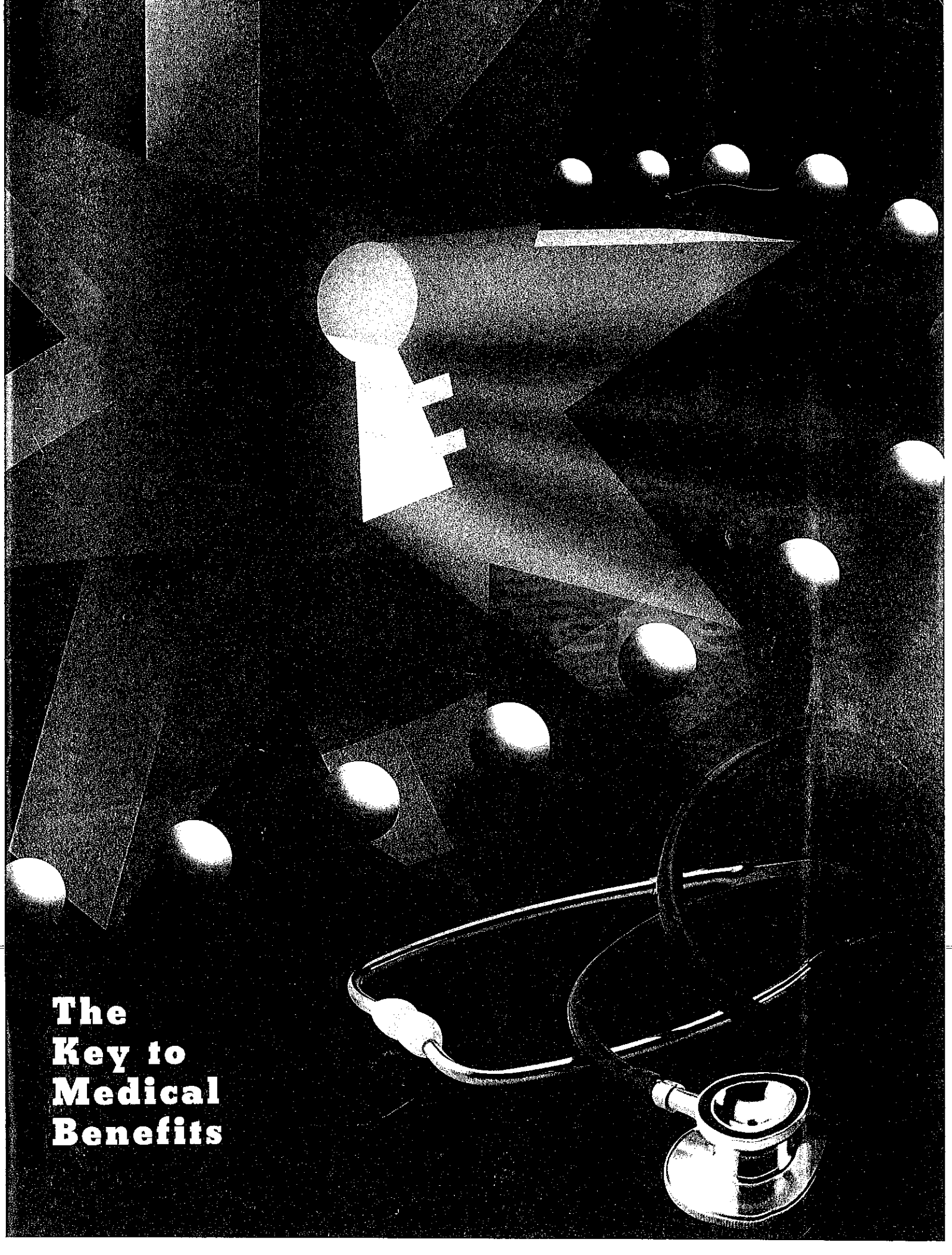

The
Key to
Medical
Benefits

Key Question

Q WHAT IF I GET SICK OR HURT?

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

THE MEDICAL PLAN IS A KEY TO YOUR GOOD HEALTH.

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

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

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

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

Contents

Key Highlights

Medical coverage

WHO IS ELIGIBLE: All full-time salaried employees and part-time employees working a regular schedule of 20 hours or more per week year-round (temporary and seasonal employees are not eligible). You may also obtain coverage for your eligible dependents. You must enroll to obtain medical coverage; otherwise, you may decline it. (See page 8 for more information.)

WHAT COVERAGE OPTIONS ARE AVAILABLE: The Peabody medical plan offers three medical options from which to choose. All of the options cover the same services and supplies; the difference between the options lies in the amount of the deductibles, copayments and out-of-pocket limits. (See pages 15-17 for more information.)

WHAT IS COVERED: The medical plan covers a wide variety of medical services and supplies. There are special provisions for prescription drugs, home health care, hospice care and treatment of mental illness and substance abuse. (See pages 26-38 for more information.)

COST TO YOU: The company pays the majority of the cost of your coverage. However, you may pay a portion of the cost depending on the option you choose. Active employees pay their contributions through before-tax payroll deductions.

You also share in the cost of the treatment you receive by paying deductibles, copayments and a percentage of expenses. Your share depends on the option you have chosen, the kind of care you receive and where you receive it. (See pages 24-26 for more information.)

MAXIMUM BENEFIT AMOUNT: The medical plan has a lifetime maximum benefit that is adjusted annually based on the Health Cost Component of the Consumer Price Index. In 2000, the maximum is $1.7 million per covered person. However, additional restrictions apply to hospice care and treatment of mental illness and substance abuse. (See pages 26 and 38 for more information.)

IF YOU LEAVE THE COMPANY: Your coverage generally ends, although under some circumstances you may be eligible for continued coverage under the federal law known as COBRA. The medical plan also contains special provisions for continuing coverage in the event of retirement, disability, a reduction in the work force or for your surviving dependents in the event of your death. (See pages 49-57 for more information.)

The medical plan may also allow you to convert your coverage to an individual insurance policy if your company-provided coverage ends. (See page 58 for more information.)

OTHER KEY POINTS: You are free to receive your care from any provider you wish, but your share of costs for the medical plan will be less if you use providers that are members of the plan's "participating provider" networks. These networks include hospitals, physicians and pharmacies. (See pages 18-19 for more information.)

The medical plan includes a Medical Services Advisory program that works with you and your doctor to review your care and avoid unnecessary hospitalization. The purpose of the program is to make sure you receive the most appropriate, cost-effective care for your condition. (See pages 20-24 for more information.)

The medical plan's coverage for a "pre-existing condition"—a condition you had before becoming covered under this plan—may be limited until you have been covered by this plan for a certain number of months. (See pages 12-13 for more information.)

If you are also covered by another medical plan, the company's plan will coordinate with the other plan to avoid duplicate payments of benefits. (See pages 45-47 for more information.)

Full-time salaried employees and part-time employees working a regular schedule of 20 or more hours per week year-round are eligible for medical coverage.

You may also cover your eligible dependents.

Eligibility and Enrollment

You are eligible for medical coverage if you are a full-time salaried employee or a part-time employee working a regular schedule of 20 or more hours per week year-round. Temporary and seasonal employees are not eligible.

Your coverage will begin on the date you enroll, provided you do so within 31 days after your date of employment. If you do not enroll within 31 days, you will have to wait until the next annual enrollment period, unless you have a change in family status. This is explained in the section called *Changing your coverage*.

If you are not actively at work on the date your coverage would otherwise begin, your coverage becomes effective on the date you are at work.

ELIGIBILITY FOR YOUR DEPENDENTS

Your eligible dependents become covered by the plan at the same time you do, provided you enroll them within 31 days after your date of employment. Dependents you acquire after your coverage begins—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.

Your eligible dependents include:

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

Children who are eligible as dependents include:

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

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

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

ENROLLMENT

You may enroll from among several options when you are first hired as an eligible employee or during the plan's annual enrollment period. You may also choose to decline coverage from the company, if you have medical coverage through another source. If you enroll in the plan, you choose the coverage that meets the needs of you and your family. You may choose coverage for:

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

If you elect dependent coverage, your dependents must be covered under the same medical option as you. For example, you cannot pick Option 250 for yourself and Option 500 for your dependents.

To enroll for coverage, you must complete an enrollment form and return it to the St. Louis benefits department.

Employees in the St. Louis office or in southern West Virginia have the option of choosing coverage in one or more health maintenance organizations (HMOs) as an alternative to the plans described in this booklet. You will receive information describing the HMO options available to you when you enroll.

If you do not enroll for medical coverage within 31 days after your hire date, or (for dependent coverage) within 31 days after the date a dependent first becomes eligible, you will not be able to obtain coverage until the next annual enrollment period, unless you have a change in family status that justifies the change. This is explained in the section called *Changing your coverage*.

THE COST OF YOUR COVERAGE

The cost for coverage depends on the option you select and the number of family members you choose to cover. The cost for each level of coverage is printed on your enrollment form. Your contributions will automatically be deducted in equal installments from your paychecks on a before-tax basis. This means you will not have to pay any federal or state taxes on the amount of your salary that is used to pay your contributions.

Should the costs for the plan go up or down in future years, the portion that you pay will reflect these changes in cost.

There is no cost for Option 1000 if you are a full-time employee. You will receive a cash payment each year when you choose this option. You may also opt out of medical coverage altogether; in this case you'll receive an even larger annual cash payment if you are full-time. The amount of the cash payment is reduced if you enroll after January 1. Note: If you retire or leave the company during the year, you will be required to repay a portion of the cash payment depending on the date your employment ended. This also applies if you enroll or increase your coverage during the year because of a qualifying change in family status.

CHANGING YOUR COVERAGE

All the choices you make when you enroll (or decline to enroll) are binding until the end of the calendar year for which you're enrolling. Except in certain cases, you will not be able to enroll, cancel or change them until the next annual enrollment period.

To enroll for coverage, you must complete an enrollment form and return it to the St. Louis benefits department.

All the choices you make when you enroll (or decline to enroll) are binding until the end of the calendar year for which you're enrolling. Except in certain cases, you will not be able to enroll, cancel or change your choices until the next annual enrollment period.

During the annual enrollment period

An annual enrollment period is conducted in the fall of each year. Changes you make during the annual enrollment period become effective on the following January 1. During the annual enrollment period, you may make the following changes to your coverage:

- If you decline medical coverage when you are first eligible, you may enroll during a subsequent annual enrollment period. However, your choice for coverage in this situation will be limited to Option 1000. This also applies if you cancel coverage and later decide to re-enroll in a subsequent year. You will have the opportunity to increase coverage by one level during each subsequent annual enrollment period.
- You may add a dependent to your current coverage option during the annual enrollment period.
- You may increase your coverage by one level at each annual enrollment period. For example, you will be permitted to switch from Option 1000 to Option 500 or from Option 500 to Option 250, but you will not be permitted to switch from Option 1000 to Option 250 at any annual enrollment. You always have the option to decrease your coverage to any level during the annual enrollment period.
- You may cancel coverage for yourself or your dependents during any annual enrollment period.
- You may change to or from HMO coverage (if available) during any annual enrollment period.

