and you do not have to file a claim. A list of participating pharmacies is available from your benefits department.

If you purchase prescriptions from a non-participating pharmacy, you will still receive your benefits, but you may have to pay the full cost of the drug up front and file a claim for reimbursement. Benefits the plan pays for prescription drugs are explained in the section *Prescription drug benefits* on page 19.

The participating provider networks serve as independent contractors to the company. For this reason, the company cannot guarantee the availability or quality of care and is not liable for any act or omission of any provider.

COORDINATED CARE OPTIONS (CCO) PROGRAM AND HOSPITAL PRECERTIFICATION

The Coordinated Care Options (CCO) program is administered by Alliance Blue Cross Blue Shield. Under this program, all hospital admissions must be reviewed by the coordinated care options program in advance. This allows CCO to "precertify" (authorize in advance as being medically necessary) the length of stay required and make sure that the inpatient hospitalization is medically necessary.

Precertification is also required for home health care, care in skilled-nursing facilities and hospice care.

Your benefits will be reduced if you do not follow the program guidelines.

The Coordinated Care Options program's goal is to ensure that you receive the most appropriate, cost-effective, quality care for your condition.

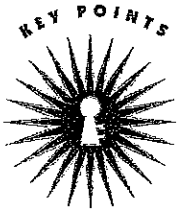
Precertification for inpatient admissions

To request precertification, simply call the CCO precertification number given in the section called *How to contact Coordinated Care Options* on page 14. Registered professional nurses will carefully evaluate the proposed hospitalization. If the nurse determines that inpatient hospitalization does not meet the guidelines for medical necessity, a consulting physician will be asked to review the case and make a determination.

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

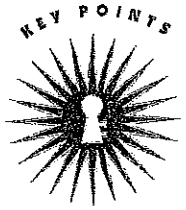
If the hospitalization is for an emergency, you do not have to notify CCO in advance, but must do so within two working days. Otherwise, the same $200 penalty will apply.

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



All hospital admissions must be reviewed by the coordinated care options program (CCO) in advance. Your benefits will be reduced if you do not follow the program guidelines.

If you do not call CCO before a hospitalization that is not an emergency, your covered hospital charges will be reduced by an additional $200. Even if it's an emergency, you must notify CCO within two working days.



You must call CCO in advance for approval of home health care, care in a skilled-nursing facility and hospice care. No benefits are provided for these services unless they have been approved as medically necessary by CCO.

Precertification alone does not guarantee coverage.

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

If you call for precertification but CCO does not approve an inpatient stay

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

Precertification of extended care services

You must call CCO in advance for approval of home health care, care in a skilled-nursing facility and hospice care. To request precertification, simply call the CCO precertification number given in the section called *How to contact Coordinated Care Options* on page 14.

No benefits are provided for extended-care services unless they have been approved as medically necessary by CCO.

Precertification alone does not guarantee coverage

The purpose of precertification is to make sure inpatient hospitalization and extended care services are medically necessary—it is not a guarantee of benefits or payment.

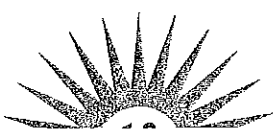
When CCO approves your admission or extended care, this does not guarantee that our plan will provide benefits for your expenses. The nurses at CCO check to determine the medical need for an inpatient admission or extended care, but they cannot verify each covered person's benefits or coverage limitations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

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

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

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

- Suggesting that tests be performed on an outpatient basis before your inpatient admission.



- Discouraging a weekend admission (because much non-emergency testing and treatment is less likely to be performed over the weekend anyway).
- Encouraging admission on the morning that surgery is to be performed.

Recertification for extending an inpatient stay

When CCO authorizes an inpatient admission, the reviewing nurse may assign the number of days that are commonly needed for inpatient care. If a physician believes it is medically necessary for you to receive inpatient care longer than originally authorized, you are responsible for obtaining approval for the additional days through CCO. (See *How to contact Coordinated Care Options* on page 14.)

If you do not call for recertification

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

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

If you call for recertification but CCO does not approve additional days

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

Concurrent review

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

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

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

Retrospective review

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

Individual case management

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

If you are hospitalized for a longer period of time than originally approved by CCO, you must obtain CCO's approval for the extended stay.

In some cases, the plan may approve special care in an environment other than a hospital.

To contact CCO, call 1-800-848-2625 and select Option 1.

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

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

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

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

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

How to contact Coordinated Care Options

When you need to contact CCO, please:

- Call 1-800-848-2625.
- Select Option 1.

Business hours are 8 a.m. to 6 p.m., Monday through Friday.

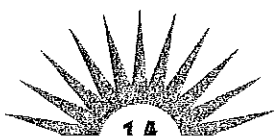
When you want to request precertification, be sure to have the following information:

- Your identification number (from your health plan ID card).
- The name and phone number of the admitting physician.
- The date of admission.
- The name of the hospital or treatment facility.
- The reason for the admission, and how long the doctor expects you to be an inpatient.

If you need to contact CCO after business hours, you may either wait until the next business day, or call and leave a message with CCO's answering service. Please be ready to leave your name, your identification number from your health plan ID card, and the telephone number at which you can be reached during the day. Be sure to include your area code. Your call will be returned the next business day. Have the other information about your admission ready when your call is returned.

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

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



If you disagree with CCO's decision

If you or your physician disagrees with any decision made by CCO, an appeal may be submitted in writing within 60 days to:

Coordinated Care Options
National Account Service Center
P.O. Box 66989
St. Louis, MO 63166-6989

The Coordinated Care Options program gives special attention to our employees and offers guidance to help coordinate care. It supports our employees in obtaining the right treatment in the right setting. CCO also provides educational assistance with health problems or questions. As an advocate for our employees, CCO helps you become wise consumers of health care.

DEDUCTIBLE

Annual deductible

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

The annual deductible is $250 for each covered individual per year, and generally applies to all covered expenses. However, there are special features and exceptions:

- You will pay no more than $500 toward the annual deductible in any one calendar year for all your family members combined.
- If two or more covered members of your family are injured in the same accident, you only have to meet one annual deductible for their combined covered expenses for that accident.
- If you have covered expenses in the last three months of a calendar year that apply towards your deductible, they may be applied to the next year's deductible as well.
- You do not have to meet a deductible for prescription drug benefits, as explained under *Prescription drug benefits* on page 19.

Hospital copayment

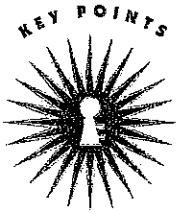
Before the plan pays benefits for an inpatient hospital stay, you must pay an additional hospital copayment of $50 if you are admitted to one of Blue Cross and Blue Shield's preferred participating hospitals, or $150 for any other hospital.

The hospital copayment is separate from the annual deductible. You must meet both before the plan pays charges for an inpatient hospital stay.

In general, a new hospital copayment applies to each hospital confinement and each covered individual. However, there is this exception: If two or more covered members of your family are injured in the same accident, you must meet only one hospital copayment for their combined covered expenses for that accident. Also, if a person is transferred from one hospital to another, only the first hospital admission requires a copayment.

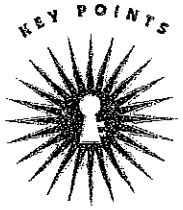
OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum provides additional protection for you by putting a cap on the amount you're required to pay in one calendar year for one person's covered expenses.



The annual deductible is the amount of covered expenses you must pay each calendar year before the medical plan will pay benefits. The annual deductible is $250 for each covered individual per year.

Before the plan pays benefits for an inpatient hospital stay, you must also pay a hospital copayment.



