EASTERN ASSOCIATED COAL CORP.

MEDICAL, DENTAL AND LIFE INSURANCE BENEFITS

For salaried employees retired before March 1, 1990

Old EACC Retiree Plan (after Medicare Elig, Supp to Med Only)
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This booklet provides information about who is eligible to participate in the medical, dental and life insurance plan for salaried Eastern Associated Coal Corp. (EACC) employees who retired before March 1, 1990. It also contains information on when coverage under the plans begins, end and continues. The company intends to maintain this plan for retired salaried employees, but reserves the right to change or end the plan at any time. Finally, it includes sections on coordination of benefits and administrative procedures that apply to most employer sponsored benefit plans.

This booklet serves as a summary plan description (SPD). It serves as the official plan document until it is amended or superseded. The plan administrator, Peabody Holding Company, Inc. maintains the right to interpret the terms of the plan, and its interpretations will be final.

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MEDICAL BENEFITS

4This section of your booklet describes the main features of your medical plan.

ELIGIBILITY AND ENROLLMENT FOR MEDICAL BENEFITS

For You: You are covered by this plan if you are an eligible retired employee of the company, provided you enrolled within 31 days of the date you retired. The plan currently requires no contributions for individual retiree coverage.

For your dependents: Your eligible dependents become covered by the plan at the same time you do provided they were enrolled within 31 days of your retirement date. There is currently no contribution required for you to cover your spouse. There is a small contribution required for you to cover your dependent children.

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. You may decide not to enroll your dependents for the EACC Health Care Plan because they have other coverage, such as through your spouse's employer. In this situation, the dependents may enroll in this plan, if the other coverage ends because either:

- You or your dependent are no longer eligible for the other coverage.
- Another employer stops making contributions towards the other coverage.
- The coverage was provided under a continuation provision of the law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and the right to this continued coverage has ended.

You must notify the Peabody Benefits Call Center at 800-633-9005 and complete an enrollment form within 31 days after the other coverage ends. Coverage will be effective on the first day of the month following enrollment.

Dependents who are eligible for coverage under this medical plan include:

- Your spouse, unless he or she is eligible for coverage as an employee of the company.
- Your unmarried children under age 19.
- 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 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. (Note: *No contribution is required to cover a disabled dependent child.*)

Children who are eligible as dependents include:

- Your natural child.
- 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. However, the plan does *not* cover:
  - A child temporarily living in your home
  - A child placed with you in your home by a social service agency that retains control of the child, or whose natural parent may exercise or share parental responsibility and control.
  - A child for whom you do not legally claim a federal income tax deduction.

Coverage for your children is available only while you or your spouse is covered by the plan. 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 retired employee may be covered as a dependent, and no one may be covered as a dependent of more than one retired employee.

LIMITATIONS FOR PRE-EXISTING CONDITION – MAJOR MEDICAL ONLY

Some of the expenses covered by the medical plan are called "major medical" expenses. In general, a major medical expense is a covered medical expense for which the plan does not pay 100% of covered charges. For major medical expenses, you pay a percentage of the covered costs, after meeting a deductible. (See *Major Medical Benefits* on page 13).

Major medical benefits from the medical plan are limited for a pre-existing condition. A pre-existing condition is an injury or illness, whether or not diagnosed, for which consultation or treatment (including prescribed drugs or medicine) was received during the six-month period before the effective date of medical coverage.

If you or your covered dependents have a pre-existing condition, major medical benefits for that condition or any related conditions will not be provided until one of the following occurs:

- The covered individual has not received treatment for the condition for three consecutive months after becoming covered by the plan.
- The covered individual has been continuously covered by the plan for 12 consecutive months. This 12-month waiting period is called the "exclusion period." It will be reduced by the amount of time the covered person had "creditable coverage" from another medical plan before being enrolled in this plan. This is explained in the next section.

The exclusion for pre-existing conditions does not apply to pregnancy. It also does not apply to your dependent child if both of the following are true:

- The child was enrolled in "creditable coverage" within 30 days of birth or placement for adoption.
- The child has not had a subsequent lapse of creditable coverage for a period of 63 or more days.

Coverage that a child had before placement for adoption is not taken into account.

Creditable Coverage

The 12-month exclusion period for pre-existing conditions will be reduced by the amount of time the covered person previously had "creditable coverage." A person receives creditable coverage for previous periods of coverage under other group medical plans, individual medical insurance and certain other state and federal health benefit programs.

Please note, however, that if a person went without creditable coverage for 63 or more consecutive days, any periods of creditable coverage before that lapse will not be counted. However, any time spent satisfying a group health plan's waiting period is not considered to be part of a lapse.

If you or a dependent have creditable coverage, you will be required to provide proof. You should contact your previous group health plan or health insurer to obtain a Certificate of Creditable Coverage or other appropriate documentation. If you need assistance, contact the Peabody Benefits Call Center at 800-633-9005.

WHEN MEDICAL COVERAGE ENDS

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

- The plan is terminated.
- The date of your death.

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

- The plan is terminated.
- Your dependents are no longer eligible.
- Your coverage ends.
  - In the event of your death, your surviving spouse may continue coverage (including coverage for your dependent children), provided he or she is not covered under another employer's health plan. There is no contribution required for your surviving spouse's coverage, but there is a contribution required for your children. This coverage (for both a surviving spouse and your children) will end on the date that your surviving spouse either dies, remarries or is covered under another employer's health plan. Once coverage ends for a surviving spouse, it cannot be reinstated.
- If the required contributions are not paid, the end of the month for which the last payment was made.
- For dependent children, the date you or your surviving spouse are no longer covered.

Refer to the section called *General provisions for both medical and dental benefits* for more information about continuing coverage.

MEDICAL BENEFITS FOR RETIREES AND DEPENDENTS WHO ARE NOT ELIGIBLE FOR MEDICARE

This section applies only if your or your dependents are not eligible for Medicare.

Annual Major Medical Deductible	$100 each covered individual per year; $200 per family
Inpatient hospital charges and outpatient hospital charges for accidents or surgery	100%
Surgical and Anesthetic	100%
Physician's Hospital Visits and Physician's Consultation	100%
Physician's Office and Home Visits	$5 per visit, up to a $50 maximum benefit per person per calendar year (any remaining expense will be considered under major medical)
X-Ray and Laboratory Examination and Radiation Therapy	100%
Emergency Accident	100% up to $25 per accident, with a calendar year maximum of $100 (any remaining expense will be considered under major medical)
Major Medical	80% after a $100 deductible per person ($200 per family) per calendar year[1]
Home Health Care (Up to plan limits)	100%
Prescription Drugs - Participating Retail Pharmacy - Nonparticipating Provider Retail Pharmacy - Mail Order Generic (90 day supply) - Mail Order Brand (90 day supply)	 90% for generic[2] - $5 minimum 85% for brand name[3] - $10 minimum 80%[2,3] $3 $15[2]

[1]*Exceptions apply to outpatient treatment of mental health conditions.*
[2]*If you or your doctor requests a brand-name drug when a generic equivalent is available you will be responsible for the generic coinsurance plus the difference in cost between the brand name medication and the generic medication.*
[3]*If you receive more than two fills of a brand-name maintenance drug from a retail pharmacy instead of using the Prescription Solutions Mail Service pharmacy, you will pay a $10 surcharge in addition to your regular coinsurance share of the cost for each additional retail fill.*

Participating Providers

Blue Cross Blue Shield has contracted with hospitals and physicians that have agreed to file your claims for you, and to charge fees that Blue Cross Blue Shield has determined to be at or below the "usual, customary and reasonable" amount. 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.

Prescription drug benefits are provided through the participating provider pharmacy program, as explained in the section *Prescription drug benefits* on Page 9.

Medical Services Advisory (MSA) Program

The Medical Services Advisory (MSA) program is administered by Blue Cross Blue Shield of Illinois. Under this program, you may contact MSA to verify that inpatient hospitalization will be considered "medically necessary" by the plan. MSA must also approve in advance hospice care and services provided by a skilled-nursing facility.

To contact MSA, call 800-325-4705. The MSA program cannot guarantee that the plan will pay benefits for your expenses. All the provisions and limitations of the plan will apply to your claim.

