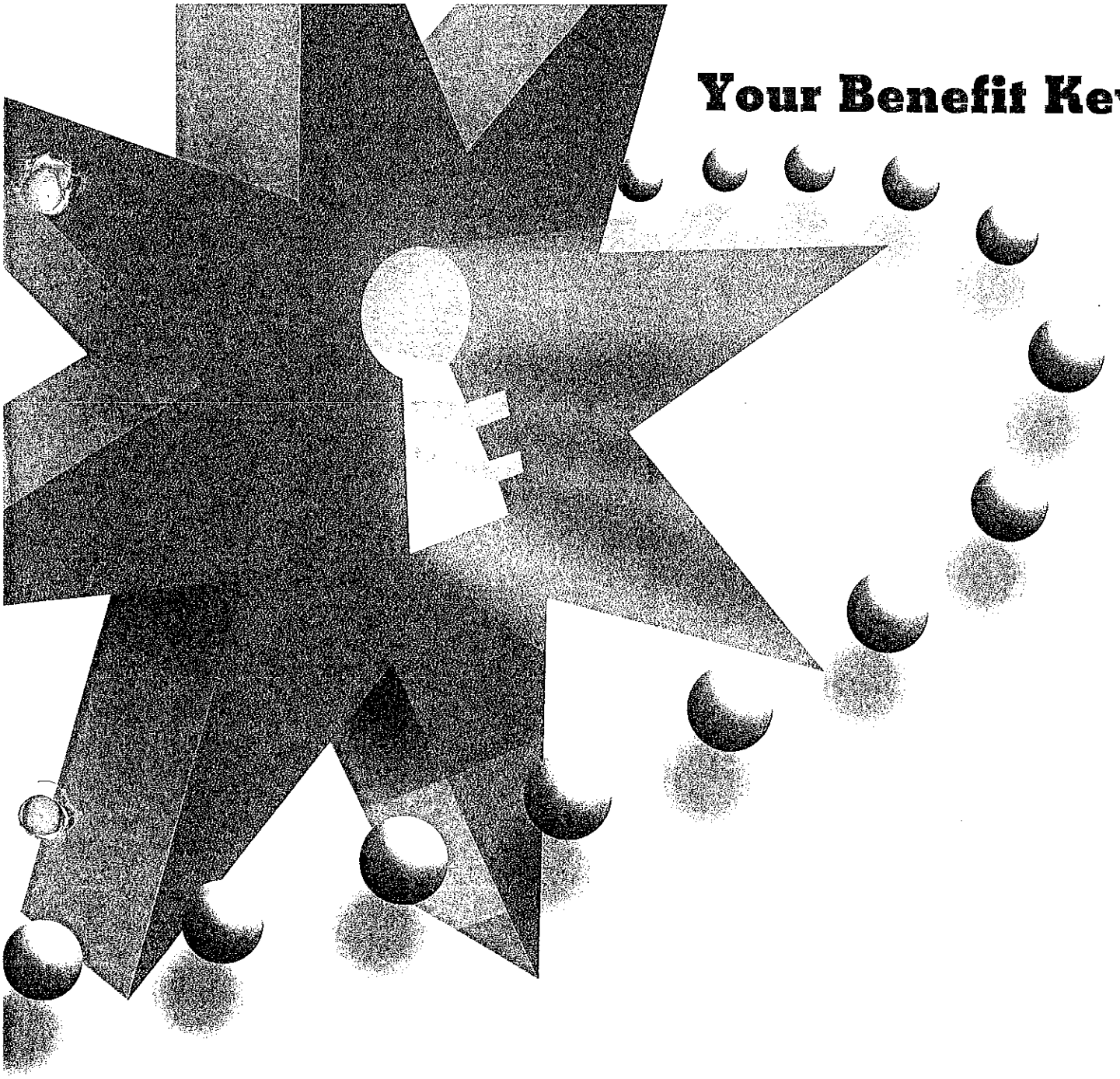
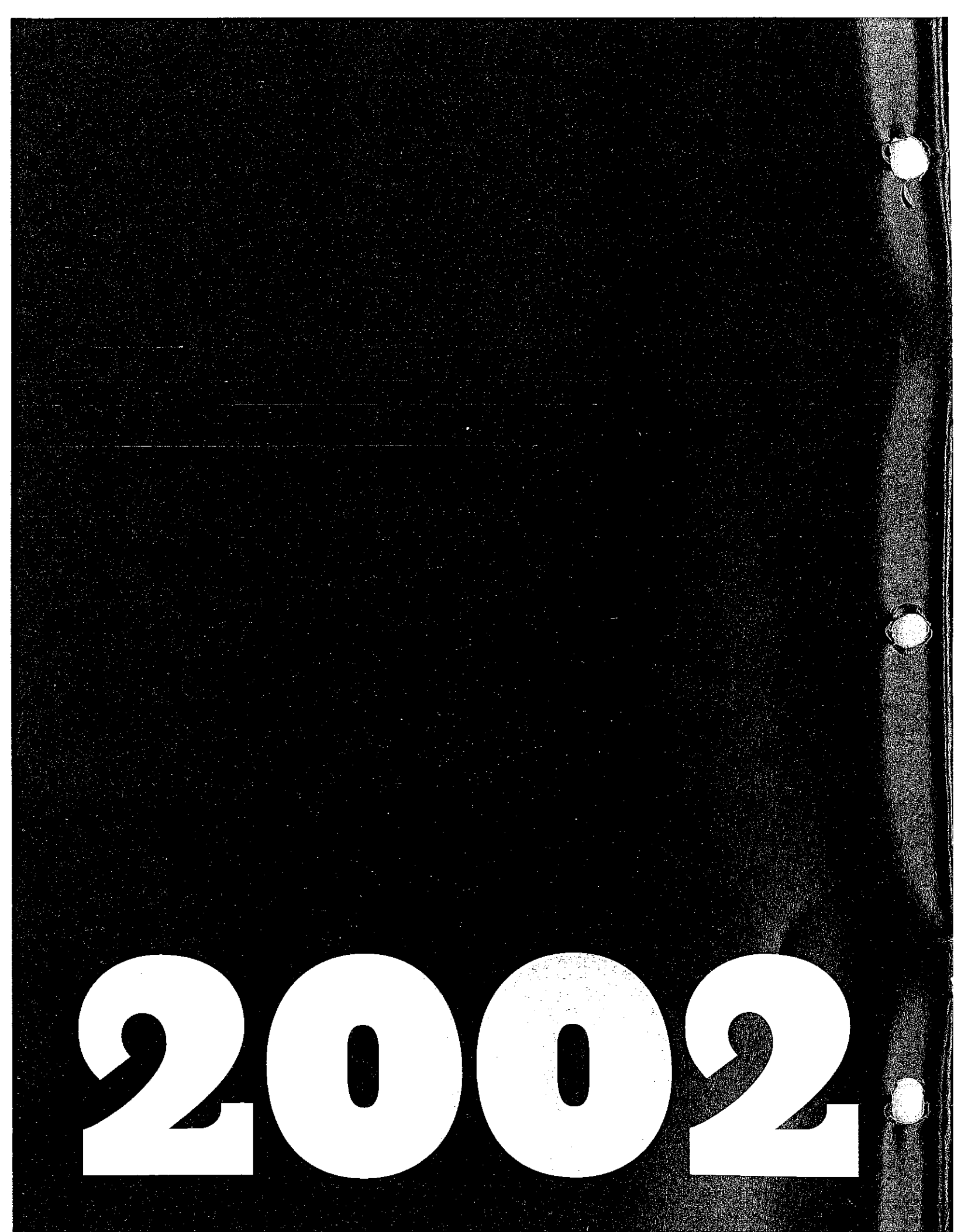


Your Benefit Keys

Everyone must complete the enrollment process!