For most types of covered medical expenses, the plan pays 100% or 80% of covered expenses after you've met the deductible and hospital copayments.

For all covered family members combined, the most you will pay out-of-pocket for covered expenses in one calendar year is $3,000. The most you will pay for any one covered person per calendar year is $1,250. This is the plan's out-of-pocket maximum.

For most types of covered medical expenses, the plan pays 100% or 80% of covered expenses after you've met the deductible and hospital copayments, if applicable. If your share of covered expenses (including the deductible, hospital copayments and the 20% you pay) reaches $1,250 for one person in one calendar year, the plan pays 100% of any additional covered expenses incurred by that person for the rest of that year.

For all covered family members combined, the most you will pay out-of-pocket for covered expenses in one calendar year is $3,000.

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

- Expenses that aren't covered by the medical plan.
- Expenses that are in excess of usual, customary and reasonable charges or other plan maximums.
- Penalties for not complying with the Coordinated Care Options program.
- Expenses for prescription drugs.
- Expenses for outpatient mental illness and substance abuse.
- Expenses that exceed the plan maximums (including the special limits on benefits for treatment of mental illness and substance abuse).

LIFETIME MAXIMUM BENEFIT

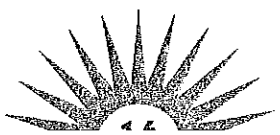
For all covered expenses, the medical plan pays a lifetime maximum of $1 million for each covered person, as of March 1, 1990. This amount is increased annually by the Health Cost Component of the Consumer Price Index. In 1994, the lifetime maximum was $1,350,000.

For treatment of mental illness and substance abuse, there is a $50,000 lifetime maximum per individual. For hospice care expenses, there is a $10,000 lifetime maximum per individual. These amounts are included in the $1 million lifetime maximum for all benefits.

COVERED MEDICAL EXPENSES

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

The medical plan provides benefits only for covered expenses that do not exceed the usual, customary and reasonable charges in the geographic area where the services or supplies are provided, as determined by Blue Cross and Blue Shield. Participating providers agree to accept these rates, and will not bill you for covered expenses other than the deductible and copayment amounts. For a nonparticipating provider, you must pay any amounts that exceed the usual, customary and reasonable charge, in addition to the deductible and your percentage share of expenses. In this situation, the plan's "hold



harmless" provision will apply—see the section on page 35.

Inpatient hospital benefits

After the deductible and the hospital copayment have been met, the plan pays 100% of the following covered expenses for an inpatient hospital stay, provided CCO has approved the hospitalization, as explained on page 11.

The plan covers charges by a hospital for the following:

- Room and board expenses in a semi-private room, including expenses for intensive care or coronary care units. Charges for a private room may be eligible for reimbursement at 95%, if medically necessary.
- Special diets.
- General nursing care.
- Use of operating, delivery, recovery, and treatment rooms and equipment.
- All FDA-approved and appropriately prescribed drugs and medicines for use in the hospital, and covered drugs or medicines sent home following hospitalization, up to a 30-day supply.
- Dressings, ordinary splints and casts.
- X-ray examinations, X-ray therapy, and radiation therapy and treatment.
- Laboratory tests.
- Physical therapy.
- Anesthesia and its administration.
- Processing and administering of blood and blood plasma to the extent it is not donated or replaced by or for the patient.
- Chemotherapy.
- Renal dialysis therapy administered according to Medicare regulations.
- Dental care due to accidental bodily injury or oral dental surgery when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition.
- Ground transportation in an ambulance to the hospital when medically necessary and when the patient is admitted. Air ambulance charges are also covered for:
  - Transportation from a remote area to the first, nearest hospital where treatment can be given.
  - Transportation to a hospital in the event of a life-threatening accidental injury or sudden, life-threatening illness.

In addition, the medical plan covers the following physician services during inpatient hospitalization:

- Up to one hospital visit per day by the admitting physician, and up to one visit per day by a physician treating another condition, until the day of surgery.
- Administration of anesthesia, when administered by a certified nurse anesthetist or a physician other than the operating surgeon or assistant surgeon.

For all covered expenses, the medical plan pays a lifetime maximum of $1 million (adjusted annually) for each covered person. However, this includes smaller special limits for treatment of mental illness and substance abuse and for hospice care.

- Services of a radiologist or pathologist.

Special outpatient benefits

After the deductible is met, the plan pays 100% of covered expenses for the following services provided by a hospital's outpatient department, in an ambulatory surgical facility or in a physician's office:

- Services provided within five days of an accidental injury.
- Treatment in connection with and on the same day that outpatient surgery is performed.
- Emergency medical treatment if you are confined to the hospital within 24 hours of outpatient medical treatment.
- Pre-admission testing that is required for a hospital admission, if performed within seven days of the scheduled admission.

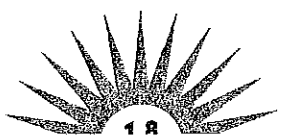
The plan also covers the following physician services in connection with outpatient care:

- Administration of anesthesia, when administered by a certified nurse anesthetist or a physician other than the operating surgeon or assistant surgeon.
- Services of a radiologist or pathologist.
- Services of an emergency room physician.

Surgical benefits

After the deductible is met, the plan pays 100% of usual and customary covered expenses for the surgical services described in this section, when performed on an outpatient basis or during a hospital stay that has been approved by CCO, as explained on page 11.

- Surgical procedures, including customary preoperative and postoperative services, performed by a physician or surgeon. (Voluntary sterilization surgery is covered but reversal of sterilization surgery is not.)
- The necessary services of an assistant surgeon who actively assists the physician in surgery when:
  - You or your covered dependent is hospitalized.
  - The type of surgery requires assistance.
  - The services of interns, residents or house officers are not available.
  - Payment for assistant surgeons will be at 25% of the primary surgeon's usual, customary and reasonable charge.
- Medical supplies required for surgery in a hospital, a hospital's outpatient department, a physician's office or a freestanding ambulatory surgical facility.
- When more than one surgical procedure is performed at the same operative session and *through the same incision,* payment for the secondary procedures will be limited to 50% of the usual, customary and reasonable charge that would apply if the procedures were performed independently. However, additional charges for "incidental surgery" are not covered. Incidental surgery is a procedure that



is usually included in the primary surgery charge.

- Oral dental surgery due to an accident, impacted teeth or alveolectomy.
- Surgical benefits for the following procedures may be covered, subject to approval by CCO:
  - Surgery for treatment of temporomandibular joint dysfunction (TMJ) if necessary to reorient the joint.
  - Reduction mammoplasty, if medically necessary (not cosmetic).
  - Obesity, if you or your covered dependent is 160% or more of the desirable weight and conservative therapies have been tried and proven unsuccessful, and CCO has given prior authorization for the surgery.
  - Cosmetic or reconstructive surgery required for:
    - Repair of defects resulting from an accident that occurred while the patient was covered under the plan.
    - Replacement of diseased tissue that was surgically removed while the patient was covered under the plan.
    - Treatment of a birth defect.

Managed second surgical opinion

To reduce the risk of unnecessary surgery, the medical plan has a managed second surgical opinion program as an optional benefit. If your physician recommends surgery, you may call CCO to see whether a second opinion is recommended. CCO will consult with a consulting physician and make a recommendation.

If CCO recommends a second surgical opinion, the medical plan will cover 100% of the usual, customary and reasonable charge for the second opinion, after the deductible.

Expenses for a second or third surgical opinion that is not recommended by CCO are covered at 80% after the deductible.

