# PEABODY GROUP HEALTH AND LIFE PLAN FOR SALARIED EMPLOYEES

As in Effect on and after June 1, 1985

Restated January 1, 1997

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# PEABODY GROUP HEALTH AND LIFE PLAN
# FOR SALARIED EMPLOYEES

WHEREAS, Peabody Holding Company, Inc. and Participating Employers (hereinafter referred to as "Plan Sponsor") have heretofore established an Employee Welfare Benefit Plan providing life, medical, vision care and dental benefits for the employees of Participating Employers and eligible dependents of such employees;

WHEREAS, a description of benefits and other provisions of the Plan were heretofore contained in the Plan document for the Peabody Group Health and Life Plan for Salaried Employees, adopted June 1, 1985 and subsequently amended;

WHEREAS, the Plan Sponsor now desires to restate the Plan to reflect certain changes to the benefits and the administration of the Plan including contracts with preferred providers;

WHEREAS, Part 4 of Title I of the Employee Retirement Income Security Act of 1974 (hereinafter referred to as "ERISA") requires that each such plan be established and maintained pursuant to a written instrument;

NOW, THEREFORE, be it resolved that the Peabody Group Health and Life Plan for Salaried Employees (hereinafter referred to as the "Plan") shall be restated pursuant to the terms and conditions of this document to be generally effective July 1, 1995 with certain specified changes to be effective January 1, 1996 and January 1, 1997.

ARTICLE I

## Plan

The Plan is described and evidenced by this written document and by any duly authorized and signed amendments to this written document which may, from time to time, be made with respect to this Plan.

With respect to life insurance benefits, this Plan is further evidenced by the insurance contract issued to the Plan Sponsor by John Hancock Mutual Life Insurance Company or, effective on and after January 1, 1996, by General American Life Insurance Company. With respect to vision care benefits on and after January 1, 1996, this Plan is further evidenced by the insurance contract issued to the Plan Sponsor by Vision Service Plan. With respect to Employee Assistance Program (EAP) benefits, this Plan is further evidenced by the contracts issued to the Participating Employer by the EAP service providers. With respect to HMO benefits, this Plan is further evidenced by the contracts issued to the Plan Sponsor by the HMO's.

The classes of employees eligible under the Plan, the requirements regarding waiting periods to become eligible, the conditions which must be met in order to become eligible for benefits, the procedures governing Participants' elections under the Plan, the amount and type of benefits available, the circumstances under which benefits under the Plan are not available or may terminate, and other provisions affecting the benefits provided by the Plan are set forth in the documents referenced above.

The terms and provisions of the above referenced documents and any amendments or supplements thereto, any and policy(ies) at any time issued in substitution therefor, shall form a part of the Plan in the same manner as if all the terms and provisions thereto were copied herein.

The Plan Year shall commence January 1 and end December 31 of each calendar year.

ARTICLE II

## Eligibility for Medical, Vision Care and Dental Benefits

### 2.01 Eligibility Definitions

As used herein, the following words and phrases, whether or not capitalized, will have the meanings as indicated in this Article II unless a different meaning is plainly required by the context. Whenever required by the context of any Plan provision, the masculine includes the feminine, the feminine includes the masculine, the singular the plural, and the plural the singular. Any headings used herein are included for reference only, and are not to be construed so as to alter any of the terms of the Plan.

A. "Active Work" means the performance of work by an Eligible Employee for a Participating Employer, either at his customary place of employment or such other place as may be required by his Participating Employer in the course of such work.

B. "Affiliate" means any corporation or other business entity that from time to time is, along with the Plan Sponsor, a member of a controlled group of businesses as defined in Section 414(b), (c) or (m) of the Internal Revenue Code. In addition, the term Affiliate includes each entity of which at least 80% of the directors, trustees or other individual members of the entity's governing body are either representatives of or directly or indirectly controlled, or are controlled by the Plan Sponsor, and further including each entity to which the Plan Sponsor provides, directly or indirectly, at least 80% of the operating funds, if there is also a degree of common management or supervision between the entities, including but not limited to the Plan Sponsor's power to appoint or nominate officers, senior management or members of the board of directors (or other governing board) of such entity, or if the Plan Sponsor is involved in the day to day operations of such entity. An entity will be treated as an Affiliate only while a member of such group.

C. "Change in Status" means any of the following events:

1. Prior to January 1, 1998:

   a. Marriage, divorce, death of a Spouse or Child, birth or adoption of a Child.

   b. Change in the Spouse's employment status or loss of health coverage attributable to a change in the Spouse's employment.

c. Unpaid leave of absence, or change from full-time to part-time status, or vice versa, of the employee or Spouse.

d. Such other events related to family status that may be provided by applicable law. Change in Status does not include termination of employment, with respect to the Eligible Employee himself.

2. Effective January 1, 1998:

a. Events that change an Eligible Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation, or annulment;

b. Events that change an Eligible Employee's number of dependents (as defined in Section 152 of the Code), including birth, adoption, placement for adoption (as defined in regulations under Section 9801 of the Code), or death of a dependent;

c. A termination or commencement of employment by the Eligible Employee or the Eligible Employee's Spouse or dependent;

d. A reduction or increase in hours of employment by the Eligible Employee or the Eligible Employee's Spouse or dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence; or

e. An event that causes an Eligible Employee's dependent to satisfy or cease to satisfy the definition of Eligible Dependent as set out below.

f. An event that causes an Eligible Employee or Eligible Dependent to become eligible for Medicare or Medicaid.

g. The issuance of a judgment, decree, or order ("Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in Section 609 of ERISA) that:

(i) Requires an Eligible Employee to provide coverage for his or her child under this Plan, or

(ii) Requires the former spouse to provide medical coverage for such child.

D. "Child" means:

1. The following persons for whom the Participant regularly provides one-half (1/2) of the annual support:

   a. A natural child of the Participant.

   b. A stepchild who resides with the Participant.

   c. A legally adopted child of the Participant.

   d. Any other child of the Participant who lives with the Participant in a permanent parent-child relationship and for whom the Participant has legal guardianship.

2. A child who has been placed for adoption with a Participant irrespective of whether the adoption has become final, where the child has not attained age 18 as of the date of such adoption or placement for adoption and the Participant has assumed and retained a legal obligation for total or partial support of such child in anticipation of adoption of such child.

3. An alternate recipient, as defined in Section 609(a)(2)(C) of ERISA, to the extent required by a QMCSO.

E. "Claims Administrator" means the agent retained by the Plan Sponsor to determine the validity of claims and administer benefit payments.

F. "COBRA Continuation Coverage" means the extension of medical coverage as described in Section H. of this Article II that must be offered pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or other similar law.

G. "Coverage Option" means the particular coverage that may be selected by a Participant.

H. "Covered Individual" means only a Participant or a Participant's Eligible Dependent for whom coverage is effective under the Plan in accordance with this Article II.

I. "Dental Benefits" means the benefits set forth in Article V of this Plan.

J. "Disabled Employee" means an Eligible Employee who ceases Active Work for a Participating Employer due to disability and is receiving salary continuance from a Participating Employer or is receiving benefits from the Peabody Long Term Disability Plan for Salaried Employees. Provided, however, that in no event will the term Disabled Employee include an

Eligible Employee who was employed by Gold Fields Mining Corporation on the date the disability began.

K. "Eligibility Date" means the date an Employee first satisfies the definition of an Eligible Employee. In the case of an individual who ceases to qualify as an Eligible Employee and later returns to employment, or in the case of an Eligible Retiree who returns to employment, "Eligibility Date" means the date the individual again satisfies the definition of Eligible Employee.

L. "Eligible Dependent" means the following persons not otherwise eligible for coverage as a Participant under this Plan:

1. A Participant's Spouse.

2. An unmarried Child of the Participant from the time of birth until the Child reaches age 19.

3. With respect to medical and vision benefits, and with respect to dental benefits on and after January 1, 1998, an unmarried Child of the Participant who is less than 23 years old and is a full-time student in attendance at an Institution of Learning.

No person may be simultaneously covered as an Eligible Dependent of more than one Participant in this Plan.

M. "Eligible Employee" means:

1. Subject to subsection (2) below, the following persons:

a. Any full-time salaried Employee of a Participating Employer who is scheduled to work at least 32 hours per week or who is considered to be a full-time salaried Employee while on vacation, pre-paid retirement or assignment by the Participating Employer.

b. On and after January 1, 1996, any part-time salaried Employee of a Participating Employer who is regularly scheduled to work at least 20 hours per week but less than 32 hours per week, or is considered to be a part-time salaried Employee while on vacation or assignment by the Participating Employer.

c. On and after January 1, 1997, an individual who continues or returns to work in a class described in subsection a. or b. above after satisfying the definition of "Eligible Retiree" shall be considered an Eligible Employee rather than an Eligible Retiree if he or she has elected coverage under the Plan as an active employee in lieu of coverage under the Retiree Benefits Program.

An election by such an individual to be covered as an active employee shall be irrevocable so long as the individual otherwise remains an Eligible Employee.

2. "Eligible Employee" shall not include the following:

   a. An Eligible Retiree who continues or returns to work in a class described in subsection 1.a or 1.b. above and who has elected coverage under the Retiree Benefits Program as described in subsection 1.c.

   b. A temporary employee.

   c. Any person who is a non-resident alien and who receives no income from the company that constitutes income from sources within the United States as defined by Section 861 (a)(3) of the Internal Revenue Code.

N. "Eligible Retiree" means an individual who is eligible for retirement health coverage in accordance with Article XIII of this Plan. The term "Eligible Retiree" shall not include an individual otherwise eligible for retirement health coverage who continues in or returns to active employment if such individual has elected coverage as an active employee in lieu of coverage under the Retiree Benefits Program. An individual who elects coverage as an active employee shall not be considered to be an Eligible Retiree so long as the individual continues in active employment.

O. "Enroll" means to properly complete the Enrollment forms prepared by the Plan Administrator to elect coverage from this Plan and authorize any necessary contributions required for coverage. With respect to dependent coverage, the term "Enroll" includes the requirement that the Eligible Employee identify each Covered Dependent by name on the Enrollment form. An Eligible Employee will be deemed to have Enrolled on the date such Enrollment forms are received by the Plan Administrator.

P. "Enrollment Period" means the period of time, designated by the Plan Administrator at its sole discretion during which Eligible Employees are permitted to Enroll or change coverage in accordance with the provisions of this Article II.

Q. "ERISA" means the Employee Retirement Income Security Act of 1974 as same may be amended from time to time and the regulations issued thereunder by the Secretaries of Labor and the Treasury.

R. "Institution of Learning" means 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 curricula. Correspondence schools, night schools or schools requiring less than full-time attendance are not included.

S. "Medical Benefits" means the benefits set forth in Article III of this Plan, except that for purposes of Section 2.05 and 2.06, Medical Benefits shall refer to either the coverage described in Article III or coverage provided through a health maintenance organization that has arranged with the Plan Sponsor to provide medical coverage to employees.

T. "Medicare" means the federal program of Health Insurance for the Aged and Disabled, otherwise referred to as Title XVIII of the Social Security Act.

"Eligible for Medicare" means that an individual is eligible to participate in the Medicare program by reason of attained age and/or entitlement to Social Security benefits.

"Entitled to Medicare" means that an individual is both Eligible for Medicare and Enrolled in Part A or Part B of Medicare.

U. "Participant" means an Eligible Employee, Disabled Employee or Eligible Retiree for whom coverage is effective under the Plan in accordance with this Article II. A Surviving Spouse for whom coverage is effective under the Plan in accordance with this Article II shall also be deemed a Participant in this Plan for purposes of the provisions set forth in Section XII only. An alternate recipient, as that term is defined in Section 609(a)(2)(C) of ERISA, shall also be deemed a Participant in this Plan to the extent required by ERISA.

Provided, however, that the following persons shall not be eligible to be a Participant in this Plan:

1. Former salaried employees of Eastern Associated Coal Corp. or NuEast Mining Corp. who are retired employees with an effective date before March 1, 1990.

2. Disabled salaried employees of Eastern Associated Coal Corp. or NuEast Mining Corp. who were receiving benefits under the Eastern Gas and Fuel Associates long-term disability plan on March 31, 1987.

3. Former salaried employees who elected to retire before March 1, 1990.

4. Former salaried employees of Gold Fields Mining Corporation who are retired or disabled, except to the extent coverage is required by federal law as described in Sections 2.10 and 2.11.

5. With respect to Vision Care and Dental benefits:

a. an eligible Retiree or

b. a Disabled Employee receiving benefits from the Peabody Long Term Disability Plan for Salaried Employees,

except to the extent coverage is required by federal law as described in Sections 2.10 and 2.11.

V. "Participant Contribution" means any amount which the Plan Sponsor may require Covered Individuals to contribute in accordance with either Article II or Article IX.

W. "Participating Employer" means the Plan Sponsor and any other corporation, partnership, company or other legal entity in which the Plan Sponsor has any ownership interest or sufficient control, such that the entity and the Plan Sponsor are Affiliates; provided such entity has adopted the Plan for the benefit of individuals eligible to participate with the approval of the Plan Sponsor. Any entity so adopting this Plan will be deemed to consent to all the terms and conditions of the Plan, including provisions authorizing the Plan Sponsor to control the content and administration of the Plan, and will further agree to contribute to the Plan an amount determined in the sole discretion of the Plan Sponsor. As of the date the Sponsor ceases to have any ownership interest in or control over any Participating Employer, such entity will cease to be a Participating Employer, and as of that date, coverage under this Plan will cease with respect to all individuals covered under this Plan by reason of their relationship to such Participating Employer, or an Employee or retiree of such employer.

X. "Plan" means The Peabody Group Health and Life Plan for Salaried Employees.

Y. "Plan Administrator" means Peabody Holding Company, Inc.

Z. "Plan Sponsor" means Peabody Holding Company, Inc. and Participating Employers.

AA. "QMCSO" means a Qualified Medical Child Support Order, as defined in Section 609 (a) of ERISA.

BB. "Retiree Benefits Program" means the program of benefits offered by the Plan Sponsor to individuals who are Eligible Retirees as defined in subsection M. above, including Medical Benefits of the Plan and retiree life insurance.

CC. "Spouse" means the legal partner of the Participant in marriage, provided the union is by civil or religious ceremony that is recognized by all state laws in

the United States. For purposes of this Plan, "Spouse" does not include status as a common law spouse.

DD. "Surviving Spouse" means the Spouse surviving the death of a Participant who at the time of death was living with or supported by the Participant.

EE. "Vision Care Benefits" means the benefits set forth in Article IV of this Plan.

## 2.02 Effective Date of Coverage for Eligible Employees

Subject to the Effective Date Provision set forth in Section 2.04, Medical, Dental and Vision Care Benefits coverage shall become effective for an Eligible Employee on the applicable date set forth below:

A. With respect to coverage prior to January 1, 1996, the Employee's Eligibility Date.

B. With respect to coverage on and after January 1, 1996 but before January 1, 1998, Medical, Dental and Vision Care Benefits coverage shall become effective for an Eligible Employee on the earliest of the following dates, subject to the Election of Coverage Options provisions set forth in Section 2.05:

1. The Employee's Eligibility Date, provided he Enrolls within 31 days following his Eligibility Date.

2. If an Eligible Employee does not Enroll within 31 days following his Eligibility Date, or terminates coverage while continuing to be eligible to participate under the Plan, coverage will become effective only on one of the following dates:

a. January 1 following a subsequent annual Enrollment Period during which the Eligible Employee Enrolls for coverage.

b. The date that the Eligible Employee experiences a Change in Status, if the Eligible Employee Enrolls within 31 days following that date. An Enrollment Form will not be accepted unless the change in coverage is necessary or appropriate in light of the Change in Status that has occurred.

c. The date the Eligible Employee returns to Active Work, if the Eligible Employee's Coverage was terminated for non-payment of Participant Contributions while the Eligible Employee was:

(i) on a leave of absence protected by the Family and Medical Leave Act of 1993, or

(ii) on a leave of an absence that was protected by the Uniformed Services Employment and Reemployment Rights Act of 1994,

and the Eligible Employee returns to employment within the time period required to preserve his or her rights under those Acts. Coverage shall be reinstated on the same terms as in effect immediately prior to such leave, without any qualifying period, physical examination or exclusion of pre-existing conditions that

would not have been required had coverage not been terminated. The preceding restriction on the imposition of any limitation upon the reinstatement of coverage shall not apply with respect to any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services while the individual was on Military Leave.

C. With respect to coverage on and after January 1, 1998, Medical, Dental and Vision Care Benefits coverage shall become effective for an Eligible Employee on the earliest of the following dates, subject to the Election of Coverage Options provisions set forth in Section 2.05:

1. The Employee's Eligibility Date, provided he Enrolls within 31 days following his Eligibility Date.

2. If an Eligible Employee does not Enroll within 31 days after his Eligibility Date, or terminates coverage while continuing to be eligible to participate under the Plan, coverage will become effective only on one of the following dates:

   a. January 1 following a subsequent annual Enrollment Period during which the Eligible Employee Enrolls for coverage.

   b. The date other medical coverage of the Eligible Employee or Eligible Dependent ends due to a "qualifying reason", if (i) the Eligible Employee or one of his Eligible Dependents was covered under another medical plan on the date the Eligible Employee initially declined coverage under the Plan and (ii) the Eligible Employee Enrolls for medical coverage under this Plan within 31 days following the date such other medical coverage of the Eligible Employee or Eligible Dependent ends. An individual's other medical coverage will be deemed to have ended due to a "qualifying reason" only if it ends because: (i) the individual is no longer eligible for such other medical coverage, (ii) employer contributions toward such other medical coverage have been terminated, or (iii) the other medical coverage was provided under COBRA and the right to such coverage has been exhausted. This enrollment opportunity shall not be available in the event that the loss of other medical coverage results from the individual's failure to pay required premiums or contributions for such other coverage on a timely basis or in the event of termination of other medical coverage for cause (such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the plan).

c. The date an Eligible Dependent is acquired by the Eligible Employee through marriage, birth, adoption or placement for adoption, if the Eligible Employee Enrolls within 31 days following such date.

d. The date an Eligible Employee experiences a change in his employment classification that results in a decrease in the contributions required for coverage, provided Eligible Employee Enrolls within 31 days following such date.

e. The date the Eligible Employee returns to Active Work, if the Eligible Employee's Coverage was terminated for non-payment of Participant Contributions while the Eligible Employee was:

(i) on a leave of absence protected by the Family and Medical Leave Act of 1993, or

(ii) on a leave of an absence that was protected by the Uniformed Services Employment and Reemployment Rights Act of 1994,

and the Eligible Employee returns to employment within the time period required to preserve his or her rights under those Acts. Coverage shall be reinstated on the same terms as in effect immediately prior to such leave, without any qualifying period, physical examination or exclusion of pre-existing conditions that would not have been required had coverage not been terminated. The preceding restriction on the imposition of any limitation upon the reinstatement of coverage shall not apply with respect to any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services while the individual was on Military Leave.