Changes During the Annual Enrollment Period

YOUR SITUATION	CHANGES YOU CAN MAKE
You declined medical coverage when you were first eligible.	You may enroll for Option 1000 or an HMO, if available, during the next annual enrollment period. This also applies if you cancel coverage and then decide to re-enroll in a subsequent year.
You declined coverage for your dependent(s) when the dependent was first eligible.	You may add the dependent(s) to your current coverage option during the next annual enrollment period.
You are enrolled for coverage under Option 250, Option 500 or Option 1000.	You may increase your coverage by one level, elect an HMO or decrease coverage to any level during the annual enrollment period. You may also cancel coverage for yourself or your dependents. (If you cancel coverage and you later decide to re-enroll in a subsequent year, your option will be limited as described above.)
You are enrolled in an HMO.	You may elect any of the other options or cancel coverage for yourself or your dependent(s). (If you cancel coverage and you later decide to re-enroll in a subsequent year, your option will be limited as described above.)

Due to a change in family status

You may enroll or cancel coverage for yourself or your dependents before the next annual enrollment period if you have a change in family status that justifies a change in coverage. The following situations qualify:

- If you gain an eligible dependent as a result of marriage, birth or adoption:
  - you may add your spouse and any newly acquired child to your current coverage option.
  - if you previously declined coverage, you may enroll yourself, your spouse and any newly acquired children in any option.

  In either case, you must enroll within 31 days of the date the individual becomes your dependent.

- If a dependent is no longer eligible as a result of a death or divorce, or because a child marries, reaches the limiting age or is no longer a full-time student, you may change your family coverage status and contribution amount provided you complete a new enrollment form within 31 days of the event. Note that regardless of your contribution level, the plan does not provide coverage for a family member after the date the person no longer qualifies as an eligible dependent, unless the person is eligible for, chooses and pays the cost of continued coverage under the federal law known as COBRA, as described under *COBRA continuation of coverage*.

- If you decide not to enroll for medical benefits under our plan, or you choose Option 1000 or Option 500 because you and/or your dependents have other coverage, such as through your spouse's employer, you may enroll and/or add dependents in any available option if your other coverage ends because:
  - you or your dependent are no longer eligible for such other coverage, or
  - the other employer stops contributing toward the cost of your other coverage, or
  - your other coverage was provided under a COBRA continuation provision and the right to that coverage has been exhausted.

  In this situation, 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 your other coverage.

- If you or your dependents become covered by another health plan as a result of marriage or a change in your spouse's employment, you may cancel coverage under this plan or change to a lower option as long as you complete a new enrollment form within 31 days of the date the other coverage begins.

If you are not actively at work on the date coverage would normally begin, coverage will not begin until you return to work. Also, see the section called Limitations for pre-existing conditions.

You may enroll or cancel coverage for yourself or your dependents before the next annual enrollment period if you have a change in family status that justifies a change in coverage.

Benefits under any option may be limited if you or your dependent has a pre-existing condition.

Changes Outside the Annual Enrollment Period

YOUR SITUATION	CHANGES YOU CAN MAKE
You are enrolled in one of the company plans and you gain an eligible dependent as a result of marriage, birth or adoption.	You may add your spouse and any newly acquired child to your current coverage option.★
You declined medical coverage when you were first eligible and you gain an eligible dependent as a result of marriage, birth or adoption.	You may enroll yourself, your spouse and any newly acquired child in any option.★
Your dependent is no longer eligible as a result of divorce or death or because a child marries, reaches the limiting age or is no longer a full-time student.	You may change your family coverage level and contribution.★
You or your dependent(s) lose coverage from another medical plan for certain reasons.	You may enroll yourself and your dependents or change to a higher option.★
You or your dependents become covered by another medical plan as a result of marriage or a change in your spouse's employment.	You may cancel coverage under this plan or change to a lower option.★

★ To make a change you must complete a new enrollment form within 31 days after the event.

LIMITATIONS FOR PRE-EXISTING CONDITIONS

Benefits under any option may be limited if you or your dependent has a pre-existing condition.

- A pre-existing condition is an illness or injury (other than pregnancy), whether or not diagnosed, for which consultation or treatment (including prescribed drugs or medicine) was received during the six months before the individual's enrollment date. For this purpose, "enrollment date" means, for an employee who enrolls when first eligible, the first day of employment as an eligible employee; in all other cases, the "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.

However, this limitation period will be reduced by the amount of time that the covered person had "creditable coverage" from another medical plan before enrolling in our plan. A person receives creditable coverage for prior periods of coverage under other group medical plans, individual medical insurance and certain other state and federal health benefit programs. However, if you or your dependent had a period of 63 consecutive days with no creditable coverage, any periods of creditable coverage that occurred prior to that lapse will not be counted. Note that any period during which you or your dependent were satisfying a group health plan's waiting period is not counted toward the 63-day lapse in creditable coverage.

You will be required to provide proof of creditable coverage. The limitation on pre-existing conditions will apply unless you can provide this proof when it is requested. You should contact your prior group health plan or health insurer to obtain a Certificate of Creditable Coverage or other appropriate documentation. The certificate may be submitted to the benefits department. If you need assistance, contact the benefits department at 1-800-633-9005.

The limitation for pre-existing conditions will not apply to pregnancy. It also does not apply to your dependent child if the child was enrolled in creditable coverage within 31 days of birth or placement for adoption and the child has not had a subsequent lapse of creditable coverage for a period of 63 or more days. Coverage that a child had prior to placement for adoption is not taken into account.

ELIGIBILITY FOR DISABLED AND RETIRED EMPLOYEES

Certain retired and disabled employees are also eligible for medical coverage—however, different enrollment rules and benefits may apply, depending on when your retirement or disability begins. Refer to the sections called *If you are disabled* and *When you retire* on pages 50 and 52.

You may choose from among Option 250, Option 500 and Option 1000.

In addition to the three options and any available HMO plans, you can choose to opt out of medical coverage altogether.

Your Medical Benefits

You can control your medical coverage costs and out-of-pocket costs by choosing one of three medical options. You may choose from among Option 250, Option 500 and Option 1000. You can also opt out of medical coverage.

To help make your choices easier to understand, we named the options based on the annual deductible per person for network expenses—for example, Option 250 means a $250 deductible, while Option 1000 means a $1,000 deductible. Otherwise, the options generally work the same and use the same BlueCross BlueShield Preferred Provider Organization (PPO) network.

Option 250 provides the highest level of coverage and requires the highest level of monthly contributions. Option 500 provides lower monthly costs in exchange for higher potential out-of-pocket expenses when you use the plan.

Option 1000 goes a step further and eliminates your monthly coverage costs altogether if you are full-time. You will receive a cash payment from Peabody each year if you choose this option as a full-time employee. Keep in mind, however, that Option 1000 has the highest level of potential out-of-pocket costs when you receive medical care.

In addition to the three options and any available HMO plans, you can choose to opt out of medical coverage altogether. If you choose no coverage, you will receive a cash payment each year (not applicable for retirees and disabled employees). Please note you must show proof of other coverage to receive the cash payment with the no-coverage option.

The illustration below highlights key differences among the medical coverage options. See the following pages for more complete descriptions, including benefits for non-network expenses.

The pages that follow summarize the benefits and costs in more detail for each of the three options.

	YOUR COST FOR COVERAGE	DEDUCTIBLE FOR NETWORK EXPENSES	YOUR SHARE OF TYPICAL NETWORK EXPENSES	NETWORK OUT-OF-POCKET MAXIMUM
OPTION 250	Highest monthly cost; you pay a percentage of the cost of coverage.	$250 each person $500 family maximum	20% after deductible	$1,500 individual $3,000 family
OPTION 500	Lower monthly cost; you pay a percentage of the cost of coverage.	$500 each person $1,000 family maximum	25% after deductible	$2,500 individual $5,000 family
OPTION 1000	No cost to full-time employees; full-time employees receive a cash payment.	$1,000 each person $2,000 family maximum	30% after deductible	$4,000 individual $8,000 family
NO COVERAGE	Full-time employees receive a cash payment.	N/A	N/A	N/A

Benefits at a Glance
Choice 1: Option 250

	NETWORK AND OUT-OF-AREA★	NON-NETWORK
DEDUCTIBLES YOU PAY		
Annual Deductible	$250	$400
Annual Deductible Family Maximum	$500	$800
Hospital Copayment (per admission)	$0	$0
Emergency Room Copayment (if not true emergency)	$50	$50
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE AND COPAYMENTS		
Inpatient Hospital and Emergency Room★★	80%	60%
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%
Most Other Medical Expenses★★	80%	60%
ANNUAL OUT-OF-POCKET MAXIMUMS YOU PAY (includes deductible, coinsurance)		
Individual Out-Of-Pocket Maximum	$1,500	$2,000
Family Out-Of-Pocket Maximum	$3,000	$4,000
PRESCRIPTION DRUG BENEFITS: AMOUNT THE PLAN PAYS (ADMINISTERED BY MERCK-MEDCO) (no deductible or out-of-pocket maximum)		
Retail Generic Prescription Drugs (30-day supply)	90% $5 minimum copay	80% $5 minimum copay
Retail Brand-Name Prescriptions★★★ (30-day supply)	85% $10 minimum copay	80% $10 minimum copay
Mail-Order Generic Prescription Drugs (90-day supply)	$3 Copay	N/A
Mail-Order Brand-Name Prescription Drugs★★★ (90-day supply)	$15 Copay	N/A
LIFETIME MAXIMUM BENEFIT THE PLAN PAYS	$1 million Indexed annually for inflation (In 2000, limit is $1.7 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. See the section called Medical Services Advisory (MSA) program and hospital precertification *on page 20.*

★ *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 Group Benefits Call Center at 1-800-633-9005 for information and forms.*

★★ *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 to the out-of-pocket maximum.*

★★★ *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 prescription drugs under Option 250 and Option 500 are provided through a separate program administered by Merck-Medco. See the section called* Prescription drug benefits —Option 250 and Option 500 *on page 26.*

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. See the section called Medical Services Advisory (MSA) program and hospital precertification *on page 20.*

★ *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 Group Benefits Call Center at 1-800-633-9005 for information and forms.*

★★ *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 to the out-of-pocket maximum.*

★★★ *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 prescription drugs under Option 250 and Option 500 are provided through a separate program administered by Merck-Medco. See the section called* Prescription drug benefits—Option 250 and Option 500 *on page 26.*