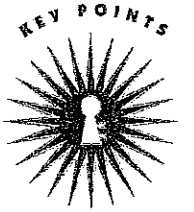
Prescription drug benefits

All benefits for prescription drugs are provided through your local participating provider pharmacy network. You are free to obtain your prescriptions from pharmacies that are members of the participating provider pharmacy network, or from non-network pharmacies. However, your benefits are paid through PCS Health Systems, Inc., and they are higher if you use participating pharmacies. No deductible applies, and benefits are paid as follows.

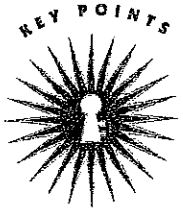
Participating provider pharmacy network

Pharmacies participating in the network have agreed to provide discounts for employees covered by the company medical plan. You can also save money by using generic drugs instead of brand names when possible—when your doctor gives you a prescription, ask if generic substitution is an option.

When you fill a prescription at a participating pharmacy, the plan will pay 85% of the cost of a brand-name drug, or 90% of the cost of a generic drug. Additionally, you may not have to file a claim when using a participating pharmacy—the pharmacy will usually file the claim directly



When you fill a prescription at a participating pharmacy, the plan will pay 85% of the cost of a brand-name drug, or 90% of the cost of a generic drug.



Note that not all pharmacies displaying the PCS logo are included in the participating pharmacy network. You may obtain a list of participating pharmacies from your benefits department.

Only prescription medicines and certain diabetic supplies are eligible for prescription drug benefits. Some prescription drugs require prior approval from CCO.

with PCS for reimbursement. Simply show your health plan ID card to the pharmacist, and you will pay only your percentage share that applies to the discounted price for the drug.

Note that not all pharmacies displaying the PCS logo are included in the participating pharmacy network. You may obtain a list of participating pharmacies from your benefits department.

Nonparticipating pharmacies

If you purchase prescriptions from a pharmacy that's not a member of the participating provider pharmacy network, you will have to pay the full cost of the drug up front and file a claim for reimbursement through PCS.

The plan pays 80% of the cost of brand-name or generic prescription drugs purchased from a nonparticipating pharmacy. Since you pay 20% of the cost of the drug, you can still save money by talking to your doctor about using lower-cost generic drugs whenever possible.

You can obtain prescription drug claim forms from your benefits department.

Covered drugs

Only medications and drugs requiring a written prescription from a physician and dispensed by a licensed pharmacist are covered—plus insulin and diabetic supplies such as syringes, lancets and glucose sticks.

The plan does not cover expenses for:

- Cosmetic products (such as topical applications for treatment of acne or wrinkles). If a drug such as Retin-A is prescribed for a person over age 26, you will be required to furnish proof of medical necessity.
- Any drug that is experimental or investigational, or one that is being used for a treatment that has not received final approval from the FDA.
- Any drug covered by workers' compensation.
- Digestive aids (unless they are needed to sustain a patient's life), minerals or other dietary supplements, taken orally or injected, regardless of whether they are prescribed by a physician. However, vitamins prescribed for certain conditions, such as prenatal vitamins, may be eligible if approved by CCO.
- Prescriptions for birth control devices or birth control pills (unless these are being used for other than contraceptive purposes, and pre-approval has been given by CCO).

Certain drugs require prior approval from CCO. If your doctor prescribes any of the following, you must contact CCO at 1-800-848-2625 and receive a prior authorization before the plan will pay benefits for:

- Contraceptive medication. (Covered only with specific diagnosis and when medically necessary. Drugs used for birth control are not covered.)
- Smoking-cessation aids.
- Prescription vitamins.
- Rogaine or Minoxidil.

- Retin-A.
- Anorectics.
- Growth hormones.
- Fertility drugs.

If you have other group health coverage for prescription drugs—through your spouse's employer, for example—refer to the *Claims procedures* section on page 33 for information about how to submit your claims.

Home health care

The medical plan pays for home health care that follows inpatient hospital treatment if approved in advance through CCO. (See the section called *How to contact Coordinated Care Options* on page 14.) For home health care that is a necessary alternative to continued hospitalization, the plan pays 100% of covered expenses after you meet the annual deductible.

Eligible expenses from an authorized home health care agency include:

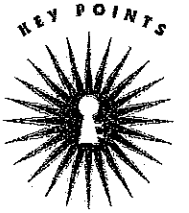
- Part-time or intermittent nursing services.
- Physical, occupational or speech therapy.
- Medical and surgical supplies that would also be covered as a hospital inpatient expense.
- Prescription drugs for IV infusion therapy or injections.

However, the following coverage limitations apply:

- The home health care must be for the continued treatment of the same condition for which the patient has already received inpatient care. It must begin within 21 days after the patient is discharged as an inpatient from a hospital or skilled-nursing facility, for treatment that was covered by the plan.
- The home health care must be provided according to a plan of treatment established by the patient's physician and approved through CCO.
- The patient must be homebound for health reasons, but the patient may leave home occasionally to obtain outpatient hospital care that cannot be provided at home, or to obtain care from a licensed health care professional.

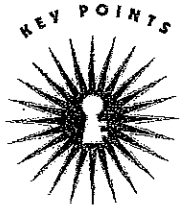
Benefits for home health care are not provided for:

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



The medical plan pays for home health care that follows inpatient hospital treatment if approved in advance through CCO.

For home health care that is a necessary alternative to continued hospitalization, the plan pays 100% of covered expenses after you meet the annual deductible.



After you meet the deductible, the plan pays for 100% of the cost of hospice care or care in a skilled-nursing facility, subject to limitations.

Hospice care

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

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

After the deductible has been met, the plan pays 100% of the reasonable and customary charges for covered hospice care expenses that are described in this section. This is subject to the following special limitations:

- All hospice care benefits are limited to a lifetime maximum of $10,000.
- The care must be provided according to a physician's written treatment plan that has been approved in advance by CCO. (See the section called *How to contact Coordinated Care Options* on page 14.)
- Counseling for the family is covered up to a maximum of $200.

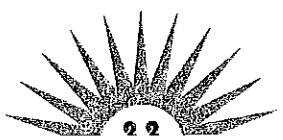
Benefits for hospice care are not provided for:

- Care given by volunteers who do not usually charge for their services.
- Pastoral services.
- Homemaker services (housecleaning, preparation of meals, etc.).
- Food or home-delivered meals.
- Care to prolong life.
- Expenses incurred by family members for temporary relief away from the patient (respite care).

Skilled-nursing facility

Care from an approved skilled-nursing facility is covered at 100% after the deductible. Benefits are subject to the following limitations:

- The care must be for the continued treatment of the same condition for which the participant previously received inpatient hospital care, and the patient must have been transferred directly to the skilled-nursing facility from the hospital.
- The care must be provided according to a physician's treatment plan and approved in advance by CCO. (See the section called *How to contact Coordinated Care Options* on page 14.)
- The care must require the skills of a registered nurse.
- The care must be likely to result in a significant improvement in the patient's condition. (Custodial care is not covered.)
- The degree of care must be more than can be given in the patient's home, but not so much as to require acute hospitalization.



Pregnancy

Necessary treatment of pregnancy is covered in the same way as an illness or injury for employees and covered spouses. All the provisions and limitations of the plan, including the pre-existing conditions limitation and the provisions of the Coordinated Care Options program, also apply to pregnancy.

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

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

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

Benefits for other medical services

After you've met the deductible, the plan pays 80% of the covered expenses listed in this section. Benefits increase to 100% of covered expenses after the out-of-pocket maximum is reached, as explained in the *Out-of-pocket maximum* section on page 15.

This section of the plan does not cover expenses that exceed the maximums given in other sections. For example, it does not cover expenses over the $50,000 maximum for treatment of mental illness and substance abuse, or the $10,000 maximum for hospice care.