Enrollment Guide

2002


2002

Enrollment Guide

WELCOME TO YOUR BENEFITS ENROLLMENT GUIDE FOR 2002. DURING THE ENROLLMENT PROCESS, YOU WILL MAKE SELECTIONS FOR THE COMING YEAR FOR MEDICAL, DENTAL, VISION, SUPPLEMENTAL EMPLOYEE TERM LIFE INSURANCE, DEPENDENT TERM LIFE INSURANCE AND OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) COVERAGE, AS WELL AS TAX-FREE REIMBURSEMENT ACCOUNTS.

* EACH FALL, YOU HAVE THE OPPORTUNITY TO REVIEW YOUR SELECTIONS AND MAKE ADJUSTMENTS IN YOUR COVERAGE TO MEET YOUR NEEDS FOR THE FOLLOWING YEAR. YOU DECIDE WHAT'S BEST FOR YOU AND YOUR FAMILY BASED ON PERSONAL CIRCUMSTANCES AND NEEDS.

* THIS FALL, EVERYONE MUST COMPLETE THE ENROLLMENT PROCESS BY NOVEMBER 16, 2001. FOR NEW HIRES, YOU MUST RETURN A PAPER ENROLLMENT FORM WITHIN 31 DAYS OF YOUR ELIGIBILITY DATE.

YOUR ENROLLMENT GUIDE IS YOUR KEY TO UNLOCKING INFORMATION ABOUT YOUR BENEFITS AND CHANGES TO THE PLANS FOR 2002. IT'S FILLED WITH CHARTS TO MAKE IT EASY FOR YOU TO DETERMINE THE BENEFIT PROGRAM THAT'S RIGHT FOR YOU.

Contents

Your Enrollment Guide

This enrollment guide summarizes the key benefits available to you in each category:

- Medical coverage (including a cash payment for employees who opt out).
- Dental coverage.
- Vision coverage.
- Basic employee term life insurance (no election needed).
- Supplemental employee term life insurance.
- Dependent term life insurance.
- Basic accidental death and dismemberment (AD&D) benefits (no election needed).
- Optional accidental death and dismemberment (AD&D) benefits.
- Disability coverage (no election needed; full-time employees only).
- Reimbursement accounts.

You'll want to carefully consider all your options and their costs before you make any final decisions. You pay for some of your benefit coverages through payroll deductions. Other benefits are completely paid for by the company.

Everyone must complete the enrollment process by November 16, 2001. **If you do not complete the enrollment process by the deadline, you will receive only basic life, accidental death and dismemberment, business travel accident and, for full-time employees, disability coverage.**

This means that effective January 1, 2002, all of your other current coverages will end and you will be enrolled for:

- No medical coverage, and you will forfeit the cash payment.
- No dental or vision coverage.
- No supplemental employee term life, dependent term life or optional AD&D coverage.
- No tax-free reimbursement accounts.

Enrollment Guide

If you're a newly hired employee and you do not return an enrollment form within 31 days after your eligibility date, you will have only basic life, basic AD&D and business travel accident coverage. Full-time salaried employees are also eligible for disability benefits. If you do not complete the enrollment process by the deadline, you will not be eligible to receive the cash payment that comes with the No Coverage election for medical.

YOUR CHOICES ARE BINDING FOR 2002

The choices you make during the enrollment period are binding for 2002. You will not have another opportunity to enroll, cancel or change your options or your dependent coverage choices until the next annual enrollment in the fall of 2002 (with changes effective January 1, 2003), unless you have a qualifying change in family status.

ANY QUESTIONS?

The steps you must take during the enrollment period are spelled out under *What You Must Do to Enroll* on page 36.

If you have questions concerning your 2002 enrollment, you may contact the Peabody Benefits Call Center by calling 1-800-633-9005 or sending an e-mail to **benefits@peabodyenergy.com**.

What's Changing in 2002

For the most part, your benefit package for 2002 will look very familiar. Still, there will be a few changes that you'll need to be aware of as you prepare to make your benefit elections for next year. Here are the highlights of these changes:

1. Although your 2002 benefits are not new, you will enroll for them in a brand-new way. Starting this fall, most employees will now make benefit elections *online* via the Peabody intranet. If you have access to the intranet from your work location, you must use the online enrollment process to choose your coverage for 2002. See the special supplement in your enrollment kit, called "How to Enroll" for more information on how to access the system. The online enrollment system will only be available during the fall re-enrollment period. New hires—and those employees without access to the company LAN (local area computer network)—will need to complete a traditional paper enrollment form. This kit should contain a personal summary showing your current (2001) choices.

2. There will be a change to the way you receive maintenance prescription drugs under medical plan Option 250 and Option 500. The plan has provided a financial incentive to help encourage the use of the more cost-effective home delivery (mail-order) service. Starting January 1, 2002, you will pay a $10 surcharge (in addition to your regular cost for the drug) when you obtain maintenance drugs from a retail pharmacy. Maintenance drugs are those medications that are used on a long-term basis (generally beyond 60 days) to treat chronic conditions such as high blood pressure, diabetes, asthma and high cholesterol (certain exceptions apply). If you were participating in the Option 250 or Option 500 medical plan in September, you should have received material explaining this new program. There will be no change to the way your short-term prescription needs are currently provided by your local retail pharmacy.

Eligibility and Enrollment

If you are a full-time salaried employee, you are eligible for coverage. Part-time employees working a regular schedule of 20 or more hours per week are also eligible for benefits, except disability coverage. Temporary employees are not eligible. Pre-paid retirees are not eligible for disability or business travel accident coverage.

DEPENDENT ELIGIBILITY

You can obtain coverage for your eligible dependents under the medical, dental, vision, dependent term life and optional AD&D plans. Members of your family who are eligible for coverage include:

- Your spouse.
- Your children under age 19.
- Your children ages 19 to 23 if they are full-time students at an accredited school, college or university and depend on you for support (for optional AD&D and dependent term life, students under age 25 are eligible). You must provide proof of full-time student status each semester for your child to remain eligible.
- For participants in the United HealthCare Select HMO (St. Louis only), eligible dependents through age 25 if they are full-time students at an accredited school, college or university and depend on you for support.
- For medical, vision, and optional AD&D coverage (but not dental coverage or dependent term life insurance), your disabled child, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability before the limiting age.

Your married children are not eligible for coverage under the plans. No one may be covered under the plans as both an employee and as a dependent, or as a dependent of more than one employee.

PAYING FOR COVERAGE

If you elect coverage, your contributions for medical, dental, vision and optional AD&D coverage will automatically be deducted in equal installments from each paycheck on a before-tax basis. This means you will not have to pay any federal or state taxes on the amount of your salary used to pay for these health plan contributions.

Your costs for supplemental employee term life and dependent term life coverage will be paid with after-tax dollars. Deductions for these benefits will be taken out of your paycheck on the 15th of each month.

Your Medical Keys

During annual enrollment, you choose the medical coverage you need for your family. Below are key features of the various options. See pages 10-11 for details, including family deductibles and out-of-network coverage.