## 2.03 Effective Date of Coverage for Eligible Dependents

Subject to the provisions of Section 2.04 and Section 2.05, Medical, Dental and Vision Care Benefits coverage will become effective with respect to each Eligible Dependent of a Participant on the applicable date determined below:

A. The date the Participant's coverage becomes effective, provided he Enrolls the Eligible Dependent for coverage within 31 days after his Eligibility Date.

B. With respect to an Eligible Dependent acquired by the Participant after his Eligibility Date, the date such individual becomes an Eligible Dependent, provided the Participant Enrolls such Eligible Dependent within 31 days of that date.

C. With respect to coverage before January 1, 1996, the date the Participant Enrolls the Eligible Dependent, if the Participant does not Enroll an Eligible Dependent within the time period set forth in paragraphs A. or B. above.

D. With respect to coverage on and after January 1, 1996 but before January 1, 1998, if an Eligible Employee does not Enroll an Eligible Dependent within the time period set forth in paragraphs A. or B. above, or terminates a dependent's coverage while the dependent continues to be eligible under the Plan, coverage will become effective only on one of the following dates:

1. January 1 following a subsequent annual enrollment period during which the Eligible Employee Enrolls the Eligible Dependent for coverage.

2. The date that the Eligible Employee experiences a Change in Status, provided the Eligible Employee Enrolls such Eligible Dependent within 31 days following that date. An Enrollment Form will not be accepted unless the change in coverage is necessary or appropriate in light of the Change in Status that has occurred.

3. The date the Eligible Employee returns to Active Work, if the Dependent's Coverage was terminated for non-payment of Participant Contributions while the Eligible Employee was:

   a. On a leave of absence protected by the Family and Medical Leave Act of 1993, or

   b. On a leave of an absence that was protected by the Uniformed Services Employment and Reemployment Rights Act of 1994,

   and the Eligible Employee returns to employment within the time period required to preserve his or her rights under those Acts. Coverage

shall be reinstated on the same terms as in effect immediately prior to such leave, without any qualifying period, physical examination or exclusion of pre-existing conditions that would not have been required had coverage not been terminated.

E. With respect to coverage on and after January 1, 1998, if an Eligible Employee does not Enroll an Eligible Dependent within the time period set forth in paragraphs A. or B. above, or terminates a dependent's coverage while the dependent continues to be eligible under the Plan, coverage will become effective only on one of the following dates:

1. January 1 following a subsequent annual enrollment period during which the Eligible Employee Enrolls the Eligible Dependent for coverage.

2. The date other medical coverage of the Eligible Employee or Eligible Dependent ends due to a "qualifying reason", if (i) the Eligible Employee or one of his Eligible Dependents was covered under another medical plan on the date the Eligible Employee initially declined coverage under the Plan and (ii) the Eligible Employee Enrolls himself and any such Eligible Dependent(s) for medical coverage under this Plan within 31 days following the date such other medical coverage of the Eligible Employee or Eligible Dependent ends. An individual's other medical coverage will be deemed to have ended due to a "qualifying reason" only if it ends because: (i) the individual is no longer eligible for such other medical coverage, (ii) employer contributions toward such other medical coverage have been terminated, or (iii) the other medical coverage was provided under COBRA and the right to such coverage has been exhausted. This enrollment opportunity shall not be available in the event that the loss of other medical coverage results from the individual's failure to pay required premiums or contributions for such other coverage on a timely basis or in the event of termination of other medical coverage for cause (such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the Plan).

3. The date an Eligible Dependent is acquired by the Eligible Employee through marriage, birth, adoption or placement for adoption, if the Eligible Employee Enrolls himself and such Eligible Dependent within 31 days following such date. If the newly-acquired Eligible Dependent is a child, an Eligible Employee may also Enroll his Spouse at such time; coverage of the Spouse shall also be effective on the date of the birth, adoption or placement for adoption of the newly acquired Eligible Dependent, provided the Spouse is Enrolled within 31 days following such date.

4. The date the Eligible Employee experiences a change in his employment classification that results in a decrease in the contributions required for coverage, provided the Eligible Employee Enrolls such an Eligible Dependent within 31 days following such date.

5. The date the Eligible Employee returns to Active Work, if the Dependent's Coverage was terminated for non-payment of Participant Contributions while the Eligible Employee was:

   a. On a leave of absence protected by the Family and Medical Leave Act of 1993, or

   b. On a leave of an absence that was protected by the Uniformed Services Employment and Reemployment Rights Act of 1994,

   and the Eligible Employee returns to employment within the time period required to preserve his or her rights under those Acts. Coverage shall be reinstated on the same terms as in effect immediately prior to such leave, without any qualifying period, physical examination or exclusion of pre-existing conditions that would not have been required had coverage not been terminated.

## 2.04 Effective Date Provision

A. Except as provided in Section 2.10, if an Eligible Employee is not Actively at Work on the Employer's scheduled work day coincident with or immediately preceding the date he would otherwise first become covered under the Plan, such Eligible Employee will not become a Participant until the date on which he returns to Active Work.

B. Except as provided in Section 2.10, if an Eligible Employee is not Actively at Work on the Employer's scheduled work day coincident with or immediately preceding the date an increase in coverage or a change in coverage options under the Plan would otherwise become effective under the Plan, such increase or change in coverage will become effective on the date the Eligible Employee returns to Active Work.

C. If on the date that any other person would otherwise become covered by the Plan he is confined in a hospital, coverage with respect to that person will not become effective until the day following the date the person has been discharged from the hospital. This requirement will not, however, apply to a newborn Child otherwise eligible for coverage at birth under the Plan nor will this provision apply to an adopted Child or to a Child who has been legally placed with the Participant for adoption, who is otherwise eligible for coverage and properly Enrolled for coverage within 31 days following the date the Participant legally adopts the Child or assumes a legal obligation for total or partial support of such Child in anticipation of adoption. Provided, further, this requirement will not apply to an Eligible Dependent of an Eligible Employee on and after January 1, 1998.

D. If on the date an increase in benefits or a change in coverage options under this Plan would otherwise become effective for any person other than an Eligible Employee, the person is confined to a hospital, such change in coverage will be delayed until the day following the date the person has been discharged from the hospital. Provided, however, this requirement will not apply to an Eligible Dependent of an Eligible Employee on and after January 1, 1998.

## 2.05 Election of Coverage Options

A. Coverage Options

1. Prior to January 1, 1997, the Plan provides for two Coverage Options:

   Option One (Medical and Dental Benefits)
   Option Two (Medical, Dental and Vision Care Benefits)

   Prior to January 1, 1997, if a Participant Enrolled for Option One or Two elects dependent coverage in accordance with Section 2.03 of this Plan, his Eligible Dependents will be covered under the same option as the Participant, except that a Participant who elects Option Two for his personal coverage effective January 1, 1996 may elect coverage under Option One for his Eligible Dependents until December 31, 1996. A Participant who does not elect personal coverage under the Plan may not elect coverage for his dependents under any other Option. Election of the Options is further subject to the terms set forth below.

   Notwithstanding the above, the following individuals may only elect Medical Benefits:

   (i) an Eligible Retiree, except as provided in subsection D. below, and

   (ii) a Disabled Employee receiving benefits from the Peabody Long Term Disability Plan for Salaried Employees.

2. Effective January 1, 1997 through December 31, 1997, the Plan provides for five Coverage Options:

   Option One (Dental Benefits only)
   Option Two (Medical Benefits only)
   Option Three (Medical and Dental Benefits only)
   Option Four (Medical and Vision Benefits only)
   Option Five (Medical, Dental and Vision Benefits)

   Effective January 1, 1997 through December 31, 1997, if a Participant who is Enrolled for a Coverage Option elects dependent coverage in accordance with Section 2.03 of this Plan, his Eligible Dependents will be covered under the same Coverage Option as the Participant, except that a Participant who elects Option Three may elect coverage under Option One or Option Two for his Eligible Dependents and a Participant who elects Option Five may elect coverage under Option Four for his Eligible Dependents. A Participant who does not elect personal coverage under the Plan may not elect coverage for his dependents under any other

Option. Election of the options is further subject to the terms set forth below.

Notwithstanding the above, the following individuals may only elect Medical Benefits:

(i) an Eligible Retiree, except as provided in subsection D. below, and

(ii) a Disabled Employee receiving benefits from the Peabody Long Term Disability Plan for Salaried Employees.

3. Effective January 1, 1998, the Plan provides for seven Coverage Options:

Option One (Dental Benefits only)
Option Two (Vision Benefits only)
Option Three (Medical Benefits only)
Option Four (Dental and Vision Benefits only)
Option Five (Medical and Dental Benefits only)
Option Six (Medical and Vision Benefits only)
Option Seven (Medical, Dental and Vision Benefits)

Effective January 1, 1998, if a Participant who is Enrolled for a Coverage Option elects dependent coverage in accordance with Section 2.03 of this Plan, his Eligible Dependents will be covered under the same Coverage Option as the Participant, except that:

a. a Participant who elects Option Four may elect coverage under Option One or Two for his Eligible Dependents

b. a Participant who elects Option Five may elect coverage under Option One or Three for his Eligible Dependents

c. a Participant who elects Option Six may elect coverage under Option Two or Three for his Eligible Dependents

d. a Participant who elects Option Seven may elect coverage under any other option for his Eligible Dependents,

A Participant who does not elect personal coverage under the Plan may not elect coverage for his dependents under any other Option. Election of the options is further subject to the terms set forth below.

Notwithstanding the above, the following individuals may only elect Medical Benefits:

(i) an Eligible Retiree, except as provided in subsection D. below, and

(ii) a Disabled Employee receiving benefits from the Peabody Long Term Disability Plan for Salaried Employees.

B. Initial Enrollment

Each Eligible Employee is required to elect his Coverage Option(s) at the time he initially enrolls in this Plan. The Coverage Option(s) elected will apply to the Participant and his dependents, if any, covered by this Plan, and will remain in effect until the Participant elects to change his Coverage Option(s), in accordance with the following provisions.

C. Coverage Option Changes During Enrollment Periods

During each Enrollment Period, a Participant may elect to enroll in a different Coverage Option. Subject to the Effective Date Provision, a change in coverage from the Coverage Option in effect immediately preceding the Enrollment Period to the Coverage Option elected during the Enrollment Period will become effective, with respect to the Participant and his dependents covered by this Plan on the January 1 of the calendar year following the Enrollment Period.

Notwithstanding the above, if a Participant who has elected a Coverage Option that includes Vision Benefits changes to a Coverage Option that does not include Vision Benefits or elects to terminate all coverage under the Plan during the Enrollment Period, such Participant shall not be permitted to Enroll in a Coverage Option that includes Vision Benefits until the Enrollment Period that is at least two years from the date that such change in coverage was made.

D. Coverage Option Changes as a Result of Change in Status

1. In the event that a Change in Status results in a loss or gain of coverage under another employer's group health plan during the period from January 1, 1997 through December 31, 1997 , Coverage Option changes shall be permitted in accordance with the following provisions, provided a new enrollment form is received by the Plan Administrator within 31 days following the date such loss or gain of other coverage occurs.

   a. A Participant may elect to change from Coverage Option One to any other Coverage Option for himself and any of his Eligible Dependents who have a loss of medical coverage under another employer's plan if medical coverage under the other employer's plan ends as a result of a Change in Status.

b. A Participant may elect to change from Coverage Option Two to Coverage Option Three, or from Coverage Option Four to Coverage Option Five, for himself and any of his Eligible Dependents who have a loss of dental coverage under another employer's plan if dental coverage under the other employer's plan ends as a result of a Change in Status.

c. A Participant may elect to change from Coverage Option Three or Five to Coverage Option One for himself and any of his Eligible Dependents who become eligible for medical coverage under another employer's plan if medical coverage under the other employer's plan begins as a result of a Change in Status.

d. A Participant may elect to change from Coverage Option Three to Coverage Option Two, or from Coverage Option Five to to Coverage Option Four, for himself and any of his Eligible Dependents who become eligible for dental coverage under another employer's plan if dental coverage under the other employer's plan begins as a result of a Change in Status.

Other Coverage Option changes will be permitted only during the Enrollment Period.

2. On and after January 1, 1998 , Coverage Option changes shall be permitted in accordance with the following provisions, provided a new enrollment form is received by the Plan Administrator within 31 days following the date of the event set forth below.

a. A Participant may elect to change from a Coverage Option that does not include Medical Benefits to a Coverage Option that includes Medical Benefits on the dates set forth in Section 2.02.C.2.b., c. or d., and Section 2.03.E.2., 3. or 4., subject to the terms of Section 2.05.A.3 and the following limitations:

(i) A Participant Enrolled for Option One for himself and/or any of his Eligible Dependents may change only to Option Five.
(ii) A Participant Enrolled for Option Two for himself and/or any of his Eligible Dependents may change only to Option Six.
(iii) A Participant Enrolled for Option Four for himself and/or any of his Eligible Dependents may change only to Option Seven.

b. Subject to the terms of Section 2.05.A.3, a Participant may elect to change from Coverage Option Two to Coverage Option Four, or from Coverage Option Three to Coverage Option Five, or from Coverage Option Six to Coverage Option Seven, for himself and any of his Eligible Dependents who have a loss of dental coverage

under another employer's plan if dental coverage under the other employer's plan ends as a result of a Change in Status.

c. A Participant may elect to change from Coverage Option Five to Coverage Option One, or from Coverage Option Six to Coverage Option Two, or from Coverage Option Seven to Coverage Option Four, for himself and any of his Eligible Dependents who become eligible for medical coverage under another plan if medical coverage under the other plan begins as a result of a Change in Status.

d. A Participant may elect to change from Coverage Option Four to Coverage Option Two, or from Coverage Option Five to to Coverage Option Three, or from Coverage Option Seven to Coverage Option Six, for himself and any of his Eligible Dependents who become eligible for dental coverage under another employer's plan if dental coverage under the other employer's plan begins as a result of a Change in Status.

Other Coverage Option changes will be permitted only during the Enrollment Period.

E. Coverage of Eligible Retirees

1. An Eligible Employee who becomes eligible for benefits as an Eligible Retiree must complete any enrollment form prescribed by the Employer within 31 days from the date he becomes an Eligible Retiree.

Except as provided in the paragraph 5 below, with respect to an Eligible Retiree who fails to Enroll himself or a dependent as prescribed, or who voluntarily elects to terminate coverage while continuing to be eligible for benefits under the Plan, the Eligible Retiree will be permitted to Enroll himself and/or an Eligible Dependent in the Retiree Benefit Program only in accordance with the following:

a. Before January 1, 1998, enrollment is permitted only if the Eligible Retiree furnishes evidence of good health satisfactory to the Plan Administrator and coverage will not become effective until the date that the Plan Administrator approves the evidence of good health with respect to such Eligible Retiree and/or dependent.

b. Effective January 1, 1998, enrollment is permitted only if other medical coverage of the Eligible Retiree or his Eligible Dependent ends due to a "qualifying reason", and only if (i) the Eligible Retiree or one of his Eligible Dependents was covered under another medical plan on the date the Eligible Retiree initially

declined coverage under the Plan and (ii) the Eligible Retiree Enrolls himself and any such Eligible Dependent(s) for medical coverage under this Plan within 31 days following the date such other medical coverage of the Eligible Retiree or Eligible Dependent ends. An individual's other medical coverage will be deemed to have ended due to a "qualifying reason" only if it ends because: (i) the individual is no longer eligible for such other medical coverage, (ii) employer contributions toward such other medical coverage have been terminated, or (iii) the other medical coverage was provided under COBRA and the right to such coverage has been exhausted. This enrollment opportunity shall not be available in the event that the loss of other medical coverage results from the individual's failure to pay required premiums or contributions for such other coverage on a timely basis or in the event of termination of other medical coverage for cause (such as making a fraudulent claim or intentional misrepresentation of a material fact in connection with the Plan).

2. An Eligible Employee who becomes eligible for benefits as an Eligible Retiree but who continues to be scheduled to work at least 20 hours per week will maintain coverage under the Coverage Option in effect immediately prior to the date he qualified for benefits as an Eligible Retiree unless the individual elects coverage under the Retiree Benefits Program within 31 days of becoming an Eligible Retiree.

   In no event will an Eligible Retiree who fails to Enroll himself or a dependent as prescribed, or who voluntarily elects to terminate coverage while continuing to be eligible for benefits as an Eligible Employee, be given an opportunity to Enroll in the Retiree Benefit Program until such time as he ceases to be an Eligible Employee.

3. An Eligible Retiree who subsequently returns to work as an Eligible Employee and who, as of his Eligibility Date, was covered under the Plan, may Enroll for coverage under a Coverage Option available to active employees, provided he does so within 31 days of his Eligibility Date. An individual who so timely Enrolls shall not be subject to any limitation or exclusion applicable to pre-existing conditions and shall not be treated as a late entrant under Section 5.14.

   In no event will an Eligible Retiree who fails to Enroll himself or a dependent as prescribed, or who voluntarily elects to terminate coverage while continuing to be eligible for benefits as an Eligible Employee, be given an opportunity to Enroll for coverage under a Coverage Option available only to active employees at a later date.