The following expenses are eligible for benefits:

- Hospital expenses that aren't covered as inpatient or outpatient hospital benefits, such as chemotherapy, radiation therapy and kidney dialysis.
- Expenses you incur at your home, a clinic, or your physician's office for the professional services of a physician or surgeon, including consultations by a qualified specialist.
- Expenses you incur for the services of a physician's assistant or nurse practitioner.
- Expenses incurred for the services of a registered nurse (RN) or licensed practical nurse (LPN), when the skills of an RN or LPN are required.
- The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye.
- Preventive and wellness care services for:
  - Routine care for newborns and children under age 5, including routine immunizations.
  - Pap tests, mammograms, screenings for hypertension and diabetes, and examinations for cancer, blindness and deafness, and other screening and diagnostic procedures.
  - Routine physician examinations, except for examinations required for admission to a school or for participation in sports. Routine

Necessary treatment of pregnancy is covered in the same way as an illness or injury for employees and covered spouses.

immunizations are not covered after age 5, except for influenza vaccines.

- The fitting of diaphragms or the insertion or removal of an IUD. (Pharmacy charges for birth control pills or contraceptive devices are not covered.)
- Artificial insemination, when medically diagnosed as an appropriate treatment for infertility. However, the plan will cover artificial insemination for only one of the following, after which the plan will no longer pay benefits:
  - No more than three times within three consecutive cycles.
  - No more than a total of four attempts within a six-month period.

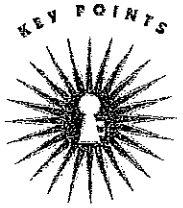
  In vitro fertilization and gamete-transfer procedures are not covered.
- Laboratory tests, radium therapy, X-rays and microscopic tests.
- Professional local ambulance services for transportation to a clinic, medical center, hospital for outpatient care, physician's office or skilled-nursing facility, when medically necessary.
- Blood and blood derivatives, to the extent they are not donated without charge or the hospital's supply is not replaced by or for the patient.
- Prosthetic appliances to replace missing or nonfunctioning parts of the body. Covered prosthetic appliances include:
  - Breast prostheses, internal and external (including a surgical brassiere, two per year), for reconstruction after a mastectomy.
  - Cardiac pacemakers, atomic or electronic.
  - Extraocular and intraocular lenses to replace either surgically removed or congenitally absent crystalline lenses of the eye.
  - Penile prosthesis in men suffering impotency resulting from an organic disease or injury.
  - Artificial eyes.
  - Artificial limbs.
  - Colostomy supplies and other equipment directly related to ostomy care.
  - Electronic speech aids after a laryngectomy.
  - Urinary collection and retention systems (Foley catheters, tubes, bags and so forth) in cases of permanent urinary incontinence.
  - Hearing aids for children under age 13 when medically necessary.

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

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

- Orthopedic devices, including:
  - Braces and trusses.
  - Custom-made and molded supportive orthotic appliances for the feet, when prescribed by a physician.
  - Custom-made shoes when prescribed by a physician.
  - Up to two pairs of surgical stockings per prescription in a six-month period, when prescribed by a medical physician for such conditions as thrombophlebitis, or conditions resulting from surgery.
- Rental of durable medical equipment for home use, up to its purchase price. CCO, at its option, may instead approve the outright purchase of the equipment if it is for long-term use.

  Home oxygen equipment, including stationary and portable oxygen systems, will be eligible for coverage according to Medicare guidelines up to the purchase price. Liquid oxygen systems, whether stationary or portable, must be approved by CCO in advance.
- Services of an inhalation therapist in the patient's home, under the orders of the attending physician.
- Physical therapy by a licensed physical therapist that is expected to produce significant improvement within a two-month period. Benefits will no longer be paid when care has become maintenance. When the therapeutic goals of the treatment plan have been achieved and/or when no more measurable progress is expected, benefits will cease. Physical therapy coverage for temporomandibular joint syndrome (TMJ) follows the same guidelines.
- Speech therapy, by a licensed speech therapist, to restore speech that has been impaired as a result of illness, surgery or injury. Speech therapy will also be covered after surgery to correct birth defects. Developmental delays in learning to talk, the perfection of speech and educational services are not covered.
- Occupational therapy for a physical or severe mental disability to restore the ability to perform ordinary tasks of daily living. Benefits will end when the therapeutic goals of a treatment plan have been achieved or when no more measurable progress is expected. Occupational therapy is not covered for most mental and chemical-dependency conditions.
- Cardiac rehabilitation for up to 12 weeks to restore health as much as possible, through exercise, education of the patient and reducing risk factors. To be eligible for benefits, cardiac rehabilitation must be provided within 12 months after one of the following:



The plan pays a lifetime maximum per individual of $50,000 for all covered treatment of mental illness and substance abuse (inpatient and outpatient).

- An acute myocardial infarction (heart attack).
- Coronary bypass surgery.
- Stable angina pectoris (heart-related chest pains).

- Biofeedback therapy, when reasonable and necessary for muscle re-education of specific muscle groups or for treating specific muscle abnormalities. This is not covered for treatment of ordinary muscle tension or for psychosomatic conditions.
- Treatment of temporomandibular joint syndrome (TMJ) to realign the joint, and removable appliances and splints when medically necessary. Services or supplies in connection with crowning, wiring or repositioning the teeth, such as orthodontia, are not covered.
- Dental care for the initial repair of an accidental injury to sound natural teeth that occurs while the patient is covered under this plan.
- Services of a Navajo medicine man who is certified by the office of Native Healing Services and the Navajo Health Authority, or the services of a Northern Cheyenne or Crow medicine man, up to $400 per covered individual per calendar year.

Mental illness and substance abuse

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

Inpatient mental illness and substance abuse

The medical plan covers inpatient mental illness and substance abuse programs for up to 30 days per individual per year, not to exceed $20,000. The annual deductible and the hospital copayment must be met. Also, the inpatient care must be approved by the Coordinated Care Options program, as explained on page 11.

Outpatient mental illness and substance abuse

For the first $1,000 of covered expenses, the medical plan pays 80% after the deductible is met. The plan pays 50% of the next $1,500 of covered services. Expenses over $2,500 per plan year are not covered. Your share of these expenses does not count toward the out-of-pocket maximum.

Lifetime maximum

The plan pays a lifetime maximum per individual of $50,000 for all covered treatment of mental illness and substance abuse (inpatient and outpatient).

Covered services

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

- Treatment for alcoholism and drug abuse for emergency detoxification or any medical treatment required following detoxification.

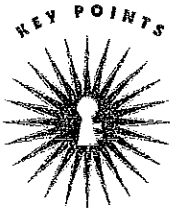
Drugs and medicines requiring the written prescription of a physician and dispensed by a licensed pharmacist will be covered under the prescription drug benefits, and are not subject to the limitations that apply to other treatment of mental illness and substance abuse.

EXCLUSIONS

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

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

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



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

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

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

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

- Any expenses that are not medically necessary for the treatment of an illness or injury.
- Procedures that are not needed when performed with other procedures, or unlikely to provide a physician with additional information when used repeatedly.
- Procedures that are not ordered by a physician, or not documented in timely fashion in the patient's medical record.
- Any services provided before the effective date of coverage, or after coverage ends.
- Services in connection with transsexual surgery.
- Accidental bodily injury or illness caused by war or any act of war, whether or not declared, including armed aggression, participation in a riot, or attempted felony or assault.
- Accidental bodily injury or illness that is covered by any workers' compensation or occupational disease law.
- Except as required by law, expenses from a U.S. government hospital or any other hospital operated by a government unit, unless there is an expense that the covered individual is legally required to pay.
- Services in connection with any treatment of the teeth, gums or alveolar process, except:
  - Dental care for the initial repair of an accidental injury to sound natural teeth that occurs while you are covered by this plan.
  - Oral dental surgery due to an accident, impacted teeth or alveolectomy.
  - Hospital expenses when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition.
- Surgery for the purpose of fitting or wearing dentures or dental implants.