Option 250

- ✳ $250 annual deductible per person for network expenses.
- ✳ Your share of typical network expenses is 20%.
- ✳ Prescription drug benefits through separate program (no deductible).
- ✳ PPO coverage through BlueCross BlueShield network.

Option 500

- ✳ Lower monthly cost for coverage.
- ✳ $500 annual deductible per person for network expenses.
- ✳ Your share of typical network expenses is 25%.
- ✳ Prescription drug benefits through separate program (no deductible).
- ✳ Same PPO coverage as Option 250 through BlueCross BlueShield network.

Option 1000

- ✳ No cost for coverage—you receive a $300 cash payment each year (for full-time employees only).
- ✳ $1,000 annual deductible per person for network expenses.
- ✳ Your share of typical network expenses is 30%.
- ✳ Prescription drug benefits paid through BlueCross BlueShield of Illinois (subject to deductible).
- ✳ Same PPO coverage as other Option choices through BlueCross BlueShield network.

No Coverage

- ✳ You receive a $600 cash payment each year ($300 for part-time employees).

If you are an employee in the St. Louis office, you also have two HMO options available.

COVERAGE CATEGORIES

For any of the Option choices, you can select coverage for:

- ✳ Yourself only.
- ✳ Yourself plus one dependent.
- ✳ Yourself plus two or more dependents.

To cover a dependent for medical, you must also elect the same coverage option for yourself.

COST FOR COVERAGE

The cost for coverage depends on how many dependents you choose to cover under the plan. The table below shows the 2002 monthly contributions for each dependent coverage level for full-time and part-time employees. The cost of coverage for the HMO plans (if available) is shown on your enrollment form.

You will share in any cost increases or decreases in subsequent years. Also, you will share in the cost of medical coverage when you retire.

The table below shows the employee share of monthly medical costs for the various plan options. The majority of the cost continues to be paid by Peabody.

Before-Tax Monthly Contributions for Medical Plan Options

	YOURSELF ONLY	YOURSELF PLUS 1 DEPENDENT	YOURSELF PLUS 2 OR MORE DEPENDENTS
OPTION 250			
FULL-TIME EMPLOYEES	$24.74	$98.80	$173.08
PART-TIME EMPLOYEES	$49.48	$197.60	$346.16
OPTION 500			
FULL-TIME EMPLOYEES	$6.40	$48.98	$91.68
PART-TIME EMPLOYEES	$14.94	$129.90	$245.22
OPTION 1000			
FULL-TIME EMPLOYEES	No cost to you—you receive a $300 annual cash payment at the beginning of each year		
PART-TIME EMPLOYEES	$0.00	$42.42	$112.04
NO COVERAGE			
FULL-TIME EMPLOYEES	You receive a $600 annual cash payment at the beginning of each year. You must have group health coverage from another source to elect this option.		
PART-TIME EMPLOYEES	You receive a $300 annual cash payment at the beginning of each year. You must have group health coverage from another source to elect this option.		

HOW YOU RECEIVE THE CASH PAYMENT

If you elect Option 1000 or No Coverage, the cash payment will be added in a lump sum to a paycheck in January (or as soon as administratively possible). This payment will be subject to the same taxes as your regular pay. If you are a new hire and you elect Option 1000 or No Coverage, you will receive a prorated amount of the cash payment based on when you enroll (cash payment for Option 1000 applies only to full-time employees).

In addition, the following rules will apply if you leave the company or change your coverage before the end of the year:

- If you leave the company or retire during the year, you will have to repay a portion of the cash payment, based on when your employment ends. The repayment amount will be deducted from your last paycheck.
- If you elect Option 1000 or No Coverage during the year (because you are decreasing your coverage due to a qualifying change in family status), you will receive a prorated amount of the cash payment based on when you elect the lower option.
- If you increase your coverage to Option 250 or Option 500 (due to a qualifying change in family status), you will have to repay a prorated amount of the cash payment, based on when you upgrade to the higher coverage.

Comparing Your Options

The table below compares the features of the three Option choices. For St. Louis-area employees, you will receive more information about additional HMO options during the enrollment period.

	OPTION 250		OPTION 500		OPTION 1000	
	NETWORK AND OUT-OF-AREA*	NON-NETWORK	NETWORK AND OUT-OF-AREA*	NON-NETWORK	NETWORK AND OUT-OF-AREA*	NON-NETWORK
DEDUCTIBLES AND COPAYMENTS YOU PAY						
Annual Deductible	$250	$400	$500	$800	$1,000	$1,500
Annual Deductible Family Maximum	$500	$800	$1,000	$1,600	$2,000	$3,000
Hospital Copayment (per admission)	$0	$0	$100	$200	$200	$300
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE AND COPAYMENTS						
Inpatient Hospital and Emergency Room**	80%	60%	75%	55%	70%	50%
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE						
Wellness Benefits (including well-child care, routine physicals and screenings)	100% up to $250 per calendar year (no deductible)	60%	100% up to $250 per calendar year (no deductible)	55%	70% up to $250 per calendar year (no deductible)	50%
Most Other Medical Expenses**	80%	60%	75%	55%	70%	50%
ANNUAL OUT-OF-POCKET MAXIMUMS YOU PAY (includes deductible, hospital copayment and coinsurance)						
Individual Out-of-Pocket Maximum	$1,500	$2,000	$2,500	$4,000	$4,000	$6,000
Family Out-of-Pocket Maximum	$3,000	$4,000	$5,000	$8,000	$8,000	$12,000
LIFETIME MAXIMUM BENEFIT						
	$1 million Indexed annually for inflation (In 2002, limit is $1.9 million)		$1 million Indexed annually for inflation (In 2002, limit is $1.9 million)		$1 million Indexed annually for inflation (In 2002, limit is $1.9 million)	

If emergency services meet the requirements of "urgent or emergency care" as defined by the plan, then the covered charges are treated as if they were from a network provider, whether you go to a network or non-network provider. All hospitalization and certain other types of care must be approved under a Medical Services Advisory program. Benefits may be reduced if you don't comply.

* If you or a covered dependent lives outside the network area, benefits will be paid at network rates. Your eligibility records must be adjusted, however, or all claims will be processed as out-of-network. Contact the Peabody Benefits Call Center at 1-800-633-9005 or e-mail **benefits@peabodyenergy.com** for information and forms. ("Out-of-area" does not apply to prescription drugs.)

** Inpatient Mental Health and Substance Abuse benefits are limited to 30 days per calendar year and up to 60 days per lifetime. Outpatient Mental Health and Substance Abuse benefits are limited to 30 visits per calendar year and do not apply toward the out-of-pocket maximum. Emergency room copayment of $50 is required if care was not for a true emergency.