Benefits at a Glance
Choice 2: Option 500

	NETWORK AND OUT-OF-AREA★	NON-NETWORK
DEDUCTIBLES YOU PAY		
Annual Deductible	$500	$800
Annual Deductible Family Maximum	$1,000	$1,600
Hospital Copayment (per admission)	$100	$200
Emergency Room Copayment (if not true emergency)	$50	$50
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE AND COPAYMENTS		
Inpatient Hospital and Emergency Room★★	75%	55%
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)	55%
Most Other Medical Expenses★★	75%	55%
ANNUAL OUT-OF-POCKET MAXIMUMS YOU PAY (includes deductible, hospital copayment, coinsurance)		
Individual Out-Of-Pocket Maximum	$2,500	$4,000
Family Out-Of-Pocket Maximum	$5,000	$8,000
PRESCRIPTION DRUG BENEFITS: AMOUNT THE PLAN PAYS (ADMINISTERED BY MERCK-MEDCO) (no deductible or out-of-pocket maximum)		
Retail Generic Prescription Drugs (30-day supply)	80% $5 minimum copay	70% $5 minimum copay
Retail Brand-Name Prescriptions★★★ (30-day supply)	75% $10 minimum copay	70% $10 minimum copay
Mail-Order Generic Prescription Drugs (90-day supply)	$15 Copay	N/A
Mail-Order Brand-Name Prescription Drugs★★★ (90-day supply)	$25 Copay	N/A
LIFETIME MAXIMUM BENEFIT THE PLAN PAYS		
	$1 million Indexed annually for inflation (In 2000, limit is $1.7 million)	

Benefits at a Glance
Choice 3: Option 1000

	NETWORK AND OUT-OF-AREA★	NON-NETWORK
DEDUCTIBLES YOU PAY		
Annual Deductible	$1,000	$1,500
Annual Deductible Family Maximum	$2,000	$3,000
Hospital Copayment (per admission)	$200	$300
Emergency Room Copayment (if not true emergency)	$50	$50
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE AND COPAYMENTS		
Inpatient Hospital and Emergency Room★★	70%	50%
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE		
Wellness Benefits (including well child care, routine physicals and screenings)	70% Up to $250 per calendar year (no deductible)	50%
Most Other Medical Expenses★★	70%	50%
PRESCRIPTION DRUGS, AMOUNT THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE★★★ (ADMINISTERED BY BLUECROSS BLUESHIELD OF ILLINOIS)		
Generic Prescription Drugs (Retail or mail order)	70% After deductible	
Brand-Name Prescriptions (Retail or mail order)	70% After deductible	
ANNUAL OUT-OF-POCKET MAXIMUMS YOU PAY (includes deductible, hospital copayment, coinsurance and prescription drugs)		
Individual Out-Of-Pocket Maximum	$4,000	$6,000
Family Out-Of-Pocket Maximum	$8,000	$12,000
LIFETIME MAXIMUM BENEFIT THE PLAN PAYS	$1 million Indexed annually for inflation (In 2000, limit is $1.7 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. See the section called Medical Services Advisory (MSA) program and hospital precertification *on page 20.*

★ *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 Group Benefits Call Center at 1-800-633-9005 for information and forms.*

★★ *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 to the out-of-pocket maximum.*

★★★ *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 covered 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.*

The plan offers you the opportunity to obtain health care for yourself and your family through a preferred provider organization, or PPO.

If an emergency visit meets 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.

BLUECARD NETWORK

The plan offers you the opportunity to obtain health care for yourself and your family through a preferred provider organization, or PPO. The PPO has been developed by BlueCross BlueShield and is called the BlueCard PPO, or "network" for short. The BlueCard PPO links Blue Plan PPO network doctors and hospitals to Blue Plans throughout the United States. For a list of BlueCard participating doctors and hospitals, you may call 1-800-810-BLUE (2583) or 1-888-873-2227, or visit their web site at www.bluecares.com/bluecard. The network is designed to provide access to comprehensive health care at a reasonable cost.

You aren't required to use the network to get health care. In fact, the plan still pays benefits when you use non-network doctors and hospitals. But if you do use the network, there are several important advantages:

- If you use a network provider, your share of the cost is less. If you choose a non-network provider, you may pay more out of your own pocket for certain expenses.
- Because the providers who participate in the network have agreed to prearranged fees, you don't have to worry about being charged more for your medical care than what's considered a usual, customary and reasonable fee. When you get care outside the network and the fee is above what's usual, customary and reasonable, you will have to pay the difference.
- In most cases, you don't have to fill out claim forms when you use the network. That saves you time and effort. Simply present your health plan ID card when you visit a network provider. Your claims will be filed automatically and BlueCross BlueShield will pay the benefits directly to the provider.

If you go to a network provider and are "balance billed"—meaning you are billed any additional amount beyond the deductible, coinsurance or hospital copayment, or charged the difference between the full amount and the discounted network amount—please call BlueCross BlueShield of Illinois at 1-888-873-2227. The BlueCross BlueShield of Illinois representative will contact the provider.

If you have an emergency

If you have an emergency, you should seek medical help immediately—within the network or from a non-network provider.

In either case, if you are admitted to a hospital, you or someone on your behalf must call Medical Services Advisory (MSA) within two working days of your admission, as described on page 20. If MSA is not notified, your benefits will be reduced.

If the emergency visit meets 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.

If you need care your network doctor can't provide

If there is no network doctor who provides a certain type of service, you may be able to go to a non-network provider and have your covered expenses paid at network levels. To be eligible for this, you must call BlueCross BlueShield of Illinois at 1-888-873-2227.

Traveling in the United States

If you need emergency medical attention, go immediately to the nearest medical facility. Then follow standard emergency procedures (see *If you have an emergency* on the previous page).

If you are traveling and you need non-emergency medical attention, call BlueCross BlueShield of Illinois at 1-888-873-2227. The Blue Cross Blue Shield of Illinois representatives will direct you to a network provider in the area if one is available. If you do not use a network provider when one is available, any covered expenses you have will be paid at non-network levels.

If you or a dependent lives outside the network area

If you or a covered dependent lives outside the network area, benefits will be paid at network rates. Your eligibility records must be adjusted, or all claims will be processed as non-network. Contact the Peabody Group Benefits Call Center at 1-800-633-9005 for information and forms.

The plan itself does not furnish health care services; it only provides reimbursement for covered services received by covered individuals. For this reason, neither the company nor the claims administrator can guarantee the availability or quality of care, and neither is liable for any act or omission of any provider.

PARTICIPATING PROVIDER PHARMACY PROGRAM

Prescription drug benefits under Option 250 and Option 500 are administered by Merck-Medco and its subsidiaries, PAID Prescriptions L.L.C. (for retail drugs) and Merck-Medco Rx Services (for mail-order drugs). Persons covered by Option 250 or Option 500 will receive discounts from retail pharmacies that participate in the Coordinated Care Plus or "CCP" Network. CCP is the participating retail pharmacy network administered by PAID Prescriptions L.L.C. In addition to the discounts, Option 250 and Option 500 pay higher benefits for prescriptions purchased from a CCP participating pharmacy, and you generally do not have to file a claim.

If you are enrolled in Option 1000, prescription drugs are covered in the same way as other medical expenses and will be processed by BlueCross BlueShield of Illinois. However, pharmacies participating in the BlueScript program will provide discounts and will file your claim for reimbursement from BlueCross BlueShield of Illinois.

The benefits the plan pays for prescription drugs are explained in the sections called *Prescription drug benefits—Option 250 and Option 500* on page 26 and *Prescription drug benefits—Option 1000* on page 28.

Prescription drug benefits under Option 250 and Option 500 are administered by Merck-Medco and its subsidiaries, PAID Prescriptions L.L.C. (for retail drugs) and Merck-Medco Rx Services (for mail-order drugs).

If you are enrolled in Option 1000, prescription drugs are covered in the same way as other medical expenses.

All hospital admissions must be reviewed by the Medical Services Advisory (MSA) program in advance. Your benefits will be reduced if you do not follow the program guidelines.

MEDICAL SERVICES ADVISORY (MSA) PROGRAM AND HOSPITAL PRECERTIFICATION

The Medical Services Advisory (MSA) program is administered by Blue Cross Blue Shield of Illinois. The program is designed to help you and the company manage costs by reviewing, in advance, the health care services you receive. This allows MSA to "precertify" (authorize in advance as being medically necessary) certain types of care and make sure that it is medically necessary.

If you use a network provider, in most cases the provider will handle precertification for you. However, it's still ultimately your responsibility to precertify by calling MSA at 1-800-325-4705 before receiving care.

If you use a non-network provider, you or your provider must first call MSA.

If you don't call first, you must pay an additional $200 penalty for each procedure that's not precertified. This precertification penalty is in addition to your annual deductible, hospital copayment and out-of-pocket maximum.

Also, if MSA determines that services are not medically necessary, the plan will not pay benefits for your expenses.

Precertification is required for all non-emergency hospitalizations and for these outpatient and extended care services:

- Home health care.
- Private-duty nursing.
- Hospice care.
- Skilled nursing facility care.
- Certain surgical procedures (listed on pages 32-33).
- Residential treatment facilities.

The goal of the Medical Services Advisory program is to ensure that you receive the most appropriate, cost-effective, quality care for your condition.

Precertification for inpatient admissions

To request precertification, simply call the MSA precertification number given in the section called *How to contact MSA* on page 24. Registered professional nurses will carefully evaluate the proposed hospitalization. If the nurse determines that inpatient hospitalization does not meet the guidelines for medical necessity, a consulting physician will be asked to review the case and make a determination.

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

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

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

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

Exceptions for maternity admissions

For an admission due to pregnancy, you should call MSA by the end of the third month of pregnancy. However, group health plans generally may not, under federal law, restrict benefits or require a provider to obtain authorization from the plan for prescribing a hospital length of stay in connection with childbirth for the mother or newborn child that does not exceed 48 hours for normal vaginal delivery or 96 hours for a cesarean section (as long as the patient is otherwise covered by the plan and eligible for benefits). The law does not prevent your physician from discharging the mother or newborn before 48 hours (or 96 hours), if after consultation with the mother it is determined that hospital confinement is no longer necessary. However, for inpatient care that continues beyond 48 hours (or 96 hours for a cesarean section), MSA must be notified before the end of these periods.

For a non-emergency hospital confinement that is needed during pregnancy but before the admission for delivery, MSA must be notified before the scheduled admission date.

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

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

Precertification of outpatient and extended care services

You must call MSA for approval of the outpatient services listed on page 20. You must precertify with MSA no later than one day before treatment starts. However, you should precertify as soon as you think you might need treatment. To request precertification, simply call the MSA precertification number given in the section called *How to contact MSA* on page 24. If you don't call, you will pay an additional $200 for each procedure.

Also, no benefits are provided for these services unless they have been approved as medically necessary by MSA.