Covered Expenses

The medical plan will pay benefits only for the services and supplies listed in the following sections. The services and supplies must be prescribed or performed by a physician for the medically necessary treatment of an illness or injury that is not work-related, or pregnancy.

The medical plan provides benefits only for covered expenses that do not exceed the usual, customary and reasonable fees in the geographic area where the services or supplies are provided, as determined by Blue Cross 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. This provision is discussed in the section called *General provisions for both medical and dental benefits.*

Hospital Benefits

The plan pays 100% of the usual, customary and reasonable charges for the covered expenses listed below while a covered individual is either:

- Confined in a hospital as a bed-patient.
- Receiving treatment in the outpatient department of a hospital for accidental injuries or emergency illness (treatment must occur within seven calendar days of the accident or onset of the illness), surgery, or 23-hour observation.

No deductibles or copayments apply.

The expenses that are eligible for hospital benefits are:

- Hospital room and board expenses in a semi-private room, including expenses for intensive care units (if you are confined for at least 24 hours).
- Hospital room and board expenses in a private room, up to the most common daily rate charged by the hospital for a semi-private room.
- Charges by a hospital for miscellaneous services and supplies, other than room and board, required for treatment of the condition.
- Charges by a physician for anesthesiology, radiology or laboratory services.

- Charges for ambulance service to the nearest hospital where care and treatment of the injury or illness can be given, provided transportation by ambulance is medically necessary.

Charges for room and board and miscellaneous services and supplies will not be covered after the 365th day of any one period confinement.

Surgical Benefits

The plan pays 100% of the usual, customary and reasonable charges for the following surgical expenses if they are medically necessary due to injury or illness (no deductibles or copayments apply):

- The surgeon's fee for any one operation.
- An assistant surgeon's fee up to 25% of the usual, customary and reasonable fee from the operating surgeon.

Anesthetic Benefits

If you or your dependent have been administered an anesthetic by a physician or professional anesthetist in connection with a surgical operation (or another procedure for which a surgical expense benefit is paid under the plan), the plan will pay 100% of the usual, customary and reasonable charge for the administration of the anesthetics.

The physician or anesthetist who is administering the anesthetic must remain in constant attendance during the procedure for the sole purpose of rendering the anesthetic service.

Benefits are not paid for administration of local anesthetics, or for administration of anesthetics by the physician who is performing or assisting with the surgical procedure.

Physician's Hospital Visits

The plan pays 100% of the physician's charge for visits during hospital confinement, not to exceed the usual, customary and reasonable fee for each visit. This benefit does not cover visits related to an operation for which surgical benefits were paid, unless the treatment is by a physician other than the one who performed the operation.

Physician's Consultation Benefits

The plan pays 100% of the usual, customary and reasonable charges for one consultation of a "board certified specialist" during each period of hospital confinement. The attending physician must request the consultation in connection with the diagnosis of an injury or illness.

The term "board certified specialist" means a physician who has been certified by a board within the medical profession as a specialist in his or her field.

Benefits are not paid for any consultation required by hospital staff regulations and are limited to one consultation per specialty per hospital confinement. Usual, customary and reasonable charges for additional consultations are eligible for major medical expense benefits, subject to the deductible.

Physician's Office and Home Visits

The plan pays a benefit for physician's home or office visit charges. This benefit is also paid for office visit charges by a doctor of chiropractic (DC). Benefits are paid at 100%, up to $5 per visit, with a calendar year maximum benefit of $50 per person.

These benefits are not provided for X-rays, X-ray treatment, radium treatment, drugs, dressings or medicines.

Usual, customary and reasonable charges for office or home visits in excess of the $5 and $50 maximums and other physician's services are eligible for major medical expense benefits, subject to the deductible.

Benefits are not paid for visits related to an operation for which surgical benefits were paid, unless the treatment is given by a physician other than the one who performed the operation.

X-Ray and Laboratory Examination Benefits

The plan pays 100% of the usual, customary and reasonable charges for laboratory examinations or X-ray examinations performed while the covered individual is not confined in a hospital, provided they are medically necessary due to an illness or injury.

Radiation and Chemotherapy Benefits

The plan pays 100% of the usual, customary and reasonable charges made by a physician for chemotherapy, X-ray or radiation treatment of a proven malignancy or a non-malignant condition.

No benefits are paid for hospital charges, except that if outpatient treatment is administered by a physician who is an employee of the hospital, it will be covered as if the charges were from the physician, and not the hospital.

Emergency Accident and Emergency Illness (Physician's Services)

If you or your covered dependents are treated by a physician in a clinic or doctor's office for accidental injuries or emergency illness, the plan will pay 100% of the usual, customary and reasonable charges for the medical services listed below, up to a maximum benefit of $100 per calendar year per person.

This benefit is provided for the following services, provided they are received within seven days of the accident or onset of the illness:

- Medical treatment and supplies used solely for treatment of the injury or illness.
- Laboratory and X-ray examinations.

This benefit does not include expenses covered under the other provision of the plan. However, usual customary and reasonable charges in excess of the $100 maximum for this benefit will be eligible for major medical expense benefits subject to the deductible.

Home Health Care

The medical plan pays 100% of covered expenses for home health care that follows inpatient hospital treatment. The home health care must be a necessary alternative to continued hospitalization.

Eligible expenses from an authorized home health care agency include:

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

However, the following coverage limitations apply:

- The home health care must be provided according to a plan of treatment established by the patient's physician.
- The patient must be homebound for health reasons, but the patient may leave home occasionally to obtain outpatient 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.

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 for covered hospice care expenses at 100%. 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 MSA. (See page 5)
- 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).
- 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 MSA. (See page 5)
- The care must require the skill 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.

Prescription Drug Benefits

All benefits for prescription drugs are provided through a participating provider pharmacy network provided through the plan's pharmacy benefit manager, Prescription Solutions. You are free to obtain your prescriptions from pharmacies that are members of the Prescription Solutions network, or from non-network pharmacies. The deductible does not apply to prescriptions.

You can save money by using generic drugs instead of brand-name drugs when possible. When your doctor gives you a prescription, ask if generic substitution is an option. If you or your physician requests a brand-name drug when a generic equivalent is available, the plan requires that you pay your generic copayment plus the difference in cost.

Prescription Solutions Network Pharmacies

Pharmacies participating in the Prescription Solutions network have agreed to provide discounts for participants. When you fill a prescription at a network pharmacy, the plan will pay 90% of the cost of a generic drug after you pay at least a $5 minimum or 85% of the cost of a brand-name drug after you pay at least $10, up to a 30-day supply of each prescription. You will pay the difference in cost if you or your physician requests a brand-name drug when a generic equivalent is available. In no event will you pay more than the cost of the medication.

In general, you will not have to file a claim when using a network pharmacy. The network pharmacy will usually file the claim directly with the plan for reimbursement. Simply show your health plan ID card to the pharmacist, and you will pay only your coinsurance that applies to the discounted price for the drug.

To locate a network pharmacy near you, contact Prescription Solutions at ~~800-797-9791~~ 888.306.3243 or visit www.rxsolutions.com. To access the ~~800~~ toll free number and the Web site, you will need to enter your Prescription Solutions member number ~~(which is your Social Security number in most cases)~~ from your health plan ID card.

Non-Network Pharmacies

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

The plan will pay 80% of the cost of your medication obtained from a non-network pharmacy.

You can obtain prescription drug claim forms by visiting www.rxsolutions.com. or by calling Prescription Solutions at ~~800-797-9791.~~

Mail Service

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

Using the mail service allows you to receive up to a 90-day supply of your maintenance medication at a flat copayment. You pay $3 when you receive a generic medication and $15 each time you fill a brand name medication through the mail service.

To use the mail service program, you should ask your physician to write a prescription for up to a 90-day supply of your maintenance drug. Complete the order form; then mail the prescription, order form and your payment in the pre-addressed envelope. You may obtain an order form and instructions by visiting www.rxsolutions.com or by calling Prescription Solutions at 800-562-6223. Or ask your doctor to call that number for instructions on how to fax the prescription.

Like the retail program, if a brand-name drug is dispensed when a generic ~~drug~~ equivalent is available, you will be required to pay the generic copayment plus the difference in cost between the generic and brand name drug.