	OPTION 250		OPTION 500		OPTION 1000	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
PRESCRIPTION DRUG BENEFITS (AMOUNT THE PLAN PAYS)	**PAID THROUGH SEPARATE PRESCRIPTION DRUG PROGRAM** (no deductible or out-of-pocket maximum)		**PAID THROUGH SEPARATE PRESCRIPTION DRUG PROGRAM** (no deductible or out-of-pocket maximum)		**PAID THROUGH BLUECROSS BLUESHIELD OF ILLINOIS[1]** (annual deductible and out-of-pocket maximum apply)	
Retail Generic Drugs (30-day supply)	85% $10 minimum copay[2]	70% $10 minimum copay[2]	75% $10 minimum copay[2]	60% $10 minimum copay[2]	70% After deductible	
Retail Brand-Name Drugs (30-day supply)	80%[2][3] $15 minimum copay	70%[2][3] $15 minimum copay	70%[2][3] $15 minimum copay	60%[2][3] $15 minimum copay	70% After deductible	
Home Delivery Pharmacy Generic Drugs (up to a 90-day supply)	$10 copay	N/A	$20 copay	N/A	N/A	
Home Delivery Pharmacy Brand-Name Drugs (up to a 90-day supply)	$20 copay[3]	N/A	$30 copay[3]	N/A	N/A	

[1] If your prescriptions are filled at a participating BlueScript pharmacy, you will receive discounts, and the pharmacy will file your claims for you. After you meet your annual deductible, BlueCross BlueShield of Illinois will reimburse 70% of the cost of each prescription for the rest of the calendar year (or 100% after you have met the annual out-of-pocket maximum). If you use a non-participating provider, you receive the same level of benefits, but you must file a claim for reimbursement with BlueCross BlueShield of Illinois.

[2] If you receive a maintenance drug from a retail pharmacy instead of using the Merck-Medco Home Delivery Pharmacy (mail-order), you will pay a $10 surcharge in addition to your regular coinsurance/copayment share of the cost.

[3] If you or your doctor requests a brand-name drug when a generic equivalent is available, you will also pay the difference in cost.

BENEFITS FOR MAINTENANCE DRUGS UNDER OPTION 250 AND OPTION 500

With Option 250 and Option 500, you receive prescription drug benefits through the Merck-Medco pharmacy program. Maintenance drugs are available from the Merck-Medco Home Delivery Pharmacy (a mail-order service). You pay only your copayment for each prescription or refill, up to a 90-day supply.

Beginning January 1, 2002, you will pay a $10 surcharge for maintenance drugs when you have your prescription filled at a retail pharmacy instead of obtaining them through Merck-Medco's Home Delivery Pharmacy. The $10 surcharge will be in addition to the coinsurance and/or copayment you already pay for retail pharmacy purchases, as shown in the medical plan summary chart on the previous page.

Maintenance drugs are those medications that are used on a long-term basis (generally beyond 60 days) to treat chronic conditions such as high blood pressure, diabetes, asthma and high cholesterol.

When you enroll for Option 250 or Option 500 medical coverage, you receive an information packet explaining the Home Delivery Pharmacy service. This packet includes a list of the most common maintenance drugs that are currently subject to the $10 surcharge if they are obtained from a retail pharmacy. Your informational packet also includes a list of exceptions to this requirement.

To ease the transition to this new program for 2002, the plan will cover up to two retail pharmacy purchases of your maintenance drug (up to a 30-day supply per prescription or refill) without applying the surcharge. After two retail pharmacy purchases of these medications on or after January 1, 2002, however, you must obtain refills through the Home Delivery Pharmacy service to avoid paying the surcharge.

This change does not affect prescription drug benefits under Option 1000 (or under the HMO options for St. Louis employees). With Option 1000, your prescription drug expenses are reimbursed by BlueCross BlueShield at 70% after you meet the $1,000 annual medical deductible.

IF YOU ENROLL YOURSELF AND YOUR DEPENDENTS UNDER TWO PLANS

If you are thinking about covering yourself and/or your dependents under two plans, be sure you find out how the two plans will coordinate benefits. Your Peabody coverage will always be primary for you as an employee, but Peabody coverage may not necessarily be primary for your children if they are also covered under your spouse's plan. Before making a decision about coverage, you'll want to find out which plan pays first for each dependent and how much the secondary plan pays. For more information, consult the *Coordination of Benefits* section of your medical summary plan description.

CHANGING YOUR MEDICAL COVERAGE

The choices you make during the annual enrollment period are effective January 1, 2002, and are binding throughout the calendar year. Except in certain cases, you will not be able to enroll, cancel or change your options or your dependent coverage choices until the next annual enrollment period. The options available to you depend on your situation, as shown in the summary below.

YOUR SITUATION	YOUR OPTIONS
You elect Option 250	You can decrease or drop coverage, or switch to an HMO, at any annual enrollment period. If you drop coverage, you must show proof of other coverage.
You elect Option 500, Option 1000, or No Coverage	You can decrease or drop coverage, upgrade your coverage one level, or switch to an HMO during any annual enrollment period. If you drop coverage, you must show proof of other coverage.
You elect HMO coverage (if available)	You can switch to any Option choice or drop coverage at any annual enrollment period. If you drop coverage, you must show proof of other coverage.
You gain coverage under another plan due to marriage or a change in your spouse's job, or because your spouse's employer offers annual enrollment at a different time of year than Peabody	You can drop or decrease Peabody coverage within 31 days of the date your other coverage starts. If you drop coverage, you must show proof of other coverage.
You gain a new dependent through marriage, birth or adoption	You can change from No Coverage to any Peabody medical option, or add the new dependent to your current Peabody coverage, within 31 days of the qualifying change.
You have coverage from another source and lose it during the plan year for certain reasons	You can enroll for any Peabody medical option, or upgrade your coverage, within 31 days of the loss of coverage. (You may not change to an HMO option in this case, unless you had previously elected No Coverage.)

Below are more details about the rules that apply to changing your coverage:

During the Annual Enrollment Period

- If you decline coverage now for you and/or your dependents, you may enroll during the next annual enrollment period, but your choice of plans will be limited to Option 1000.
- If you enroll for one of the Option choices, you can only increase your coverage by one level in the following year. For example, you can switch from Option 1000 to Option 500, or from Option 500 to Option 250. You cannot increase **two** coverage levels—from Option 1000 to Option 250.
- You may change to or from an HMO (if available) during any annual enrollment period. If you are moving from an HMO, you can choose any Option choice.

Enrollment Guide

Special Situations (Changes in Family Status)

- If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you may add the new dependent to your current coverage option. Or, if you previously elected No Coverage, you may enroll yourself, your spouse and any newly acquired dependent child in any one of the Option choices (or an HMO alternative, if available). You must do so within 31 days of the date the person becomes your dependent. If you enroll during this 31-day period, coverage will begin on the day you acquired the new dependent.

- You may cancel coverage or drop a dependent if you need to because of a divorce, death, or because a dependent is no longer eligible. You must complete a new enrollment form within 31 days of the event.

- If you become covered under another medical plan due to marriage or a change in your spouse's employment, or because your spouse's employer offers annual enrollment at a different time of year than our company, you may cancel coverage or decrease to a lower option if you complete a new enrollment form within 31 days.

- You may decide not to elect medical benefits under a company plan or select a lower plan option because you and/or your dependents have other coverage, such as through your spouse's employer. In this situation, you may enroll and/or add dependents to your coverage—or upgrade your coverage—if (1) the other coverage ends because you or your dependent are no longer eligible for such other coverage; (2) an employer makes a significant change to the cost or benefits of the other coverage; or (3) the other coverage ends because it was provided under a COBRA continuation provision and the right to coverage has been exhausted. You must complete a new enrollment form within 31 days after the other coverage ends. You may be required to provide evidence of loss of coverage.

PRE-EXISTING CONDITIONS LIMITATION

As a reminder, certain limits will continue to apply to pre-existing conditions when you or your dependents are first enrolled for medical coverage or you change from No Coverage to one of the Option choices in the future.