4. An Eligible Retiree who subsequently returns to work as an Eligible Employee and who, as of his Eligibility Date, was not covered under the Plan, may Enroll for coverage under a Coverage Option available to active employees, provided he does so within 31 days of his Eligibility Date. An individual who so timely Enrolls shall be subject to the limitation applicable to the pre-existing conditions of newly eligible employees under the Plan but shall not be treated as a late entrant under Section 5.14.

   In no event will an Eligible Retiree who fails to Enroll himself or a dependent as prescribed, or who voluntarily elects to terminate coverage while continuing to be eligible for benefits as an Eligible Employee, be given an opportunity to Enroll for coverage under a Coverage Option available only to active employees at a later date.

5. An Eligible Employee who enrolls for coverage under a Coverage Option available to active employees in lieu of the Retiree Benefit Program as set forth above, and who remains so enrolled until the date he is no longer eligible to be covered as an Eligible Employee, will be permitted to enroll in the Retiree Benefit Program during the 31 day period following the date he is no longer an Eligible Employee. Evidence of good health will not be required to enroll at such time.

6. An Eligible Retiree who does not elect personal coverage under the Plan pursuant to this Section 2.05 may not elect coverage for his dependents.

## 2.06 Special Rules for Employees with HMO Option

Subject to the terms and conditions set out in Sections 2.02, 2.03 and 2.04, an Eligible Employee who lives in an area serviced by a health maintenance organization (HMO) that has arranged with the Plan Sponsor to provide medical coverage to employees may elect to: (a) enroll himself and his Eligible Dependents to receive the Medical Benefits described in Article III of this Plan document or (b) enroll himself and his Eligible Dependents in such HMO in lieu of receiving the Medical Benefits described in Article III of this Plan. Provided, further, that before January 1, 1998, an Eligible Employee who elects such HMO option will also receive dental benefits from the HMO and will not be eligible for the Dental Benefits under Article V of this Plan.

The medical benefit option selected by the Eligible Employee when he first enrolls in the Plan shall remain in effect until changed by the Eligible Employee. Changes in coverage are permitted only as follows:

A. A Participant may elect to change his medical benefit option only during the annual Enrollment Period. Subject to Section 2.04, a change in coverage shall be effective with respect to the Participant and his Covered Dependents on the January 1st of the calendar year following the close of the Enrollment Period.

B. Notwithstanding the above, a Participant who has enrolled in the health maintenance organization may elect the medical coverage described in Article III of this Plan in the event he moves out of the health maintenance organization's service area or the health maintenance organization ceases operations, provided such election is made within 31 days of the date the Participant moves out of the health maintenance organization's service area or the health maintenance organization ceases operations. A timely election will be effective upon receipt of the election form by the Plan Administrator.

## 2.07 Termination of Participant Coverage

Except as provided in Sections 2.10 and 2.11 of this Article II, coverage of a Participant will terminate at midnight on the earliest of the following dates:

A. With respect to a Participant whose contributions are made other than by payroll deduction, the last day of the calendar month for which the Participant last makes a required Participant Contribution with respect to the applicable Coverage Option on a timely basis;

B. The date the Participant elects to terminate coverage, provided such election is made within 31 days after the date the Participant becomes covered under another group health plan as a result of a Change in Status. Provided, however, that if an Eligible Employee elects to terminate coverage before the 16th day of a calendar month, coverage will not terminate until the 15th day of such calendar month. If an Eligible Employee elects to terminate coverage on or after the 16th day of a calendar month, coverage will not terminate until the last day of such calendar month;

C. December 31 of the calendar year in which such Participant elects to terminate coverage during an Enrollment Period designated by the Plan Administrator;

D. The date as of which the Plan is amended so as to eliminate from coverage the class of employees of which the Participant is a member.

E. The date on which the Plan is discontinued by the Participating Employer then employing the Participant.

F. The date of termination of the Plan by the Plan Sponsor.

G. The date the Eligible Employee ceases Active Work or otherwise fails to meet the definition of an Eligible Employee. Provided, however, that:

1. Medical, Vision Care and Dental Benefits may be continued while an Employee is receiving salary continuance benefits from a Participating Employer.

2. Medical Benefits only may be continued if the Participant is a Disabled Employee who is receiving benefits from the Peabody Long Term Disability Plan for Salaried Employees. Coverage terminates on the date the individual no longer satisfies the definition of a Disabled Employee or is no longer receiving benefits from the Peabody Long Term Disability Plan for Salaried Employees.

3. Medical Benefits only may be continued if the Participant is an Eligible Retiree, in accordance with the terms of Article XIII.

4. If an Eligible Employee ceases Active Work due to a leave of absence which is approved according to the established Family and Medical Leave of Absence policies of his Participating Employer, he will be eligible for continuation of coverage under the Plan in accordance with the terms of Section 2.10.

5. If an Eligible Employee ceases Active Work due to a reduction in work force, as designated by a Participating Employer, Medical Benefits only may be continued through three (3) calendar months following the end of the month in which the reduction in work force occurred, provided the individual is not covered by another employer's group health plan.

6. If an Eligible Employee ceases Active Work before the 16th day of a calendar month, coverage will not terminate until the 15th day of such calendar month. If an Eligible Employee ceases Active Work on or after the 16th day of a calendar month, coverage will not terminate until the last day of such calendar month.

## 2.08 Termination of Dependent Coverage

Except as provided in Sections 2.10 and 2.11 of this Article II, coverage for the dependent(s) of a Participant will automatically terminate at midnight on the earliest of the following dates:

A. With respect to Medical Benefits, the date on which the Participant's Medical Benefits coverage terminates.

B. With respect to Vision Care Benefits, the date on which the Participant's Vision Care Benefits coverage terminates.

C. With respect to Dental Benefits, the date on which the Participant's Dental Benefits coverage terminates.

D. As to any particular dependent, the date the dependent ceases to qualify as an Eligible Dependent.

Provided, however, that

1. with respect to Medical and Vision Care Benefits only, a covered unmarried Child who:

   a. before the date he would otherwise cease to be eligible solely due to attained age becomes incapable of self-sustaining employment by reason of mental or physical disability, and

   b. is dependent upon the Participant for his principal support and maintenance

   will not cease to qualify as an Eligible Dependent solely because of attained age while he remains so incapacitated and dependent. For purposes of this provision, "support" shall include living in the same household with the Participant or confinement to an institution for care or treatment.

2. with respect to a dependent who ceases to qualify as an Eligible Dependent before the 16th day of a calendar month, coverage will not terminate until the 15th day of such calendar month; with respect to a dependent who ceases to qualify as an Eligible Dependent on or after the 16th day of a calendar month, coverage will not terminate until the last day of such calendar month

E. With respect to a Participant whose contributions are made other than by payroll deduction, the last day of the period for which the last required contribution for dependent coverage is made on a timely basis.

F. The date the Participant elects to terminate dependent coverage, provided such election is made within 31 days after the date an Eligible Dependent becomes covered under another group health plan as a result of a Change in Status. Provided, however, that if an Eligible Employee elects to terminate coverage before the 16th day of a calendar month, coverage will not terminate until the 15th day of such calendar month. If an Eligible Employee elects to terminate coverage on or after the 16th day of a calendar month, coverage will not terminate until the last day of such calendar month;

G. December 31 of the calendar year in which such Participant elects to terminate dependent coverage during an Enrollment Period designated by the Plan Administrator;

H. The date all dependent coverage under this Plan terminates.

I. The date on which the dependent coverage is discontinued by the Participating Employer then employing the Participant.

The Participant shall be responsible for notifying the Plan Administrator of new Eligible Dependents and of any changes in the eligibility status of a dependent. Benefits provided to an ineligible dependent will be recouped by the Plan in accordance with Section 11.06.

## 2.09 Coverage for Surviving Dependents

Medical benefits coverage of a Surviving Spouse and Eligible Dependent Children of the Participant may be continued as follows:

A. Subject to the terms of subsection D. below, coverage may be continued by the unmarried Surviving Spouse and Eligible Dependent Children of an Eligible Employee or a Disabled Employee who, with proper election immediately preceding the date of death, would have met the requirements for retiree health coverage set forth in Article XIII, provided the Surviving Spouse elects to begin receiving retirement benefits from the Plan Sponsor's retirement plan within 31 days after the death of the Eligible Employee or Disabled Employee.

B. Subject to the terms of subsection D. below, coverage may be continued by the unmarried Surviving Spouse and Eligible Dependent Children of an Eligible Retiree, provided

1. The Eligible Retiree made an election for a joint and survivor option for receiving pension benefits from the Participating Employer, or retired on or after September 1, 1977, and

2. The Surviving Spouse was covered by this Plan on the date the Eligible Employee retired and during the entire 12 month period before the death of the Eligible Retiree.

C. Subject to the terms of subsection D. below, coverage may be continued by the unmarried Surviving Spouse and Eligible Dependent Children of an Eligible Employee or Disabled Employee who does not meet the requirements of subsection A. above until the end of a period of three (3) consecutive calendar months following the month in which the death of the Eligible Employee or Disabled Employee occurred.

D. Coverage may be continued until the earliest of the following to occur:

1. The date the surviving Spouse marries.

2. The date the surviving Spouse dies.

3. The date on which the Surviving Spouse fails to authorize the withholding of, or to timely make, any required contributions associated with such coverage. Contributions will be considered "timely" if received by the Plan Administrator by the time provided for in Article IX.

4. With respect to any particular type of benefit, the date such benefit is no longer available under the Plan, or the date such benefit is specifically made unavailable with respect to Eligible Retirees and/or Surviving Spouses, if earlier, even if such benefit is still available to other Eligible Employees and/or their Eligible Dependents.

5. With respect to an Eligible Dependent Child, the date the Child no longer satisfies the definition of an Eligible Dependent, except as provided in Section 2.08.D.

6. The date on which the Plan is terminated by the Plan Sponsor.

7. The date all dependent coverage under this Plan terminates.

8. The date on which the dependent coverage is discontinued by the Participating Employer then employing the Participant.

9. With respect to individuals described in subsection C above, the end of a period of three (3) consecutive calendar months following the month in which the death of the Eligible Employee or Disabled Employee occurred.

10. Dental and Vision benefits are not provided under this Section 2.09. Provided, however, that Dental Benefits otherwise available under the Plan shall be continued until the end of a period of 30 days following the end of the month in which the Eligible Employee dies.

## 2.10 Maintenance of Coverage with Respect to Participants on Leave protected by the Family and Medical Leave Act of 1993 or the Uniformed Services Employment and Reemployment Rights Act of 1994

A. Continuation of Coverage under the Family and Medical Leave Act of 1993

1. A Participant who is on a leave of absence protected by the Family and Medical Leave Act of 1993 ("FMLA Leave") may choose to maintain his health coverage, and the health coverage of his Eligible Dependents covered by the Plan on the day immediately prior to such leave for the duration of his FMLA Leave at the level and under the conditions that such coverage would have been provided if he had continued Active Work. The Participant's right to maintain such coverage shall end on the earliest of the following to occur:

   a. The date the Participant terminates employment by either notifying the Participating Employer that he does not intend to return from FMLA Leave or the date the Participant fails to return from FMLA Leave when such leave is exhausted.

   b. The date the Participant's employment would have terminated and coverage would have been lost if he had not taken FMLA Leave as the result of lay-off or the downsizing of the Participating Employer.

   c. The date the Participant fails to make a required premium payment, if any, within the later of 30 days of the date due or 15 days after the Participating Employer notifies the Participant that his coverage will end for failure to pay required premiums.

   Coverage with respect to a Participant for whom a required premium payment has not been made shall cease as of the last day of the period for which the last contribution was made.

2. A "key employee" as defined in 29 CFR §825.217, who does not return from FMLA Leave when notified of the Participant's intent to deny reinstatement to employment, shall be entitled to have his coverage maintained until the earlier of the following dates:

   a. The date he notifies the Employer that he does not desire to return to Active Work.

   b. The date he is denied reinstatement after the conclusion of his FMLA Leave.

3. Nothing in this Section shall affect the Participating Employer's obligation to provide for continuation of coverage under Section 2.11, Optional Continuation of Coverage of this Plan.

B. Continuation of Coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994

1. A Participant who is on a leave protected by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("Military Leave") may choose to maintain his coverage, and the coverage of his Eligible Dependents covered by the Plan on the day immediately prior to such leave for the duration of his Military Leave at the level and under the conditions that such coverage would have been provided if he had continued Active Work. The Participant's right to maintain such coverage shall end on the earliest of the following to occur:

   a. The date the Participant terminates employment by either notifying the Participating Employer that he does not intend to return from Military Leave or by failing to return from Military Leave within the time specified by law for protecting rights under the Act.

   b. The last day of the period for which the Participant last makes a contribution if the Participant fails to make a required premium payment.

   c. The last day of the 18 month period beginning of the first day of Military Leave.

   d. Any other date permitted by law.

   Continuation of coverage under this Section shall run concurrently with the continuation of coverage provided in Section 2.11, and shall be credited towards satisfaction of the maximum coverage periods specified in that Section, to the extent permitted by law.

C. Premium Amount

1. Any premium paid by the Participant while on FMLA Leave shall be at the rate which the Participant would pay if he had remained at Active Work with no additional charge for administrative expenses.

2. A Participant on Military Leave that does not exceed 31 days shall pay a premium at the same rate that the Participant would pay if he had remained at Active Work with no additional charge for administrative expenses. A Participant on Military Leave that exceeds 31 days shall pay a premium at the rate provided for in Section 2.11 of the Plan.

D. Recovery of Employer Contributions for Providing FMLA Coverage

1. To the extent permitted by law, the Participating Employer may recover its share of the cost of providing coverage under the Plan paid during a period of unpaid FMLA Leave from a Participant if the Participant fails to return to Active Work after the Participant's FMLA Leave entitlement has been exhausted or expires, unless the Participant's failure to return is due to either:

   a. The continuation, recurrence, or onset of a serious health condition which would entitle the Participant to leave under FMLA.

   b. Other circumstances beyond the Participant's control.

   or the Participant is a "key employee" who has been denied restoration as permitted under the Family and Medical Leave Act of 1993. The Participating Employer may require medical certification of the serious health condition which precludes the Participant from returning to Active Work. Such certification must be provided within 30 days of the date of the Employer's request.

   An Employee shall be considered to have "returned to Active Work" for purposes of this Section only if he works at least 30 calendar days after the conclusion of his FMLA Leave. A Participant who transfers directly from taking the FMLA Leave to retirement, or who retires during the first 30 days after returning to Active Work shall be deemed to have returned to Active Work for the purposes of this item D.

2. The amount that the Participating Employer may recover under 1. above is limited to the Participating Employer's share of the amount that would be payable under Section 2.11B., excluding any additional fee for administrative costs.

3. The Participating Employer may also recover the Participant's share of any cost of continuing coverage for any FMLA Leave period during which the Employer maintains health coverage by paying the Participant's cost of coverage after the Participant fails to make a required contribution.

## 2.11 Optional Continuation of Coverage

A Covered Individual who experiences a Qualifying Event as defined below may elect COBRA Continuation Coverage under this Plan if, in absence of this Section 2.11 or other Plan provisions of similar purpose, eligibility for coverage would otherwise cease as a result of such Qualifying Event and such individual is not entitled to Medicare. A Covered Individual described above shall be known as a "Qualified Beneficiary" for purposes of this Section 2.11. The term "Qualified Beneficiary" shall also include a child born to, adopted by or placed for adoption with a covered employee while COBRA Continuation Coverage is in effect but shall not include any other Eligible Dependent who was Enrolled in this Plan on or after the date a Covered Individual first became a Qualified Beneficiary covered under this Plan under the terms of this Section 2.11.

Coverage continued by a Qualified Beneficiary under these provisions will be identical to that provided similarly situated Covered Individuals who have not experienced a Qualifying Event. Provided, however, that the coverage a Qualified Beneficiary is entitled to under the provisions of this Section 2.11 will be deemed to have been provided by the Plan to the extent that the Qualified Beneficiary has received or had the opportunity to receive coverage on the same or more favorable terms under the other provisions of this Article II, to the extent permitted by law. A Qualified Beneficiary will be deemed to be a Participant to the extent required by COBRA.

A. A Qualifying Event is any of the following:

1. For an Employee, Spouse and/or Dependent Child(ren), the Covered Employee's termination of employment (other than for gross misconduct), retirement, or reduction of hours worked. Provided, however, that in the case of a Covered Employee whose hours of work have been reduced as a result of a leave of absence protected by the Family and Medical Leave Act of 1993 ("the Act"), no Qualifying Event shall be deemed to occur until the expiration of such leave, as determined under the Act;

2. For a Spouse or Dependent Child, death, divorce or legal separation from the Covered Employee;

3. For a Spouse and Eligible Dependent Child(ren), the Covered Employee's entitlement to Medicare;

4. For a Dependent Child of a Covered Employee, ceasing to qualify as a dependent under the Plan.

For purposes of this provision, a "Covered Employee" means an individual who is (or was) covered by this Plan by reason of employment.

B. Qualified beneficiaries who elect COBRA Continuation Coverage must pay the full cost of such coverage, as determined in the sole discretion of the Plan Administrator from time to time, plus any additional amount permitted by law.

C. COBRA Continuation Coverage will extend until the earliest of the following:

1. For a Qualifying Event described in subsection A.1. above (termination, or reduction of hours of the Employee), the date which is 18 months after the date of the Qualifying Event, except as provided in subsection D. or E. below;

2. For a Qualifying Event described in 2., 3., or 4. of subsection A. above, the date which is 36 months after the date of the Qualifying Event. Provided, however, if such a Qualifying Event occurs (1) subsequent to a previous Qualifying Event and (2) while a Qualified Beneficiary is covered by this Plan under the terms of this Section 2.11 or other Plan provisions of similar purpose, the continued coverage provided under this Section 2.11 will extend only until the date which is 36 months after the date of the first Qualifying Event;

3. The date the Plan Sponsor and/or the Participating Employer that employs the Eligible Employee on whose employment continuation coverage is based ceases to provide any group health Plan to any Employee;

4. The date coverage ceases by reason of the Qualified Beneficiary's failure to make the required payment for the cost of coverage within 30 days of the due date; provided, however, that the first payment will not be required earlier than 45 days after the date of the election.