Precertification alone does not guarantee coverage

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

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

You must also call MSA in advance for approval of certain outpatient and extended care services. If you do not call MSA before a hospitalization that is not an emergency, your covered hospital charges will be reduced by an additional $200. Even if it's an emergency, you must notify MSA within two working days.

Precertification alone does not guarantee coverage.

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

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

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

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

- Suggesting that tests be performed on an outpatient basis before your inpatient admission.
- Discouraging a weekend admission (because much non-emergency testing and treatment is less likely to be performed over the weekend anyway).
- Encouraging admission on the morning that surgery is to be performed.

Recertification for extending an inpatient stay

When MSA authorizes an inpatient admission, the reviewing nurse may assign the number of days that are commonly needed for inpatient care. If a physician believes it is medically necessary for you to receive inpatient care longer than originally authorized, you are responsible for obtaining approval for the additional days through MSA. (See *How to contact MSA* on page 24.)

If you do not call for recertification

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

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

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

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

Concurrent review

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

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

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

Retrospective review

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

Managed second surgical opinion

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

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

Expenses for a second or third surgical opinion that is not recommended by MSA are also covered.

Individual case management

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

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

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

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

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

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

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

To contact MSA, call 1-800-325-4705.

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

How to contact MSA

When you need to contact MSA, please call 1-800-325-4705.

If you're calling to request precertification, be sure to have the following information:

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

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

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

If you disagree with MSA's decision

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

Medical Services Advisory
P.O. Box 1220
Chicago, IL 60690-1220

The Medical Services Advisory program offers you guidance to help coordinate care. It supports you in obtaining the right treatment in the right setting. MSA also provides educational assistance with health problems or questions. MSA helps you become a wise consumer of health care.

ANNUAL DEDUCTIBLE

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

The annual deductible depends on the option you have chosen and whether your expenses are network or non-network. Deductibles are shown in the *Benefits at a Glance* charts on pages 15-17. However, there are special features and exceptions:

- The deductible may be satisfied with a combination of network and non-network expenses.
- You will pay no more than two times the individual deductible amount in any one calendar year for all your family members combined.
- If two or more covered members of your family are injured in the same accident, you only have to meet one annual deductible for their combined covered expenses for that accident.

- If you have covered expenses in the last three months of a calendar year that apply toward your deductible, they may be applied to the next year's deductible as well.
- You do not have to meet a deductible for prescription drug benefits under Option 250 and Option 500, as explained under *Prescription drug benefits—Option 250 and Option 500* on page 26.
- No deductible applies to wellness benefits received from network providers, as explained under *Wellness benefits* on page 31.

HOSPITAL COPAYMENT

Before the plan pays benefits for an inpatient hospital stay under Option 500 and Option 1000, you must pay an additional hospital copayment. The hospital copayments are shown in the *Benefits at a Glance* charts on pages 15-17.

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

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

EMERGENCY ROOM COPAYMENT

You will pay an additional $50 copayment for emergency room care that is not medically necessary for a true emergency or urgent situation, as defined by the plan. The copayment is in addition to the annual deductible.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum provides additional protection for you by putting a cap on the amount you're required to pay in one calendar year for each person's covered expenses. The out-of-pocket maximum varies depending on the option you choose and whether your expenses are network or non-network.

For most types of care, you pay a percentage of the covered expenses (called coinsurance) after the deductible and copayments are met. If the amount you have paid in one year for one person's covered medical expenses reaches the out-of-pocket maximum amount shown in the network column on the *Benefits at a glance* charts on pages 15-17, (including the deductible, copayments and coinsurance), the plan will pay 100% of any additional covered network expenses incurred by that person for the rest of that year. If the amount you have paid in one year for one person's covered medical expenses reaches the out-of-pocket maximum amount shown in the non-network column on the charts on pages 15-17, the plan will pay 100% of any additional covered expenses (network and non-network) incurred by that person in that calendar year.

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

Persons covered by Option 250 or Option 500 will receive discounts from retail pharmacies that participate in the Coordinated Care Plus or "CCP" Network.

For all covered family members combined, the most you will pay out-of-pocket for covered expenses in one calendar year is the family maximum amount shown in the charts on pages 15-17.

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

- Expenses that aren't covered by the medical plan.
- Expenses that are in excess of usual, customary and reasonable charges or other plan maximums.
- Penalties for not complying with the Medical Services Advisory program.
- Emergency room copayments.
- Expenses for prescription drugs under Option 250 and Option 500.
- Expenses for outpatient mental illness and substance abuse.
- Expenses that exceed the plan maximums.

LIFETIME MAXIMUM BENEFIT

For all covered expenses, the medical plan pays a lifetime maximum of $1 million for each covered person, as of March 1, 1990. This amount is increased annually by the Health Cost Component of the Consumer Price Index. In 2000, the lifetime maximum is $1.7 million.

For hospice care expenses, there is a $10,000 lifetime maximum per individual. This amount is included in the $1 million lifetime maximum for all benefits.

PRESCRIPTION DRUG BENEFITS—OPTION 250 AND OPTION 500

If you select Option 250 or Option 500, all benefits for prescription drugs are administered by Merck-Medco and its subsidiaries, PAID Prescriptions L.L.C. (for retail drugs) and Merck-Medco Rx Services (for mail-order drugs).

Persons covered by Option 250 or Option 500 will receive discounts from retail pharmacies that participate in the Coordinated Care Plus or "CCP" Network. CCP is the participating retail pharmacy network administered by PAID Prescriptions L.L.C. You are free to obtain your prescriptions from pharmacies that are members of the CCP network or from non-network pharmacies. However, the plan pays higher benefits if you use CCP participating pharmacies, and you generally do not have to file a claim. See the list of covered and excluded drugs starting on page 29.

Generic substitution

The plan also requires that you receive a generic drug whenever one is available. Generic drugs have the same chemical make-up and produce the same effect on the body as brand-name drugs, but they usually cost much less. If you or your physician requests a brand-name drug when a generic is available, you will pay the difference in cost, in addition to your regular brand-name coinsurance/copayment. The only exception is if the brand-name drug is determined to be medically necessary.

Using CCP Network Pharmacies

Pharmacies participating in the Coordinated Care Plus or "CCP" Network have agreed to provide discounts for participants in Option 250 and Option 500. When you fill a prescription at a CCP participating pharmacy, the plan will pay the benefits as shown in the *Benefits at a glance* charts on pages 15-17 for up to a 30-day supply of each prescription. Note that you will be required to pay the minimum copayment shown on the chart or your coinsurance amount for the option you have chosen, whichever is greater. For example, if you have chosen Option 250, you will pay the greater of $5 (the minimum copayment) or 10% of the cost for a 30-day supply of a generic drug. If the actual cost of the drug is less than the minimum copayment, you will pay the full cost of the drug. You will also pay the difference in cost if you or your physician requests a brand-name drug when a generic equivalent is available.

In general, you will not have to file a claim when using a participating pharmacy. With Option 250 and Option 500, the 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/copayment that applies to the discounted price for the drug.

You may obtain a list of participating pharmacies by calling Merck-Medco at 1-800-711-3796 or by visiting their web site at www.merck-medco.com. To access the 800 number and the on-line pharmacy listings, you will need to enter your Social Security number from your health plan ID card.

Non-participating pharmacies

If you purchase prescriptions from a pharmacy that's 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 Merck-Medco.

The plan will pay the benefits as shown in the *Benefits at a glance* charts on pages 15-17 for up to a 30-day supply of each prescription. The discussion in the previous section regarding the minimum copayment and generic drug substitution also applies to prescriptions filled at a non-participating pharmacy, if you are enrolled in Option 250 or Option 500.

You can obtain prescription drug claim forms by calling Merck-Medco at 1-800-711-3796 or by visiting their web site at www.merck-medco.com. To access the 800 number and the web site, you will need to enter your Social Security number from your health plan ID card.

Mail-order program

If you have enrolled in Option 250 or Option 500, you may also use the Merck-Medco mail-order program for maintenance prescription drugs. Maintenance drugs include those 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 this program allows you to receive up to a 90-day supply of your maintenance medication for a copayment. Copayments are shown in the *Benefits at a glance* charts on pages 15-17.

Option 250 and Option 500 will provide greater benefits when you fill a prescription at a CCP participating pharmacy and when you receive generic medications.

You can also receive a 90-day supply of maintenance medications through the Merck-Medco mail-order program if you are enrolled in Option 250 or Option 500.

If you are enrolled in Option 1000, covered prescription drugs are reimbursed at 70% after you have met the medical plan deductible each year.

To use the mail-order 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 calling Merck-Medco at 1-800-711-3796 or visiting the web site at www.merck-medco.com. (To access the 800 number and the web site, you'll need to enter your Social Security number from your health plan ID card.) Or ask your doctor to call 1-888-327-9791 for instructions on how to fax the prescription.

If a brand-name drug is dispensed when a generic drug is available, you will be required to pay the applicable 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 14-day supply and the other for a 90-day supply. Take the first prescription to a local network retail pharmacy for medication to tide you over until your first mail order arrives.

After you've made the first order, you can order a refill of the same prescription by phone by calling 1-800-473-3455 or visiting the web site at www.merck-medco.com. To use this service, you'll need your Merck-Medco member number (which is your Social Security number) from your health plan ID card and your credit card number.

PRESCRIPTION DRUG BENEFITS—OPTION 1000

If you are enrolled in Option 1000, covered prescription drugs are reimbursed at 70% after you have met the medical plan deductible each year.

You may purchase prescription drugs from any retail pharmacy and still receive the same benefit. However, pharmacies that participate in the BlueScript pharmacy network have agreed to provide discounts to Option 1000 participants, and they will file claims for you with BlueCross BlueShield of Illinois.

How the plan works

Here's how you receive benefits for prescription drugs:

- When you have a prescription filled, you will be required to pay the full cost of the drug up front. If you are using a BlueScript participating pharmacy, your cost will be discounted. Then, the participating pharmacy will file your claim with BlueCross BlueShield of Illinois.
- BlueCross BlueShield will credit the amount you have paid for covered prescriptions, along with your other covered medical expenses, toward your annual medical plan deductible and send you a check in the amount

of the benefits payable for your expenses. After you have met the deductible, you will be reimbursed at 70% for all covered prescription drugs for the rest of the calendar year. (If your overall medical costs reach the out-of-pocket maximum in a calendar year, the plan will then pay 100% of eligible prescription drugs for the rest of that year.)

- If you use a non-participating pharmacy, you will not receive the BlueScript discounts and you must file your own claim with BlueCross BlueShield of Illinois. BlueCross BlueShield of Illinois will then reimburse you as described above.
- In any case, you will receive an explanation of benefits from BlueCross BlueShield of Illinois showing the amount that was applied to your deductible and how your benefits were determined.