- A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care or treatment (including prescription drugs) was recommended or received within the six-month period ending on the individual's enrollment date. For this purpose, the term "enrollment date" means, for an employee who enrolls when first eligible, the first day of employment as an eligible employee; in all other cases, enrollment date is the date coverage begins.
- Charges related to a pre-existing condition are not covered during the 12-month period starting on the individual's enrollment date, as defined above.
- This 12-month period will be reduced by the length of time an individual had "creditable coverage" under a previous plan.
- The limit for pre-existing conditions will not apply to pregnancy. It also does not apply to a child enrolled within 31 days of birth or placement for adoption, in most cases.

Your medical summary plan description booklet contains details about the pre-existing conditions limitation.

IMPORTANT INFORMATION ABOUT MEDICAL COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

Under federal law, group health plans that provide medical and surgical benefits for mastectomies must also provide coverage for the following services, which are to be provided in a manner determined in consultation with the attending physician and the patient:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications in all stages of the mastectomy, including lymphedemas.

As with other covered services, the usual deductibles, copayments or percentage share of expense you are required to pay will apply.

Your Dental Keys

During annual enrollment you choose the dental coverage you need for your family. You may select the company dental plan, or you may choose no coverage. Your dental coverage choice is completely separate from your medical election.

COVERAGE CATEGORIES

For dental, you can select coverage for:

* Yourself only.
* Yourself plus one dependent.
* Yourself plus two or more dependents.

To cover a dependent for dental, you must also elect that coverage for yourself.

Before-Tax Monthly Contributions for Dental Coverage

	YOURSELF ONLY	YOURSELF PLUS ONE DEPENDENT	YOURSELF PLUS TWO OR MORE DEPENDENTS
FULL-TIME EMPLOYEES	$2.00	$7.98	$13.98
PART-TIME EMPLOYEES	$4.00	$15.96	$27.96

You will share in any cost increases or decreases in subsequent years.

Dental Benefits Summary

	PREVENTIVE	BASIC	MAJOR	ORTHODONTIA
Deductible	$0	$50 (lifetime)	$50 (per calendar year)	$100 (lifetime)
Amount the plan pays	100%★	80%★	60%★	60%★
Maximum benefits	$750 (per calendar year)			$1,000 (lifetime)

★ Coverage limited to allowable fees charged by the majority of Delta Dental participating dentists.

DELTA DENTAL PARTICIPATING DENTISTS

Your dental benefits are administered by Delta Dental, which 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.

NON-PARTICIPATING DENTISTS

If you go to a non-participating 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 non-participating 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 in the following example.

Example

	DELTA DENTAL PARTICIPATING DENTIST	NON-PARTICIPATING DENTIST
Charge for fillings (basic care)	$60	$65
Allowable charge★	$60	$55
Plan pays (80% assuming deductible is satisfied)	$48	$44
Employee pays (20% plus amount over allowable charge)	$12	$21

★ Participating Delta dentists' fees have been accepted in advance. For non-participating dentists, the allowable charge may be lower.

Also, you are responsible for paying the non-participating dentist and filing your own claim. The address for dental claim filing is on your Delta Dental ID card. Benefits will be paid directly to you, and may not be assigned to the dentist.

To find out how your dentist can join the network, call 1-800-392-1167.

CHANGING YOUR DENTAL COVERAGE

The choices you make during the annual enrollment period are effective January 1, 2002, and are binding throughout the calendar year. Except in certain cases, you will not be able to enroll, cancel or change your dependent coverage choices until the next annual enrollment period.

The following rules apply to changing your coverage:

During the Annual Enrollment Period

* If you decline coverage now for you and/or your dependents, you may enroll during the next annual enrollment period (for 2003), but your coverage will be limited to preventive care benefits only during the first 12 months of your coverage. This also applies if you did not elect dental coverage for 2001 and now wish to enroll for 2002.

Special Situations (Changes in Family Status)

* If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you may add that dependent as long as you do so within 31 days of the date the person becomes your dependent. If you enroll during this 31-day period, coverage will begin on the day you acquire the new dependent.

* You may cancel coverage or drop a dependent if you need to because of a divorce, death, or because a dependent is no longer eligible. You must complete a new enrollment form within 31 days of the event.

* If you decide not to enroll in the plan because you and/or your dependents have coverage under your spouse's plan, and then you lose that coverage as the result of a divorce, death or a change in your spouse's employment, you may enroll in the plan at that time. To do so, you must complete an enrollment form within 31 days of the date the other coverage ends.

In these situations, there will be no special restrictions on your dental coverage. However, the plan will not cover treatment already in progress on the date your coverage begins.

Your Vision Keys

During annual enrollment, you choose the vision coverage you need for your family. You may select vision coverage, or you may choose no coverage. Vision coverage is offered through Vision Service Plan (VSP).

COVERAGE CATEGORIES

For vision, you can select coverage for:

- Yourself only.
- Yourself plus one dependent.
- Yourself plus two or more dependents.

To cover a dependent for vision benefits, you must also elect that coverage for yourself.

Vision Care Benefits Summary

SERVICE	NETWORK BENEFIT (VSP Providers)	NON-NETWORK BENEFIT (maximum reimbursement)
Eye examination	100%*	$38*
Eyeglass lenses		
Single-vision	100%**	$31**
Bifocal	100%**	$51**
Trifocal	100%**	$64**
Lenticular	100%**	$80**
Frames	100%**	$45**
Contact lenses (instead of eyeglasses)		
Necessary	100%**	$210**
Elective	$105	$105

Note: Contact lenses are elective when your vision could be corrected with glasses, but you choose contact lenses instead. Necessary contact lenses are those that are the only option for correcting your vision.

* You pay a $10 copayment.

** You pay a $15 copayment. The allowances shown for lenses are for a pair of lenses. If only one lens is needed, the allowance will be half the amount for a pair. Benefits for frames are limited to the maximum VSP allowance.

Before-Tax Monthly Contributions for Optional Vision Care Coverage

	YOURSELF ONLY	YOURSELF PLUS ONE DEPENDENT	YOURSELF PLUS TWO OR MORE DEPENDENTS
Employee Cost*	$6.44	$9.36	$16.80

* The company does not contribute toward the cost of optional vision care coverage.

NETWORK CARE

When glasses or contacts are prescribed by VSP providers, VSP guarantees the quality of the materials, including fittings and adjustments, to ensure the highest level of care and comfort for you and your family.

When you need vision care, all you have to do is call a VSP participating doctor for an appointment and identify yourself as a VSP member. You aren't required to complete any up-front paperwork or obtain a benefit form.

If you need assistance in locating a VSP participating doctor, you may call VSP at 1-800-VSP-7195 (877-7195) or go to **www.vsp.com** on the Internet.

When you call, the VSP participating doctor will also need to know your identification number (usually the Social Security number), and the organization that provides your benefits (Peabody). You'll need to have this information on hand.

If you obtain services from a VSP network provider, VSP will pay the provider directly. You pay only a $10 copayment for each examination or a $15 copayment for eyeglass lenses and frames (once in any 24-month period). You are responsible for the cost of any additional services such as tints, coated lenses, progressive lenses, etc., or the cost of a frame over the VSP allowance. The majority of frames available are covered. If you purchase elective contact lenses, you pay the amount of the cost in excess of the VSP allowance shown in the summary chart, plus the eye examination copayment.

NON-NETWORK CARE

You may obtain vision services from any licensed vision provider, although using non-network providers will affect the claims procedure and the amount of benefits you receive. When you receive your vision care from a non-network provider, you pay the provider's charge at the time of service, and you must file a claim with VSP within six months of the date services were provided.