- Any medical observation or diagnostic study when no illness or injury is revealed, unless you provide the claims administrator with satisfactory proof that the covered person had definite symptoms of illness or injury other than hypochondria. This limitation does not apply to benefits for preventive care services listed under *Benefits for other medical services.*

- Hearing aids (except for children under age 13), or for their prescription or fitting.

- Vision training, eyeglasses and contact lenses or examinations for their prescription or fitting, except:
  - The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye.
  - Contact lenses, as long as the contacts are for the replacement of the eye's lenses.
  - Vision training following eye surgery.

  (See page 32 of this booklet to see how vision exams, contact lenses and eyeglasses are covered by the vision plan.)

- Physical and speech therapy that is educational in nature.

- Supervised exercise programs that are not traditionally medical in nature, such as swimming, horseback riding, etc.

- Cosmetic treatment, except:
  - To repair defects resulting from an accident that occurred while covered under the plan.
  - Replacement of diseased tissue that was surgically removed while covered under the plan.
  - Treatment of a birth defect.

- Actual or attempted impregnation or fertilization that involves the covered individual as a surrogate or donor, or the pregnancy of a surrogate mother.

- Expenses in connection with assisted reproductive technology or "ART." ART means any combination of chemical or mechanical means of obtaining gametes and placing them in a medium (whether internal or external to the human body) to improve the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer or pronuclear state tubal transfer. Artificial insemination is covered by the plan, subject to the limitations described under *Benefits for other medical services.*

- Expenses for reversals of sterilization procedures.

- Home obstetrical delivery.

- Expenses for abortion, unless medically necessary to protect the life of the mother.

- Charges for more than one ultrasound test for a normal, uncomplicated pregnancy.

- Adoption expenses.
- Charges incurred as a result of a pregnancy of the daughter of an employee, disabled employee, retired employee or surviving spouse.
- Birth control devices or birth control pills, unless used for other than contraceptive purposes and approved by the plan.
- Digestive aids (unless they are needed to sustain a patient's life), vitamins, minerals or other dietary supplements, taken orally or injected, regardless of whether they are prescribed by a physician. Vitamins are covered only as described under Prescription drug benefits.
- Hypnosis and acupuncture.
- Naturopathic or holistic services.
- Massage therapy or rolfing.
- Treatment, instructions, or activities for control or reduction of weight, except medical treatment approved by CCO or surgery for morbid obesity as described under *Surgical benefits* on page 18.
- Expenses for telephone conversations with a physician in the place of an office visit, for writing a prescription, or for medical summaries and preparing medical invoices.
- Marriage counseling, encounter or self-improvement group therapy, and school-related behavioral problems.
- Treatment received from a person who is your close relative or ordinarily resides with the patient. A "close relative" means you, your spouse or a person related to you or your spouse as a brother, sister or parent.
- Services by a licensed chiropractor, whether or not the services are covered by the chiropractor's license.
- Any care that does not require the services of a specifically trained medical professional.
- Routine foot care, including but not limited to treatment of corns and calluses, and nonsurgical treatment of bunions.
- Eye surgery for a condition that could be corrected with lenses instead, including but not limited to radial keratotomy—unless it's the plan administrator's opinion that no other treatment is medically acceptable, and the plan administrator determines that the surgery is a generally approved procedure in the medical community as a whole.
- Expenses for an autopsy or postmortem surgery.
- Transportation for delivery of home health care.
- Dentures, replacement of teeth or structures directly supporting teeth.
- Electrical continence aids, anal or urethral.
- Wigs or hairpieces.
- Implants for cosmetic purposes.

- Penile prostheses for psychogenic impotence.
- Personal comfort or service items for use during confinement in a hospital, including but not limited to a radio, television, telephone and guest meals.
- Services or supplies not specifically listed under *Covered medical expenses*, including but not limited to:
  - Air conditioners, humidifiers, dehumidifiers, purifiers or tanning booths.
  - Over-the-counter orthopedic or corrective shoes.
  - Exercise equipment.
- Medical care, services or supplies for any injury that may have been caused by the act or omission of a third party, unless the covered individual has fully complied with the plan's subrogation provision. (See the section called *The plan's right to recover payment from third parties [subrogation] on page 38.*)
- Services or supplies related to a pre-existing condition, as explained in the section called *Limitations for pre-existing conditions* on page 8.
- Claims received more than 12 months after the date the services or supplies were received.

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

Your Vision Care Benefits

BENEFITS AT A GLANCE

The vision care plan pays 100% of the charges by a vision care provider, up to the benefit amount listed below:

CHARGES COVERED	MAXIMUM BENEFITS
VISION EXAMINATION (ONCE EVERY 24 MONTHS)	$20
LENSES (UP TO TWO LENSES EVERY 24 MONTHS)	(PER LENS)
SINGLE VISION	$10
BIFOCAL	$15
TRIFOCAL	$20
LENTICULAR	$25
CONTACT	$15
FRAMES	$14

The cost of new lenses is not covered unless the new prescription differs significantly from the last one. This means both of the following must apply:

- The new lenses improve vision by at least one line on the standard eye chart.
- The new lens prescription differs from the last one by an axis change of 20 degrees, or a sphere or cylinder change of .50 diopter.

EXCLUSIONS

The vision plan does not cover:

- Sunglasses other than tints Number 1 or Number 2.
- Extra charges for photosensitive or anti-reflective lenses.
- Drugs or medications (other than for a vision examination, or medical or surgical treatment of the eyes).
- Special procedures, such as orthoptics.
- Vision training.
- Aids for subnormal vision, aside from covered lenses and frames.
- Aniseikonic lenses and tonography.
- Services or supplies that are experimental, developmental or investigatory.
- Replacement of lenses or frames because they have been lost or broken, unless the replacement is eligible under the rules for prescription changes, or the lenses or frames have not been replaced for at least 24 months.
- Services or supplies that a licensed physician, optometrist or optician has not prescribed as necessary.

- Services or supplies for which the covered individual is entitled to benefits under the provisions of any other plan or under a mine safety-glass program.
- Services that are covered by any workers' compensation or employer's liability laws, or services that an employer is required to provide by law.
- Services or supplies obtained from any governmental agency without cost.

This is only a list of the more common limitations and exclusions. The plan reserves the right to limit or exclude other services or supplies and their charges.

Claims Procedures

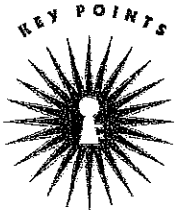
Claims must be filed within one year of the date you incur an expense. Blue Cross and Blue Shield participating providers and participating pharmacies will file their claims directly with the plan. For all other providers you must file a claim, using this process:

1. Obtain a claim form and envelope from your benefits department. Claims for prescription drugs must be filed using the PCS claim form.

2. Securely attach your itemized bills and/or prescriptions to the claim form. Check your bills to make sure the information on the bill includes the:
   - Patient's name.
   - Diagnosis (for medical claims).
   - Date and type of service.
   - Itemized charges.
   - Name of the provider, provider number and address.

   Do not send cash register receipts, balance-due statements, proof-of-payment receipts, or canceled checks in place of an itemized bill.