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

After your initial order, you can request a refill of the same prescription by visiting www.rxsolutions.com or by phone at 800-562-6223. To use this service, you'll need your Prescription Solutions member number (~~which is usually your Social Security number~~) from your health plan ID card and your credit card number.

Maintenance Medications

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

Prior Authorization

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

- Acne therapy medication for participants over the age of 35
- ADHD Agents
- Anorexients
- Asthma/COPD Preparations
- Antiulcer/Gerd Agents
- Bone Metabolism Agents
- Hypertension/Heart Failure Agents
- Impotency Drugs
- Insulin prefilled pens and pen devices
- Narcotic Analgesics
- Non-Narcotic/Arthritis Analgesics
- Oral contraceptives
- Self injectables (other than insulin)

Keep in mind the above is not all inclusive and may change from time to time. Visit www.rxsolutions.com for a current list of medications requiring prior authorization. To determine if your medication requires a prior authorization you may contact Prescription Solutions at 800-711-4555, or to obtain a copy of the most current list of prior authorization medications, contact the Peabody Benefits Call Center at 800-633-9005.

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

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

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

You can check the status of a prior authorization request at any time by calling the Prescription Solutions Member Services department at ~~800-797-9791.~~

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

These provisions are designed to ensure that you receive the most appropriate drug therapy for your condition.

Covered Drugs

Coverage is limited to medications and drugs requiring a written prescription from a physician and which are dispensed by a licensed pharmacist – plus insulin and diabetic supplies such as syringes, lancets and test strips.

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 35, you will be required to furnish proof that it is medically necessary.
- Any drug that is experimental or investigational, or one that is being used for 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 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 Prescription Solutions in advance.
- Prescriptions for birth control devices or birth control pills (unless these are being used for other than contraceptive purposes).

If you have other group health coverage for prescription drugs – through your spouse's employer, for example – refer to *Filing a medical or prescription drug claim* on page 23 for information about how to submit claims.

If you have any questions about your prescription drug coverage, you may call Prescription Solutions at ~~800-797-9791~~ Have your identification number ready (from your health plan ID card).

Major Medical Benefits

"Major medical benefits" are provided for covered medical expenses that are not paid in full under the other provisions of the plan, or not covered by other provisions at all. After you pay the $100 annual deductible, the plan pays 80% of the usual, customary and reasonable charges for covered major medical expenses.

However, the plan pays 50% (after the deductible) of the usual, customary and reasonable charges for covered expenses for mental health conditions (other than inpatient hospital care and convulsive therapy).

Prescription drugs are not eligible for major medical benefits.

Annual Deductible

The annual deductible is the amount of covered major medical expenses you must pay each calendar year before the major medical portion of the plan will pay benefits. This deductible applies only to those benefits described under the section titled *Covered major medical expenses.*

The annual major medical deductible is $100 for each covered individual per year, and generally applies to all covered expenses under the major medical portion of the plan. However, there are special features and exceptions:

- If two covered family members each meet the annual deductible in any one calendar year, the deductible requirement will be considered to be met for all your family members in that calendar year.
- 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.

Prescription drug expenses do not count toward the major medical deductible.

Maximum Out-of-Pocket

Once you pay $500 "out-of-pocket" for covered major medical expenses (including your 20% share of expenses and the major medical deductible) for one person in a calendar year, the plan will pay 100% of covered expenses incurred by the person for the remainder of that calendar year.

If you and your covered dependents combined pay $1,000 "out-of-pocket" for covered major medical expenses (including your 20% share of expenses and the major medical deductible) in a calendar year, your benefits will be paid at 100% of the usual, customary and reasonable charge for covered major medical expenses incurred by all covered family members for the remainder of that calendar year.

This plan feature does not apply to outpatient treatment of mental health conditions or substance abuse. Also, prescription drug expenses and deductibles paid for hospital confinement,

emergency room visits or physician's office visits under the other provisions of the plan do not count toward the out-of-pocket maximum.

Covered Major Medical Expenses

Covered major medical expenses include the usual, customary and reasonable charges incurred by a covered individual for the services and supplies listed below. These charges must be for services and supplies that the attending physician certifies as necessary for treatment. Covered major medical expenses do not include any portion of an expense that is covered under any other provision of this plan.

The covered major medical expenses are:

- Physician's fee for medical care and surgical operations.
- Charges of a registered graduate nurse (RN), or a practical nurse (LPN) who is either licensed as a practical nurse or is registered with an organization having the approval of the medical profession, provided the skills of an RN or LPN are required.
- Artificial limbs or eyes (but not their replacement), casts, splints, trusses, braces, crutches and other medical supplies.
- Rental of wheelchair, hospital-type bed, iron lung or other durable equipment used exclusively for treatment of injury or illness (up to the purchase price).
- Anesthetics and their administration.
- Diagnostic laboratory services.
- Use of X-ray, radium and other radioactive substances.
- Oxygen and rental of equipment for administration of oxygen, up to the purchase price.
- Transportation by railroad or scheduled commercial airline to (but not from) a hospital equipped to furnish special treatment for the injury or illness (excluding any transportation from or to points outside the continental United States and Canada).
- Local professional ambulance service to the nearest hospital where care and treatment of injury or illness can be given, provided transportation by ambulance is medically necessary.
- Physical therapy by a licensed physical therapist that is expected to produce significant improvement within a two-month period. Benefits will no longer be paid when care has become maintenance. When the therapeutic goals of the treatment plan have been achieved and/or when no more measurable progress is expected, benefits will cease. Physical therapy coverage for temporomandibular joint syndrome (TMJ) follows the same guidelines.
- Speech therapy, by a licensed speech therapist, to restore speech that has been impaired as a result of illness, surgery or injury. Speech therapy will also be covered after surgery to correct birth defects. Developmental delays in learning to talk, the perfection of speech and educational services are not covered.
- Occupational therapy for a physical or severe mental disability to restore the ability to perform ordinary tasks of daily living. Benefits will end when the therapeutic goals of a treatment plan have been achieved or when no more measurable progress is expected. Occupational therapy is not covered for most mental and chemical-dependency conditions.

- Cardiac rehabilitation to restore health as much as possible, through exercise, education of the patient and reducing risk factors. To be eligible for benefits, cardiac rehabilitation must be provided within 12 months after one of the following:
  - An acute myocardial infarction (heart attack).
  - Coronary bypass surgery.
  - Stable angina pectoris (heart-related chest pains).

A charge is considered to be "incurred" on the date the service or supply is rendered or received.

Exclusions

Benefits will not be paid under any provision of the medical plan for:

- Expenses in connection with work-related injuries.
- Expenses in connection with illnesses covered under any workers' compensation act or similar law.
- Care for pregnancy of a dependent child.
- Termination of pregnancy, unless medically necessary.
- Infertility treatment, or reversal of sterilization surgery.
- Routine foot care, including but not limited to treatment of corns and calluses, and non-surgical treatment of bunions.
- Transsexual surgery.
- Charges for treatment of alcohol or drug abuse/addiction.
- Medical examinations not necessary for the treatment of an existing injury or illness, such as routine check-ups and immunizations. However, this limitation does not apply to physician's services for sterilization surgery, prescription of oral contraceptives, fitting of a diaphragm or insertion/removal of an IUD. (Pharmacy charges for oral contraceptives or devices are not covered).
- Eye refractions, eyeglasses or the fitting of eyeglasses, except one pair of glasses following cataract surgery, if surgery changes the refraction ability of the eye.
- Hearing aids or the fitting of hearing aids.
- Cosmetic surgery, except to repair disfigurement due to an accident.
- Treatment of the teeth or gums, except tumors and treatment of an accidental injury to natural teeth (including their replacement) due to an accident that occurs while you are covered for major medical expense benefits under this plan.
- Any operation or treatment in connection with the fitting or wearing of dentures.
- Treatment of injury or illness caused by war, declared or undeclared.
- Charges incurred outside the United States or Canada, unless you or a dependent is a resident of the United States or Canada and the charges are incurred while traveling on business or pleasure.
- Except as required by law, charges from a U.S. government facility, or for services and supplies for which you are not required to pay.

- Treatment received by you or your dependent spouse that is performed by a member of the immediate family of you or your spouse.
- Expenses incurred for transportation or lodging, except as provided for ambulance, rail, or commercial airline transportation under the major medical provisions of this plan.
- Drugs and medicines that may lawfully be obtained without a physician's written prescription.
- Treatment of obesity or any expenses for weight control.