5. The date on which the Qualified Beneficiary first becomes, after the date of the election,:

   a. covered under any other employer's group health plan which does not contain any limitation or exclusion with respect to a pre-existing condition of the Qualified Beneficiary; or

   b. entitled to Medicare coverage.

The maximum coverage period with respect to a Qualified Beneficiary who is child born to, adopted by or placed for adoption with the covered employee during a period of COBRA Continuation Coverage shall be measured from the initial Qualifying Event that gave rise to such period of COBRA Continuation Coverage.

Any period of continued coverage which an individual has received under any other provision of this Article II will reduce the duration of COBRA Continuation Coverage, to the extent permitted by law.

D. Notwithstanding the other provisions of this Section 2.11, with respect to a Medicare-entitled Employee, COBRA Continuation Coverage for any of the Employee's dependents who become Qualified Beneficiaries will not end before the earliest of the following dates:

1. If the Qualifying Event occurs on or after the date on which the Employee became entitled to Medicare, the date which is 36 months from the date the Employee became entitled to Medicare.

2. If an Employee becomes entitled to Medicare during a period of coverage continued by or for such dependents as a result of a previous Qualifying Event, the date which is 36 months after the date of the first Qualifying Event.

3. The date on which an event described in subparagraphs 3., 4., or 5. of subsection C. above occurs.

Provided that in no event will a Qualified Beneficiary receive a shorter period of continued coverage than that to which he or she would otherwise be entitled in the absence of this subsection D.

E. Notwithstanding the above, all Qualified Beneficiaries with respect to the same Qualifying Event shall be entitled to continue coverage under the Plan for up to 29 months provided that each of the following conditions are satisfied:

1. the Qualifying Event is an event described in paragraph A.1. above;

2. one of such Qualified Beneficiaries is determined by the Social Security Administration to have been disabled (as defined by the Social Security Act) during the first 60 days of COBRA Continuation Coverage; and

3. the Plan Administrator is provided with a copy of the determination of disability by one of the Qualified Beneficiaries on a date which is both within 60 days after the determination is issued and before the end of the initial 18 months of COBRA continuation coverage.

COBRA Continuation Coverage will terminate before the end of such 29-month period for any of the reasons specified in subparagraphs 3., 4. or 5. of subsection C., above, or as of the first day of the first calendar month following the 30-day period that begins on the date of the final determination by the

Social Security Administration that the Qualified Beneficiary is no longer disabled.

To the extent permitted by law, the Plan may charge a Qualified Beneficiary:

1. 150% of the otherwise applicable cost of coverage for each of the 19th through 29th months of COBRA Continuation Coverage; and

2. 150% of the otherwise applicable cost of coverage for each of the 30th through 36th months of coverage if such Qualified Beneficiary becomes entitled to an extension of COBRA Continuation Coverage as a result of a second Qualifying Event that occurs during the period of disability extension,

but only if:

1. the disabled Qualified Beneficiary is covered during the extension period, and

2. the coverage would not have been required to have been provided in the absence of a disability extension.

F. Notification Requirements and Election Period

1. In the event of divorce or a Child ceasing to be an Eligible Dependent, the Employee or the Qualified Beneficiary must notify the Plan Administrator within 60 days of such event.

2. Within 14 days after receiving notice of a Qualifying Event described in subparagraph 1. above, or within 44 days following any other Qualifying Event, the Plan Administrator will notify the Qualified Beneficiary(ies) of the continuation and election procedures described in this Section 2.11.

3. The Qualified Beneficiary must complete and return the election form within 60 days from the later of (a) notification by the Plan Administrator, or (b) the date coverage would otherwise terminate as a result of the Qualifying Event.

4. In the event that a Qualified Beneficiary fails to comply with any of the notification, election or timely payment requirements within the time period specified in 2. or 4. above, such an individual's right to elect continued coverage under the Plan will terminate, and the Plan will not have any further obligation to provide continued coverage under this Section 2.11.

## 2.12 Conversion of Coverage

A Covered Individual whose medical coverage under this Plan is terminated (a) because the individual no longer satisfies the definition of Eligible Employee, Eligible Retiree or Eligible Dependent, other than by reason of termination of the Plan or failure to pay the required contributions for coverage or (b) because the maximum continuation coverage period expires, as described in Section 2.11.C.1. and 2.; shall be given the opportunity to purchase an individual conversion policy without evidence of insurability, subject to the overinsurance rules of the insurance company selected by the Plan Administrator to provide such conversion policies. The individual must make written application and pay the required premium to the insurance company within 31 days after his termination of coverage.

The form of individual conversion policy, the coverage thereunder, and all other terms and conditions thereof, shall be applied by the rules of the insurance company selected by the Company to provide such conversion benefits, at the time of application.

ARTICLE III

## Medical Care Benefits

Subject to the Exclusions and other provisions of the Plan, the amount of benefits hereinafter described will be payable by the Plan in accordance with the payment of claims provision in Article XII for the Covered Expenses incurred by a Covered Individual.

### 3.01 Benefit Schedule

A. Annual Deductible (Section 3.03)

Before 1/1/96:

| | | |
|---|---|---|
| 1. | Network | |
| | a. Individual | $250 |
| | b. Family Maximum | $500 |
| 2. | Non-Network Provider | |
| | a. Individual | $250 |
| | b. Family Maximum | $500 |

Effective 1/1/96:

| | | |
|---|---|---|
| 1. | Network | |
| | a. Individual | $250 |
| | b. Family Maximum | $500 |
| 2. | Non-Network Provider | |
| | a. Individual | $400 |
| | b. Family Maximum | $800 |

B. Hospital Copayments (Section 3.04)

| | | |
|---|---|---|
| 1. | Inpatient | |
| | a. Participating Provider | $50 |
| | b. Nonparticipating Provider | $150 |
| 2. | Emergency Room | $50 |

C. Annual Out-of-Pocket Maximum (Section 3.17)
(Does not apply to benefits set forth under subsections 9, 10 and certain other expenses described in Section 3.16)

Before 1/1/96:

| | | |
|---|---|---|
| 1. | Network | |
| | a. Individual | $1,250 |
| | b. Family Limit | $3,000 |
| 2. | Non-Network | |
| | a. Individual | $1,250 |
| | b. Family Limit | $3,000 |

Effective 1/1/96:

| | | |
|---|---|---|
| 1. | Network | |
| | a. Individual | $1,500 |
| | b. Family Limit | $3,000 |
| 2. | Non-Network | |
| | a. Individual | $2,000 |
| | b. Family Limit | $4,000 |

D. Covered Portion (Section 3.05)

| | | |
|---|---|---|
| 1. | Inpatient Hospital Expense (Section 3.06) (after Annual Deductible and Inpatient Hospital Copayment) | |
| | a. Network | 100% |
| | b. Non-Network | 80% |
| 2. | Special Outpatient Expense (Section 3.07) (after Annual Deductible and Emergency Room Copayment, if applicable) | |
| | a. Network | 100% |
| | b. Non-Network | 80% |

| | | |
|---|---|---|
| 3. | Surgery Expense (Section 3.08) (after Annual Deductible) | |
| | a. Network | 100% |
| | b. Non-Network | 80% |
| 4. | Second Surgical Opinion (Section 3.09) (after Annual Deductible) | |
| | a. If recommended by MSA | 100% |
| | b. If not recommended by MSA | 80% (100% effective 1/1/98) |
| 5. | Home Health Care (Section 3.10) (after Annual Deductible) | |
| | a. Network | 100% |
| | b. Non-Network | 80% |
| 6. | Hospice Care (Section 3.11) (After Annual Deductible. Benefits limited in accordance with Section 3.11) | |
| | a. Network | 100% |
| | b. Non-Network | 80% |
| 7. | Skilled Nursing Facility (Section 3.12) (after Annual Deductible) | 100% |
| 8. | Inpatient mental health and substance abuse. (Section 3.13) (After Annual Deductible and Inpatient Hospital Copayment. Benefits limited in accordance with Section 3.13.) | |
| | a. Network | 100% |
| | b. Non-Network | 80% |

9. Outpatient mental health and substance abuse (Section 3.13) (After Annual Deductible and Emergency Room Copayment, if applicable. Benefits limited in accordance with Section 3.13.)

| | |
|---|---|
| Before 1/1/98: | 80% of the first $1,000, 50% of the next $1,500 |
| Effective 1/1/98 | 80% for the first 10 visits<br>50% for the next 20 visits |

10. Prescription Drugs
(Benefits limited in accordance with Section 3.14)

a. Participating Provider Retail Pharmacy (per 30-day supply)

| | |
|---|---|
| Brand name | Lower of 100% less $10 copayment or 85% |
| Generic | Lower of 100% less $5 copayment or 90% |

b. Nonparticipating Retail Pharmacy (per 30-day supply)

| | |
|---|---|
| Brand name | Lower of 100% less $10 copayment or 80% |
| Generic | Lower of 100% less $5 copayment or 80% |

c. Mail-Order Program (per 90-day supply) (Effective 1/1/98)

| | |
|---|---|
| Brand name | 100% after $15 copayment per prescription or refill |
| Generic | 100% after $3 copayment per prescription or refill |

11. Network Wellness Benefit (Section 3.15) (Effective 1/1/98)

| | |
|---|---|
| (No Annual Deductible) maximum | 100% up to $250 annual benefit per Covered Individual |

12. Other Medical Expenses (Section 3.16) (After Annual Deductible and/or Emergency Room Copayment)

| | |
|---|---|
| a. Network | 80% |
| b. Non-Network | 60% |

### 3.02 Definitions

The following words and phrases, whether or not capitalized, will have the respective meanings set forth in this Section 3.02, unless the context clearly indicates otherwise.

A. "Ambulatory Surgical Facility" means 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.

B. "Allowable Charges" means, with respect to a Participating Provider, the fees a provider agrees to charge Plan Participants under the terms of the contract between the provider and the Plan Sponsor. With respect to any other Provider, "Allowable Charges" means Usual, Customary, and Reasonable Charges, as defined by this Plan.

C. "Claims Administrator" means the organization retained by the company for granting or denying claims, currently BlueCross BlueShield of Illinois for medical claims, and PCS for prescription drug claims.

D. "Coinsurance" means the portion of Covered Expenses remaining after the Plan pays the Covered Portion.

E. "Copayment" means the amount that a Covered Individual is required to pay to a provider at the time a covered service is rendered.

F. "Cosmetic Surgery" means surgery that is intended to (1) improve the appearance of a patient or (2) preserve or restore a pleasing appearance. Cosmetic Surgery does not mean surgery that is intended to correct normal functions of the body.

G. "Covered Expenses" means Allowable Charges incurred by a Covered Individual for the services and supplies set forth in the Covered Expense sections of this Article III, provided such services and supplies are recommended by the attending Physician, are Medically Necessary and are not excluded by the Plan in accordance with Section 3.21. An expense or charge will be deemed *incurred* as of the date the service is rendered or purchase is made from which the expense or charge arises.

H. "Covered Individual" means only a Participant or a Participant's Eligible Dependent for whom coverage is effective under the Plan in accordance with Article II.

I. "Covered Portion" means the amount of benefits the Plan pays for Covered Expenses, subject to the other provisions and limitations of the Plan.

J. "Custodial Care" means 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.

K. "Durable Medical Equipment" means equipment that meets all of the following conditions:

1. It can withstand repeated use.

2. It is primarily and customarily used in the therapeutic treatment of sickness or injury.

3. It is generally not useful to a person in the absence of a sickness or injury.

4. It is appropriate for use in the home.

5. It is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature.

6. It is not primarily for the convenience of the person caring for the patient.

7. It is not used for exercise or training.

L. "Emergency" means 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 the Covered Individual seeks medical condition after the onset.

M. "Generic Prescription Drug" means a drug identified by its official or chemical name, rather than a brand name.

N. "Home Health Care" means services provided by either:

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

2. A community home health care agency approved by Medicare.

O. "Home Health Care Agency" means a federally certified public or private organization that meets all the following conditions:

1. It is primarily engaged in providing skilled-nursing and other therapeutic services.

2. 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.

3. It maintains medical records on all patients.

4. It is licensed and approved by state or local law.

5. It is a hospital certified by the state public health law to provide home health services.

P. "Hospice Care" means care that relieves pain and meets the basic life-supporting needs of a Covered Individual who is terminally ill and has a life expectancy of six months or less.

Q. "Hospital" means an institution that meets all of the following conditions:

1. 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.

2. It provides 24-hour nursing services by registered nurses.

3. It is not a rest home, home for the aged, facility to treat drug or alcohol addiction, nursing home, hotel or similar institution.

4. 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:

1. A facility approved by the claims administrator for inpatient or outpatient treatment of chemical abuse.

2. Psychiatric hospitals classified and accredited by the Joint Commission on Accreditation of Healthcare Organizations.

3. A residential treatment facility, if approved under the MSA Program set forth in Section 3.20 when necessary treatment cannot be provided while the patient is living at home.

R. "Illness" means any disease or disorder of the body, or Pregnancy.

S. "Injury" means an accidental bodily injury caused directly and exclusively by sudden and violent means, and is not self-inflicted.

T. "Medically Necessary" means 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:

1. It is provided for the diagnosis or direct treatment of an injury or illness. Provided, however, that Covered Expenses incurred in connection with elective sterilization surgery and the routine and preventive care services and family planning services set forth in Sections 3.15, 3.16.A.6 and 3.16.A.7 will be deemed Medically Necessary to the extent that the other conditions of this subsection T. are met.

2. It is appropriate and consistent with the diagnosis and treatment of the injury or illness.

3. It is provided in accordance with generally accepted medical practice on a national basis at the time it is provided.

4. It is the most appropriate supply or level of service that can be provided on a cost-effective basis.

5. It is not provided in connection with medical or other research.

6. 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.

U. "Mental Illness" means 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.

V. "MSA" means the Medical Services Advisory program administered by BlueCross BlueShield of Illinois. The telephone number of MSA is provided in the summary plan description and the medical plan identification cards issued to Participants. Prior to January 1, 1998, the term "MSA" means the Coordinated Care Options program administered by Alliance Blue Cross Blue Shield

W. "Network Charges" means charges by Participating Providers for Covered Expenses and the following Covered Expenses even if such medical care, services or supplies were provided by a Non-Participating Provider:

1. Covered Expenses incurred by a Covered Individual who resides outside an area serviced by a Network, provided the Participant has notified the Plan Administrator and has completed the necessary form required to adjust eligibility records.

2. Covered Expenses incurred by a Covered Individual if there is no Participating Provider who provides the services required by such individual, provided the Participant has obtained prior authorization from MSA.

3. Covered Expenses relating to Urgent or Emergency Care where the Covered Individual is not hospitalized or for hospitalization if authorized by MSA.

4. Covered Expenses incurred by a Covered Individual with respect to a course of treatment with a Non-Participating Provider which commenced prior to July 1, 1995, provided that MSA has authorized such care. For this purpose, a "Course of Treatment" means a planned program of one or more services or supplies, whether rendered by one or more Providers, for the treatment of a diagnosed medical condition. The Course of Treatment commences on the date a Provider first renders a service to correct or treat such diagnosed medical condition.

5. Covered Expenses incurred prior to January 1, 1998 by a Covered Individual while traveling in a state where no Participating

Providers are located, unless the Covered Individual traveled to such state for the purpose of receiving medical care.

X. "Non-Network Charges" means charges for Covered Expenses that do not satisfy the definition of Network Charges.

Y. "Non-Participating Provider" means a Provider who does not have a written agreement with the Plan Sponsor or the Claims Administrator to provide medical services to Covered Individuals.

Z. "Participating Provider" means a Provider that has a written agreement with the Plan Sponsor or the Claims Administrator to provide medical services to Covered Individuals.

AA. "Physician" or "Surgeon" means an individual licensed to diagnose and treat illnesses, prescribe and administer drugs and medicines or perform surgery. The definition also includes:

1. 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.

2. A podiatrist operating within the scope of his or her license for certain covered podiatry services that are common to both medicine and podiatry.

3. A certified, registered psychologist providing diagnosis or treatment of a mental and nervous condition.

BB. "Pre-existing Condition" means:

1. Prior to January 1, 1996 an injury or illness for which a Covered Individual received medical care in the three months before coverage became effective under this Plan, or any conditions related to that injury or illness.

2. Effective January 1, 1996 until December 31, 1997, "Pre-existing Condition" means either of the following:

   a. In the case of a Participant or Covered Dependent who was Enrolled in the Plan after his or her initial eligibility in accordance with Section 2.02.B.2.a. or Section 2.03.D.1., "Pre-existing Condition" means an injury or illness for which a Covered Individual received medical care in the six months before coverage became effective under this Plan, or any conditions related to that injury or illness.

b. In all other cases, "Pre-existing Condition" means an injury or illness for which a Covered Individual received medical care in the three months before coverage became effective under this Plan, or any conditions related to that injury or illness.

3. Effective January 1, 1998, "Pre-existing Condition" has the meaning set out in Section 3.22 below.

As used in this provision, the term "medical care" includes diagnostic tests and treatment services rendered or supplies furnished by any medical provider, consultation with a physician or other medical professional, and prescription drugs prescribed for or used by the individual.

CC. "Pregnancy" means normal delivery, cesarean section, miscarriage, complications resulting from pregnancy, or termination of pregnancy if Medically Necessary, certified and performed by a physician.

DD. "Prescription Drug" means an FDA-approved drug or medicine that is legally obtainable only with a Physician's prescription and which must be dispensed by a registered pharmacist.

EE. "Provider" means a Hospital, Physician, pharmacy or other provider of medical care, services or supplies.

FF. "Registered Psychologist" means 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:

1. 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.

2. 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.

GG. "Second Surgical Opinion" means a consulting opinion and the directly related diagnostic services rendered by a Physician who is either a fellow of the American College of Surgeons or a diplomat of the College of Surgeons, to confirm the need for recommended surgery.