Mail-order program

You can save money on maintenance prescription drugs through the BlueScript mail-order program, administered by RxAmerica. Maintenance drugs include those you take for periods of 30 days or longer for chronic health conditions such as diabetes, asthma, arthritis, high blood pressure and heart disease.

To use the mail-order program:

- Ask your doctor to write a prescription for up to a 90-day supply of the drug.
- Call RxAmerica at 1-800-293-2202 to find out the discounted price of the drug.
- Complete the order form provided in the mail-order information packet. You may obtain a mail-order information packet by calling BlueCross BlueShield of Illinois at 1-888-873-2227.
- Mail the form along with your prescription and your payment amount to the address shown on the form.
- RxAmerica will send the drug to your home and file your claim with BlueCross BlueShield of Illinois.
- BlueCross BlueShield of Illinois will credit the amount you have paid for covered prescriptions toward your annual medical plan deductible and send you a check in the amount of the benefits payable for your expenses, as described above under *How the plan works*.

COVERED DRUGS

Under all options (Option 250, Option 500 and Option 1000), coverage is limited to medications and drugs requiring a written prescription from a physician and dispensed by a licensed pharmacist—plus insulin and diabetic supplies such as syringes, lancets and glucose sticks. Dispensing limits may apply.

The plan does *not* cover expenses for:

- Cosmetic products (such as Rogaine, Minoxidil or topical applications for treatment of acne or wrinkles). If a drug such as Retin-A is prescribed for a person over age 25, you will be required to furnish proof of medical necessity.

KEY POINTS

Under Option 1000, you can save money on maintenance prescription drugs through the BlueScript mail-order program, administered by RxAmerica.

5/29/01
Employee/dependent would need a letter from doctor stating the medical necessity for a glucose monitor plus a prescription. Purchase the monitor and send to BC with letter + claim form. Would go toward deductible, etc.

Certain drugs require prior approval from the plan.

- Any drug that is experimental or investigational, or one that is being used for a treatment that has not received final approval from the FDA.
- Any drug covered by workers' compensation.
- Prescriptions for birth control devices or birth control pills (unless these are being used for other than contraceptive purposes, and pre-approval has been given by the plan).
- Refills before 75% of the prescription is used.
- Smoking cessation prescriptions in excess of a 90-day program within any 12-month period (over the counter products are not eligible).

Certain drugs require prior approval from the plan. If your doctor prescribes any of the following, you must receive a prior authorization before the plan will pay benefits for:

- Contraceptive medication. (Covered only with a specific diagnosis and when medically necessary. Drugs used for birth control are not covered.)
- Acne therapy medication for participants over age 25.
- Anorectics.
- Growth hormones.
- Fertility drugs.
- Erectile dysfunction therapy.
- Interferon.
- Myeloid stimulants.
- Alzheimer therapy.
- Amphetamines.
- CNS stimulants.
- Betaseron.
- Erythroid stimulants.

This list may change from time to time.

To request prior authorization, you may call:

- Option 250 or Option 500—call 1-800-458-8001. Have your Merck-Medco member number ready (from your health plan ID card).
- Option 1000—call BlueCross BlueShield of Illinois at 1-888-873-2227.

You may also obtain educational information about your prescription drugs by visiting the web site at www.merck-medco.com. If you have other group health coverage for prescription drugs—through your spouse's employer, for example—refer to the *Claims procedures* section on page 43 for information about how to submit your claims.

COVERED MEDICAL EXPENSES

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

The medical plan provides benefits only for covered expenses that do not exceed the usual, customary and reasonable charges, as determined by BlueCross BlueShield of Illinois. Participating providers agree to accept these rates and will not bill you for covered expenses other than the deductible, copayment and your percentage share of expenses. For a non-participating provider, you must pay any amounts that exceed the usual, customary and reasonable charge, in addition to the deductible, copayment and your percentage share of covered expenses.

Wellness Benefits

The plan provides benefits for certain wellness and preventive care services. For Option 250 and Option 500, when the care is received from a network provider, the plan will pay 100% of covered wellness expenses up to $250 per person per calendar year with no deductible. For Option 1000, the plan pays 70% of covered wellness services with no deductible, up to $250 per person per calendar year. For all three options, covered expenses in excess of the $250 annual maximum and covered wellness charges by non-network providers will be subject to the deductible and considered under the benefits or other medical expenses shown on the chart on pages 15-17.

Covered wellness expenses include:

- Routine well-child care for newborns and children under age 6, including routine immunizations.
- Pap tests, mammograms, screenings for hypertension and diabetes, and examinations for cancer, blindness and deafness, and other screening and diagnostic procedures.
- Routine physician examinations, except for examinations required for admission to a school or for participation in sports. Routine immunizations are not covered after the sixth birthday, except for influenza vaccines.

Note that these wellness benefits can be provided only for charges your physician identifies as routine. Services for which a diagnosis is provided or symptom indicated will be paid in accordance with regular plan benefits.

Hospital charges

Covered expenses include the following inpatient and outpatient hospital charges. For an inpatient hospital stay, MSA must approve the hospitalization, as explained on page 20.

- Room and board expenses in a semi-private room, including expenses for intensive care or coronary care units. The cost of a private room may be eligible if medically necessary.
- Special diets.
- General nursing care.
- Use of operating, delivery, recovery and treatment rooms and equipment.
- Emergency room services.
- All FDA-approved and appropriately prescribed drugs and medicines for use in the hospital, and covered drugs or medicines sent home following hospitalization, up to a 30-day supply.
- Dressings, ordinary splints and casts.
- X-ray examinations, X-ray therapy and radiation therapy and treatment.
- Laboratory tests.
- Physical therapy.

When the care is received from a network provider, the plan will cover wellness expenses up to $250 per person per calendar year with no deductible.

- Anesthesia and its administration.
- Blood and blood derivatives, to the extent they are not donated without charge or the hospital's supply is not replaced by or for the patient.
- Processing and administering of blood and blood plasma to the extent it is not donated by the patient.
- Chemotherapy.
- Renal dialysis therapy administered according to Medicare regulations.
- Dental care due to accidental bodily injury or oral dental surgery when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition.

Surgical charges

Covered expenses include the following surgical services:

- Surgical procedures, including customary preoperative and postoperative services, performed by a physician or surgeon. (Voluntary sterilization surgery is covered but reversal of sterilization surgery is not.)
- The necessary services of an assistant surgeon who actively assists the physician in surgery when:
  - You or your covered dependent is hospitalized.
  - The type of surgery requires assistance.
  - The services of interns, residents or house officers are not available.
  - Payment for assistant surgeons will be at 25% of the primary surgeon's usual, customary and reasonable charge.
- Medical supplies required for surgery in a hospital, a hospital's outpatient department, a physician's office or a freestanding ambulatory surgical facility.
- Administration of anesthesia when administered by a certified nurse anesthetist or a physician other than the surgeon or assistant surgeon.
- When more than one surgical procedure is performed at the same operative session and *through the same incision,* payment for the secondary procedures will be limited to 50% of the usual, customary and reasonable charge that would apply if the procedures were performed independently. However, additional charges for "incidental surgery" are not covered. Incidental surgery is a procedure that is usually included in the primary surgery charge.
- Oral dental surgery due to an accident, impacted teeth or alveolectomy.
- Surgical benefits for the following procedures may be covered, subject to prior approval by MSA:
  - Surgery for treatment of temporomandibular joint dysfunction (TMJ) if necessary to reorient the joint.
  - Reduction mammoplasty, if medically necessary (not cosmetic).

- Obesity, if you or your covered dependent is 160% or more of the desirable weight and conservative therapies have been tried and proven unsuccessful, and MSA has given prior authorization for the surgery.

- Cosmetic or reconstructive surgery required for:

  - Repair of defects resulting from an accident.

  - Following a mastectomy, reconstruction of the affected breast and reconstruction of the other breast to create a symmetrical appearance, including services required as a result of complications.

  - Replacement of diseased tissue that was surgically removed.

  - Treatment of a birth defect.

  The surgery must be performed within 12 months following the date of the accident, removal of diseased tissue or birth, or if surgery must be delayed because of the patient's physical condition, it is performed as soon as medically necessary and appropriate based on the patient's physical condition.

Home health care

Covered expenses include home health care that follows inpatient hospital treatment if approved in advance through MSA. (See the section called *How to contact MSA* on page 24.) 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 injections.

However, the following coverage limitations apply:

- The home health care must be for the continued treatment of the same condition for which the patient has already received inpatient care. It must begin within 21 days after the patient is discharged as an inpatient from a hospital or skilled-nursing facility for treatment that was covered by the plan.

- The home health care must be provided according to a plan of treatment established by the patient's physician and approved through MSA.

- The patient must be homebound for health reasons, but the patient may leave home occasionally to obtain outpatient hospital care that cannot be provided at home, or to obtain care from a licensed health care professional.

Benefits for home health care are not provided for:

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

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.

The following special limitations apply to hospice care:

- 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 the section called *How to contact MSA* on page 24.)
- Counseling for the family is covered up to a maximum of $200.

Benefits for hospice care are not provided for:

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

Skilled nursing facility

Covered expenses include care from an approved skilled-nursing facility, 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 the section called *How to contact MSA* on page 24.)
- The care must require the skills of a registered nurse.

- The care must be likely to result in a significant improvement in the patient's condition. (Custodial care is not covered.)

- The degree of care must be more than can be given in the patient's home, but not so much as to require acute hospitalization.

Other medical services

The following expenses are eligible for benefits:

- Expenses you incur at your home, a hospital, a clinic or your physician's office for the professional services of a physician or surgeon, including consultations by a qualified specialist.

- Expenses you incur for the services of a physician's assistant or nurse practitioner.

- Expenses incurred for the services of a registered nurse (RN) or licensed practical nurse (LPN), when the skills of an RN or LPN are required.

- The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye.

- The fitting of diaphragms or the insertion or removal of an IUD. (Pharmacy charges for birth control pills or contraceptive devices are not covered.)

- Artificial insemination, when medically diagnosed as an appropriate treatment for infertility. However, the plan will cover artificial insemination for only one of the following, after which the plan will no longer pay benefits:

  - No more than three times within three consecutive cycles.

  - No more than a total of four attempts within a six-month period.

  In vitro fertilization and gamete-transfer procedures are not covered.

- Laboratory tests, radium therapy, X-rays and microscopic tests including the services of radiologist or pathologist.

- Professional local ambulance services for transportation to a clinic, medical center, hospital, physician's office or skilled-nursing facility, when medically necessary.

  Air ambulance charges are also covered for:

  - Transportation from a remote area to the first, nearest hospital where treatment can be given.

  - Transportation to a hospital in the event of a life-threatening accidental injury or sudden, life-threatening illness.