VSP will then reimburse you for the charges (minus the copayments), up to the non-network maximum amount. For example, if you receive an eye examination from a non-network provider who charges $50, you pay the $10 copayment plus $2 (the amount of the remaining charge in excess of the maximum reimbursement of $38).

CHANGING YOUR VISION CARE COVERAGE

You may elect or continue vision coverage for 2002 if:

* You are currently enrolled for vision coverage, or
* You are electing vision coverage for the first time.

However, if you dropped your vision coverage during the 2001 enrollment period, you may not enroll for coverage in 2002. (Your next opportunity to enroll will be in the fall of 2002, with coverage effective January 1, 2003.)

You may also drop your vision coverage during the annual enrollment period. However, if you do, you will have to wait two years before you can re-enroll in this coverage.

Your election is binding for 2002. You may add or drop dependents from your coverage during the year if you have a change in family status that justifies a change. In addition, you may change your election during the next annual enrollment period.

Your Employee Term Life Insurance Keys

To help provide your loved ones with financial protection in the event of your death, you have the opportunity to choose from a variety of term life insurance levels.

The company provides a "basic" employee term life insurance benefit equal to one times your annual basic salary at no cost to you. You do not need to make an election for this basic coverage. In addition to this coverage, you can choose "supplemental" employee term life insurance coverage equal to one, two, three or four times your annual basic salary.

Because there is much in common between these two types of term life insurance coverage, they are discussed together in this section.

HOW YOUR BASIC AND SUPPLEMENTAL COVERAGE WORKS

All eligible employees receive a basic term life insurance benefit equal to one times annual basic salary. The IRS requires that the employer cost of your basic employee term life insurance coverage in excess of $50,000 be considered taxable income to you. Because you do not have to make an election for your basic term life benefit, this coverage will not appear as one of your choices when you enroll for benefits.

In addition to your basic term life insurance benefit, you have the option to purchase supplemental employee term life insurance coverage.

For purposes of both the basic employee term life insurance plan and the supplemental employee term life insurance plan, the coverage amount will be based on your current annual basic salary rounded to the next $100. The coverage amount(s) will automatically be adjusted for salary fluctuations.

If you die, the amount of your term life insurance coverage will be paid to the beneficiary you designate.

Note: When you retire, your term life insurance amount is reduced to 25% of your annual pay in effect immediately before your retirement. At age 70, this amount is further reduced to a maximum of $10,000.

YOUR SUPPLEMENTAL EMPLOYEE TERM LIFE INSURANCE

As you can see from the following chart, supplemental employee term life insurance options are multiples of your annual basic salary rounded to the next $100. For example, if your annual basic salary is $20,000 and you choose Option 2 (two times annual basic salary), your supplemental employee term life insurance benefit is $40,000, and your basic term life insurance benefit is $20,000 (for a total coverage amount of $60,000).

Supplemental Employee Term Life Insurance Coverage Amounts

Option 1	One times annual basic salary
Option 2	Two times annual basic salary
Option 3	Three times annual basic salary
Option 4	Four times annual basic salary

In no event, however, can your combined basic and supplemental employee term life insurance amount exceed $1 million.

Changing Your Coverage

You may increase your supplemental employee life coverage by one level (or change from no coverage to Option 1) during the annual enrollment period, subject to evidence of good health requirements described in the next section. You can decrease your coverage as many levels as you choose. The choices you make during this enrollment period are effective January 1, 2002. However, if you choose to increase your coverage, that coverage may be delayed if you are not actively at work, or if your coverage choice requires evidence of good health.

The only other time you may change your supplemental employee term life insurance coverage is if you have a change in family status that justifies a change. You must submit the proper change forms within 31 days of the event. At that time, you can decrease your coverage to any level or increase your supplemental term life insurance coverage one level, subject to the rules for evidence of good health, provided the change you make is consistent with the family status event.

Evidence of Good Health Requirements

Because employees have a wide variety of coverage choices under the supplemental employee term life insurance plan, the insurance company restricts the amount of coverage you can choose without having to provide evidence of good health.

Supplemental employee term life insurance greater than $300,000 requires evidence of good health. Coverage in excess of this limit will not be effective until you complete a health questionnaire and the insurance company approves your application.

Your current (2001) coverage amount may already exceed $300,000. If so, you will not have to requalify unless you are applying for an increase in your coverage amount.

This limit applies only to the supplemental employee term life insurance plan.

Tobacco Versus Non-Tobacco Rates

Supplemental employee term life insurance rates vary depending whether or not you smoke or use other tobacco products. Any time you have gone at least 12 consecutive months without smoking or using other tobacco products, you are eligible for the lower "Non-Tobacco" rates. If you use tobacco now and elect the "Tobacco" rates but later stop using tobacco, you can change to the "Non-Tobacco" rates after you have been tobacco-free for 12 months.

How to Make the Right Choice

Your premium rates will depend on your age (as of January 1, 2002), your coverage amount and whether or not you use tobacco. For more information about your life coverage options, including information about coverage for retired and disabled employees, refer to your summary plan description booklet.

Your Dependent Term Life Insurance Keys

If you choose, you may also purchase life insurance for your spouse and/or your eligible dependent children. This benefit helps provide you with protection against financial difficulties in the event of a loved one's death.

These are your choices for covering your spouse:

* No spouse coverage.
* Spouse coverage in the amount of $10,000.
* Spouse coverage in the amount of $20,000.

These are your choices for covering your eligible dependent child or children:

* No child coverage.
* Child coverage in the amount of $5,000 per child.

The cost of life insurance for your children is the same, regardless of how many children you have.

Your choice of whether to cover your spouse, if any, is separate from your choice of whether to cover your children. You may cover your spouse only, your children only, both or neither.

You are automatically the beneficiary of your dependents' life insurance coverage.

If your eligible dependent is totally disabled on the date that coverage would normally begin, his or her coverage will not start until the date he or she is no longer disabled.

After-Tax Monthly Contributions for Dependent Term Life

	COVERAGE AMOUNT	EMPLOYEE COST*
SPOUSE COVERAGE AMOUNT	$10,000	$3.50
	$20,000	$7.00
CHILD COVERAGE AMOUNT	$5,000	$1.00 (regardless of number of children)

*The company does not contribute toward the cost of dependent term life insurance.

CHANGING YOUR COVERAGE

You may choose dependent life insurance or change the amount of your spouse's coverage during the annual enrollment period. The choices you make during this enrollment period are effective January 1, 2002. However, coverage may be delayed if you are not actively at work, or your coverage choice requires evidence of good health.

The only other time you may enroll or change your dependent life coverage choices is if you have a change in family status that justifies a change—for example, if you gain a dependent through marriage, birth or adoption, or lose a dependent through divorce or death, or because a child no longer qualifies as an eligible dependent. Your coverage change must be logically consistent with the change in family status, and you must submit the proper change forms within 31 days of the event.

EVIDENCE OF GOOD HEALTH REQUIREMENTS

If you enroll your eligible dependents for dependent term life insurance, within 31 days of when they first become eligible—you may do so without providing evidence of your dependents' good health.

If you do not enroll your dependents within 31 days of when they first become eligible, and then you decide to enroll them later, you will have to provide evidence of good health for each person you wish to cover, and coverage for your spouse will be limited to the $10,000 option. During the following annual enrollment, you may choose to increase the spouse coverage amount to $20,000 without having to provide evidence of good health.