HH. "Semi-private Room Rate" means the standard charge by a Hospital (as defined) for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges.

II. "Skilled Nursing Facility" means a facility that is qualified to participate in and receive payments from Medicare. In addition, the facility must do all the following:

1. Operate legally in the area it is located.

2. Be accredited as a skilled-nursing facility by the Joint Commission on Accreditation of Healthcare Organizations.

3. Be under the full-time supervision of a licensed physician or registered nurse.

4. Regularly provide room and board.

5. Provide 24-hour-a-day skilled-nursing care.

6. Maintain a daily medical record of each patient under the care of a physician.

7. Be authorized to administer medications ordered by a physician.

JJ. "Substance Abuse" means the uncontrollable or excessive use of addictive substances and the resultant physiological and/or psychological dependency that develops with continued use, requiring care as determined by a Physician. Addictive substances include, but will not be limited to, alcohol, morphine, cocaine, opium and other barbiturates and amphetamines.

KK. "Usual, Customary, and Reasonable Charges" ("UCR") will be defined and determined in accordance with the following:

1. Usual: A charge is "usual" when it is the most consistent charge by an individual Physician for a given procedure.

2. Customary: A charge is "customary" when it is the "usual" fee for a procedure charged by the majority of Physicians with similar training and experience within the same districts as used by the Plan to develop statistics.

3. Reasonable: A charge is "reasonable" when it meets the above two criteria or when, in the opinion of a medical committee, it merits special consideration based on the complexity of treatment.

### 3.03 Annual Deductible Requirement

The Annual Deductible is applicable each calendar year to the expenses incurred by each Covered Individual. No Annual Deductible applies to Prescription Drug Benefits set forth in Section 3.14 or, effective January 1, 1998, to the Network Wellness Benefits set forth in Section 3.15. Benefits for all other Covered Expenses are payable only after the Annual Deductible is satisfied, as follows:

A. The Deductible is satisfied with respect to Network Charges as soon as any Covered Expenses subject to the Annual Deductible are incurred by a Covered Individual in an amount equal to the Individual Annual Deductible amount specified in Section 3.01.A.1.a. during one calendar year, except as otherwise provided below.

   The Deductible is satisfied with respect to Non-Network Charges as soon as any Covered Expenses subject to the Annual Deductible are incurred by a Covered Individual in an amount equal to the Individual Annual Deductible amount specified in Section 3.01.A. 2.a. during one calendar year, except as otherwise provided below.

B. If, during any one calendar year, the amount of Covered Expenses incurred and applied to the Annual Deductible by the members of any one family unit, consisting of the Participant and his Eligible Dependents covered under the Plan, reaches the Family Deductible Maximum amount specified in Section 3.01.A.1.b., all members of such family unit will be automatically deemed to have satisfied the Annual Deductible with respect to Network Charges for that calendar year.

   If, during any one calendar year, the amount of Covered Expenses incurred and applied to the Annual Deductible by the members of any one family unit, consisting of the Participant and his Eligible Dependents covered under the Plan, reaches the Family Deductible Maximum amount specified in Section 3.01.A.2.b., all members of such family unit will be automatically deemed to have satisfied the Annual Deductible with respect to Non-Network Charges for that calendar year.

C. If two or more Covered Individuals of one family unit, consisting of the Participant and his Eligible Dependents covered under the Plan, are injured in the same accident, only one Annual Deductible will apply each calendar year to the combined total Covered Expenses resulting from such accident.

D. Covered Expenses incurred during the last 90 days of one calendar year and applied to the Annual Deductible for that year may be used toward satisfying the Annual Deductible requirement in the next succeeding calendar year.

In no event will any Coinsurance or Copayment amount paid by the Participant be considered a Covered Expense for purposes of satisfying any part of the Deductible Requirement.

### 3.04 Hospital Copayment Requirements

A. Inpatient Hospital Copayment.

The Inpatient Hospital Copayment is applicable to each admission of a Covered Individual as a registered bed patient.

The Inpatient Hospital Copayment is satisfied with respect to charges by a Participating Provider as soon as Covered Expenses set forth in Section 3.06 are incurred by a Covered Individual in an amount equal to the Inpatient Hospital Copayment amount specified in Section 3.01.B.1.a. for each Hospital admission.

The Inpatient Hospital Copayment is satisfied with respect to charges by a Non-Participating Provider as soon as Covered Expenses set forth in Section 3.06 are incurred by a Covered Individual in an amount equal to the Inpatient Hospital Copayment amount specified in Section 3.01.B.1.b. for each Hospital admission.

For purposes of this provision, two hospital admissions are considered one admission if the patient is transferred from the hospital where the patient was first admitted directly to another hospital for the second admission.

If two or more Covered Individuals of one family unit, consisting of the Participant and his Eligible Dependents covered under the Plan, are injured in the same accident, only one Inpatient Hospital Copayment will apply to the combined total Covered Expenses resulting from such accident.

B. Emergency Room Copayment.

The Emergency Room Copayment is applicable for each visit to an emergency room where the care provided was not Medically Necessary for an Emergency as defined in Section 3.02.L. The amount of the Emergency Room Copayment is set forth in Section 3.01.B.2.

### 3.05 Covered Expenses and Covered Portion - In General

Subject to the provisions of theMSA Program set forth in Section 3.20 and all other provisions, limitations and maximums of this plan document, the Plan will pay benefits in an amount equal to the Covered Portion set forth in the following provisions of this Article III after any applicable Annual Deductible and/or Hospital Copayment Requirements are satisfied.

### 3.06 Inpatient Hospital Expense

A. Covered Expense

Except as otherwise provided or limited by the following provisions of this Article III, Covered Expenses include:

1. Daily inpatient charges made by a Hospital for room and board and general nursing services up to the Semiprivate Room Rate, except that the full cost of room and board will be considered a Covered Expense while an individual is confined in intensive or coronary care accommodations. When Medically Necessary, the charge for a private room will be a Covered Expense.

2. Charges made by a Hospital, in its own behalf, for the following medical care, services and supplies rendered or used during a covered period of Hospital confinement as a registered bed patient:

   a. Special diets.

   b. Use of operating, delivery, recovery, and treatment rooms and equipment.

   c. FDA-approved and appropriately prescribed drugs and medicines for use in the hospital, and Prescription Drugs sent home following hospitalization, up to a 30-day supply.

   d. Dressings, ordinary splints and casts.

   e. X-ray examinations, X-ray therapy, and radiation therapy and treatment.

   f. Laboratory tests.

   g. Physical therapy.

   h. Anesthesia and its administration.

   i. Processing and administering of blood and blood plasma to the extent it is not donated or replaced by or for the patient.

   j. Chemotherapy.

k. Renal dialysis therapy administered according to Medicare regulations.

l. 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.

3. Ground transportation in an ambulance to the hospital when medically necessary and when the patient is admitted. Air ambulance charges are also covered for:

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

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

4. The following Physician services provided during inpatient hospitalization:

a. Up to one hospital visit per day by the admitting physician, and up to one visit per day by a physician treating another condition, until the day of surgery.

b. Administration of anesthesia, when administered by a certified nurse anesthetist or a physician other than the operating surgeon or assistant surgeon.

c. Services of a radiologist or pathologist.

B. Covered Portion

Benefits for Network Charges set forth above are payable in an amount equal to the Covered Portion designated in Section 3.01.D.1.a. Benefits for Non-Network Charges set forth above are payable in an amount equal to the Covered Portion designated in Section 3.01.D.1.b.

## 3.07 Special Outpatient Expenses

A. Covered Expenses

Except as otherwise provided or limited by the following provisions of this Article III, Covered Expenses include the following services provided by a hospital's outpatient department, an ambulatory surgical facility or a physician:

1. Services provided in connection with, and within five days after, an accidental injury.

2. Treatment in connection with, and on the same day that outpatient surgery is performed, including administration of anesthesia, when administered by a certified nurse anesthetist or a physician other than the operating surgeon or assistant surgeon.

3. Emergency medical treatment if the individual is confined to a hospital within 24 hours of outpatient medical treatment.

4. Pre-admission testing that is required for a hospital admission, if performed within seven days of the scheduled admission.

5. Services of a radiologist or pathologist rendered in connection with the treatment described above.

6. Services of an emergency room physician rendered in connection with the treatment described above.

B. Covered Portion

Benefits for Network Charges set forth above are payable in an amount equal to the Covered Portion designated in Section 3.01.D.2.a. Benefits for Non-Network Charges set forth above are payable in an amount equal to the Covered Portion designated in Section 3.01.D.2.b.

## 3.08 Surgery Expense

A. Covered Expense

Except as may be provided or limited by the following Sections of this Article III, Covered Expenses include a physician's charges for the following:

1. Services of a Physician for 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.)

2. Necessary services of an assistant surgeon who actively assists the Physician in surgery when:

   a. The Covered Individual is hospitalized.

   b. The type of surgery requires assistance.

   c. 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.

3. Charges for medical supplies required for surgery in a hospital, a hospital's outpatient department, a physician's office or a freestanding ambulatory surgical facility.

4. Charges described above which are incurred in connection with oral dental surgery due to an accident, impacted teeth or alveolectomy.

5. 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.

6. The following surgery requires approval under the MSA Program set forth in Section 3.20:

   a. Surgery for treatment of temporomandibular joint dysfunction (TMJ) if necessary to reorient the joint.

   b. Reduction mammoplasty, if medically necessary (not Cosmetic).

   c. Obesity, if the Covered Individual 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 in accordance with Section 3.20.

   d. Cosmetic or reconstructive surgery required for:

      (i) Repair of defects resulting from an accident;

      (ii) Replacement of diseased tissue that was surgically removed; or

      (iii) Treatment of a birth defect;

      but only if such surgery is 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, such surgery is performed as soon as medically necessary and appropriate based on the patient's physical condition.

B. Covered Portion

Benefits for Network Charges set forth above are payable in an amount equal to the Covered Portion designated in Section 3.01.D.3.a. Benefits for Non-Network Charges set forth above are payable in an amount equal to the Covered Portion designated in Section 3.01.D.3.b.

### 3.09 Second Surgical Opinion Expense

A. Covered Expense

Charges by a Physician for a Second Surgical Opinion.

B. Covered Portion

Benefits are payable in an amount equal to 100% of Covered Expenses incurred in connection with a Second Surgical Opinion, after the Annual Deductible is satisfied, if the Covered Individual has contacted MSA before the surgery is performed and a second opinion has been recommended by MSA in accordance with Section 3.20. Covered Expenses incurred in connection with any other Second Surgical Opinion will be payable in an amount equal to the Covered Portion specified in Section 3.01.D.4, after the Annual Deductible is satisfied. Provided, however, that effective January 1, 1998, benefits are payable in an amount equal to 100% of Covered Expenses incurred in connection with a Second Surgical Opinion, after the Annual Deductible is satisfied.

### 3.10 Home Health Care Expense

A. Covered Expense

1. Charges by a Home Health Care agency for the following services provided in accordance with the conditions set forth in item 2 below:

   a. Part-time or intermittent nursing services.

   b. Physical, occupational or speech therapy.

   c. Medical and surgical supplies that would be covered if provided by a Hospital.

   d. Prescription drugs for IV infusion therapy or injections.

2. Covered Expenses for Home health care must satisfy the following conditions:

   a. 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.

   b. The home health care must be provided according to a plan of treatment established by the patient's physician and approved through MSA under the terms of Section 3.20.

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

   d. Benefits are not provided for home health care provided in connection with the following:

      (i) Private-duty nursing.

      (ii) Dietary services or food.

      (iii) Homemaker services (housecleaning, preparation of meals, etc.).

(iv) Convalescent, custodial, maintenance or domiciliary care.

(v) Purchase or rental of dialysis equipment.

(vi) Care for mental illness, alcoholism or drug addiction.

B. Covered Portion

Benefits for Network Charges set forth above are payable in an amount equal to the Covered Portion specified in Section 3.01.D.5.a. Benefits for Non-Network Charges set forth above are payable in an amount equal to the Covered Portion specified in Section 3.01.D.5.b.

## 3.11 Hospice Care

A. Covered Expense

1. Charges by hospital, home health care agency or other Provider that may legally provide hospice care for Hospice Care services that are otherwise included as Covered Expenses under the other provisions of this Article III and that are provided in accordance with the conditions set forth in item 2. below.

2. The care must be provided according to a physician's written treatment plan that has been approved in advance by MSA under the terms of Section 3.20. Benefits for hospice care are not provided for:

   a. Care given by volunteers who do not usually charge for their services.

   b. Pastoral services.

   c. Homemaker services (housecleaning, preparation of meals, etc.).

   d. Food or home-delivered meals.

   e. Care to prolong life.

   f. Expenses incurred by family members for temporary relief away from the patient (respite care).

B. Covered Portion

Benefits for Network Charges set forth above are payable in an amount equal to the Covered Portion designated in Section 3.01D.6.a. Benefits for Non-Network Charges set forth above are payable in an amount equal to the Covered Portion designated in Section 3.01D.6.b. Provided, however, that all such benefits will be subject to the following limitations:

1. The amount of benefits payable by the Plan in connection with Hospice Care will not exceed $10,000 in the aggregate for all Covered Expenses incurred by a Covered Individual during the individual's lifetime (whether or not there has been any interruption in the continuity of coverage and whether or not there is any change in the status of such person from employee to dependent and vice versa).

3. Benefits for charges incurred in connection with counseling for the Covered Individual's family are limited to a maximum of $200.

### 3.12 Skilled-nursing Facility

A. Covered Expense

Charges by a Skilled Nursing Facility for services provided in accordance with the following:

1. The care must be for the continued treatment of the same condition for which the patient previously received inpatient hospital care, and the patient must have been transferred directly to the skilled-nursing facility from the hospital.

2. The care must be provided according to a physician's treatment plan and approved in advance by MSA under the terms of Section 3.20.

3. The care must require the skills of a registered nurse.

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

5. 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.

B. Covered Portion

Benefits are payable an amount equal to the Covered Portion designated in Section 3.01.D.7.

### 3.13 Mental Illness and Substance Abuse Limitations

Benefits for Covered Expenses set forth in the other Sections of this Article III which are incurred in connection with treatment of Mental Illness and Substance Abuse will be subject to the provisions of this Section 3.13.

A. Covered Expenses

1. Covered Expenses will include only charges by a Hospital, Physician or licensed social worker who is under the supervision of a Physician in connection with the following services provided in accordance with item 2. below:

   a. 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.

   b. Treatment for Substance Abuse for emergency detoxification or medical treatment required following detoxification.

2. Covered Expenses will be subject to the following limitations:

   a. Covered Expenses incurred by a Covered Individual in connection with treatment received while confined in a Hospital as a registered bed patient will be limited to 30 days during any calendar year and, effective for expenses incurred after January 1, 1998, no more than 60 days during a Covered Individual's lifetime (whether or not there has been any interruption in the continuity of coverage and whether or not there is any change in the status of such person from employee to dependent and vice versa).

   b. Covered Expenses incurred prior to January 1, 1998 by a Covered Individual in connection with treatment received while not confined in a Hospital as a registered bed patient will not include expenses in excess of $2,500 during any calendar year. With respect to expenses incurred on and after January 1, 1998, Covered Expenses will be limited to 30 visits during any calendar year.

B. Covered Portion

1. Inpatient treatment

Benefits for Network Charges incurred while confined in a Hospital as a registered bed patient will be payable in an amount equal to the Covered Portion designated in Section 3.01.D.8.a. Benefits for Non-Network Charges incurred while confined in a Hospital as a registered bed patient will be payable in an amount equal to the Covered Portion designated in Section 3.01.D.8.b. Provided, however, that in no event will benefits exceed $20,000 for all expenses incurred by a Covered Individual while confined in a Hospital as a registered bed patient in one calendar year prior to January 1, 1998.

2. Outpatient

Prior to January 1, 1998, benefits for Covered Expenses incurred while not confined in a Hospital as a registered bed patient will be payable in an amount equal to 80% of the first $1,000 of Covered Expenses incurred in a calendar year after the Annual Deductible and any applicable Emergency Room Copayments are satisfied and 50% of the next $1,500 in Covered Expenses incurred in such calendar year.

With respect to expenses incurred on and after January 1, 1998, benefits for Covered Expenses incurred while not confined in a Hospital as a registered bed patient will be payable in an amount equal to 80% of Covered Expenses in connection with the first 10 visits in a calendar year after the Annual Deductible and any applicable Hospital Copayments are satisfied and 50% of Covered Expenses in connection with the next 20 visits in such calendar year.

The Out-of-Pocket Maximum set forth in Section 3.17 does not apply to these benefits.

3. Aggregate Maximum Benefits

The amount of benefits payable by the Plan in connection with treatment of Mental Illness and Substance Abuse will not exceed $50,000 in the aggregate for all Covered Expenses incurred by a Covered Individual prior to January 1, 1998 (whether or not there has been any interruption in the continuity of coverage and whether or not there is any change in the status of such person from employee to dependent and vice versa).

## 3.14 Prescription Drug Benefits

Prescription Drugs dispensed by a Hospital or other covered inpatient facility which are used while the Covered Individual is receiving treatment at such a facility, will be payable in the same manner as any other Covered Expense. Benefits for any other Prescription Drug are subject to the limitations of this Section 3.14.

A. Covered Expenses

1. Subject to the conditions set forth in item 2. below, Covered Expenses include Prescription Drugs, insulin and the following diabetic supplies: syringes, lancets and glucose sticks.