SUPPLEMENTAL MEDICAL EXPENSE BENEFITS FOR RETIRED EMPLOYEES AND DEPENDENTS WHO ARE ELIGIBLE FOR MEDICARE

This coverage provides benefits in place of any other benefits under the plan when you or your covered dependents become eligible for Medicare, as summarized in this chart.

Expenses	Amount the plan pays
Hospital Care	The plan pays the full cost of your Medicare Part A deductibles and copayments and Part B coinsurance
Medical and Surgical Services	The plan pays the full cost of your Medicare Part B coinsurance
Prescription Drugs	The plan does not cover prescription drugs.

The Medicare Part B annual deductible is not covered by the plan

As new Medicare legislation is enacted, the plan will coordinate all Medicare plan options with the benefit plan as allowed by law. Once the Medicare Part D prescription drug benefit becomes available in 2006, a communication will be provided explaining how the plan will coordinate with the new Medicare Part D program.

If you enroll in Medicare Part C, an alternative to traditional Medicare and recently named "Medicare Advantage," your benefits under the Company plan will be reduced by the amount of benefits that would have been payable under your plan if you had followed all applicable rules to obtain benefits. In most cases, no benefits will be payable from the Company plan. For additional information on this program, you may contact your local Social Security Office. You and your covered dependents are responsible for all Medicare premiums.

The medical plan pays benefits only for the services and supplies listed in this section. These services and supplies must be prescribed or performed by a physician for the medically necessary treatment of an illness or injury that is not work-related.

No coverage is provided for charges paid by Medicare, or for which Medicare would pay benefits if you or your dependent had properly enrolled for Parts A and B of Medicare.

Diabetic Supplies

Although insulin is not covered by Medicare, diabetes supplies, including glucose test monitors, blood glucose test strips, lancing devices, lancets, insulin pumps and control solution are covered by Medicare, which is the primary plan for all diabetes supplies. The company plan will pay

second. However, to receive coverage under Medicare, you must purchase supplies from a provider who is authorized to bill Medicare directly.

Because Medicare is primary, your claim for diabetic supplies must be sent to Medicare first. The medical claims administrator will pay the balance of the cost not covered by Medicare.

Hospital Care

The plan will pay the full amount of the following expenses:

- Your Medicare Part A deductible while you are confined as a bed-patient during each period of illness.
- Medicare daily copayments during your 61st through 90th day of confinement as a bed-patient, during each period of illness.
- Medicare Part A daily copayments during your 91st through 120th day of confinement as a bed-patient during each period of illness.
- Medicare Part B coinsurance for outpatient hospital charges in connection with treatment of accidental bodily injuries or surgery.
- Medicare Part A daily copayments for the 21st through the 100th day in a licensed skilled-nursing facility.
- The cost of blood if not replaced (the cost of first three pints of blood, which is not covered by Medicare).

The term "period of illness" means a period of consecutive days beginning with the first day on which you or your dependent is confined as a bed-patient in a hospital, nursing home or convalescent home while insured for supplemental medical expense insurance under the plan, and ending 60 consecutive days after the person is no longer confined.

Other Medical and Surgical Services

After you pay the deductible under Part B of Medicare, the plan will pay the 20% coinsurance required by Part B of Medicare for medical or surgical services.

Exclusions

Supplemental medical expense benefits for Medicare-eligible persons are not paid for:

- Prescription drugs, medical services or supplies that are not eligible for benefits under Medicare, private room charges or amounts in excess of Medicare's allowable charge limits.
- Treatment of an injury or illness for which any benefits are provided under any workers' compensation or similar law.
- Except as required by law, charges from a U.S. Government facility, or for services and supplies for which you are not required to pay.
- Treatment of any injury or illness caused by war, whether declared or undeclared.
- Premiums for Medicare coverage. You and your dependents are responsible for paying your Part B Medicare premium.

A charge is considered to be "incurred" on the date the service or supply is rendered or received.

Dental Benefits

Your dental benefits are described in this section of your booklet.

ELIGIBILITY AND ENROLLMENT FOR DENTAL BENEFITS

For you: If you are an eligible retired employee of the company and you are under age 65, you are eligible for dental benefits.

Your coverage began on the date you signed an enrollment card, if you did so within 31 days of the date you retired.

The plan currently requires no contributions for individual retiree coverage.

For your dependents: Your eligible dependents become covered by the plan at the same time you do, as long as you enroll them within 31 days of the date you retired. Dependents you acquire after you are 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. Otherwise, a three-month waiting period for coverage will apply.

Your eligible dependents include:

- Your spouse, unless eligible for coverage as an employee of the company.
- Your unmarried children under age 19 (or up to the date they reach 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 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
- 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. However, the plan does not cover:
  - A child temporarily living in your home.
  - A child placed with you in your home by a social service agency that retains control of the child, or whose natural parent may exercise or share parental responsibility and control.
  - A child for whom you do not legally claim a federal income tax deduction.

Coverage for your children is available only while you or your spouse is covered by the plan. 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 retiree may be covered as a dependent, and no one may be covered as a dependent of more than one retiree.

WHEN DENTAL COVERAGE ENDS

For you: Coverage for dental care benefits will end on the day any of the following events occur:

- The plan is terminated.
- You attain age 65.

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

- The plan is terminated.
- Your dependents are no longer eligible.
- Your coverage ends.*
- For dependent children, the date you or your surviving spouse are no longer covered.

**In the event of your death, your surviving spouse may continue coverage, including coverage for your dependent children, provided your spouse is not covered under another employer's plan. There is no contribution required for your surviving spouse's coverage, but there is a contribution required to continue coverage for your children. Coverage for both your surviving spouse and children will end on the date that your surviving spouse either dies, remarries, becomes covered under another employer's group health plan, or reaches age 65. Once coverage for a surviving spouse ends, it cannot be reinstated.*

Refer to the section called *General provisions for both medical and dental benefits* for information about other provisions for continuing coverage.

DENTAL PLAN HIGHLIGHTS

The following chart provides highlights of your dental benefits:

Deductible	$25 per person per calendar year
Amount the Plan Pays	80% after the deductible
Maximum Benefits	$500 maximum per person per calendar year *(excluding orthodontia)*
Orthodontia Maximum	$800 maximum per period of treatment per person

Coverage is limited to fees charged by the majority of Delta Dental participating dentists (the "allowable charge").

Refer to the following pages for information about conditions and limitations that may apply to these benefits.

Delta Dental Participating Dentists

Your dental benefits are administered by Delta Dental of Missouri. Delta Dental has unique "participating agreements" with the majority of dentists in areas where our employees live. These agreements mean that the participating dentist's fee has been accepted in advance by Delta Dental. All you have to do is present your membership card. Participating dentists will then file your claim for you and Delta Dental will pay them directly. You will have to pay only your deductible and your coinsurance percentage for covered services.

You can obtain information about participating provides by contacting Delta Dental at 800-335-8266 or you can visit Delta Dental's website at www.deltadental.com.

Nonparticipating Dentists

If you go to a nonparticipating dentist, you will still receive benefits, but payment will be based on the fee that the majority of participating dentists would charge for the same service. This is called the "allowable charge." For services from a nonparticipating dentist, you will pay the difference between the dentist's fee and the allowable charge, in addition to your deductible and a percentage of the allowable charge as shown on the *Dental plan highlights* chart.

Also, you are responsible for paying the nonparticipating dentist and filing your own claim. Benefits must be paid directly to you, not to the dentist.

Deductible

The deductible is the amount of covered expenses you must pay before the dental plan begins to pay benefits. The deductible amount under the dental plan is the first $25 of dental expenses incurred by you and each of your covered dependents during each calendar year.

However, covered expenses incurred in the last three months of a calendar year and applied to your deductible will be applied to the next year's deductible as well.

Amount the Plan Pays

The plan will pay 80% of covered expenses up to the maximum benefits.

Covered Expenses

Covered expenses include reasonable and customary charges for the following preventive, basic and major services provided by a dentist or a dental hygienist:

- Examinations and teeth cleaning (twice per year), X-rays, emergency treatment of dental pain, and equilibration, not including restoration.
- Sodium fluoride treatments for dependent children under age 19, once per calendar year.