Your Basic Accidental Death & Dismemberment Keys

The company provides all eligible employees with basic accidental death and dismemberment (AD&D) insurance benefits equal to three times your annual basic salary. This coverage pays a benefit to your beneficiary in the event of your death or to you if you sustain certain types of injuries as the result of an accident.

The company will continue to provide a business travel accident insurance benefit equal to five times your annual basic salary ($500,000 maximum).

Because you do not have to make an election for basic AD&D and business travel accident coverage, these benefits will not appear when you enroll for benefits.

Both basic and optional AD&D coverage terminate at retirement.

Your Optional Accidental Death & Dismemberment Keys

You may purchase optional accidental death and dismemberment (AD&D) coverage as a supplement to your basic AD&D coverage. This optional AD&D coverage pays a benefit to your beneficiary in the event of your death, or to you if you sustain certain types of injuries as the result of an accident. The benefits paid by this optional coverage are in addition to benefits paid by your basic employee term life insurance and your basic AD&D coverage. You pay your optional AD&D premiums with before-tax payroll deductions.

OPTIONAL AD&D COVERAGE AMOUNT

You may choose any amount of coverage from $10,000 to $500,000, in multiples of $10,000. However, you may not choose more than $250,000 if that amount is more than 10 times your annual basic salary. The plan pays all or a portion of your benefit amount if you die or sustain certain types of injuries within 365 days of a covered accident. Covered losses include accidental death or paralysis, loss of hands, feet, speech, hearing or sight. There also are several plan features that provide additional benefits to help you and your family recover from the financial losses these injuries may cause. Refer to your summary plan description booklet for details.

FAMILY COVERAGE OPTION

You may also choose AD&D coverage for your spouse and eligible dependent children. If you choose the family coverage option, the plan will pay a benefit to you in the event that a covered accident causes death or certain injuries to one of your covered family members. Benefit amounts will depend on the coverage level you choose for yourself and the family members you have at the time of a covered accident. If you choose to cover your spouse and dependent children, your dependents' coverage amount will equal a percentage of your own amount, as follows:

IF AT THE TIME OF AN ACCIDENT YOUR FAMILY INCLUDES THESE DEPENDENTS:	DEPENDENT'S COVERAGE EQUALS THIS PERCENTAGE OF YOUR COVERAGE:
Spouse and dependent children	55% spouse, 10% each child*
Spouse, no children	60% spouse
Dependent children, no spouse	20% each child*

* The maximum benefit for each child is $30,000.

COVERAGE AMOUNT AFTER AGE 70

Your optional AD&D coverage amount will be reduced when you or your spouse reach certain ages, as explained in your summary plan description booklet. Your premiums will be based on the original coverage amount, before the reduction.

CHANGING YOUR COVERAGE

Generally, the annual enrollment period is the only time you can enroll in or increase optional AD&D coverage. However, you also can begin or increase your coverage, or choose to cover your spouse and dependent children, within 31 days of either of the following events:

* Your marriage.
* The birth or adoption of your first child.

In either case, your new coverage will become effective the first of the month following the date you complete and return your enrollment form, provided you do so within 31 days of the event.

If you are not actively at work due to illness or injury on the date your coverage would otherwise begin, your coverage will not be effective until you return to work.

Your Disability Keys

The company provides short-term and long-term disability coverage under the Disability Plan to all full-time salaried employees. Part-time employees and employees on pre-paid retirement are not eligible for disability benefits. Because you do not have to make an election for disability benefits, these coverages will not appear when you enroll for benefits.

SHORT-TERM DISABILITY (STD) BENEFITS

For those full-time employees with fewer than five years of service, the plan pays 100% of your monthly basic salary for the first month of an approved disability and 60% of your monthly basic salary through five additional months of an approved disability. For those full-time employees with five or more years of service, the plan will provide 100% of your monthly basic salary for up to six months of an approved disability.

Peabody currently pays 100% of the cost for this coverage.

EMPLOYEES WITH FEWER THAN 5 YEARS OF SERVICE	EMPLOYEES WITH 5 OR MORE YEARS OF SERVICE
100% of monthly basic salary for first month; 60% of monthly basic salary through 5 additional months of disability	100% of monthly basic salary for up to 6 months of disability

LONG-TERM DISABILITY (LTD) BENEFITS

If your approved disability continues after six months of STD, the Disability Plan provides LTD benefits equal to 60% of your monthly basic salary. Your monthly benefit will be reduced by any additional benefits you are eligible for, such as workers' compensation and Social Security disability. LTD benefits may continue until you reach age 65, or longer if you become disabled after age 60.

IF YOU BECOME DISABLED

Our disability claims administrator is VPA. VPA will work with employees and the company to help guide you through the disability claim process and to assist you in returning to work as quickly and as safely as possible.

Here's a reminder about how your disability claims will be managed. If you are absent from work due to an illness or injury for seven consecutive calendar days or longer, you must call VPA on the eighth day at 1-800-520-9714 to file an STD claim. VPA will work with you and your doctor to evaluate your claim for benefits. If you do not file a claim, your pay will not continue. VPA will manage your claim for STD and later for LTD, if necessary. If you have a recurrence of a prior disability, you must call VPA immediately.

VPA will:

- Ask you about your condition and medical treatment.
- Ask you to have your physician provide relevant medical information to VPA.
- Review the medical information provided by your doctor.
- Consult with your supervisor about the job requirements.
- Approve your absence, if appropriate.
- Notify you in writing whether benefits will continue to be paid.
- Contact you as needed during your disability.
- Refer and coordinate rehabilitation services when needed.
- Assist you in obtaining Social Security Disability Income, if appropriate.
- Provide assistance in planning your return to work.

After your initial call with VPA, you can call the same toll-free number (1-800-520-9714) 24 hours a day, seven days a week, to hear the status of your claim. If you call during normal business hours, you can discuss your claim with a VPA claims representative.

Your Reimbursement Accounts Keys

You have two reimbursement accounts that allow you to pay for many common expenses using untaxed money deducted from your paycheck: the health care reimbursement account and the day care reimbursement account. Enrollment in these accounts is voluntary—you may decide to use one, both or neither. They are separate accounts, although they have many similar features. The IRS requires that you spend this money by the end of the year or lose it. With a little planning, you can save an amount equal to your tax bracket for many eligible expenses.

HEALTH CARE REIMBURSEMENT ACCOUNT

As you review your health care coverage costs, keep in mind that the tax-free health care reimbursement account can help you reduce your annual health care expenses. Your monthly health plan contributions automatically will be paid with tax-free payroll deductions. However, you can also save taxes on your deductibles and other out-of-pocket expenses by using the health care reimbursement account. Check your summary plan description booklet for more details on which expenses are covered.

Through the health care reimbursement account, you may set aside any amount from $120 to $2,400 a year. This money is conveniently deducted from your pay—before it is taxed—in equal installments for each pay period throughout the year and placed in your health care reimbursement account.

DAY CARE REIMBURSEMENT ACCOUNT

You can use the day care reimbursement account to pay the cost of day care for young children or a dependent adult. You decide how much you want to deposit in your account, up to a maximum of $5,000 per year (if you are married and file separate tax returns, the maximum deposit is $2,500). The minimum annual deposit is $120. Check your summary plan description booklet for more details on which expenses are covered. Be sure to compare the tax advantages of the day care reimbursement account and the federal child care tax credit. You will need to decide which one provides more tax savings for you. In general, if your annual family income is more than $24,000, you will pay less in income and Social Security taxes by using the day care reimbursement account.