2. Covered Expenses will not include charges incurred in connection with the following:

   a. Cosmetic products (such as topical applications for treatment of acne or wrinkles). If a drug such as Retin-A is prescribed for a person over age 25, proof of Medical Necessity will be required.

   b. 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.

   c. Any drug covered by workers' compensation.

   d. Digestive aids (unless they are needed to sustain a patient's life), minerals or other dietary supplements, taken orally or injected, regardless of whether they are prescribed by a physician. However, vitamins prescribed for certain conditions, such as prenatal vitamins, may be eligible if approved by the prescription drug Claims Administrator.

   e. 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 prescription drug Claims Administrator.

   f. With respect to Brand Name Drugs purchased from January 1, 1996 until December 31, 1997, the difference in cost between the Brand Name Drug and the cost of its Generic equivalent if a Generic equivalent is available and acceptable to the prescribing Physician.

g. With respect to Brand Name Drugs purchased on or after January 1, 1998, the difference in cost between the Brand Name Drug and the cost of its Generic equivalent, unless the prescription drug Claims Administrator has approved the Brand Name Drug as Medically Necessary.

h. Charges in connection with any of the following, unless pre-approval has been given by the prescription drug Claims Administrator:

(i) Contraceptive medication, when Medically Necessary and used for purposes other than birth control.
(ii) Smoking-cessation aids.
(iii) Prescription vitamins.
(iv) Rogaine or Minoxidil.
(v) Retin-A, when prescribed for a person over age 25.
(vi) Anorectics.
(vii) Growth hormones.
(viii) Fertility drugs.
(ix) Viagra

The prescription drug Claims Administrator may be contacted at the phone number provided on the Covered Individual's health identification card.

i. Mail-order drugs in excess of a 90-day supply per prescription or refill.

j. Retail prescription drugs in excess of a 30-day supply per prescription or refill.

B. Covered Portion

1. With respect to charges made by a Participating Provider retail pharmacy, Covered Expenses are payable in an amount equal to the Covered Portion designated in Section 3.01.D.10.a. Provided, however, no benefits shall be paid by this Plan in the event that the cost of a covered prescription drug is less than the copayment amount specified in Section 3.01.D.10.a.

2. With respect to charges made by any other retail pharmacy, Covered Expenses are payable in an amount equal to the Covered Portion designated in Section 3.01.D.10.b. Provided, however, no benefits shall be paid by this Plan in the event that the cost of a covered prescription drug is less than the copayment amount specified in Section 3.01.D.10.b.

3. With respect to charges made by the Participating Provider mail-order pharmacy, Covered Expenses are payable in an amount equal to the Covered Portion designated in Section 3.01.D.10.c.

The Out-of-Pocket Maximum provision set forth in Section 3.17 does not apply to these benefits.

## 3.15 Network Wellness Benefits

A. Covered Expenses

For purposes of this Section 3.15, Covered Expenses include the following services rendered by a Participating Provider:

1. Well-child care for newborns and children under age six.

2. Pap tests, mammograms and other routine screenings.

3. Routine physical examinations, except for examinations required for admission to a school or for participation in sports. Routine immunizations are not covered after a child reaches age six, except for influenza vaccines.

B. Covered Portion

Benefits are payable in an amount equal to 100% of the Covered Expenses set forth above, up to a maximum benefit of $250 for expenses incurred by a Covered Individual in one calendar year. Benefits for Covered Expenses in excess of the $250 maximum are payable in accordance with Section 3.16.

## 3.16 Other Medical Expenses

A. Covered Expense

For purposes of this Section 3.16, Covered Expenses include the following services and supplies. Except as provided under Network Wellness Benefits described in Section 3.15, in no event will benefits be payable under this Section 3.16 for the services and supplies described in the preceding Sections of this Article III, or for the amount of expenses which exceed the maximums and limitations set forth in such Sections.

1. Outpatient hospital services such as chemotherapy, radiation therapy and kidney dialysis.

2. Professional services of a physician or surgeon, including consultations by a qualified specialist.

3. Services of a physician's assistant or nurse practitioner.

4. Services of a registered nurse (RN) or licensed practical nurse (LPN), when the skills of an RN or LPN are required.

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

6. Preventive and wellness care services for:

   a. Routine care for newborns and children under age six, including routine immunizations.

   b. Pap tests, mammograms, screenings for hypertension and diabetes, and examinations for cancer, blindness and deafness, and other screening and diagnostic procedures.

   c. Routine physician examinations, except for examinations required for admission to a school or for participation in sports. Routine immunizations are not covered after a child reaches age six, except for influenza vaccines.

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

7. 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:

a. No more than three times within three consecutive cycles.

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

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

8. Laboratory tests, radium therapy, X-rays and microscopic tests.

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

10. 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.

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

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

b. Cardiac pacemakers, atomic or electronic.

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

d. Penile prosthesis in men suffering impotency resulting from an organic disease or injury.

e. Artificial eyes.

f. Artificial limbs.

g. Colostomy supplies and other equipment directly related to ostomy care.

h. Electronic speech aids after a laryngectomy.

maintenance, when the therapeutic goals of the treatment plan have been achieved and/or when no more measurable progress is expected. Physical therapy coverage for temporomandibular joint syndrome (TMJ) follows the same guidelines.

17. 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.

18. 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.

19. 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:

    a. An acute myocardial infarction (heart attack).

    b. Coronary bypass surgery.

    c. Stable angina pectoris (heart-related chest pains).

20. 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.

21. 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.

22. Dental care for the initial repair of an accidental injury to sound natural teeth but only if the services are received within 12 months after the date of the accident.

23. 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.

B. Covered Portion

Benefits for Network Charges set forth above are payable in an amount equal to the Covered Portion specified in Section 3.01.D.12.a. Benefits for Non-Network Charges set forth above are payable in an amount equal to the Covered Portion specified in Section 3.01.D.12.b.

### 3.17 Out-of-Pocket Maximum

A. If, during one calendar year, the total amount of Allowable Out-of-Pocket Expenses incurred by one Covered Individual equals the Individual Out-of-Pocket Maximum amount specified in the Benefit Schedule, Section 3.01.C.1.a., the Plan will pay 100% of any additional Network Charges incurred by such Covered Individual during the remainder of that calendar year, subject to the applicable maximum amounts.

If, during one calendar year, the total amount of Allowable Out-of-Pocket Expenses incurred by one Covered Individual equals the Individual Out-of-Pocket Maximum amount specified in the Benefit Schedule, Section 3.01.C.2.a., the Plan will pay 100% of any additional Non-Network Charges incurred by such Covered Individual during the remainder of that calendar year, subject to the applicable maximum amounts.

B. If, during one calendar year, the total amount of Allowable Out-of-Pocket Expenses incurred by the Covered Individuals in one family unit (consisting of the Participant and his Eligible Dependents covered by the Plan) equals the Family Out-of-Pocket Maximum amount specified in the Benefit Schedule Section 3.01.C.1.b., the Plan will pay 100% of any additional Network Charges incurred by the Covered Individuals in such family unit during the remainder of that calendar year, subject to the applicable maximum amounts.

If, during one calendar year, the total amount of Allowable Out-of-Pocket Expenses incurred by the Covered Individuals in one family unit (consisting of the Participant and his Eligible Dependents covered by the Plan) equals the Family Out-of-Pocket Maximum amount specified in the Benefit Schedule Section 3.01.C.2.b., the Plan will pay 100% of any additional Non-Network Charges incurred by the Covered Individuals in such family unit during the remainder of that calendar year, subject to the applicable maximum amounts.

C. The term "Allowable Out-of-Pocket Expenses" means the sum of any Covered Expenses which are incurred but are not reimbursable by the Plan because they are applied to satisfy the Annual Deductible or Inpatient Hospital Copayment amount or they represent the Coinsurance amount not payable as the Covered Portion.

Provided, however, that Allowable Out-of-Pocket Expenses will not include, nor will benefits be payable at 100% for:

1. Charges for which benefits are described in Section 3.14 (prescription drugs) and Section 3.13.B.2. (outpatient treatment of mental illness and substance abuse).

2. Charges which are not reimbursable by the Plan as a result of plan maximums or limitations.

3. Charges for services and supplies which are excluded by the Plan under Section 3.21.

4. Charges for which benefits are excluded or reduced by the terms of the MSA Program set forth in Section 3.20.

5. Emergency Room Copayments.

### 3.18 Pregnancy

Necessary treatment of Pregnancy is covered in the same way as an Illness for Eligible Employees and Eligible Dependent Spouses. Provided, however, that in no event will the Plan restrict or reduce benefits otherwise payable for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of these periods.

For purposes of determining the benefit amount payable, any charges incurred by a covered newborn child for nursery and routine newborn laboratory testing made by the Hospital, and a Physician's charges for routine hospital visits, for any day on which both mother and child are confined in the Hospital will be considered Covered Expenses incurred by the mother, subject to all other exclusions and limitations of the Plan.

No benefits are payable for termination of Pregnancy unless the attending physician certifies that the life of the mother would be endangered if the fetus were carried to term.

No benefits are payable for charges incurred in connection with the Pregnancy of an Eligible Dependent Child.

### 3.19 Aggregate Lifetime Maximum

The amount of benefits payable under the medical benefit provisions of Articles III of this Plan for all Covered Expenses incurred by a Covered Individual during the individual's lifetime (whether or not there has been any interruption in the continuity of coverage and whether or not there is any change in the status of such person from employee to dependent and vice versa) will not exceed $1,000,000 in aggregate. This amount will be escalated annually by the Health Cost Component of the Consumer Price Index, as determined by the Plan Administrator. The increase to the maximum benefit shall be effective on each January 1 and shall apply to expenses incurred after the date the increase is effective.

Provided, further, that in no event will benefits exceed the lifetime maximum benefits set forth in the other provisions of this Article III.

## 3.20 MSA Program

A. Definitions

For purposes of this Section 3.20, the following terms will have the meanings set forth below:

1. "Emergency Admission" means a Hospital confinement for a condition which occurs suddenly and which, unless promptly treated on an inpatient basis, would put the patient's life in danger.

2. "Precertification" means a request for review by MSA before care is received, in accordance with subsection C. below.

3. "Recertification" means a request for review by MSA of care beyond the precertified length of stay, in accordance with subsection D. below.

4. "Concurrent Review" means review by MSA of a continuing hospital confinement, in accordance with subsection E. below.

5. "Retrospective Review" means review by MSA after care is received, in accordance with subsection F. below.

6. "Individual Case Management" means identification of alternative treatment options, by MSA, in accordance with subsection G. below.

B. Benefit Limitations

Except as provided in Section 3.18, noncompliance with the MSA Program will cause benefits to be limited or reduced in the following ways:

1. Charges which would otherwise be Covered Expenses under this Plan will be reduced by $200 unless Precertification is received from MSA: (a) prior to the date of admission for an inpatient hospital confinement; (b) in the case of an Emergency Admission, within two working days after admission; and (c) at least one day prior to the date treatment starts in the case of services described in Subsection 4 below.

2. If Precertification or Recertification is not obtained, or through Precertification or Recertification MSA determines that the proposed care is not approved as Medically Necessary, the Plan

will not pay any charges related to the unapproved days of the hospital admission, unless the care is later determined to be Medically Necessary through Concurrent Review, Retrospective Review or the Appeals Process. If MSA determines that the care should have been provided on an outpatient basis, the Plan 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.

3. If through Concurrent Review MSA determines that continuing care is not approved as Medically Necessary, the Plan will not pay any charges incurred on or after the day following the date the Participant is notified of such determination, unless the care is later determined to be Medically Necessary through Retrospective Review or the Appeals Process. If MSA determines that the continuing care should have been provided on an outpatient basis, the Plan 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.

4. No benefits are payable for the following services unless MSA determines through Precertification that such services are Medically Necessary:

   a. Home Health Care set forth in Section 3.10.

   b. Skilled Nursing Facility Care set forth in Section 3.12.

   c. Hospice Care set forth in Section 3.11.

   d. Certain surgical procedures set forth in Section 3.08.A.6.

   e. Residential treatment facilities in accordance with the Hospital definition set forth in Section 3.02.P.

   f. Prior to January 1, 1998, certain prescription drugs set forth in Section 3.14.A.2.g. (Effective January 1, 1998, pre-approval of certain prescription drugs must be obtained through the prescription drug Claims Administrator.).

   g. Prior to January 1, 1998, cardiac rehabilitation set forth in Section 3.16.A.19.

   h. Hearing aids set forth in Section 3.16.A.11.j.

i. Prior to January 1, 1998, magnetic resonance imaging tests (MRIs).

j. Prior to January 1, 1998, oxygen and equipment for its administration used on an out-patient basis set forth in Section 3.16.A.14.

k. Private-duty nursing set forth in Section 3.16.A.4.

l. Prior to January 1, 1998, durable medical equipment set forth in Section 3.16.A.13.

5. Benefits are payable in an amount equal to 100% of Covered Expenses incurred in connection with a Second Surgical Opinion, after the Annual Deductible is satisfied, if the Covered Individual has contacted MSA before the surgery is performed and a second opinion has been recommended by MSA. Covered Expenses incurred in connection with any other Second Surgical Opinion will be payable in an amount equal to the Covered Portion specified in Section 3.01.D.4, after the Annual Deductible is satisfied. Provided, however, that effective January 1, 1998, benefits are payable in an amount equal to 100% of Covered Expenses incurred in connection with any Second Surgical Opinion, after the Annual Deductible is satisfied

6. The Plan Administrator may authorize payment of benefits for services and supplies that are not otherwise listed as Covered Expenses in this Article III, if such services and supplies are medically necessary and provide a cost-effective alternative to the listed Covered Expenses, as determined in advance by MSA through Individual Case Management.

Covered Expenses incurred for which payment is excluded by the terms set forth in this Section will not be considered as expenses incurred for the purpose of any other part of this Plan.

Approval by MSA does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all of the terms of the Plan.

C. Precertification Procedures

Except as provided in Section 3.18, the Covered Individual must initiate Precertification when inpatient hospitalization or one of the services listed under B.4. above is recommended by a Physician. The procedures for precertification are as follows:

1. The Covered Individual or his attending Physician must contact MSA prior to the hospital admission, or, in the case of an Emergency Admission, within two working days after the date of admission. To request precertification, the following information must be provided to MSA:

   a. The Participant's identification number (from the health plan ID card).

   b. The name and phone number of the admitting physician.

   c. The date of admission.

   d. The name of the hospital or treatment facility.

   e. The reason for the admission and the expected length of stay.

2. The Covered Individual or his attending Physician must contact MSA prior to receiving the services described in subsection B. 4. above.

3. The MSA will approve or disapprove the care with confirmation of any disapproval sent to the attending Physician, the Hospital and the Covered Individual.

4. A hospitalization that receives approval may be assigned an initial length of stay based on the Covered Individual's specific situation and the optimal-length-of-stay guidelines established by MSA.

D. Recertification

After the date of admission, if the attending Physician indicates the Covered Individual requires an extended length of stay beyond that certified by MSA, the Covered Individual or the attending Physician must call MSA and provide additional information substantiating the continued inpatient Hospital confinement. After evaluating the medical information MSA will determine if continued hospitalization is necessary.

E. Concurrent review

In many cases, MSA will review the medical necessity of an admission and the need for continued treatment while the Covered Individual is hospitalized. If the attending Physician indicates the Covered

Individual requires an extended length of stay, MSA will request additional information substantiating the continued inpatient Hospital confinement and will evaluate the medical information. MSA will issue a letter to the Participant and the provider(s) if it is determined that the current care is no longer necessary.

F. Retrospective review

MSA may perform reviews of inpatient and outpatient services after they are received and/or claims paid, in order to determine whether the care was Medical Necessity and eligible for benefits from the Plan.

G. Individual case management

MSA may contact the Covered Individual, the attending physician, social workers and home health agencies, the hospital and the Covered Individual's family to provide cost-effective treatment options on a voluntary basis. Possible candidates for individual case management may be suggested by MSA, BlueCross BlueShield 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 Plan must be the patient's primary coverage. If the patient is eligible for individual case management and an appropriate alternative treatment plan is developed, the physician and the patient's family must voluntarily agree to the plan in writing.

H. Appeals Process

If the Covered Individual or the attending physician disagrees with any decision made by MSA, an appeal may be submitted in writing within 60 days to the BlueCross BlueShield of Illinois address shown in the Participant's health plan ID card.

### 3.21 Exclusions

No benefits are payable by the Plan for expenses incurred in connection with any of the following:

A. Convalescent care, custodial, domiciliary or sanitarium care, or rest cures.

B. Expenses from a continuous hospital confinement that began before a person's coverage under this plan became effective.

C. Travel expenses.

D. 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.

E. Expenses in excess of Usual, Customary and Reasonable charges.

F. Expenses for the plan's penalties for failure to precertify a hospital admission, or for hospitalizations that exceed the length of stay approved by MSA under the terms of Section 3.20.

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

H. Services in connection with any intentionally self-inflicted injury.

I. 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:

   a. 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.

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

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

   d. 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:

a. 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.

b. 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.

J. Any expenses that are not Medically Necessary for the treatment of an illness or injury.

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

L. Procedures that are not ordered by a Physician, or not documented in timely fashion in the patient's medical record.

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

N. Services in connection with transsexual surgery.

O. 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.

P. Accidental bodily injury or illness that is covered by any workers' compensation or occupational disease law.

Q. 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.

R. Services in connection with any treatment of the teeth, gums or alveolar process, except:

1. Dental care for the initial repair of an accidental injury to sound natural teeth, provided such care is received within 12 months following the date of the accident.

2. Oral dental surgery due to an accident, impacted teeth or alveolectomy.

3. 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.

S. Dentures, replacement of teeth or structures directly supporting teeth, surgery for the purpose of fitting or wearing dentures or dental implants.

T. Any medical observation or diagnostic study when no illness or injury is revealed, unless there is satisfactory proof that the covered person had definite symptoms of illness or injury other than hypochondria. This limitation does not apply to benefits for preventive care services listed under Section 3.15.A and 3.16.A.6.

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

V. Vision training, eyeglasses and contact lenses or examinations for their prescription or fitting, except:

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

2. Contact lenses, as long as the contacts are for the replacement of the eye's lenses.

3. Vision training following eye surgery.

W. Physical and speech therapy that is educational in nature.

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

Y. Cosmetic treatment, except when required for the following:

1. Repair of defects resulting from an accident;

2. Replacement of diseased tissue that was surgically removed; or

3. Treatment of a birth defect;

and only if such surgery is 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, such surgery is performed as soon as medically necessary and appropriate based on the patient's physical condition.

Z. Actual or attempted impregnation or fertilization that involves the Covered Individual as a surrogate or donor, or the pregnancy of a surrogate mother.