- Treatment of disease of the gums and tissues.
- Sealants for children under age 19, once in any five-year period. This is limited to occlusal services of cavity-free first and second permanent molars.
- Space maintainers for dependent children under age 16, once per lifetime for the same tooth.
- Tooth extraction, alveolectomies, and post-operative care.
- Root canal.
- Fillings, inlays and crowns.
- Full and partial dentures and bridgework, including their replacement and restoration, but not more than one replacement every three years.
- General anesthetics.
- Orthodontic treatments.

Maximum Benefits

The plan will pay up to $500 for eligible preventive, basic and major care dental expenses for each covered person in a calendar year. Benefits for orthodontic services are limited to $800 per person per period of treatment. If orthodontic services begin within five years after a previous treatment program, all the services will be considered one "period of treatment" and will be subject to the original $800 maximum.

Dental Treatment Plan

Before your dentist provides treatment, he or she should submit a form describing a proposed course of treatment if:

- The cost of treatment will total $125 or more.
- The treatment includes orthodontia.

The form should:

- Show the itemized dental services recommended.
- Show the charge to be made for each dental services.
- Be accompanied by supporting preoperative X-rays or other appropriate materials required by the claims administrator.
-

For orthodontic procedures, the treatment plan must:

- Provide a classification of the malocclusion.
- Recommend and describe the necessary treatment by orthodontic procedures.
- Estimate the time period over which treatment will be completed.
- Estimate the total charge for treatment.
- Be accompanied by cephalometric X-rays, study models and other supporting evidence the claims administrator may require.

The claims administrator will review the form submitted by your dentist and will determine what is paid so you will know in advance what portion of the cost you must pay. Forms can be obtained by contacting the Peabody Benefits Call Center at 800-633-9005 or participating dentists have the forms needed in their office.

By approving your form, the plan accepts the course of treatment your dentist has recommended and agrees to consider the expenses covered. If you do not submit a form before treatment begins, however, the plan has the right to pay only the amount it would have paid for another, less expensive form of treatment.

Alternative Course of Treatment

In many cases, there may be more than one way to treat a dental condition. In these situations, the plan will pay benefits only for the least expensive services that:

- Are customarily used in the treatment of the condition.
- Are recognized in the dental profession to be appropriate according to broadly accepted national standards of practice.

You and your dentist may decide you want the more expensive treatment. If so, you pay the difference in cost out of your own pocket. It is important for you to request a predetermination of benefits so you know in advance how much the plan will pay for your treatment.

Exclusions

The following charges are not covered by the plan:

- Oral surgery that is not specifically listed as a covered expense.
- Charges incurred outside the U.S. and Canada, unless you or a dependent incurs charges while traveling abroad.
- Services or supplies that were supplied free of charge.
- Full or partial dentures or bridgework made to replace teeth extracted before coverage under this plan began. This limitation does not apply after three consecutive years of coverage by the employee or dependent.
- Accidental injury or illness caused by war or any act of war, whether or not declared, including armed aggression, or by participating in a riot, or the attempt to commit a felony or assault.
- Accidental injury or illness arising out of or in the course of employment, or which is compensated under any workers' compensation or occupational disease act or law.
- Charges incurred in connection with any intentionally self-inflicted injury.
- Charges for cosmetic treatment.
- Charges for replacement of lost or stolen appliances.
- Except when required by law, services furnished by or on behalf of any federal, state, county or any other governmental unit.
- Charges covered under the company's medical plan.

- Oral hygiene, dietary or plaque control instructions and programs.
- Procedures, services or supplies that do not meet accepted standards of dental practice.
- Treatment that began before you were covered under this plan.
- Claims received more than 12 months after the date the services or supplies were received.
- Charges for a missed or broken appointment.

General Provisions for Both Medical and Dental Benefits

The following provisions apply to all benefits provided under both the medical and dental plans, unless otherwise noted.

FILING A MEDICAL OR PRESCRIPTION DRUG CLAIM

Your medical and prescription claims must be filed within one year of the date you incur an expense. If your claims are administered by BlueCross BlueShield of Illinois, participating providers will file their claims directly with the plan. In addition, Prescription Solutions participating pharmacies will submit your claims directly to Prescription Solutions. For all other providers, you must file a claim using this process:

1. Complete a BlueCross BlueShield of Illinois or AAG claim form which can be obtained by contacting the Peabody Benefits Call Center at 800-633-9005. Claims for prescription drugs must be filed using the Prescription Solutions claim form which also can be obtained from the Peabody Benefits Call Center.

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

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

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

4. If you or your dependents are also covered by another medical plan that is the primary payer, including Medicare, 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.

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

If you also have prescription drug coverage through another plan that is your primary plan (as described in the "Coordination of Benefits" section on page 27), you may also claim secondary benefits under our plan.

Remember that before a hospital admission, you should call the Medical Services Advisory program for pre-certification unless you have primary coverage under another insurance plan including Medicare. The telephone number is 800-325-4705. You must also call MSA 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 medical claims questions can be answered quickly and efficiently by either calling the claims administrator or submitting a written request for review to:

For medical claims:

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

or

AAG Benefit Plan Administrators
P.O. 230
Ephraim, UT 84627-0230
800-557-8832

For prescription drug claims:

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

PAYMENT OF MEDICAL BENEFITS

If your claims are processed by Blue Cross Blue Shield, payments will be made directly to the participating provider. Claim payments from AAG and Prescription Solutionswill be made to you.

Once the claims administrator has paid your provider its portion of the eligible charges, you will be responsible for any deductible or copayment amounts that apply.

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.

FILING A DENTAL CLAIM

Ask your dentist if he or she is a Delta Dental participating dentist, or call the Delta Dental office at 800-392-1167.

If You Use a Participating Dentist

If you go to a participating dentist, present your membership card when you arrive for your appointment. If the care you need:

- Costs less than $125 or is emergency care, your dentist will proceed with treatment.
- Costs more than $125 and is not emergency care, your dentist will determine what treatment you need and submit a treatment plan to Delta Dental for predetermination of benefits. This will enable you to know in advance how much of the cost will be paid by your dental coverage and how much you will be responsible for paying.

Participating dentists have the forms needed to submit a claim. You may be asked to fill out part of the form. Your dentist will submit the form for you.

You will be responsible for the deductible amount, the copayment amount and any non-covered charges. Your dentist may request payment at the time of treatment or bill you later.

If You Use a Nonparticipating Dentist

If you go to a nonparticipating dentist, benefits will be based on the fees charged by the majority of participating Delta Dental dentists. Also, you are responsible for paying the dentist and filing your claim.

Obtain a claim form from the Peabody Benefits Call Center at 800-633-9005 or from Delta Dental before your dental appointment. Fill out spaced 1 through 15 on the form and ask your dentist to complete the rest. Then mail the form to Delta Dental at the address below:

Delta Dental Plan of Missouri
P. O. Box 16921
St. Louis, MO 63105-1321

If the treatment will cost more than $125 and is not emergency care, ask your dentist to submit a treatment plan to Delta Dental for predetermination of benefits. This will enable you to know in advance how much of the cost will be paid by your dental coverage and how much you will be responsible for paying.

Claims must be submitted within one year from the date the expense is incurred.

PAYMENT OF DENTAL BENEFITS

Benefits for participating Delta Dental dentists will be paid directly to the dentists. For nonparticipating dentists, benefits will be paid directly to you.

RECOVERY OF EXCESS PAYMENTS

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

THE PLAN'S RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

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

PAYMENT OF BENEFITS TO PERSONS OTHER THAN YOU

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

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

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

RIGHT TO AUDIT

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

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.

COORDINATION OF BENEFITS

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

If you or any of your dependents are eligible to receive benefits under more than one group health care plan, our plan's COB provision allows you to receive benefits so that the total amount of benefits paid by all plans can be as much as 100% of the total expense.

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. The plan of the parent whose birthday falls later in the calendar year will be secondary. If both parents' birthdays are on the same day, the plan which has covered the parent for the longer period of time will be 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 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.

If our plan is secondary, the regular benefits will be reduced so that the amount paid by both plans will not exceed 100% of the expenses incurred as covered under our plan. In other words, after the primary plan pays its benefits, our plan will pay the difference up to 100% of the total expense. In no event will our plan pay more than it would have if there were no other coverage.

