Claims Procedures for the Welfare Benefit Plans Administered by Peabody Holding Company, Inc. for all Affiliates

The following claims procedures are effective January 1, 2003 and apply to all employees, retirees and surviving spouses covered under the benefit plans administered by Peabody Holding Company, Inc. for its affiliates. This Summary of Material Modification should be kept with the most current summary plan description booklet for that plan. These procedures reduce the time period that the plan has for making an initial decision regarding a claim and increase the time during which you may appeal a claim denial. The procedures also reduce the time period for deciding appeals. Questions regarding this Summary of Material Modification can be addressed by calling the Peabody Benefits Call Center at 1-800-6335.

MEDICAL AND PRESCRIPTION DRUGS (This section applies to active employees, retirees, and surviving spouses and their dependents.)

A claim for benefits is a specific request for a plan benefit that is submitted in accordance with the plan's procedures for filing claims. There are three types of claims for medical benefits, each of which is subject to different rules.

A **pre-service claim** is a claim for a benefit that requires prior approval under the terms of the plan, such as inpatient admission pre-certification.

An **urgent care claim** is 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 to the claim.

A **post-service claim** is 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.

Urgent care claims. 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.

Pre-service claims. 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

Post-service claims, including claims involving prescription drugs. 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 for a benefit is denied in whole or in part, you will receive a written notice that will provide the reason for the denial, reference to the plan provision on which the determination was based, a description of any additional information necessary to complete the claim, and your right to file an appeal and any other information required by law.

Review of Denied Claims

You have 180 calendar days after receiving notice that your claim has been 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 in 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.*

Expedited procedures for urgent care claims. You may request an expedited appeal of a denial involving an urgent care claim. This request may be oral or in writing to the claims administrator. 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 other available similarly expeditious method.

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.

DETERMINATIONS ON APPEAL

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

Urgent care claims. In the case of an urgent care claim, you will be notified of the determination within 72 hours after your appeal is received by the claims administrator.

Pre-service claims. 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, Missouri 63101-1826

Your second level appeal request must be submitted within 60 days of receipt of 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.

Post-service claims. 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, Missouri 63101-1826

Your second level appeal request must be submitted within 60 days of receipt of 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 reason 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.

VISION (If applicable)

A claim for benefits is a specific request for a plan benefit that is submitted in accordance with the plan's procedures for filing claims. There are two types of claims for vision benefits, each of which is subject to different rules.

A **pre-service claim** is a claim for a benefit that requires prior approval under the terms of the plan, such as necessary contact lenses or low-vision treatment and supplies.

A **post-service claim** is 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 vision 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 claims. 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

Post-service claims. The 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 for a benefit is denied in whole or in part, you will receive a written notice that will the provide the reason for the denial, reference to the plan provision on which the determination was based, a description of any additional information necessary to complete the claim, and your right to file an appeal and any other information required by law.

Review of Denied Claims

You have 180 calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal

the determination. Your appeal must be in writing. *If you do not file an appeal within this 180-day period, you will lose the right to appeal the determination.* Appeals should be submitted to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670

DETERMINATIONS ON APPEAL

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

Pre-service claims. You will be notified of the determination on appeal within 30 days after it is submitted.

Post-service claims. The claims administrator will review and decide your appeal within 60 days after it is submitted.

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 of the decision on appeal. If the decision upholds the denial of your claim, the notification will provide the specific reason 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 claims administrator is final and binding on all individuals dealing with or claiming benefits under the plan.

LIFE AND AD&D BENEFITS (If applicable)

The insurance company will make a determination on the claim within 90 days after the claim is received 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.

If your 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 information to complete your claim and your right to file an appeal.

REVIEW OF DENIED CLAIMS

You may appeal the denial of your claim to the appropriate insurance company. Your appeal must be made in writing within 60 days after you receive the written notice from the insurance company that your claim has 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. Appeals should be submitted to:

Life Insurance Claims (UNUM)	Accidental Death and Dismemberment Claims (AIG)
UNUM Life Insurance Company of America 2211 Congress Street Portland, Maine 04122	AIG Life Insurance Company One Alico Plaza Wilmington, Delaware 19801

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.

The insurance company will review and decide your appeal within 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 notified in writing if the decision on appeal upholds the initial denial of your claim. The notification will provide the specific reason for the denial, reference to specific plan provisions 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 insurance company is final and binding on all individuals dealing with or claiming benefits under the plan.

DENTAL BENEFITS (If applicable)

INITIAL CLAIMS DETERMINATIONS

A claim for benefits is a specific request for a plan benefit that is submitted in accordance with the plan's procedures for filing claims. The claims administrator will decide a claim within 30 days after it is received. This time period may be extended for an additional 15 days when necessary due to matters beyond the control of the claims administrator or if your claim is incomplete.

If the claims administrator denies your claim for a benefit in whole or in part, you will receive a written notice that will provide the reason for the denial, reference to the plan provision on which the determination was based, a description of any additional information necessary to complete the claim, and your right to file an appeal and any other information required by law.

REVIEW OF DENIED CLAIMS

You have 180 calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal the determination. The appeal must be in writing and must be submitted to the claims administrator at the address set out in the summary plan description. *If you do not file an appeal within this time period, you will lose the right to appeal the determination.*

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. You may also request the plan to identify any dental experts 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.

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 submit a second level appeal to the plan administrator. This appeal should be submitted to:

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

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

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 reason 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 shall be final and binding on all individuals dealing with or claiming benefits under the plan.

DISABILITY PLAN (This section applies to active employees only.)

INITIAL CLAIMS DETERMINATIONS

The claims administrator will decide undisputed claims within fourteen days of receipt of the claim. The claims administrator will make a determination on a disputed claim within 45 days after a claim is received. This time period may be extended for an additional 60 days, in the form of two 30-day extensions, when necessary due to matters beyond the control of the claims administrator.

If the claims administrator denies your claim for a benefit in whole or in part, you will receive a written notice that will provide the reason for the denial, reference to the plan provision on which the determination was based, a description of any additional information necessary to complete the claim, and your right to file an appeal and any other information required by law.

REVIEW OF DENIED CLAIMS

You have 180 calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal the determination. The appeal must be in writing and must submitted to the claims administrator at the address set out in the summary plan description. *If you do not file an appeal within this time period, you will lose the right to appeal the determination.*

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 th claim.

The claims administrator will review and decide your appeal within 45 days after it is submitted. If you are not satisfied with the decision of the claims administrator, you have the right to submit a second level appeal to the plan administrator. This appeal should be submitted to:

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

Your second level appeal request must be submitted within 60 days from receipt of first level appeal decision. The plan administrator will make a determination on the appeal no more than 45 days after your second level appeal is submitted.

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 reason 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 shall be final and binding on all individuals dealing with or claiming benefits under the plan.