AA. 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 Section 3.16.A.7.

BB. Expenses for reversals of sterilization procedures.

CC. Home obstetrical delivery.

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

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

FF. Adoption expenses.

GG. Charges incurred as a result of a pregnancy of the daughter of an Eligible Employee, Disabled Employee, Eligible Retiree or Surviving Spouse.

HH. Birth control devices or birth control pills, unless used for other than contraceptive purposes and approved by the Plan.

II. Digestive aids (unless they are needed to sustain a patient's life) or dietary supplements, taken orally or injected, regardless of whether

they are prescribed by a physician. Vitamins are covered only as described under Prescription Drug Benefits in Section 3.14.

JJ. Hypnosis and acupuncture.

KK. Naturopathic or holistic services.

LL. Massage therapy or rolfing.

MM. 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 benefits in Section 3.08.

NN. 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.

OO. Marriage counseling, encounter or self-improvement group therapy, and school-related behavioral problems.

PP. Treatment received from a close relative or a person who ordinarily resides with the patient. A "close relative" means the Covered Individual, the Covered Individual's spouse or a person related to either as a brother, sister or parent.

QQ. Services rendered or prescribed by a Doctor of Chiropractic (DC), whether or not the services are covered by the chiropractor's license.

RR. Any care that does not require the services of a specifically trained medical professional.

SS. Routine foot care, including but not limited to treatment of corns and calluses, and nonsurgical treatment of bunions.

TT. Eye surgery for a condition that could be corrected with lenses instead, including but not limited to radial keratotomy—unless it is 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.

UU. Expenses for an autopsy or postmortem surgery.

VV. Transportation for delivery of home health care.

WW. Services or supplies not specifically listed as Covered Expenses, including but not limited to:

1. Electrical continence aids, anal or urethral.

2. Wigs or hairpieces.

3. Implants for cosmetic purposes.

4. Penile prostheses for psychogenic impotence.

5. Personal comfort or service items for use during confinement in a hospital, including but not limited to a radio, television, telephone and guest meals.

6. Air conditioners, humidifiers, dehumidifiers, purifiers or tanning booths.

7. Over-the-counter orthopedic or corrective shoes.

8. Exercise equipment.

XX. 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 set forth in Article VII.

YY. Expenses in excess of $1,000 incurred prior to January 1, 1998 in connection with a Pre-existing Condition described in Section 3.02 BB.2.b. above, unless such expenses are incurred after the earliest of the following dates:

1. With respect to an individual covered by the Plan other than as an Eligible Employee, the individual has been covered by this Plan for 12 consecutive months.

2. With respect to an Eligible Employee, the individual has been continuously covered by this Plan and performing Active Work for six consecutive months.

   Provided, however,

   a. With respect to any individual whose coverage has been continued and/or reinstated after a period of protected leave under the Family & Medical Leave Act of 1993 or under the Uniformed Services Employment and Reemployment Rights Act of 1994, coverage shall be provided under the conditions that would apply if the employee had continued coverage

while Actively at Work without lapse. The preceding sentence shall not apply to an Injury, Illness or other condition determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

b. This limitation shall not apply to an adopted Child nor to a Child legally placed with the Participant for adoption, provided the child is properly enrolled for coverage within 31 days following the date the Participant assumes a legal obligation for total or partial support of such Child in anticipation of adoption.

ZZ. Expenses incurred before January 1, 1998 in connection with a Pre-existing Condition described in Section 3.02 BB.2.a above except with respect to expenses incurred after the individual has been covered by this Plan for 12 consecutive months. This limitation shall not apply in the case of an individual who immediately prior to Enrolling in the Plan, received medical benefits through a health maintenance organization with which the Plan Sponsor had entered into a contract to provide medical benefits to employees.

AAA. 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.

## 3.22 Limitations on Pre-existing Conditions Effective January 1, 1998

A. Definitions

For definitions purposes of this Section 3.22, the following terms shall have the meaning indicated below:

1. "Creditable Coverage" means periods of coverage under a Qualified Medical Plan, without regard to any Waiting Period. For purposes of counting the number of days of Creditable Coverage, each day on which the individual was covered by a Qualified Medical Plan shall count as one day, even if the individual was covered by more than one qualified medical plan on that day. An individual's "Creditable Coverage" shall not include any periods of Creditable Coverage that occurred prior to a Significant Break-in-Coverage.

2. "Enrollment Date" means, with respect to a Covered Individual: (a) the date that coverage becomes effective or (b) in the case of an Eligible Employee and his Eligible Dependent who are Enrolled in accordance with Section 2.02.C.1 and Section 2.03 A, the first day of employment as an Eligible Employee.

3. "Exclusion Period" means the 365-day period commencing on a Covered Individual's Enrollment Date.

4. "Pre-existing Condition" means any Injury or Sickness or any related Injury or Sickness for which medical advice, diagnosis, care or treatment (including prescription drugs) was recommended by or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law during the six-month period ending on the Covered Individual's Enrollment date.

5. "Qualified Medical Plan" means coverage: (i) which is described in 29 CFR Section 2590.701-4(a)(1) and (ii) which does not consist solely of coverage of excepted benefits described in 29 CFR Section 2590.732.

6. "Significant Break-in-Coverage" means a period of 63 consecutive days during which an individual had no Creditable Coverage. In determining whether an individual had a Significant Break-in-Coverage, any Waiting Period, as described below, shall not be taken into account.

7. "Waiting Period" means: (i) with respect to an individual who enrolls in a group health plan on the earliest date on which coverage can become effective under the terms of the plan, the period that must elapse before the first day of coverage; and (ii) with respect to an individual who seeks and obtains coverage in the individual market, any period after the date the individual filed a substantially completed application for coverage and before the first day of coverage. If an employee or dependent does not enroll in a group health plan when first eligible to do so, any period before the individual's first day of coverage shall not be considered a Waiting Period.

B. Pre-existing Condition Exclusion

1. No benefits are payable by the Plan for Covered Expenses incurred in connection with a Pre-existing Condition during the Exclusion Period. Provided, however, that the Exclusion Period will be reduced by the number of days of Creditable Coverage that the Covered Individual had on the Enrollment Date.

2. The Covered Individual will be required to provide proof of Creditable Coverage. In the event the Covered Individual does not have a certificate of Creditable Coverage from a prior plan, he or she may present other evidence of Creditable Coverage, provided the Covered Individual cooperates with the Plan's efforts to verify such coverage.

C. Exceptions

1. The exclusion for pre-existing conditions will not apply to pregnancy. It also will not apply to a covered dependent child if: (a) the child was enrolled in a Qualified Medical Plan within 30 days of birth or placement for adoption and (b) the child has not had a Break-in-Coverage. Coverage that a child had prior to placement for adoption is not taken into account.

2. The exclusion set out in this Section 3.22 also shall not apply to a Covered Individual whose coverage is reinstated following a voluntary lapse in coverage which occurs during a leave protected by the FMLA or by the Uniformed Services Employment and Reemployment Rights Act of 1994, except to the extent the Covered Individual was subject to this limitation on the date coverage lapsed. In that event, coverage shall be reinstated at the level and under the conditions that would apply if the Employee had continued coverage without lapse. However, this waiver of the pre-existing conditions limitation shall not apply with respect to such Covered Individual's service-related Injury or Sickness.

ARTICLE IV

## Vision Care Benefits

Subject to the provisions and limitations of the Plan, the amount of the benefits hereinafter described shall be payable by the Plan in accordance with the Plan's claims procedures for the Covered Vision Care Expenses incurred by a Covered Individual.

### 4.01 Benefit Schedule

Prior to January 1, 1996, vision care benefits for each Covered Individual shall be determined in accordance with the following schedule:

| Service | Maximum Amount Payable |
|---|---|
| Vision examination (once every 24 months) | $20 |
| Lenses (up to two lenses every 24 months) | |
| Single vision | $10* |
| Bifocal | $15* |
| Trifocal | $20* |
| Lenticular | $25* |
| Contact | $15* |
| Frames (one every 24 months) | $14 |

*Per lens

On and after January 1, 1996, benefits will be provided pursuant to the terms of the contract entered into between the Plan and Vision Service Plan.

## 4.02 Vision Care Definitions

The following words and phrases, whether or not capitalized, will have the respective meanings set forth in this Section 4.02, unless the context clearly indicates otherwise.

A. "Covered Expenses" means charges incurred by a Covered Individual for the services and supplies set forth in this Article IV, provided such services and supplies are recommended by an Optician, Optometrist or Ophthalmologist and are not excluded by the Plan under the terms of Section 4.03. An expense or charge will be deemed *incurred* as of the date the service is rendered or purchase is made from which the expense or charge arises.

B. "Covered Individual" means only a Participant or a Participant's Eligible Dependent for whom coverage under Option III is effective under the Plan in accordance with Article II, provided, however, that the following individuals shall not be eligible for these benefits:

1. Eligible Retirees

2. Disabled Employees who are receiving benefits from the Peabody Long Term Disability Plan for Salaried Employees

3. Surviving Spouses

4. Eligible Dependents of Participants described in 1, 2 and 3 above.

C. "Optician," "Optometrist" or "Ophthalmologist" shall mean any person who is legally qualified and currently licensed to practice each profession by the appropriate governmental authority having jurisdiction over the licensing and practice of such profession and who is acting within the scope of his or her license.

**4.03 Covered Expense and Covered Portion**

A. Benefits are payable in an amount equal to 100% of the charges specified in Section 4.01 incurred by a Covered Individual prior to January 1, 1996 up to the applicable maximum benefit.

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

1. The new lenses improve vision by at least one line on the standard eye chart; and

2. The new lens prescription differs from the last one by an axis change of 20 degrees, or a sphere or cylinder change of .50 diopter.

**4.04 Exclusions**

No benefits are payable for expenses incurred in connection with the following:

A. Sunglasses other than tints Number 1 or Number 2.

B. Extra charges for photo-sensitive or anti-reflective lenses.

C. Drugs or medications (other than for a vision examination, or medical or surgical treatment of the eyes).

D. Special procedures, such as orthoptics.

E. Vision training.

F. Aids for subnormal vision, aside from covered lenses and frames.

G. Aniseikonic lenses and tonography.

H. Services or supplies that are experimental, developmental or investigatory.

I. Replacement of lenses or frames because they have been lost or broken, unless the replacement is eligible under the rules for prescription changes, or the lenses or frames have not been replaced for at least 24 months.

J. Services or supplies that a licensed physician, optometrist or optician has not prescribed as necessary.

K. Services or supplies for which the Covered Individual is entitled to benefits under the provisions of any other plan or under a mine safety-glass program.

L. Services that are covered by any workers' compensation or employer's liability laws, or services that an employer is required to provide by law.

M. Services or supplies obtained from any governmental agency without cost.

ARTICLE V

**Dental Benefits**

Subject to the provisions and limitations of the Plan, the amount of the benefits hereinafter described shall be payable by the Plan in accordance with the Plan's claims procedures for the Covered Dental Expenses incurred by a Covered Individual.

**5.01 Benefit Schedule**

Dental benefits for each Covered Individual shall be determined in accordance with the following schedule:

A. Deductible Requirements:

| | | |
|---|---|---|
| 1. | For Preventive Care | None |
| 2. | For Basic Care (per lifetime) | $50 |
| 3. | For Major Care (per calendar year) | |
| | a. Individual | $50 |
| | b. Family Maximum | $100 |
| 4. | For Orthodontia (per lifetime) | $100 |

| B. Covered Portion: | | Before 1/1/96 | Before 1/1/97 | Effective 1/1/97 |
|---|---|---|---|---|
| 1. | Preventive Care | 80% | 100% | 100% |
| 2. | Basic Care (after deductible) | 50% | 50% | 80% |
| 3. | Major Care (after deductible) | 50% | 50% | 60% |
| 4. | Orthodontic Care (after deductible) | 50% | 50% | 60% |

| C. | | | | |
|---|---|---|---|---|
| | Annual maximum for preventive, basic and major care | $750 | $750 | $750 |

| | | | |
|---|---|---|---|
| D. Lifetime maximum for orthodontic care | $500 | $1,000* | $1,000* |

*The lifetime maximum for a course of treatment beginning prior to 1/1/96 is $500.

## 5.02 Dental Benefit Definitions

The following words and phrases, whether or not capitalized, will have the respective meanings set forth in this Section 5.02, unless the context clearly indicates otherwise.

A. "Allowable Charge" means: (1) in the case of a Delta Dental participating Dentist, the fee accepted in advance by Delta Dental Plan for the services or supplies provided, or (2) in the case of a Non-Participating Dentist, the fee that the majority of Delta Dental participating dentists would charge for the services or supplies as determined by Delta Dental.

B. "Claims Administrator" means Delta Dental Plan of Missouri, Inc. Prior to January 1, 1997, "Claims Administrator" means Alliance Blue Cross Blue Shield.

C. "Coinsurance" means the portion of Covered Expenses remaining after the Plan pays the Covered Portion.

D. "Course of Treatment" means a planned program of one or more services or supplies, whether rendered by one or more Dentists, for the treatment of a dental condition diagnosed by the attending Dentist as a result of an oral examination. The course of treatment commences on the date a Dentist first renders a service to correct or treat such diagnosed dental condition. With respect to orthodontic care, treatment begins on the date such appliance (bands) is placed and ends on the date such appliance is removed.

E. "Covered Expenses" means Allowable Charges incurred by a Covered Individual for the services and supplies set forth in the Covered Expense sections of this Article V, provided such services and supplies are recommended by the attending Dentist, constitute Necessary Care, do not exceed the Allowable Charge for such services and supplies and are not excluded by the Plan in accordance with Section 5.10.

F. "Covered Individual" means only a Participant or a Participant's Eligible Dependent for whom coverage is effective under the Plan in accordance with Article II, provided, however, that the following individuals shall not be eligible for these benefits:

1. Eligible Retirees.

2. Disabled Employees who are receiving benefits from the Peabody Long Term Disability Plan for Salaried Employees.

3. Eligible Dependents after the end of a 30 day period following the month in which the Eligible Employee dies.

4. Eligible Dependents of Participants described in 1 and 2 above.

5. Prior to January 1, 1998, Eligible Dependent Children age 19 or older.

G. "Covered Portion" means the amount of benefits the Plan pays for Covered Expenses, subject to the other provisions and limitations of the Plan.

H. "Dentist" means a licensed doctor of dental medicine or doctor of dental surgery acting within the scope of his or her license and any other physician furnishing any dental services which he or she is licensed to perform.

I. "Dental Emergency" means an urgent, unplanned diagnostic visit to a dentist for alleviation of an acute dental condition caused by an accident.

J. "Dental Hygienist" means a person currently licensed to practice dental hygiene, who works under the direct supervision of a dentist.

K. "Non-Participating Dentist" means a Dentist who has not entered into an agreement with Delta Dental Plan.

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

M. "Orthodontic Procedure" means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

N. "Participating Dentist" means a Dentist who has entered into an agreement with Delta Dental Plan.

## 5.03 Dental Deductible Requirement

A. Basic Care Deductible

The Basic Care Deductible requirement is applicable once in a Covered Individual's lifetime to all covered Basic Care expenses incurred by the Covered Individual. The Basic Care Deductible is satisfied as soon as a Covered Individual incurs Covered Expenses set forth in Section 5.06 in the amount specified in Section 5.01 A. 2.

B. Major Care Deductible

The Major Care Deductible requirement is applicable each calendar year to all covered Major Care expenses incurred by each Covered Individual. The individual deductible requirement is satisfied as soon as a Covered Individual incurs Covered Expenses set forth in Section 5.07 in the amount specified in Section 5.01 A. 3. during one calendar year.

If, during any one calendar year, Covered Expenses set forth in Section 5.07 are incurred and applied to the deductible by Covered Individuals of any one family unit, consisting of the Participant and his dependents covered under this Plan, in the amount specified in Section 5.01 A. 3. b., then each Covered Individual in such family unit shall be automatically deemed to have satisfied the Major Care Deductible requirement for that calendar year on the date the total amount of such Covered Expenses is incurred.

C. Orthodontia Deductible

The Orthodontia Deductible requirement is applicable once in a Covered Individual's lifetime to all covered Orthodontia expenses incurred by the Covered Individual. The Orthodontia Deductible is satisfied as soon as a Covered Individual incurs Covered Expenses set forth in Section 5.08 in the amount specified in Section 5.01 A. 4.

## 5.04 Covered Expense and Covered Portion – In General

Subject to the applicable deductible requirement and maximum amounts, benefits are payable in an amount equal to the applicable covered portion specified in the following Sections for the Covered Expenses incurred by a Covered Individual. Benefits are not payable for Covered Dental Expenses used to satisfy the deductible or incurred prior to the date on which the deductible is satisfied.

An expense or charge shall be deemed to be "incurred" on the date on which the particular service or supply which gives rise to the expense or charge is rendered or obtained. In the absence of due proof to the contrary, when a single charge is made for a series of services, each service shall be deemed to bear a pro rata share of the charge. Any dental expense will be considered to have been incurred as follows:

A. For fixed bridges, full or partial dentures, on the date the abutment teeth are fully prepared or the first impressions are taken.

B. For crowns, inlays or onlays, on the date the teeth are first prepared.

C. For root canal therapy, on the date the pulp chamber of the tooth is opened.

D. For all other services, on the date the service is performed.

## 5.05 Preventive Care

A. Covered Expense

Covered Preventive Care Expenses include charges for the following:

1. Routine periodic examinations, twice in any calendar year;

2. Bitewing and periapical X-rays, as required;

3. Full-mouth X-rays, once in any 36 consecutive month period;

4. Prophylaxis (cleaning, scaling and polishing), twice in any calendar year;

5. Topical fluoride application for Covered Individuals under age 19, once in any calendar year;

6. Space maintainers, including adjustments within six months after installation, limited to the initial appliance only and for Covered Dependent Children under age 16;

7. Topical application of sealants on posterior teeth for Covered Dependent Children under age 19, once in any five year period.