Special Rules

While the reimbursement accounts provide a good way for you to reduce your taxes, you should be aware of several rules:

- You will lose any money that you put into your accounts and do not use by the end of the year. This is an IRS rule. Therefore, you should put aside money only for those expenses that you feel certain you will have in 2002.
- If your family status changes because of a birth, death, marriage, divorce or a spouse losing his or her job, you can enroll, cancel or change your monthly deposit for either account subject to the plan rules explained in your summary plan description booklet. Also, you may change your deposits to the day care reimbursement account if you must do so due to a change in day care providers, a change in your need for dependent day care, or a significant increase in your cost for day care (other than a cost increase imposed by a relative). Otherwise, according to IRS rules, you may change your deposits to either account only during the annual enrollment period.
- Reimbursement under the day care reimbursement account cannot exceed the amount you currently have deposited. Health care reimbursement account claims will be paid as long as they do not exceed the amount of your annual election.
- The deadline for submitting reimbursement expenses incurred during the current calendar year is March 31 of the following year.
- You cannot transfer amounts between your accounts, nor can you use funds from one account to pay expenses eligible under the other account, or vice versa.
- Expenses you incur before you become a participant, or after your participation ends, are not eligible.
- Your salary-related benefits, including your short-term and long-term disability, basic and supplemental term life insurance and basic and optional AD&D, are not affected by the reimbursement accounts. These benefits are based on your total, unreduced pay.
- You cannot fund your monthly medical, dental or vision plan contributions through a reimbursement account. These contributions are automatically deducted on a tax-free basis through separate payroll deductions.

Use the worksheets provided in the following pages to help you determine how much to set aside in your reimbursement accounts.

Health Care Reimbursement Account Worksheet

Use this worksheet to help estimate how much money to contribute to your health care reimbursement account for health expenses not covered by the benefit choices you're making. You may contribute up to $2,400 annually. Remember to plan your contributions carefully. If you contribute more to your account than you can use during the year, you lose the balance. As a first step, it may be helpful to list your expenses for this year. Annual contributions will be withheld in equal installments from your paychecks throughout the year.

ESTIMATED ANNUAL EXPENSES (that are not reimbursed by an insurance plan)	ESTIMATED COST	
	Current year	Next year
Medical plan deductibles	$	$
HMO or medical plan copayments or expenses not covered—up to the out-of-pocket maximum per year	$	$
Copayments for prescription drugs	$	$
Dental deductibles, copayments or expenses not covered by the plan	$	$
Eye examinations, contacts and/or glasses not paid in full by the vision plan, or not paid if you choose not to enroll in the vision plan	$	$
Expenses for mental illness and substance abuse care above the medical plan limits	$	$
Chiropractic care	$	$
Hearing care	$	$
Birth control pills and devices prescribed by a physician	$	$
Special services or equipment for the mentally or physically disabled	$	$
Other	$	$
TOTAL ANNUAL ESTIMATED OUT-OF-POCKET HEALTH CARE EXPENSES	$	$
	÷12	÷12
ESTIMATED MONTHLY CONTRIBUTION FOR HEALTH CARE EXPENSES =	$	$

See your summary plan description booklet for a description of eligible expenses.

Day Care Reimbursement Account Worksheet

Use this worksheet to help estimate how much money to contribute to your day care reimbursement account to cover expenses for the care of your dependents while you work. You may contribute up to $5,000 annually depending on the income and tax filing status of you and your spouse. Remember to plan your contributions carefully. If you contribute more to your account than you can use during the year, you lose the balance. As a first step, it may be helpful to list your expenses for this year. Annual contributions will be withheld in equal installments from your paychecks throughout the year.

ESTIMATED ANNUAL EXPENSES	ESTIMATED COST	
	Current year	**Next year**
Day care expenses for dependent children under age 13 and living with you		
✳ Babysitter	$	$
✳ Day care center	$	$
✳ Nursery school (not in first grade and above)	$	$
✳ Summer day care or camp (excluding overnight camp)	$	$
Expenses for mentally/physically disabled children of any age	$	$
Expenses for adults who are incapable of caring for themselves, who spend at least eight hours a day in your home and who are totally dependent on you for support	$	$
TOTAL ANNUAL ESTIMATED OUT-OF-POCKET DAY CARE EXPENSES	$	$
	÷12	÷12
ESTIMATED MONTHLY CONTRIBUTIONS FOR DAY CARE EXPENSES =	$	$

See your summary plan description booklet for a description of eligible expenses.

What You Must Do to Enroll

It's important that you complete the enrollment process during the enrollment period. If you have access to the Peabody intranet, you must complete the online enrollment process by November 16, 2001. Your enrollment packet includes instructions for online enrollment. For employees who do not have online access, a completed enrollment form must be returned to the Peabody Benefits Office in St. Louis no later than **November 16, 2001**, or if you are a new employee, within 31 days of your eligibility date.

WHAT YOU NEED TO DO NOW

The following table summarizes the steps you need to take depending on your situation. If you have any questions, you may ask the Peabody Benefits Call Center by calling 1-800-633-9005 or sending an e-mail to **benefits@peabodyenergy.com.**

YOUR SITUATION	WHAT YOU NEED TO DO
You want to keep medical, dental, vision and all other coverage the same for 2002.	You must complete the enrollment process. If you do not, your current medical, dental, vision, supplemental life insurance, and optional AD&D will end on December 31, 2001, and you will forfeit the cash payment for the No Coverage medical option. You also will not be enrolled for the reimbursement accounts.
You want to change your medical coverage to another option.	Complete the enrollment process. If you elect Option 1000, your choice in subsequent years will be limited to the Option 500 plan unless you have a qualifying change in family status.
You want to elect the No Coverage medical option.	You must complete the enrollment process, including providing details on other coverage and completing a "Medical Waiver Statement." (If you do not, you will forfeit the cash payment.) If you decide to enroll in future years, your choice will be limited to Option 1000 unless you have a qualifying change in family status.
You want to enroll for medical or dental coverage for the first time, cancel medical coverage or add or drop a dependent from your coverage.	Complete the enrollment process. Medical benefits may be limited for pre-existing conditions. Dental benefits may also be limited.
You want to cancel dental coverage for 2002.	Complete the enrollment process. If you cancel dental coverage, your benefits will be limited if you decide to re-enroll at the next enrollment period.
You want to cancel optional vision coverage or enroll for optional vision coverage for the first time.	Complete the enrollment process. If you cancel your vision coverage, you will have to wait two years to re-enroll.
You want to change your supplemental life insurance or optional AD&D coverage level, or enroll for dependent term life coverage.	Complete the enrollment process. You may be required to furnish evidence of good health to increase your life insurance to certain levels above your current amount.
You want to participate in one or both reimbursement accounts for 2002.	Complete the enrollment process indicating the amount you want to deposit for 2002.

Enrollment

This enrollment guide provides highlights of your benefit plans. This is not a complete detailed description. See your summary plan description booklets for more details about the program. The benefit plans are operated according to the terms of legal documents including insurance contracts and plan documents. If there is a difference between this enrollment guide or the summary plan description booklet and the actual plan documents, the plan documents will govern. This enrollment guide is not a substitute for the official plan documents nor is it an employment contract. The company reserves the right to amend or terminate the program in whole or in part at any time. This summary of material modifications is part of your summary plan description and should be kept with your other booklets.