3. Be sure to sign the claim form and complete all the sections that apply.



Claims must be filed within one year of the date you incur an expense.

Blue Cross and Blue Shield participating providers and participating pharmacies will file their claims directly with the plan. For all other providers you must file a claim.

Prescription drug claims must be submitted to PCS at the address shown on the PCS claim form. A separate claim form is required for each family member.

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

If you use a nonparticipating provider and provide proof that you've paid that provider in full, the benefit payment will be made to you. Otherwise, payment will go directly to your provider.

4. If you or your dependents are covered by another medical or vision plan that is the primary payer, you must attach a copy of the other plan's explanation of benefits to your bill before submitting it. Refer to the *Coordination of benefits section* for more information.

   Remember—you should keep a copy of all bills you submit.

5. Submit medical and vision claims to the address shown on the medical claim form.

Prescription drug claims must be submitted to PCS at the address shown on the PCS claim form. A separate claim form is required for each family member.

However, if you also have prescription drug coverage through another plan that is your primary plan (as described in the *Coordination of benefits* section), you must submit your claim for secondary benefits from our plan to:

Alliance Blue Cross Blue Shield
P.O. Box 66952
St. Louis, Missouri 63166-6952
Attention: COB Drug Department

It is very important to remember to address your claim to the COB Drug Department in order for it to be processed in a timely manner.

Remember that before any hospital admission, you must call the Coordinated Care Options program (CCO) for precertification. The telephone number is on the back of your ID card. You must also call CCO within two working days of any emergency hospitalization.

If any part of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things you can do to appeal the decision. Most of your questions can be answered quickly and efficiently by either calling or writing the claims administrator. Formal claim-review procedures are discussed in the *Plan administration information* section of this booklet.

PAYMENT OF BENEFITS

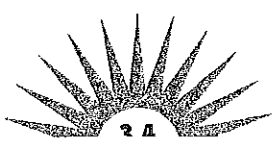
If you use a participating provider, the benefit payment will be made directly to the provider.

If you use a nonparticipating provider and provide proof that you've paid that provider in full, the benefit payment will be made to you. Otherwise, payment will go directly to your provider.

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

RECOVERY OF EXCESS PAYMENTS

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



THE PLAN'S RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

The plan may provide or obtain any information necessary to carry out the plan's provisions, without having to give any person notice or obtain anyone's agreement. When you submit a claim for benefits, you must provide all the information needed to carry out the plan's provisions.

PAYMENT OF BENEFITS TO PERSONS OTHER THAN YOU

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

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

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

LEGAL DEFENSE AGAINST EXCESSIVE FEES ("HOLD HARMLESS" PROVISION)

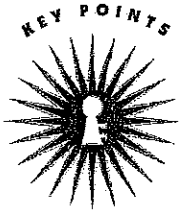
If a provider attempts to collect expenses that either exceed the usual, customary and reasonable level or are not considered medically necessary, the plan administrator may—with your written consent—attempt to resolve the matter by either:

- Negotiating a resolution with the provider.
- Defending you and the plan against any legal action the provider may begin.

If the plan administrator takes any action, you will not be responsible for any legal fees, settlements, judgments, or other expenses the plan administrator incurs to resolve the matter. (Legally, you are said to be "held harmless" for these responsibilities.) The plan administrator will control the negotiation or legal defense, including decisions whether to settle the claim or to appeal any legal decisions. However, you may be liable for any services or supplies from the provider that are not covered by the plan.

RIGHT TO AUDIT

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



The plan may provide or obtain any information necessary to carry out the plan's provisions.

Coordination of Benefits

If you or your dependents are covered by more than one group health plan, the company's medical and vision plans contain a coordination of benefits provision to prevent duplicate payments of benefits.

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

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

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

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

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

would normally pay, then the company plan will pay the difference. For example:

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

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

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

PRIMARY COVERAGE FOR ACTIVE EMPLOYEES WHO ARE ELIGIBLE FOR MEDICARE

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

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

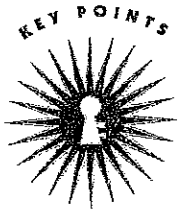
For individuals entitled to Medicare because of end-stage renal disease, after 18 months of coverage the company plan will be secondary and Medicare will be primary.

EFFECT OF MEDICARE ON BENEFITS FOR RETIRED AND DISABLED EMPLOYEES

For retired employees who are eligible for Medicare, as well as their dependents covered under the company plan, Medicare is the primary plan and the company plan is secondary. Medicare is also the primary plan for disabled employees who are covered by both Medicare and the company plan because of a long-term disability.

If you or any of your dependents are eligible to receive benefits under Medicare, the company plan's benefits will be reduced by the amount of Medicare's benefits for the same claim. This is the same way the plan coordinates with other group health plans that are primary, as explained at the beginning of the *Coordination of benefits* section.

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



Employees who are retired or on long-term disability should enroll for Medicare coverage as soon as they are eligible.

Your benefits will be reduced in this manner if you are eligible for coverage under Medicare Parts A and B, even if you are not enrolled in both parts of Medicare. The company plan's benefits will still be reduced by the amount that Medicare *would* have paid if the patient had enrolled for coverage and had made a claim under Medicare. *For this reason, employees who are retired or on long-term disability should enroll for Medicare coverage as soon as they are eligible. Medicare provides a special enrollment period for employees who are covered by an employer-sponsored group health plan when they stop working. Contact your Social Security office for more information. You and your covered dependents are responsible for all Medicare premiums for both Parts A and B.*

THE PLAN'S RIGHT TO NECESSARY INFORMATION

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

THE PLAN'S RIGHT TO MAKE PAYMENTS TO OTHER ORGANIZATIONS

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

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

THE PLAN'S RIGHT TO RECOVER PAYMENT FROM THIRD PARTIES (SUBROGATION)

This provision applies if the plan pays benefits because of an injury for which a third party may be liable (such as in an auto accident caused by a third party). In such cases, you have the right to pursue a claim for damages against the third party. If you fail or refuse to pursue the damage claim against the third party, the plan is entitled, if it chooses, to pursue the claim directly against the third party in order to recover the benefits the plan paid.

If either you or the plan obtains payment from the third party, the plan is entitled to be paid back for the benefits it paid on your behalf.

In addition, the plan is not obligated to pay benefits for any medical expenses for which a third party may be liable, unless you or someone legally authorized to act for you promises in writing to:

- Include the medical expenses in any claim that you or your dependents make against a third party for the injury or condition.

- Reimburse the plan for any benefit payment that you or your dependents receive from a settlement with a third party. You must make this reimbursement within 30 days of receiving the settlement.
- Cooperate fully with the plan in asserting its rights to attempt recovery of payments, and supply the plan with any information and fill out any forms needed for this purpose.

If you or your dependents fail or refuse to complete or sign any document requested by the plan, the plan will no longer be obligated to pay any benefits for the injury or condition.

When Coverage Ends

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

- The plan is terminated.
- Your employment ends.
- The date you no longer meet the definition of an eligible employee. Medical coverage will be continued if you are an eligible disabled employee or eligible retired employee, as defined on pages 44 and 45. However, vision benefits end when you retire or become eligible for benefits under the company's long-term disability plan.

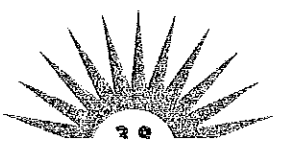
Coverage for your dependents will end on the date the earliest of the following occurs:

- Your dependents are no longer eligible.
- Your coverage ends.
- You die.

COVERAGE WHILE ON LEAVE OF ABSENCE

Your medical and vision coverage will be continued while you are on an approved leave of absence according to the company's family and medical leave policy.