- Prosthetic appliances to replace missing or nonfunctioning parts of the body. Covered prosthetic appliances include:

  - Breast prostheses, internal and external (including two surgical brassieres per year), for reconstruction after a mastectomy.

  - Cardiac pacemakers, atomic or electronic.

  - Extraocular and intraocular lenses to replace either surgically removed or congenitally absent crystalline lenses of the eye.

  - Penile prostheses in men suffering impotency resulting from an organic disease or injury.

- Artificial eyes.
- Artificial limbs.
- Colostomy supplies and other equipment directly related to ostomy care.
- Electronic speech aids after a laryngectomy.
- Urinary collection and retention systems (Foley catheters, tubes, bags and so forth) in cases of permanent urinary incontinence.

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

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

- Orthopedic devices, including:
  - Braces and trusses.
  - Custom-made and molded supportive orthotic appliances for the feet, when prescribed by a physician.
  - Custom-made shoes when prescribed by a physician.
  - Up to two pairs of surgical stockings per prescription in a six-month period, when prescribed by a medical physician for such conditions as thrombophlebitis or conditions resulting from surgery.
- Rental of durable medical equipment for home use, up to its purchase price. In some cases, MSA may instead approve the outright purchase of the equipment if it is for long-term use.
- Home oxygen equipment, including stationary and portable oxygen systems, will be eligible for coverage according to Medicare guidelines up to the purchase price.
- Services of an inhalation therapist in the patient's home, under the orders of the attending physician.
- Physical therapy by a licensed physical therapist that is expected to produce significant improvement within a two-month period. Benefits will no longer be paid when care has become maintenance. When the therapeutic goals of the treatment plan have been achieved and/or when no more measurable progress is expected, benefits will cease. Physical therapy coverage for temporomandibular joint syndrome (TMJ) follows the same guidelines.
- Speech therapy, by a licensed speech therapist, to restore speech that has been impaired as a result of illness, surgery or injury. Speech therapy will also be covered after surgery to correct birth defects. Developmental delays in learning to talk, the perfection of speech and educational services are not covered.
- Occupational therapy for a physical or severe mental disability to restore the ability to perform ordinary tasks of daily living. Benefits will end when the therapeutic goals of a treatment plan have been achieved or when no more measurable progress is expected.

Occupational therapy is not covered for most mental and chemical-dependency conditions.

- Cardiac rehabilitation 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).
- Biofeedback therapy, when reasonable and necessary for muscle re-education of specific muscle groups or for treating specific muscle abnormalities. This is not covered for treatment of ordinary muscle tension or for psychosomatic conditions.
- Treatment of temporomandibular joint syndrome (TMJ) to realign the joint, and removable appliances and splints when medically necessary. Services or supplies in connection with crowning, wiring or repositioning the teeth, such as orthodontia, are not covered.
- Dental care for the initial repair of an accidental injury to sound natural teeth only if the services are received within 12 months after the date of the accident.
- Services of a Navajo medicine man who is certified by the office of Native Healing Services and the Navajo Health Authority, or the services of a Northern Cheyenne or Crow medicine man, up to $400 per covered individual per calendar year.

PREGNANCY

Necessary treatment of pregnancy is covered in the same way as an illness or injury for you or (if covered) your spouse with the following exceptions:

- The pre-existing conditions limitation does not apply to pregnancy.
- Precertification is not required for a hospital stay that does not exceed 48 hours for a normal delivery or 96 hours for a cesarean section (see the *Medical Services Advisory (MSA) program and hospital precertification* on page 20 for more information).

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

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

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

Necessary treatment of pregnancy is covered in the same way as an illness or injury for you or (if covered) your spouse.

The plan pays benefits for treatment of mental illness and substance abuse, up to certain limits.

MENTAL ILLNESS AND SUBSTANCE ABUSE

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

Inpatient mental illness and substance abuse

The medical plan covers inpatient mental illness and substance abuse programs for up to 30 days per individual per year, not to exceed 60 days per lifetime. After the annual deductible and the hospital copayment are met, covered expenses are paid at the level shown for inpatient hospital expenses in the *Benefits at a glance* charts on pages 15-17. Also, the inpatient care must be approved by the Medical Services Advisory program, as explained on page 20.

Outpatient mental illness and substance abuse

The plan covers outpatient treatment of mental illness and substance abuse for up to 30 visits per calendar year. After you've met the annual deductible, covered expenses are paid at the level shown for other medical expenses in the *Benefits at a glance* charts on pages 15-17. Your share of these expenses does not count toward the out-of-pocket maximum.

Covered services

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

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

EXCLUSIONS

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

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

- Convalescent care, custodial, domiciliary or sanitarium care or rest cures.
- Travel expenses.
- Expenses for any services you have no legal obligation to pay or for which no charge would be made if you had no medical coverage.
- Expenses in excess of usual, reasonable and customary charges.
- Expenses for the plan's penalties for failure to precertify a hospital admission or for hospitalizations that exceed the length of stay approved by the Medical Services Advisory program.

- Institutional care, when the covered individual does not have to be an inpatient to receive medically effective care.

- Services or supplies in connection with treatment that the claims administrator determines to be experimental or investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational if any of the following applies:

  - There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.

  - When required by the FDA, approval has not been granted for marketing.

  - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.

  - The written protocol or written informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

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

  - The disease can reasonably be expected to cause death within one year in the absence of effective treatment, and all other, more conventional methods of treatment have been exhausted.

  - The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the claims administrator will take into account the results of a review by a panel of independent medical professionals, selected by the claims administrator.

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

- Any expenses that are not medically necessary for the treatment of an illness or injury (except as described for wellness benefits under *Covered medical expenses).*

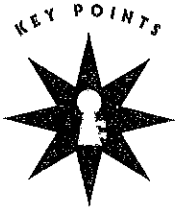
- Procedures that are not needed when performed with other procedures or that are unlikely to provide a physician with additional information when used repeatedly.

- Procedures that are not ordered by a physician or that are not documented in timely fashion in the patient's medical record.

- Any services provided before the effective date of coverage or after coverage ends.

- Services in connection with transsexual surgery.

- Accidental bodily injury or illness caused by war or any act of war, whether or not declared, including armed aggression, participation in a riot or attempted felony or assault.



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

- Accidental bodily injury or illness that is covered by any workers' compensation or occupational disease law.
- Except as required by law, expenses from a U.S. government hospital or any other hospital operated by a government unit, unless there is an expense that the covered individual is legally required to pay.
- Services in connection with any treatment of the teeth, gums or alveolar process, except:
  - Dental care for the initial repair of an accidental injury to sound natural teeth provided the care is received within 12 months, following the date of the accident.
  - Oral dental surgery due to an accident, impacted teeth or alveolectomy.
  - Hospital expenses when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition.
- Surgery for the purpose of fitting or wearing dentures or dental implants.
- Any medical observation or diagnostic study when no illness or injury is revealed, unless you provide the claims administrator with satisfactory proof that the covered person had definite symptoms of illness or injury other than hypochondria. This limitation does not apply to wellness benefits listed under *Covered medical expenses*.
- Hearing aids or for their prescription or fitting.
- Vision training, eyeglasses and contact lenses or examinations for their prescription or fitting, except:
  - The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye.
  - Contact lenses, as long as the contacts are for the replacement of the eye's lenses.
  - Vision training following eye surgery.

  (See your vision care summary plan description to see how vision exams, contact lenses and eyeglasses are covered by the vision plan.)
- Eye surgery for a condition that could be corrected with lenses instead, including but not limited to radial keratotomy—unless it's the plan administrator's opinion that no other treatment is medically acceptable and the plan administrator determines that the surgery is a generally approved procedure in the medical community as a whole.
- Physical and speech therapy that is educational in nature.
- Supervised exercise programs that are not traditionally medical in nature, such as swimming, horseback riding, etc.
- Cosmetic treatment, except:
  - To repair defects resulting from an accident.
  - Replacement of diseased tissue that was surgically removed.
  - Treatment of a birth defect.

- Following a mastectomy covered by the plan, reconstruction of the affected breast and reconstruction of the other breast to create a symmetrical appearance, including services required as a result of complications.

  The surgery must be performed within 12 months following the date of the accident, removal of diseased tissue or birth, or if surgery must be delayed because of the patient's physical condition, it is performed as soon as medically necessary and appropriate based on the patient's physical condition.

- Actual or attempted impregnation or fertilization that involves the covered individual as a surrogate or donor, or the pregnancy of a surrogate mother.
- Expenses in connection with assisted reproductive technology or "ART." ART means any combination of chemical or mechanical means of obtaining gametes and placing them in a medium (whether internal or external to the human body) to improve the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer or pronuclear state tubal transfer. Artificial insemination is covered by the plan, subject to the limitations described under *Covered medical expenses*.
- Expenses for reversals of sterilization procedures.
- Home obstetrical delivery.
- Expenses for abortion, unless medically necessary to protect the life of the mother.
- Charges for more than one ultrasound test for a normal, uncomplicated pregnancy.
- Adoption expenses.
- Charges incurred as a result of a pregnancy of a dependent child.
- Birth control devices or birth control pills, unless used for other than contraceptive purposes and approved by the plan.
- Hypnosis and acupuncture.
- Naturopathic or holistic services.
- Massage therapy or rolfing.
- Treatment, instructions or activities for control or reduction of weight, except medical treatment approved by MSA or surgery for morbid obesity as described under *Surgical charges* on page 32.
- Expenses for telephone conversations with a physician in the place of an office visit, for writing a prescription or for medical summaries and preparing medical invoices.

- Marriage counseling, encounter or self-improvement group therapy and school-related behavioral problems.
- Treatment received from a person who is your close relative or ordinarily resides with the patient. A "close relative" means you, your spouse or a person related to you or your spouse as a brother, sister or parent.
- Services by a licensed chiropractor, whether or not the services are covered by the chiropractor's license.
- Any care that does not require the services of a specifically trained medical professional.
- Routine foot care, including but not limited to treatment of corns and calluses, and nonsurgical treatment of bunions.
- Expenses for an autopsy or post-mortem surgery.
- Transportation for delivery of home health care.
- Dentures, replacement of teeth or structures directly supporting teeth.
- Electrical continence aids, anal or urethral.
- Wigs or hairpieces.
- Implants for cosmetic purposes.
- Penile prostheses for psychogenic impotence.
- Personal comfort or service items for use during confinement in a hospital, including but not limited to a radio, television, telephone and guest meals.
- Services or supplies not specifically listed under *Covered medical expenses*, including but not limited to:
  - Air conditioners, humidifiers, dehumidifiers, purifiers or tanning booths.
  - Over-the-counter orthopedic or corrective shoes.
  - Exercise equipment.
- Medical care, services or supplies for any injury that may have been caused by the act or omission of a third party, unless the covered individual has fully complied with the plan's subrogation provision. (See the section called *The plan's right to recover payment from third parties and subrogation* on page 48.)
- Services or supplies related to a pre-existing condition, as explained in the section called *Limitations for pre-existing conditions* on page 12.
- Claims received more than 12 months after the date the services or supplies were received.