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 payments 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.

THE PLAN'S SUBROGATION AND REIMBURSEMENT RIGHTS

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

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

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

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

Example: Suppose you are injured in an automobile accident that was the other driver's fault. The Plan pays most of the cost of your hospital bills. Later, the other driver's insurance company also pays you for your medical bills. So now you have essentially been paid twice for your medical bills as a result of this accident -- once from the Plan and once from the other

driver. The "right of recovery" provisions now come into play, and the Plan is entitled to a refund of the benefits paid. The Plan may also pursue recovery directly from the third party.

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

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

  Further, the Plan may sue you or your dependents, or as applicable, your heirs, guardians, executor or other representative in order to recover the amount due the Plan under these provisions. Where the Plan is successful, in whole, or in part, the Plan shall also be entitled to reimbursement from you or your dependents all costs of collection, including reasonable attorney's fees. The Plan's obligation will resume when both of the following have occurred: (a) the Plan receives full reimbursement for any conditional benefit payments previously provided; and (b) arrangements satisfactory to the Plan have been made with regard to its rights of recovery for future covered medical expenses.

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).

As a condition to receiving benefits from this plan, you and your dependents agree to transfer to the plan the right to make a claim, sue and recover medical expenses from any money paid or payable as a result of a personal injury claim or reimbursement of medical expenses. This is called "subrogation." The plan may require that you pursue a claim against the third party or other insurance covering the expenses. If you fail to or refuse to pursue the claim, the plan is entitled, if it chooses, to pursue the claim itself in order to recover the benefits the plan paid.

Alternatively, if either you or your dependent obtains any payment from the third party, or any insurance covering the third party or any "no-fault" automobile insurance, the plan is entitled to be paid back in full, "in first priority," for the benefits it paid on your behalf. In other words, the plan must be fully reimbursed first from any money you received as a result of a claim against the third party or other insurance.

You have an obligation to reimburse the plan in full, in first priority, regardless of whether or not you or your dependent is fully reimbursed for the expenses for which a third party is liable, or whether the settlement or judgment requires the third party to pay for medical expenses.

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. You must notify the plan at least 30 days before you settle or compromise any claim.
- Reimburse the plan in full, in first priority, for any benefits payment if you or your dependents receive a settlement with a third party or payment for medical expenses. 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 within five days of receiving a request from the plan.

You must notify the plan of any personal injury claim or any claim for reimbursement of medical expenses within five days after the date you make the claim.

If you or your dependents do not comply with these provisions, or 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. However, the plan's subrogation and reimbursement rights apply whether or not you sign any repayment agreement. In addition, the plan may reduce future benefits paid for any other medical expenses in order to recover the amount it is entitled to under this provision.

COBRA 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 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 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 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 occurs.

Extension of Coverage if Disabled

Continued coverage may be further extended if you or your dependent is determined to be totally disabled anytime prior to or during the first 60 days of continued coverage that is due to a reduction in hours worked or termination of your employment. The maximum coverage period 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.)

Special Rules for Retirees

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

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

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, after the date of the COBRA election, covered under another group health plan, unless coverage under the other plan is limited due to the individual's pre-existing condition. Please notify the benefits department immediately if you or a dependent becomes covered under another group health plan.
- An individual becomes, after the date of the COBRA election, 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 Peabody Benefits Call Center at 800-633-9005 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 Peabody Benefits Call Center 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.

Pursuant to the Trade Act of 2002, if you are eligible for Trade Adjustment Assistance, you may be eligible for a second COBRA election period if you did not elect COBRA Continuation Coverage after termination of your employment and you later become eligible for Trade Adjustment Assistance or "alternative trade adjustment assistance" under the Trade Act of 1974. In this event, you must elect COBRA during the 60-day period that begins on the first day of the month in which you are determined to be eligible for Trade Adjustment Assistance and not more than six months after you initially lost Coverage. Contact the benefits department for more information on this special election period.

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.

The Trade Act of 2002 created a tax credit for enrolled employees who become eligible for Trade Adjustment Assistance Benefits or who are at least 55 years of age and receiving pension benefits paid by the Pension Benefit Guaranty Corporation. Under the new provisions, if you are eligible, you can either take a tax credit or get advance payment of 65% of the cost of coverage for qualified health insurance, including COBRA continuation coverage. You will be notified if you are eligible for this tax credit. For more information, contact the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282 or 1-866-6726-4282 (TTD/TTY), or visit http://www.doleta.gov/tradeact/2002act/index.asp.

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.

Any family member covered under the plan on the date of the original qualifying event will be considered a qualified beneficiary and will have independent rights to elect continued coverage. A child born to or adopted by the employee while enrolled for continued coverage also will be considered a qualified beneficiary.

Qualified beneficiaries who elect continued coverage have the opportunity to add dependents or change coverage under the same rules that apply to actively working employees under the plan.

SPECIAL EXTENSIONS OF CERTAIN BENEFITS

Benefits for Hospital, Surgical, Laboratory and X-Ray Examinations and X-Ray and Radiation Therapy

If you or your dependent spouse is hospitalized at the time your coverage ends, hospital benefits will continue to apply to that period of hospital confinement, subject to the maximum limits of the plan, except that no benefits will be paid for hospital care for which you or a dependent are entitled to benefits under Medicare, or for which no payment is required of you or a dependent because of Medicare.

Additionally, if you (but not your dependent spouse) are totally disabled by injury or illness on the date your coverage is terminated, then benefits will be extended during your disability for the following, if they take place within three months after termination of coverage:

- Hospitalization.
- Surgical operations.
- Consultations.
- Laboratory and X-ray examinations.
- Radiation therapy treatments.

This provision will cease to apply as of the date you become eligible to participate in Part A of Medicare.

Benefits for Major Medical Expenses

If coverage ends while you or a dependent is totally disabled and receiving covered medical services, benefits are extended to apply to covered expenses incurred after coverage ended for continued treatment of that injury or illness. However, in no case will the plan pay benefits for expenses incurred after recovery from total disability or after one year from the date the coverage ended, whichever occurs first.

This extension of benefits ends on either of the following:

- The date you or your dependent spouse becomes covered under any other similar group plan provided by Blue Cross Blue Shield or any other insurer.
- With respect to the types of covered expenses for which any coverage is provided under Medicare, the date you or your dependent spouse become eligible to participate in Part A of Medicare.

Benefits for Supplemental Medical Expenses (for Retired Employees and Dependents Eligible for Medicare)

If coverage ends while you or a dependent is totally disabled and receiving covered medical services, benefits are extended to apply to cover expenses incurred after coverage ended for continued treatment of that injury or illness. However, in no case will the plan pay benefits for expenses incurred after recovery from total disability or after one year from the date coverage ended, whichever occurs first.

This extension of benefits ends on the date you or your dependent spouse becomes covered under any other similar group plan.

Dental Benefits

If you or one of your covered dependents has dental work already in progress on the date coverage would normally end, benefits will be extended for:

- Appliances or modification of appliances, if the master impression was taken by a dentist before coverage termination and if the appliance is delivered or installed within two calendar months following termination.
- A crown, bridge, inlay, or onlay restorations, if the tooth or teeth were prepared before coverage termination and if the crown, bridge or cast restoration is installed within two calendar months after termination.
- Orthodontic treatment, beginning while dental benefits are in force through the end of the month in which termination occurs based on a prorating of the applicable treatment fee.
- Root canal therapy, if the pulp chamber was opened prior to termination of coverage, if such root canal therapy is completed within two calendar months after the termination of coverage.

CONVERTING TO AN INDIVIDUAL POLICY

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

Dependents cannot be added to the individual policy if they were not covered by the plan at the time your coverage ended. Furthermore, the benefits available under an individual insurance policy are not necessarily the same as the benefits offered under the company's medical plan. You should examine the new individual policy carefully.

To convert coverage, you must submit a written application and the first premium payment to the designated insurance company within 31 days of the date your coverage ends. You or your

covered dependents do not have to provide proof of good health. The policy will be effective on the day after your plan coverage ends.

Please note: Dental coverage cannot be converted to an individual policy.

Life Insurance Benefits

The company provides a life insurance plan that pays your family or other beneficiaries a benefit in the event of your death.