If you fail to return to work at the end of your leave, you may be required to pay



back the company for its cost for providing coverage during your leave. However, you will not be required to repay the company if the reason you don't return is due to a serious health condition that would entitle you to leave under the Family and Medical Leave Act, or other circumstances beyond your control.

For any other leave of absence, your coverage will end during the leave unless you elect coverage under COBRA, or you are eligible for coverage as a disabled employee, as defined on page 44.

IF THERE IS A REDUCTION IN THE WORK FORCE

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

This provision does not apply to vision coverage.

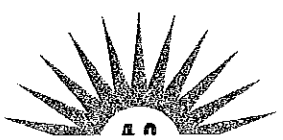
FOR SURVIVING SPOUSES AND DEPENDENT CHILDREN

For the medical plan only: In the event of your death, your surviving spouse and children may continue their medical coverage as described below:

- If you are an active employee or disabled employee and on the date of your death you would have met the definition of a retired employee, your surviving spouse's coverage will continue until his or her death or remarriage. Otherwise, your surviving spouse's coverage will continue only for the rest of the month of your death plus three additional months. Dependent children are eligible for as long as the surviving spouse is eligible and they continue to meet the plan's definition of a dependent child.
- If you are either an eligible retired employee who chose a joint-and-survivor option for receiving pension benefits, or a retired employee who retired after August 31, 1977, your surviving spouse's coverage will continue until his or her death or remarriage. However, your spouse is eligible for the benefit only if he or she was covered by this plan on your retirement date and during the entire year before your death.

  Dependent children are eligible for as long as the surviving spouse is eligible, and they continue to meet the plan's definition of a dependent child.

This provision does not apply to vision coverage.



Continuation of Coverage

Under the law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your dependents may continue company-provided group health coverage (including medical and vision coverage) if it ends for certain reasons. To be eligible, you must follow several requirements described by the law.

If you qualify for coverage under COBRA, the law requires the company to continue coverage for certain minimum periods. You may enroll for COBRA coverage only if your coverage has not already been extended for the minimum period under some other plan provision.

ELIGIBILITY FOR CONTINUED COVERAGE

You or your dependents may continue medical and vision coverage for up to 18 months if coverage ends due to either a reduction in the number of hours you work, or the termination of your employment for any reason other than gross misconduct.

Your dependents may continue their medical and vision coverage under this plan for up to 36 months if their coverage ends for any of the following reasons:

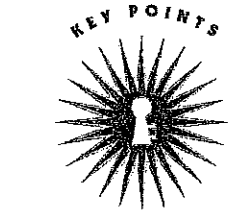
- Divorce or legal separation.
- Your death.
- You become entitled to Medicare.
- Your dependent child reaches the age limit or otherwise ceases to qualify as a dependent.

These periods of continued coverage begin on the date of the event that caused the loss of eligibility—for example, on the date you leave the company, or the date a dependent becomes ineligible. No more than a total of 36 months of continued coverage will be provided to any individual, even if more than one of these events occur.

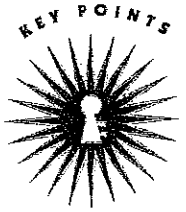
EXTENSION OF COVERAGE IF DISABLED

Continued coverage may be further extended if you or your dependent is totally disabled on the date coverage ends due to a reduction in hours worked or termination of your employment. The maximum coverage period for the disabled individual will be 29 months, instead of 18 months.

To be eligible for the extension, the disabled person must meet the definition of disability under the Social Security Act. He or she must notify the benefits department during the first 18 months of continued coverage, and within 60 days after the date the Social Security Administration has determined that he or she is disabled. (The disabled person must also notify the benefits department within 30 days after the Social Security Administration determines he or she is no longer disabled.)



Under the law, you and your eligible dependents may be able to continue company-provided medical and vision coverage, if it ends for certain reasons.



If you choose to continue coverage under the plan, you must pay the full cost of that coverage on a monthly basis, plus any additional administrative costs as permitted by law.

WHEN CONTINUED COVERAGE ENDS

Continued coverage ends automatically if any one of the following occurs:

- The cost of continued coverage is not paid by the date it is due.
- A person becomes covered under another group health plan, unless coverage under the other plan is limited due to the individual's pre-existing condition. Please notify your benefits department immediately if you or a dependent becomes covered under another group health plan.
- An individual becomes entitled to Medicare.
- The plan terminates for all employees.
- The applicable maximum coverage period ends.

APPLYING FOR CONTINUED COVERAGE

You or your eligible dependents have the responsibility to inform the benefits department within 60 days in the event of a divorce, legal separation, or when a child no longer qualifies as a covered dependent under the plan.

After the benefits department has been informed of any of these events—or if your employment ends, you retire, or you die—you and your eligible dependents will be notified of the right to choose continued coverage. This notification will include instructions to help you enroll and will tell you the required costs. You must submit your election form within 60 days of the date coverage would otherwise end, or the date you are notified, whichever is later. If continued coverage is not chosen, or if the premium is not paid within 45 days of the date the choice is made, coverage will not be extended beyond its usual ending date.

COST OF CONTINUED COVERAGE

If you choose to continue coverage under the plan, you must pay the full cost of that coverage on a monthly basis, plus any additional administrative costs as permitted by law.

BENEFITS UNDER CONTINUED COVERAGE

Aside from the special rules that apply specifically to COBRA continuation, continued coverage will be exactly the same health coverage you or your dependent would have been entitled to if your employment or his or her dependent status had not changed. Any future changes in benefits or the cost of coverage for the plan also will apply to you.

Converting Medical Coverage to an Individual Policy

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

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

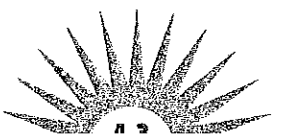
Furthermore, the benefits available under an individual insurance policy are not necessarily the same as the benefits offered under the company's medical plan. You should examine the new individual policy carefully.

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

Vision plan coverage cannot be converted to an individual policy.

You may be able to convert your medical (but not vision) coverage to an individual policy if it otherwise ends.

You pay the premiums.



Key Terms

AMBULATORY SURGICAL FACILITY

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

CLAIMS ADMINISTRATOR

The organization retained by the company for granting or denying claims, currently Alliance Blue Cross Blue Shield for medical and vision claims, and PCS for prescription drug claims.

COMPANY

Peabody Holding Company, Inc., and its subsidiaries and affiliates.

However, the plan does not cover:

- Former salaried employees of Eastern Associated Coal Corp. or NuEast Mining Corp. who are retired employees with an effective date before March 1, 1990, as described in these definitions.
- Disabled salaried employees of Eastern Associated Coal Corp. or NuEast Mining Corp. who are receiving benefits under the Eastern Gas and Fuel Associates long-term disability plan on March 31, 1987.

CUSTODIAL CARE

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

DISABLED EMPLOYEE

Any employee who is receiving company-paid salary continuance or receiving benefits under the company's long-term disability plan for salaried employees.

DURABLE MEDICAL EQUIPMENT

Equipment that meets all of the following conditions:

- It can withstand repeated use.
- It is primarily and customarily used in the therapeutic treatment of sickness or injury.
- It is generally not useful to a person in the absence of a sickness or injury.

- It is appropriate for use in the home.
- It is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature.
- It is not primarily for the convenience of the person caring for the patient.
- It is not used for exercise or training.

EDUCATIONAL INSTITUTION

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

ELIGIBLE RETIRED EMPLOYEE

A former salaried employee who has stopped working for the company because of retirement on or after January 1, 1970, and within 31 days of leaving the company begins to receive a retirement benefit from the company's retirement plan.