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

Claims Procedures

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

1. Obtain a claim form and envelope from your benefits department. Claims for prescription drugs under Option 250 and Option 500 must be filed using the Merck-Medco claim form.

2. Securely attach your itemized bills and/or prescriptions to the claim form. Check your bills to make sure the information on the bill includes the:

   - Patient's name.
   - Diagnosis (for medical claims).
   - Date and type of service.
   - Itemized charges.
   - Name of the provider, provider number and address.

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

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

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

5. Submit medical and prescription drug claims under Option 1000 to the address shown on the medical claim form.

Retail prescription drug claims under Option 250 and Option 500 must be submitted to Merck-Medco at the address shown on the Merck-Medco claim form. A separate claim form is required for each family member. Mail-order prescription drug claims under these options must be submitted to the Merck-Medco mail-order program at the address shown on the mail order form.

If you also have prescription drug coverage through another plan that is your primary plan (as described in the *Coordination of benefits* section), you may also claim secondary benefits under our plan (Merck-Medco for Option 250 and Option 500, or BlueCross BlueShield of Illinois for Option 1000).

Remember that before a hospital admission, you must call the Medical Services Advisory (MSA) program for precertification. The telephone number is on the back of your ID card. You must also call MSA within two working days of any emergency hospitalization.

Exceptions apply to maternity admissions, as explained on page 37.

KEY POINTS

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

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

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

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

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 at 1-888-873-2227 or submitting a written request for review to:

BlueCross BlueShield of Illinois
2001 Fox Drive
Champaign, IL 61820-7331

For prescription drug claims, you should direct claims questions to Merck-Medco at 1-800-711-3796. Formal claim-review procedures are discussed on page 67.

PAYMENT OF BENEFITS

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

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

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

RECOVERY OF EXCESS PAYMENTS

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

THE PLAN'S RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To determine the benefits for your claim, the plan may require additional information such as itemized bills, a statement from your provider, medical 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.

Coordination of Benefits

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

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

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

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

To make sure you receive the benefits to which you are entitled under both plans, it is important to submit your claims properly.

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

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

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

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

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

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

PRIMARY COVERAGE FOR ACTIVE EMPLOYEES WHO ARE ELIGIBLE FOR MEDICARE

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

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

For individuals entitled to Medicare because of end-stage renal disease, after 30 months of coverage the company plan will be secondary and Medicare will be primary.

EFFECT OF MEDICARE ON BENEFITS FOR RETIRED AND DISABLED EMPLOYEES

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

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

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

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

THE PLAN'S RIGHT TO NECESSARY INFORMATION

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

THE PLAN'S RIGHT TO MAKE PAYMENTS TO OTHER ORGANIZATIONS

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

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

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

This provision applies if the plan pays benefits because of an injury for which a third party may be liable (such as in an auto accident caused by a third party).

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 first-party benefits such as uninsured motorist 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 receive 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 benefit 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.

When Coverage Ends

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

- The plan is terminated.
- You no longer meet the definition of an eligible employee. If your employment ends before the 16th day of the calendar month, coverage will terminate on the 15th of that month. If employment ends on or after the 16th day of the calendar month, coverage will terminate on the last day of that month. Medical coverage will be continued if you are an eligible disabled employee or an eligible retired employee, as explained on pages 50 and 52.
- You elect to terminate your coverage because of a change in family status. If your request is received before the 16th day of the calendar month, coverage will terminate on the 15th of that month. If your request is received on or after the 16th day of the calendar month, coverage will terminate on the last day of that month.
- You elect to terminate your coverage during the annual enrollment period. In this case, coverage will end on December 31 following the annual enrollment period.
- You fail to pay the required contribution for coverage.

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

- Your dependents are no longer eligible (for example, your child reaches the limiting age or marries). If eligibility ends before the 16th day of the calendar month, coverage will terminate on the 15th of that month. If eligibility ends on or after the 16th day of the calendar month, coverage will terminate on the last day of that month.
- You elect to terminate your dependent's coverage because of a change in family status. If your request is received before the 16th day of the calendar month, coverage will terminate on the 15th of that month. If your request is received on or after the 16th day of the calendar month, coverage will terminate on the last day of that month.
- You elect to terminate your dependent's coverage during the annual enrollment period. In this case, coverage will end on December 31 following the annual enrollment period.
- Your coverage ends.
- You die (except as provided under *For surviving spouses and dependent children*).
- You fail to pay the required contribution for coverage.

The following sections describe continuation provisions that may apply in certain circumstances.

Your medical coverage will be continued while you are on an approved leave of absence according to the company's family and medical leave policy, provided you pay the required contributions for coverage.

COVERAGE WHILE ON LEAVE OF ABSENCE

Your medical coverage will be continued while you are on an approved leave of absence according to the company's family and medical leave policy, provided you pay the required contributions for coverage. If you choose not to continue your coverage, it will be reinstated without restrictions on the date you return to work from a leave that is protected by the Family and Medical Leave Act.

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

You may also continue medical coverage for yourself and your covered dependents during a leave protected by the Uniformed Services Employment and Reemployment Rights Act of 1994, provided you pay any required contributions. Assuming you pay your contributions when due, your right to continue coverage under this provision will end 18 months after you begin your protected military leave or when you fail to return to work within the time period prescribed by the Act, whichever is earlier. If your coverage is canceled while you are on a protected leave, it will be reinstated on the date you return from the leave, provided that date is within the period prescribed by the Act. You will not be required to satisfy any pre-existing conditions limitation period to the extent that this period was satisfied before the start of your protected leave.

For any other leave of absence, your coverage will end during the leave unless you elect coverage under COBRA, or you are eligible for coverage as a retired or disabled employee, as defined on pages 50 and 52.

IF YOU ARE DISABLED

You remain eligible for coverage while you are receiving short-term disability benefits. Thereafter, you may remain eligible as described below:

- If you are receiving long-term disability (LTD) benefits, you may elect to continue your medical coverage provided you pay the required contributions.
- Coverage will end when you are no longer receiving LTD benefits. (LTD benefits generally continue to age 65 or retirement, if you remain disabled). If you are age 55 or older and have 10 years of service at that time, you may continue your coverage under the plans offered to retired employees. Years of service include the time you were receiving social security disability benefits, provided you had five years of actual service before the disability began or if your disability was caused by a work-related injury.

The coverage provided under this provision will reduce the maximum period of continuation of coverage available under COBRA as described on page 56.

IF THERE IS A REDUCTION IN THE WORK FORCE

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

The coverage provided under this provision will reduce the maximum period of continuation of coverage available under COBRA as described on page 56.

FOR SURVIVING SPOUSES AND DEPENDENT CHILDREN

In the event of your death, your surviving spouse and eligible dependent children may continue their medical coverage for the rest of the month of your death plus three additional months. Thereafter coverage may be continued only if one of the following applies:

- If you are an active employee or disabled employee and on the date of your death you would have met the definition of a retired employee, your surviving spouse's coverage will continue under the plan that would have been available to you if you had retired on the date of your death. This coverage may be continued until his or her death or remarriage.★
- If you are an eligible retired employee, your surviving spouse may continue coverage as described in the section called *When you retire.*
- Dependent children are eligible for as long as the surviving spouse is eligible, and they continue to meet the plan's definition of a dependent child. If there is no surviving spouse at the time of your death, coverage for your dependent children will end.

The coverage provided under this provision will reduce the maximum period of continuation of coverage available under COBRA as described on page 56.

★ *The company may amend or terminate benefits in the future.*

If you retire on or before January 1, 2003, and you are eligible for retiree medical coverage as described in this booklet, you may choose medical coverage under Option 250, Option 500 or Option 1000 provided you were enrolled in one of these options (or an HMO) when you retired.

When You Retire

The benefits available to you and your eligible dependents after retirement depend on when you retire, as explained in the following sections.

RETIREMENT ON OR BEFORE JANUARY 1, 2003

If you retire on or before January 1, 2003, you will be eligible for coverage described in this section if both of the following apply:

- On the date you retire, you are at least age 55 and have completed 10 or more years of service as defined by the plan.
- You begin receiving retirement benefits from the company's retirement plan within 31 days after you stop working for the company, unless you were receiving long-term disability benefits immediately before your retirement benefits begin.

If you are eligible for retiree medical coverage as described above, you may choose medical coverage under Option 250, Option 500 or Option 1000 provided you were enrolled in one of these options (or an HMO) when you retired. You will be required to pay contributions for the coverage you choose. The following rules apply to enrollment:

- If you elected no coverage from the company before retirement because you have coverage under another medical plan, you may enroll on or after your retirement date only if you lose that other coverage as described in the section called *Changing your coverage*.
- If you do not enroll for coverage within 31 days after your retirement date, or if you enroll and later decide to cancel your coverage, you may re-enroll in the future only if you lose coverage from another plan as described in the section called *Changing your coverage*. You may also increase your coverage option (from Option 1000 to Option 250, for example) in this situation.
- If you enroll in one of the options, you can only increase your coverage by one level during the annual enrollment period.
- As a retiree, you must pay a contribution for coverage under any of the options, and no cash payment is provided by the company with any option after retirement. (If you received a cash payment for the year in which you retired, you will be required to repay the company for a portion of the cash payment based on your retirement date.)
- For retirees, the cost of coverage is deducted from your pension check on an after-tax basis. If your pension check is not sufficient to cover this cost, you must pay your contributions directly to the plan by the first of each month to avoid a loss of medical coverage. Should the costs for the plan go up or down in future years, the portion that you pay will reflect these changes in cost.

RETIREMENT AFTER JANUARY 1, 2003

If you retire after January 1, 2003, you will be eligible for coverage described in this section if, on the date you leave the company, you are at least age 55 and have completed 10 years or more of service as defined by this plan. However, you will be eligible for the company's medical premium reimbursement (MPR) program instead of the plan described in this booklet.★ You will have a choice of purchasing your own private insurance policy or you can elect coverage through a retiree catastrophic plan offered by the company (see page 54). In either case, you can request reimbursement from the MPR program for any health insurance plan you purchase for yourself and/or your eligible dependents, including individual policies, Medicare and Medicare supplement plans. You may also use your MPR to pay the cost of COBRA continuation coverage while you are eligible for COBRA as described on page 56.

The maximum amount you can be reimbursed from the MPR is based on your years of service with the company. Cumulative reimbursement for medical premium payments will be limited to an amount determined by your years of service, multiplied by $1,000. For example, if you had 20 years of service when you retired, your total reimbursement allowance would be $20,000.

If you should die before your maximum allowance has been exhausted, your eligible dependents may continue to request reimbursement until the allowance is fully used.