ELIGIBILITY AND ENROLLMENT FOR LIFE INSURANCE BENEFITS

You are covered by this plan if you are an eligible retired employee of the company provided you retired on or after August 1, 1975 and you enrolled within 31 days of the date you retired. The plan currently requires no contribution for retiree life insurance coverage.

WHEN COVERAGE ENDS

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

- The plan is terminated.
- The date of your death.

LIFE INSURANCE BENEFITS

If you die while covered by this plan, your beneficiary will receive a life insurance benefit based on your age at the time of your death, as follows:

If you are under age 65, your life insurance benefit will be equal to one times the amount of your basic annual salary that was in effect on February 1 prior to your retirement date.

If you are age 65 or older, your life insurance benefit will be equal to 30% of your basic annual salary, based on the same five-year average used to calculate your pension benefits. In no event will your benefit be less than $5,000 or more than $15,000.

If you retired before August 1, 1975, you are not covered for these benefits. However, your beneficiary may be eligible for death benefits through an annuity from the Eastern Gas & Fuel Associates Retirement Plan, unless you received life insurance benefits under the disability provision of the plan for actively working employees.

NAMING YOUR BENEFICIARY

You may designate anyone as the beneficiary of our life insurance. You may change your beneficiary at any time by filling out a form which can be obtained by contacting the Peabody Benefits Call Center at 800-633-9005.

The change will become effective when the benefits department receives the completed form. It will be effective as of the date you signed the request, regardless of whether you are alive at the time the benefits department receives it. However, benefits that have been paid before the

company receives the change form will remain the property of the person who received them, and will not be paid to the new beneficiary.

PAYMENT OF BENEFITS

Full payment of your coverage amount will be made to your beneficiary (or beneficiaries) upon your death. This payment will be made in one lump sum.

If you do not designate a beneficiary, or if your beneficiary dies before receiving your benefit payment, your benefit will be paid instead in the following manner:

- To your spouse.
- If you have no living spouse, to your children in equal shares.
- If you have no living children, to your parents in equal shares.
- If you have no living parents, to your brothers and sisters in equal shares.
- If you have no living brothers and sisters, to your estate.

The insurance company may also pay a portion of your benefit to anyone who it determines had assumed primary responsibility for your support or who incurred expenses for your last sickness and death.

If you die, your beneficiary should contact the Peabody Benefits Call Center at 800-633-9005 to file a claim. Your beneficiary must provide a certified copy of the death certificate.

Retained Asset Account

An account called a "retained asset account" is automatically established for each beneficiary receiving a lump-sum benefit payment of $10,000 or more. The payment received by your beneficiary will be placed in this account. (Beneficiaries receiving less than $10,000 will receive a single payment by check.) Your beneficiary may withdraw the entire amount of the account at once, or only a portion at a time (minimum of $250), leaving the balance to accumulate interest. Your beneficiary will also receive information about other ways to receive payment if he or she wishes.

Assignment of Benefits

If you wish, you may also "assign" your basic life insurance benefits to any individual as a gift. This is different from designating a beneficiary. The person who is "assigned" benefits then legally owns the insurance policy—you no longer have the right to change beneficiaries—and the benefit is taxed differently. Assignment is usually done for tax purposes. You may want to consult a tax adviser if you wish to learn more about this option.

A copy of the assignment request must be filed with your benefits department and approved by the insurance company.

Special Benefit for Terminal Illness

If you become terminally ill, you may choose to receive a portion of your basic life insurance in advance of your death. You can use this amount to help defray the costs associated with your

condition. "Terminal illness" means a medical condition that can be expected to result in death within 12 months.

This special benefit is subject to the following conditions:

- You may choose to receive up to 50% of your basic life insurance amount.
- You must be diagnosed by a physician as having a terminal illness. The insurance company may require a second opinion and examination.
- You may receive this benefit only once in your lifetime. The remaining part of your life insurance will be paid to your beneficiary when you die.
- You may not receive this benefit if you've previously made an assignment of benefits or irrevocable beneficiary designation, unless the assignee or beneficiary agrees in writing in a form acceptable to the insurance company.
- This accelerated benefit does not apply if you are required by law to use such benefits to meet the claims of creditors or as a condition of receiving a government entitlement or benefit.

APPEALING A CLAIM

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 insurance company. Formal claim-review procedures are discussed in the *Plan administration information* section of this booklet.

CONVERTING TO AN INDIVIDUAL POLICY

If your basic life insurance coverage ends because your employment ends, or if your coverage is reduced because you are a retired employee or disabled employee at age 65, you may buy individual coverage up to the amount of coverage you had before it ended or was reduced. You will not need to provide evidence of your good health.

You must submit your application for the individual policy to the insurance company and make the required premium payment within 31 days of the date your employment ended or your coverage was reduced.

If our basic life insurance plan is changed or ended, you can convert your coverage under the conditions described in the policy issued by your insurance carrier.

If you die within the 31-day period after your coverage ends but before your individual policy is issued, your benefit will be paid to your beneficiary.

Contact the Peabody Benefit Call Center at 800-633-9005 for information about how to convert your coverage.

Key Terms

Claims Administrator
The organization retained by the company for granting or denying claims, currently Blue Cross Blue Shield of Illinois and AAG for medical benefits, Prescription Solutions for prescription drug benefits, and Delta Dental of Missouri for dental benefits.

Company
Eastern Associated Coal Corp.

Convalescent facility
A lawfully operating institution, or a distinct part of an institution, primarily engaged in providing skilled nursing care to patients recovering from injury or illness and that:

- Is under the resident supervision of a physician or a registered graduate nurse.
- Requires that the health care of every patient be under the supervision of a physician.
- Provides that a physician be available to furnish necessary medical care in emergencies.
- Provides for nursing service continuously for 24 hours of every day.
- Provides facilities for the full-time care of five or more patients.
- Maintains clinical records on all patients.
- Is not an institution or part of an institution that is primarily devoted to the care of the aged.

Covered expenses
Medical and dental expenses for which the plan pays benefits.

Dentist
A licensed doctor of dental medicine or doctor of dental surgery acting within the scope of his or her license, or any other physician furnishing any dental services he or she is licensed to perform.

Dental emergency
An urgent, unplanned diagnostic visit to a dentist for alleviation of an acute dental condition caused by an accident.

Dental hygienist
A person currently licensed to practice dental hygiene, who works under the direct supervision of a dentist.

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
An employee of Eastern Associated Coal Corp. who was hired before April 1, 1987, elected to retire on or before March 1, 1990, and who immediately began receiving pension benefits from the Eastern Gas and Fuel Associates Retirement Plan or the Peabody Holding Company Inc.

Retirement Plan for salaried employees on his or her retirement date. This plan does not cover EACC employees who were approved for long-term disability benefits after July 1, 1988 and qualified for a disability retirement under the Peabody Holding Company Inc. Retirement Plan for Salaried Employees, even if they elected to retire before March 1, 1990.

For purposes of "surviving spouse" eligibility, the term "eligible retiree" also includes an EACC employee who dies on or before March 1, 1990, and who, on the date of death, would have been eligible to receive pension benefits from the Eastern Gas and Fuel Associates Retirement Plan.

Hospital
An institution legally operating as a hospital that is:

- Primarily engaged in providing, for compensation from its patients, inpatient medical and surgical facilities for diagnosis and treatment of injury and illness.
- Operated under the supervision of a staff of physicians and continuously provides nursing services by registered graduate nurses for 24 hours of every day.

However, "hospital" does not include any institution that is operated principally as a rest, nursing or convalescent home or for the care and treatment of drug addicts or alcoholics, or any institution that is principally devoted to the care of the aged, or any institution engaged in the schooling of its patients.

Illness
Sickness or disease, including pregnancy (of the retired employee or a spouse, not a child) or mental infirmity, that requires treatment by a physician.

Injury
Bodily injury that requires treatment by a physician.

Insurance company
For life insurance, UNUM Life Insurance Company of America.

Intensive care
An accommodation that is reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending physician, and that provides room and board, nursing care by nurses whose duties are confined to care of patients in intensive care, and special equipment or supplies immediately available on a standby basis segregated from the rest of the hospital's facilities.

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.

Note: Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of syay not in excess of these periods.