To be considered a retired employee for the purposes of the medical plan, you must be one of the following:

- Age 55 with at least 10 years of service.
- A totally and permanently disabled salaried employee with at least 10 years of service. Your disability must be approved by the Social Security Administration as eligible for Social Security disability benefits.

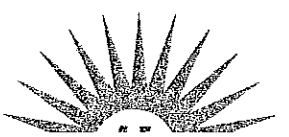
  In this case, you will be considered a retired employee only as long as the total and permanent disability continues. This is subject to verification by the company from time to time until you reach age 65. If you refuse to cooperate in verifying such a disability, you will no longer be considered a retired employee until you agree to cooperate and the verification is made.

  Retired employees are not eligible for vision coverage.

EMPLOYEE

Any full-time salaried employee of the company who is scheduled to work at least 30 hours per week, or is considered to be a full-time salaried employee while on vacation, prepaid retirement or assignment by the company, and who is not a disabled employee or retired employee.

This definition does not include any part-time or temporary employees, or any person who is a non-resident alien and who receives no income from the company that constitutes income from sources within the United States as defined by Section 861(a)(3) of the Internal Revenue Code.



HOME HEALTH CARE

Services provided by either:

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

HOME HEALTH CARE AGENCY

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

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

HOSPITAL

An institution that meets all of the following conditions:

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

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

- A facility approved by the claims administrator for inpatient or outpatient treatment of chemical abuse.
- Psychiatric hospitals classified and accredited by the Joint Commission on Accreditation of Healthcare Organizations.

- A residential treatment facility, if approved by the Coordinated Care Options program when necessary treatment cannot be provided while the patient is living at home.

ILLNESS

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

INJURY

An accidental bodily injury caused directly and exclusively by sudden and violent means, and is not self-inflicted.

MEDICALLY NECESSARY

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

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

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

MEDICARE

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

MENTAL ILLNESS

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

PHYSICIAN OR SURGEON

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

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

PRE-EXISTING CONDITION

An injury or illness for which you or your covered dependent consulted with a physician, received treatment or took prescribed drugs or medicines in the three months before your coverage became effective, or any conditions related to that injury or illness.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

REGISTERED PSYCHOLOGIST

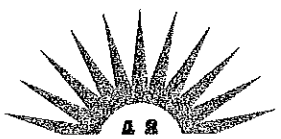
A person providing registered psychological services for diagnosis or treatment of mental, psychoneurotic or personality disorders. The psychologist must qualify in the jurisdiction in which he or she is practicing in the following ways:

- If state licensing or certification exists, he or she must hold a valid license or certificate as a psychologist.
- If state licensing or certification does not exist, he or she must hold a valid, nonstatutory (professional) certification established by that area's recognized psychological association.
- If neither statutory or nonstatutory licensing or certification exists, the psychologist must hold a statement of qualification by a committee established by that area's psychological association. If no committee exists, he or she must hold a diploma in the appropriate specialty from the American Board of Examiners in Professional Psychology.

SKILLED NURSING FACILITY

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

- Operate legally in the area it is located.



- Be accredited as a skilled-nursing facility by the Joint Commission on Accreditation of Healthcare Organizations.
- Be under the full-time supervision of a licensed physician or registered nurse.
- Regularly provide room and board.
- Provide 24-hour-a-day skilled-nursing care.
- Maintain a daily medical record of each patient under the care of a physician.
- Be authorized to administer medications ordered by a physician.

Skilled-nursing care is covered only as an alternative to hospitalization.

SPOUSE

Your legal partner in marriage by a civil or religious ceremony. Common-law marriage is not recognized by the plan.

SURVIVING SPOUSE

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

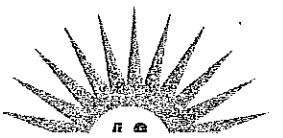
TERMINATION OF EMPLOYMENT

Includes any of the following:

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

VISION CARE PROVIDER

A licensed optometrist, optician or ophthalmologist acting within the scope of his or her license.



Plan Administration Information

PLAN NAME

The Peabody Group Health and Life Plan for Salaried Employees.

TYPE OF PLAN

Life insurance, accidental death and dismemberment, medical, dental and vision care benefits. Life insurance, accidental death and dismemberment, and dental benefits are described in a separate booklet.

EMPLOYER IDENTIFICATION NUMBER

The employer identification number assigned to the company by the Internal Revenue Service is 13-2871045.

PLAN NUMBER

501

EFFECTIVE DATE

June 1, 1985

LAST AMENDED

March 1, 1990

PLAN FISCAL YEAR

January 1 to December 31

PLAN SPONSOR

Peabody Holding Company, Inc., and its subsidiaries and affiliates.

You may direct correspondence to:
Peabody Holding Company, Inc.
701 Market Street, Suite 700
St. Louis, Missouri 63101-1826

PLAN ADMINISTRATOR

Peabody Holding Company, Inc.
701 Market Street, Suite 700
St. Louis, Missouri 63101-1826

AGENT FOR SERVICE OF LEGAL PROCESS

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

Peabody Holding Company, Inc.
701 Market Street, Suite 700
St. Louis, Missouri 63101-1826

Your ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan members shall be entitled to:

- Examine, without expense, at the plan administrator's office and at other specified locations, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The plan administrator may make a reasonable charge for copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

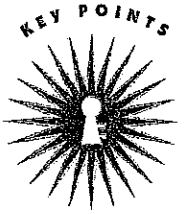
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan administrator review and reconsider your claim.

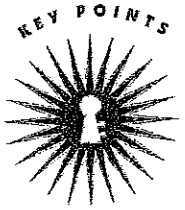
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If you believe that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator.



Under the law, you have certain rights as a participant in this plan.



If your claim is denied or you disagree with the handling of a claim, you have a right to appeal the decision.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the U.S. Labor Management Services Administration, Department of Labor.

IF YOUR CLAIM IS DENIED

If your claim is denied in whole or in part, you will be notified in writing within 90 days after your claim is received. The written notice will include:

- The specific reasons for the denial.
- A specific reference to the plan provisions on which the denial is based.
- A description of any additional material necessary to approve your claim.
- An explanation of the plan's claim review procedures.

Under special circumstances, a response to your claim may take more than 90 days. If such an extension of time is needed, you will receive written notice before the end of the 90-day period. The time will not be extended by more than 90 days.

The plan intends to respond to your claim promptly. The fact that you do not have a response within 90 days does not mean that your claim is being ignored. However, if you do not receive a response within 90 days, allowing reasonable time for mailing, you may proceed to the claim review stage.

Within 60 days of receiving a written notice that your claim has been denied, you or your authorized representative (such as an attorney) may submit a written request for review. In your request, state the reasons you believe the claim should not have been denied and submit any additional supporting information, material or comments which you consider appropriate. You may also review any pertinent plan documents.

The plan administrator will make a decision on the review within 60 days after receiving your request. If more time is needed, you will be notified within 60 days. A decision will be made as soon as possible, but no later than 120 days after you first make the request for review.

The decision on the review will be in writing and will include the specific reasons for the decision, as well as specific references to the appropriate plan provisions on which the decision is based. The decision of the plan administrator is final.

AMENDING THE PLAN

The plan is adopted with the intention that it will be continued for the benefit of present and future employees and retired employees of the company. However, the company reserves the right to terminate the plan, change required contributions, or modify this plan in whole or in part at any time or for any reason, including changes in any and all of the benefits provided. This may cause employees and retired employees to lose all or a portion of their benefits under the plan, but will not affect the right of any employee or retired employee to be reimbursed for any covered expense that has already been incurred.

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