Your MPR allowance is a lifetime maximum—it is not reinstated each year or at any other time in the future. Once your maximum MPR allowance is exhausted, you will no longer be eligible for any medical premium reimbursement from the company.

Please note that MPR benefits are not considered taxable income.

★*Note: For employees who became disabled before January 1, 1999, the options for coverage at retirement will be available as described under* Retirement on or before January 1, 2003, *regardless of the retirement date.*

YEARS OF SERVICE

Years of service means the number of days of full-time employment with the company, divided by 365. Any remainder is divided by 30 to determine the number of full months of service, with a remainder of 15 days or more considered as an additional full month of service.

For purposes of measuring years of service, the following provisions will apply:

- Years of service include only full-time employment. Full-time employment means performance of active work for your regularly scheduled hours on a full-time basis (35 hours or more per week). It does not include part-time employment or temporary employment or employment that is not year-round. It does, however, include certain absences from full-time work, including:
  - Absence due to termination of employment, if you are reemployed within 12 months.
  - Absence due to a military leave protected by the Uniformed Services Employment and Reemployment Act, if you return to work within the time period provided in the act.

If you retire after January 1, 2003, you will be eligible for the company's medical premium reimbursement (MPR) program instead of the plan described in this booklet.

- Absence due to a reduction in the workforce, if you return to work within 180 days.
- Absence due to disability, if you are receiving short-term disability benefits from the company during the absence and you return to work within 180 days.
- Absence due to disability if you are receiving long-term disability (LTD) benefits from the company's plan and you return to work within 24 months after LTD benefits begin.
- Absence due to disability if you are receiving LTD benefits and you are also receiving Social Security disability benefits, provided you had five years of service before the disability began or the disability is work-related.

- Years of service are generally based on the continuous period of full-time employment with the company immediately before your retirement. However, the following exceptions will apply:
  - If you leave the company and are reemployed, you will receive credit for the prior period of employment if you return to work before a "break in service" occurs.
  - "Break in service" means a period of 365 consecutive days (366 in a leap year) during which you were not employed by the company. However, in the case of an absence due to pregnancy or birth of a child, or placement of a child with you for adoption or care of a child immediately following birth or adoption, a break in service means a period of 730 days (731 in a leap year) during which you were not employed by the company.
  - If you have a break in service and then return to work, you will receive credit for the period of employment prior to the break in service if (a) you had five years of service prior to the break, or (b) the break did not exceed the greater of (i) the number of years and months of service you had before the break or (ii) five years.

RETIREE CATASTROPHIC PLAN

The retiree catastrophic plan will be offered to employees who first become eligible for retiree medical coverage after January 1, 2003. The retiree catastrophic plan provides a basic level of coverage, with a high deductible. It is designed to provide an option for individuals who are unable to obtain a private insurance policy at an affordable cost. You will receive a description of the retiree catastrophic plan and the rules for enrollment at the time you retire. If you elect this option, the premiums will be applied against your MPR allowance. The premiums will be at a level where the plan is entirely funded by the participants.

COVERAGE FOR DEPENDENTS AFTER RETIREMENT

Your spouse and dependent children will also be eligible for coverage when you retire, if you are eligible. However, if at the time you retire you have eligible dependents who are not enrolled for coverage under the plan, you may not obtain coverage for the dependents unless they lose coverage under another health plan. This limitation also applies if you decline dependent coverage at retirement. You may re-enroll dependents in the future only if they lose coverage under another health plan. In addition, beginning January 1, 2000, you may not enroll a spouse or child who becomes your dependent after you retire.

For example, if you were married on your retirement date, but chose single coverage, you would be allowed to add your spouse to your coverage due to a loss of other coverage because your spouse was eligible for coverage on the date you retired. However, if you divorced, then remarried after your retirement date, you would not be allowed to add your new spouse to your coverage, since your new spouse was not eligible for coverage on your retirement date.

In the event of your death while covered under the retiree medical plan, your surviving spouse will remain eligible provided the spouse is eligible for the plan on the date you become an eligible retiree and during the entire year before your death.★ An eligible surviving spouse may continue coverage until the date the surviving spouse dies or remarries.

Your children are eligible for as long as the surviving spouse is eligible and they continue to meet the definition of a dependent child. If there is no surviving spouse, your children are not eligible.

★ *This continued coverage does not apply if you retired before September 1, 1977, unless you chose a joint-and-survivor option for receiving pension benefits.*

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

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. However, if your employment stops during a leave of absence protected by the FMLA, the period will be measured from the date the protected leave ends. No more than a total of 36 months of continued coverage will be provided to any individual, even if more than one of these events occur.

EXTENSION OF COVERAGE IF DISABLED

Continued coverage may be further extended if you or your dependent is 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.)

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 benefits department within 60 days in the event of a divorce, legal separation or when a child no longer qualifies as a covered dependent under the plan.

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

COST OF CONTINUED COVERAGE

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

BENEFITS UNDER CONTINUED COVERAGE

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

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 will have the opportunity to add dependents or change coverage under the same rules that apply to actively working employees under the plan.

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.

You may be able to convert your medical coverage to an individual policy if it otherwise ends. You pay the premiums.

Converting Medical Coverage 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.

Key Terms

AMBULATORY SURGICAL FACILITY

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

CLAIMS ADMINISTRATOR

The organization retained by the company for granting or denying claims, currently BlueCross BlueShield of Illinois for medical claims and Option 1000 prescription drug claims, and Merck-Medco for Option 250 and Option 500 prescription drug claims.

COMPANY

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

However, the plan does not cover:

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

CUSTODIAL CARE

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

DISABLED EMPLOYEE

Any employee who is receiving short-term or long-term disability benefits under the company's disability plan.

DURABLE MEDICAL EQUIPMENT

Equipment that meets all of the following conditions:

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

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

EDUCATIONAL INSTITUTION

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

ELIGIBLE RETIRED EMPLOYEE

A former salaried employee who has stopped working for the company on or after January 1, 1970, and who, on the date he or she stopped working★, is one of the following:

- Age 55 with at least 10 years of service.
- A totally and permanently disabled salaried employee with at least 10 years of service who became disabled before January 1, 1998. Your disability must be approved by the Social Security Administration as eligible for Social Security disability benefits.

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

★ *If you retire on or before January 1, 2003: To be eligible for medical coverage, you must begin receiving a retirement benefit from the company's retirement plan within 31 days from the date you leave the company.*

EMERGENCY OR URGENT CARE

A serious medical condition resulting from injury or sickness that arises suddenly and requires immediate medical care to avoid serious physical impairment or loss of life, and for which you seek medical attention after the onset.

EMPLOYEE

Any full-time (working 35 or more hours per week) salaried or part-time employee of the company who is regularly scheduled to work at least 20 hours per week year-round, or is considered to be a full-time salaried employee while on vacation, prepaid retirement or assignment by the company, and who is not a disabled employee or retired employee.

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

HOME HEALTH CARE

Services provided by either:

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

HOME HEALTH CARE AGENCY

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

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

HOSPITAL

An institution that meets all of the following conditions:

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

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

- A facility approved by the claims administrator for inpatient or outpatient treatment of chemical abuse.
- Psychiatric hospitals classified and accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- A residential treatment facility, if approved by the Medical Services Advisory program when necessary treatment cannot be provided while the patient is living at home.

ILLNESS

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

INJURY

An accidental bodily injury caused directly and exclusively by sudden and violent means.

MEDICALLY NECESSARY

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

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

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

MEDICARE

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

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

With respect to retired employees and their dependents covered under the plan, the term "Medicare benefits" will include the following:

(a) The amount of benefits that would have been payable by Medicare if the covered individual had made a claim for Medicare benefits.

(b) In the case of a covered individual who has either (1) not enrolled for Medicare Part A and Part B; (2) has enrolled in a Medicare managed care alternative or other Medicare+Choice plan and received reduced Medicare benefits due to failure to comply with managed care rules or use of non-network providers; or (3) received services

under a private contract with a provider who has opted out of Medicare, the covered individual shall be deemed to have received Medicare benefits in an amount determined in accordance with the deductible and coinsurance factors then applicable under original Medicare, and in accordance with the covered expense definitions of this plan. The preceding sentence will not apply to benefits under hospital insurance (Part A) of Medicare with respect to an individual whose eligibility for such hospital insurance (Part A) of Medicare requires payment of premium.

(c) Any benefits paid or payable by another group plan, due to its obligation to provide benefits without regard to Medicare coverage for an actively working employee or dependent of such person.

MENTAL ILLNESS

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

PHYSICIAN OR SURGEON

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

REGISTERED PSYCHOLOGIST

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

- If state licensing or certification exists, he or she must hold a valid license or certificate as a psychologist.
- If state licensing or certification does not exist, he or she must hold a valid, non-statutory (professional) certification established by that area's recognized psychological association.

- If neither statutory or nonstatutory licensing or certification exists, the psychologist must hold a statement of qualification by a committee established by that area's psychological association. If no committee exists, he or she must hold a diploma in the appropriate specialty from the American Board of Examiners in Professional Psychology.

SKILLED NURSING FACILITY

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

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

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

SPOUSE

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

SURVIVING SPOUSE

Your spouse surviving after your death, who at the time of your death was living with you or supported by you. (The duration of continued coverage for a surviving spouse is explained elsewhere in this booklet.)

TERMINATION OF EMPLOYMENT

Includes any of the following:

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

Plan Administration Information

PLAN NAME

The Peabody Group Health and Life Plan for Salaried Employees.

TYPE OF PLAN

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

EMPLOYER IDENTIFICATION NUMBER

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

PLAN NUMBER

501

EFFECTIVE DATE

June 1, 1985

LAST AMENDED

January 1, 2000

PLAN FISCAL YEAR

January 1 to December 31

PLAN SPONSOR

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

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

PLAN ADMINISTRATOR

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

AGENT FOR SERVICE OF LEGAL PROCESS

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

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

FUNDING AND DISBURSEMENTS

The Plan is funded by contributions from Peabody Group 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 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 which 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 among the administrator and the Plan. However, the copayments, and/or coinsurance which are your responsibility will be calculated without regard to such rebates.

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

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:

- 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 copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports (Form 5500 Series).
- 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.

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 on the rules governing your COBRA continuation coverage rights.
- Receive a copy of the plan's qualified medical child support procedures without charge from the plan administrator.
- 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, 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).

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. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan 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 which 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 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.

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, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

IF YOUR CLAIM IS DENIED

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

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

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

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

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

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

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

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

AMENDING THE PLAN

The plan is adopted with the intention that it will be continued for the benefit of present and future employees and retired employees of the company. However, the company reserves the right to terminate the plan, change required contributions or modify this plan in whole or in part at any time or for any reason, including changes in any and all of the benefits provided.

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

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