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

Necessary dental care
Care that is customarily used in the treatment of the condition and is recognized in the dental profession to be appropriate according to broadly accepted national standards of practice.

Orthodontic procedure
Movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

Period of illness
A period of consecutive days beginning with the first day on which you or your dependent is confined as a bed-patient in a hospital, nursing home or convalescent home while covered for supplemental medical expense coverage under the plan, and ending 60 consecutive days after the person is no longer confined.

Physician
Any of the following:

- A doctor or surgeon of medicine or osteopathy who is legally authorized to practice medicine and surgery by the state in which he or she practices.
- A doctor of chiropractic who is practicing with the scope of his or her license.
- A doctor of dentistry, or of dental or oral surgery, who is legally authorized to practice dentistry in the state in which he or she practices. However, with respect to medical benefits, covered services are limited to:
  - Surgery related to the jaw or any structure contiguous to the jaw.
  - The reduction of any fracture of the jaw or any facial gone.

Qualified medical child support order (QMCSO)
A "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.

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

Usual, customary and reasonable fee
The maximum covered charge as determined by Blue Cross Blue Shield, taking the following into consideration:

- The usual fee that is charged for a given services by an individual physician in his personal practice.
- The range of usual fees customarily charged by physicians or similar training and experience for the same service within a given specific limited geographic or socio-economic area.
- A reasonable fee that meets the above two criteria or in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question.

Plan Administration Information

Plan Name

Eastern Associated Coal Corporation

Type of Plan

Life insurance, medical and dental benefits.

Employer Identification Number

The employer number assigned to the company by the Internal Revenue Service is 61-1258748.

Plan Number

501

Effective Date

July 1, 1999

Last Amended

January 1, 2004

Plan Fiscal Year

January 1 to December 31

Plan Sponsor

Eastern Associated Coal Corporation

You may direct correspondence to:

Eastern Associated Coal Corporation
Attn: Human Resources Department
800 Laidley Tower
Charleston, WV 25301

Plan Administrator

Peabody Holding Company, Inc.
Attn: Human Resources Department
701 Market Street
St. Louis, MO 63101

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.
Attn: Human Resources Department
701 Market Street
St. Louis, MO 63101

Funding and Disbursements

The Plan is funded by contributions from Peabody Holding Company, Inc. and/or participating employees. Disbursements are made by the applicable claims administrator in accordance with the terms of the plan.

Medical and prescription drug benefits are self-insured by Peabody Holding Company, Inc. and its affiliates and are not guaranteed under a policy or contract of insurance.

Participating Provider Arrangements

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

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

YOUR ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan for information concerning your COBRA continuation coverage rights.

- Receive a copy of the plan's qualified medical child support procedures without charge upon request.
- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan; when you become entitled to elect COBRA continuation coverage; or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion or limitation, as described in the summary plan description. Note that this right is available only if you are a participant in a group health plan that is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the

Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration

Claims Review and Appeals for Medical and Prescription Claims

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

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

Initial Claims Determinations

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

- **Pre-service claim** – You will be notified whether your pre-service claim has been approved or denied within 15 days after the claim is received. The 15-day period may be extended an additional 15 days if the extension is necessary due to matters beyond the control of the plan. You will be given at least 45 days from the time you receive the notice to provide the requested information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice.
- **Urgent care claim** – You will be notified whether your urgent care claim has been approved or denied within 72 hours after the claim is received. If more information is needed in order for a determination to be made, you will be advised of the specific information necessary to complete the claim within 24 hours after receipt of the claim. You will be allowed at least 48 hours to provide the necessary information. You will be notified of the determination within 48 hours after the earlier of (1) the plan's receipt of the requested information or (2) the end of the period you were given in which to provide the information
- **Post-Service Claim** – The appropriate claims administrator will decide a post-service claim within 30 days after the claim is received. This time period may be extended for an additional 15 days when necessary due to matters beyond the control of the plan or if your claim is incomplete.

If your claim is denied

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

- The reason for the denial.

- A reference to the plan provision on which the determination is based.
- A description of any additional information necessary to complete your claim.
- A notice of your right to file an appeal.
- Other information as required by law.

Review of Denied Claims

You have 180 calendar days after receiving notice that your claim was denied, in whole or in part, in which to appeal the determination to the claims administrator. Except in the case of an appeal involving an urgent care claim, your appeal must be in writing and must be submitted to the claims administrator at the address set out on pages 24 of the summary plan description. *If you do not file an appeal within this 180-day period, you will lose the right to appeal the determination.*

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

Expedited Procedures for Urgent Care Claims. You may request an expedited appeal of a denial involving an urgent care claim to the claim administrator. The request may be verbal or written. Under these expedited procedures, all necessary information, including the determination on appeal, may be transmitted to and from the claims administrator by telephone, facsimile or another available similarly expeditious method.

Determinations on Appeal

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

- **Pre-service claim** – You will be notified of the determination on the appeal within 15 days after it is submitted to the claims administrator. If you are not satisfied with the decision, you have the right to file a second level appeal with the plan administrator. This appeal should be submitted to:

  Director, Benefit Services and Administration
  Peabody Holding Company, Inc.
  701 Market Street
  St. Louis, MO 63101-1826

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

- **Urgent care claim** – You will be notified of the determination within 72 hours after your appeal is received by the claims administrator.
- **Post-service claim** – The claims administrator will review and decide your appeal within 30 days after it is submitted. If you are not satisfied with the decision of the claims

administrator, you have the right to file a second level appeal with the plan administrator. This appeal should be submitted to:

Director, Benefit Services and Administration
Peabody Holding Company, Inc.
701 Market Street
St. Louis, MO 63101-1826

Your second level appeal request must be submitted within 60 days of receipt of the first level appeal decision. The plan administrator will make a determination on your appeal no more than 30 days after your second level appeal is submitted.

The review at each level of appeal will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination or at a lower level of appeal.

Except in instances in which notice is provided pursuant to the expedited procedures for urgent care claims described above, you will be notified in writing of the decision on appeal. If the decision upholds the denial of your claim, the notification will provide the specific reasons for the denial, reference to the plan provision on which the determination was based, your right to bring a civil action under ERISA and any other information required by law.

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

Claims Review and Appeals for Life Insurance Claims

If any portion 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 that you can do to appeal the decision. Most of your questions can be answered quickly and efficiently if you call or write the insurance company.

If your claim for a plan benefit is denied or reduced, you or your beneficiary will be notified in writing within a reasonable period of time, but no longer than 90 days unless special circumstances require extra time for processing. If such a time extension is necessary, you will receive written notice before the end of the initial 90 days. This notice will tell you why additional time is needed and the date you can expect a final decision. This decision must be made within 90 days after the end of the initial 90-day period.

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

- The specific reason for the denial.
- A specific reference to the plan provisions on which the denial is based.
- A description of any additional material or information necessary for you to substantiate your claim and an explanation of why such material is needed.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including your right to submit written comments and have them considered, your right to receive (upon request and free of charge) reasonable access to, and

copies of, all documents, records, and other information relevant to your claim, and your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.

Review of Denied Claims

You may appeal the denial of your claim to the insurance company. This appeal must be made in writing within 60 days after you receive the written notice from the insurance company that your claim had been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial.

Your written appeal should set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim. Your appeal should be forwarded to:

UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

The insurance company will review and decide your appeal within a reasonable period of time but no longer than 60 days after it is submitted. This time period may be extended for an additional 60 days if the insurance company determines that there are special circumstances that require an extension. You will be advised in writing of the need for an extension during the initial 60-day period and a determination will be made no more than 120 days after the date the claim was submitted. If the extension is needed because you failed to submit information necessary to decide the claim, the period for deciding the appeal shall be tolled from the date on which the insurance company sends you notification of the extension until the date on which you respond to the request for additional information.

The review will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination.

You will be notified in writing if the decision on appeal upholds the initial denial of your claim. The notification will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- A statement of your right to bring a civil action under Section 502 of ERISA.

The decision of the insurance company is final and binding on all individuals dealing with or claiming benefits under the plan.

AMENDING THE PLAN

The plan is adopted with the intention that it will be continued for the benefit of present and future employees of the company. However, the company reserves the right to terminate the plan,

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

This means that an employee 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. This plan will comply with all requirements of the law and will be changed, if necessary, in order to meet any such requirements.