B. Covered Portion

Benefits are payable in an amount equal to the applicable Covered Portion of Covered Expenses specified in Section 5.01 B. 1., with no deductible requirement.

## 5.06 Basic Care

A. Covered Expenses

Covered Basic Care Expenses include charges for the following:

1. Office visits.

2. Oral surgery (including alveolar or gingival constructions, excision of cysts, surgical extractions, etc.).

3. Simple extractions.

4. Injectable antibiotics.

5. Anesthesia (general anesthesia is covered only for oral surgery).

6. Periodontics (gum disease treatment).

7. Endodontics, including root canal therapy (but not the final restoration or treatment of non-vital teeth).

8. Amalgam and synthetic restorations (including pins used instead of crowns).

B. Covered Portion

Benefits are payable in an amount equal to the applicable Covered Portion of Covered Expenses specified in Section 5.01 B. 2., after the lifetime Basic Care Deductible is satisfied.

## 5.07 Major Care

A. Covered Expenses

Covered Major Care Expenses include charges for the following:

1. Crowns, inlays and onlays if necessary due to decay or traumatic injury and only when the restoration cannot be restored with routine filling material.

2. Initial installation of bridgework or full or partial dentures.

3. Addition of teeth to any existing denture or bridgework.

4. Replacement of an existing crown, inlay or onlay restoration, partial or full removable denture or fixed bridgework, if one of the following conditions exist:

   a. The existing crown, restoration, denture or bridgework cannot be made serviceable and was installed at least five years prior to the replacement date.

   b. Replacement is necessary because of an accidental injury.

   c. Replacement is necessary to replace one or more teeth extracted while covered by this plan.

5. Repair and adjustment of crowns, bridgework, full and partial dentures, including relining, rebasings, and recementations.

B. Covered Portion

Benefits are payable in an amount equal to the applicable Covered Portion of Covered Expenses specified in Section 5.01 B. 3, after the Major Care Deductible is satisfied.

## 5.08 Orthodontia

A. Covered Expenses

Covered Expenses incurred in connection with movement of teeth to correct the position of maloccluded or malpositioned teeth include only charges for orthodontic services provided to an individual under age 19 in connection with one or more of the following conditions:

1. Overbite or overjet of at least four millimeters.

2. Maxillary (upper) and mandibular (lower) arches in either protrusive or retrusive relation of at least one cusp.

3. Cross-bite.

4. An arch length discrepancy of more than four millimeters in either the upper or lower arch.

B. Covered Portion

Benefits are payable in an amount equal to the applicable Covered Portion of Covered Expenses specified in Section 5.01 B. 4., after the Orthodontia Deductible is satisfied.

Benefits for orthodontia treatment may be prorated over the time period of the treatment program and paid on a quarterly basis. A reasonable fee for the initial placement of the appliance will be deemed a Covered Expense on the date the orthodontic appliance is first installed. The remaining expense shall be prorated and benefit payments may be made in installments payable at the end of each three (3) month period following the initial placement.

## 5.09 Maximum Benefits

The aggregate maximum benefits payable for all Covered Expenses incurred by a Covered Individual for Orthodontic Care during his entire lifetime shall not exceed $500. This maximum is increased to $1,000 with respect to Course of Treatment that begins on and after January 1, 1996; provided however that such increased maximum shall be reduced by all benefits paid by the Plan for Orthodontic Care expenses incurred before January 1, 1996. The aggregate maximum benefits payable for all Covered Expenses incurred by a Covered Individual for Preventive, Basic and Major Care during one calendar year shall not exceed $750.

## 5.10 Exclusions

No benefits are payable for expenses incurred in connection with any of the following:

A. Accidental injury or illness caused by war or any act of war, whether or not declared, including armed aggression, or by participating in a riot, or the attempt to commit a felony or assault.

B. Accidental injury or illness arising out of or in the course of employment, or which is compensable under any workers' compensation or occupational disease act or law.

C. Charges incurred in connection with any intentionally self-inflicted injury.

D. Charges for cosmetic treatment required for correction unless necessitated as a result of accidental injury sustained by the Covered Individual while this plan is in force. For purposes of these limitations, bleaching discolored teeth and facings on crowns or pontics posterior to the second bicuspid shall always be considered cosmetic.

E. Expenses for any services to which there is no legal obligation to pay, or for which no charge would be made if you were not covered under this plan.

F. Expenses for services or supplies which are not Necessary, or expenses in excess of Usual, Reasonable and Customary charges.

G. Charges for replacement of lost or stolen appliances.

H. Charges for appliances, restorations, or procedures for altering vertical dimension, analyzing, restoring or maintaining occlusion, splinting, or replacing tooth structures lost as a result of abrasion or attrition or treatment of disturbances of the temporomandibular joint.

I. A service furnished by or on behalf of any federal, state, county or any other governmental unit unless a charge is made that the Covered Individual is legally required to pay without regard to existence of the plan coverage.

J. The replacement of any denture, crown, inlay or onlay restoration or fixed bridge within five years of the date of the last placement, unless the replacement is required as a result of accidental body injury or because of a tooth that has been extracted while the individual is covered by this plan.

K. Any orthodontic procedure in connection with an active appliance that has been installed before the effective date of coverage under this plan.

L. Charges incurred in connection with dental implantology, such as endosseous or alloplastic implants.

M. Charges for any services covered under the medical benefits set forth in Article III of this Plan.

N. Charges for orthodontic services which begin after the individual has reached age 19.

O. Services not furnished by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or is an X-ray ordered by a dentist.

P. Oral hygiene, dietary or plaque control instructions and programs.

Q. Procedures, services or supplies that do not meet accepted standards of dental practice.

R. Charges incurred prior to the effective date of coverage under this Plan.

S. Services provided after the date the individual's coverage terminates under this Plan, except as provided in Section 5.13.

T. Medical care, services or supplies received as the result of any injury which 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.

U. Claims received more than 12 months after the date the services or supplies were received.

V. Charges for a missed or broken appointment.

W. General anesthesia or intravenous sedation, except where provided for oral surgery.

X. Charges made for analgesia or desensitizing medication or nitrous oxide.

Y. Charges for hospitals or home visits, consultations or behavior management.

Z. Charges for medications, other than injectable antibiotics.

AA. Charges for sealants, except as permitted under Section 5.05.

BB. Services rendered by a member of your immediate family or your spouse's immediate family.

CC. Charges for denture adjustments for the first six months after the dentures are initially received.

DD. Services rendered by a dentist beyond the scope of his or her license.

EE. Hypnosis.

The plan reserves the right to limit or exclude other services or supplies and their charges.

### 5.11 Alternate Treatment Limitation

If alternate services or supplies may be employed to treat a dental condition, Covered Expenses will be limited to the Usual, Customary and Reasonable charges which are or would otherwise have been made for the services or supplies which are customarily employed nationwide in the treatment of the disease or injury and are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the current total oral condition of the Covered Individual.

## 5.12 Predetermination of Benefits

If the charges of a Dentist or Dentists for a proposed course of treatment for a Covered Individual are expected to be $125 or more, or the treatment includes orthodontia, a pretreatment plan must be filed with the Claims Administrator prior to the commencement of the course of treatment. The Administrator will predetermine the estimated benefits payable for the Covered Dental Expenses which are expected to be incurred for the course of treatment and inform the Covered Individual and the Dentist, in advance of treatment, of the amount of estimated benefits payable in connection with the course of treatment. If the proposed course of treatment is not begun within 90 days of the date of the predetermination, the Dentist shall resubmit the treatment plan to the Claims Administrator for reevaluation. If predetermination has not been made, benefits will be determined by the Administrator in the same manner as though predetermination had been made.

If the charges of a Dentist or Dentists of a proposed course of treatment is not expected to exceed $125, or is for emergency care, predetermination will not be required.

## 5.13 Extended Dental Benefits

If a Covered Individual has dental work in progress on the date coverage would normally end and the dental treatment began before that date, benefits will be extended for:

A. Appliances or modification of appliances, if the master impression was taken by a dentist before coverage termination and if the appliance is delivered or installed within two months following termination.

B. A crown, bridge, inlay, or onlay restorations, if the tooth or teeth were prepared before coverage termination and if the crown, bridge or cast restoration is installed within two calendar months after termination.

C. Orthodontic treatment, benefits are in force for services provided through the end of the month in which termination occurs based on a proration of the applicable treatment fee.

D. Root canal therapy, if the pulp chamber was opened prior to termination of coverage, if such root therapy is completed within two calendar months after the termination of coverage.

**5.14 First 12 Months of Coverage Limitation.**

Effective January 1, 1997, if an Eligible Employee fails to enroll himself or his Eligible Dependent for Dental Benefits within 31 days of the date he, or his Eligible Dependent, first becomes eligible for coverage under the Plan, benefits during the first 12 months of dental coverage of such Eligible Employee or Eligible Dependent shall be limited to expenses with respect to those Preventive Care services described in Sections 5.05. This limitation shall not apply in the case of an elections made as a result of a Change in Family Status causing a loss of other dental coverage, as described in Section 2.02.B.2.b., Section 2.03.D.2. or Section 2.05.D.1.

ARTICLE VI

## Coordination of Benefits Provision

### 6.01 Definitions

As used in this Coordination of Benefits Provision, the following terms, whether or not capitalized, shall have the meanings indicated:

A. "Allowable Expense" means any medically necessary, reasonable and customary item of medical, dental or vision expense at least a portion of which is covered under this Plan; provided, however, that in the case of a plan which provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

In the event that this Plan contains a preferred provider feature whereby a provider has agreed to a discounted or reduced charge for Participants in this Plan, the amount of such discount or reduction shall not be considered an Allowable Expense.

When benefits are reduced under another plan because a Covered Individual does not comply with plan provisions, such as those related to precertification of admissions or services, the amount of such reduction will not be considered an Allowable Expense, except to the extent that the charge would otherwise be covered by this Plan.

B. "Claim Determination Period" means a calendar year or any portion thereof during which a person subject to this provision is insured under this Plan.

C. "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by: (a) group, blanket or franchise insured or uninsured coverage, (b) group Blue Cross, Blue Shield and other prepayment coverage provided on a group basis, (c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group and (d) when permitted by law, any organization under governmental programs and any coverage required or provided by any statute. Medicare will not be deemed a "plan" with respect to actively working employees and Eligible Dependents of actively working employees, except when secondary coverage by the plan is permitted by law with respect to

Medicare coverage for End Stage Renal Disease after 30 months (prior to January 1, 1998, after 18 months).

With respect to Hospital indemnity-type coverage, the definition of "plan" shall be construed to include only that amount of group or group-type Hospital indemnity benefits which exceeds $50.00 a day.

The term "plan" shall be construed separately with respect to each policy, contract or other arrangements for benefits or services and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

D. "This Plan" means that portion of the Plan which provides benefits that are subject to this provision.

**6.02 Benefit Determination**

The benefits payable under this Plan shall be subject to the following:

A. This Coordination of Benefits provision shall apply in determining the benefits as to a person covered under this Plan for any Benefit Determination Period if any benefits are paid, payable or furnished under other plans in connection with Allowable Expenses incurred by or on behalf of such person during such period.

B. As to any Benefit Determination Period with respect to which this provision is applicable, the benefits that would otherwise be payable under this Plan in the absence of this provision for the Allowable Expenses incurred by or on behalf of such person during such Benefit Determination Period shall be reduced, except as provided in item C. below, to the extent necessary so that the sum of such reduced benefits and all the benefits paid for, payable or furnished in connection with such Allowable Expenses under all other plans shall not exceed the amount of benefits that would otherwise have been payable under this Plan in the absence of this provision.

For the purposes of this provision, all benefits payable or furnished under another plan shall be taken into account whether or not claim has been duly made therefor. Where permitted by law, benefits payable under Medicare shall be deemed to include the benefits that would have been payable had claim been duly made therefore, and if the Covered Individual had Enrolled for such coverage. In the event that the Covered Individual has not enrolled for such Medicare

coverage, Medicare benefits shall be determined in accordance with the deductible and coinsurance factors then applicable under Medicare, and in accordance with the Covered Expense definition of this Plan.

In the event that another plan contains a preferred provider feature, whereby a provider has agreed to a discounted or reduced charge for Participants in that plan, the amount of such discount or reduction shall be deemed a benefit paid by that plan.

C. If coverage under another plan is involved as provided in item A above, and:

1. Such plan contains a provision coordinating the benefits thereunder with those of the Plan and according to its terms and conditions, benefits thereunder would not be determined until after the benefits of this Plan have been determined, and

2. The terms and conditions set forth in item D. below would require benefits under this Plan to be determined before benefits are determined under such other plan,

the benefits otherwise provided under such other plan will not be taken into account for the purposes of determining the benefits under this Plan.

D. For the purposes of item C. of this Section 6.02, the rules establishing the order of benefit determination are:

1. The benefits of a plan that has no provision for coordination of benefits will be determined before this Plan.

2. The benefits of a plan which covers the person on whose expense claim is based other than as a dependent will be determined before the benefits of a plan which covers such person as a dependent.

3. In the case of a child whose parents are not divorced or separated, the benefits of a plan which covers a dependent child as a dependent of the parent whose birthday occurs earlier in the year shall be determined before the benefits of a plan which covers such person as a dependent of the person whose birthday falls later in the year; for purposes of this provision, the year of birth is not relevant.

4. In the case of a person for whom claim is based as a dependent child of separated or divorced parents:

   a. The benefits of the plan of the parent with custody of the child are determined first.

   b. The benefits of the plan, if any, of the spouse of the parent with custody of the child (the stepparent) are determined next.

   c. The benefits of the plan of the parent without custody are determined last.

   Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility, the benefits of the plan which covers the child as a dependent of the parent with such court-assigned financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent. If the terms of the court decree state that the parents shall share joint custody without stating that one of the parents is responsible for the health care expenses of the child, this Plan shall follow the rule set forth in item D.3. above.

5. Provisions for active versus retired/laid off employees.

   a. The benefits of a plan covering the person on whose expense claim is based as a laid-off, retired or other former employee shall be determined after the benefits of any other plan covering such person as an employee other than as a laid-off, retired or other former retired employee.

   b. The benefits of a plan covering the person on whose expense claim is based as a dependent of a laid-off, retired or other former employee shall be determined after the benefits of any other plan covering such person as a dependent of an employee that is not a laid-off, retired or other former retired employee.

   c. If either plan does not have a provision regarding laid-off or retired employees, and, as a result, each plan determines its benefits after the other, then the provisions of a. and b. above shall not apply.

6. Provisions for federal or state continuation law.

a. The benefits of a plan covering the person on whose expense claim is based under federal or state continuation laws shall be determined after the benefits of any other plan covering such person as an employee, member or subscriber or a dependent of such person.

b. If either plan does not have a provision regarding federal or state continuation coverage and, as a result, each plan determines its benefits after the other, then the provisions of d. above shall not apply.

7. Provisions where none of the rules above are applicable.

When the above rules do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expense claim is based for the longer period of time will be determined before the benefits of a plan which has covered such person the shorter period of time.

**6.03 Right to Receive and Release Necessary Information**

To determine the applicability of and to implement the terms of this provision of similar purpose in any other plan, the Claims Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization any information, with respect to any person, which the Claims Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Claims Administrator such information as may be necessary to implement this provision.

**6.04 Facility of Payment**

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Claims Administrator shall have the right, exercisable alone and in its sole discretion, to pay to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Plan shall be fully discharged from liability under this Plan.

### 6.05 Right of Recovery

Whenever payments have been made by the Plan, with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Claims Administrator shall determine: any persons to or for or with respect to whom such payments were made, any other insurance companies, any other organizations.

### 6.06 Excess Coverage

If one or more of the other plans involved (as defined in this Coordination of Benefits provision) provides benefits on an Excess Insurance or Excess Coverage basis, items C. and D. of the Benefit Determination provisions shall not apply to such plan(s) and this Plan will pay as excess coverage.

ARTICLE VII

## Subrogation and Reimbursement Rights

### 7.01 Recovery From Third Parties

A. In the event that a Covered Individual sustains a bodily injury or illness for which a third party may be legally responsible, the Plan is not obligated to pay benefits for medical, dental or vision expenses incurred in connection with such injury or condition unless or until the Covered Individual or someone legally qualified and authorized to act for the Covered Individual promises in writing to:

1. Notify the Plan of any personal injury claim or any claim for reimbursement of medical expenses within five days of the date such claim is made.

2. Include such medical expenses in any claim the Covered Individual makes against a third party for the injury or conditions.

3. Notify the Plan at least 30 days before settling or compromising any claim against a third party.

4. Reimburse the Plan in full, in first priority, for any benefit paid, from any funds received from a third party as a result of a personal injury claim or any reimbursement of medical expenses, such reimbursement to be made within 30 days of the receipt of such funds.

5. Cooperate fully with the Plan in asserting its subrogation rights as set forth below, and within five days of receiving a request by the Plan, supply the Plan with any and all information and execute any and all instruments the Plan reasonably needs for that purpose.

B. The Plan shall be subrogated to any right of recovery which the Covered Individual may have against any person as a result of the injury or illness, whether by suit, judgment, settlement, compromise or otherwise. "Person" includes any party or parties to a lawsuit, individual, insurance company, firm or corporation, including the

Covered Individual's insurance company in the case no-fault automobile insurance coverage. The Plan's right to recovery includes, but is not limited to, rights against the Covered Person or any other person or entity that caused, contributed to, or is responsible for the Injury or Sickness or other loss to the Covered Person. The term "responsible for the injury" shall include any party, such as an insurance company, that acquires the responsibility through the actions of its insured. The Plan's subrogation and reimbursement rights extend to both tortfeasor's insurance company and the Covered Individual's insurance company in the case of no-fault automobile insurance coverage.

C. The Plan's rights of recovery includes the right to recover all amounts that it paid to the Covered Individual as reimbursement for medical or dental expenses. The Plan has the right to recover the amounts it paid as benefits from any moneys received by the Covered Individual by way of judgment, settlement or otherwise, from any other person as defined above, regardless of whether the amounts recovered were designated for payment of medical expenses. The Plan's subrogation and reimbursement rights shall take priority over the Covered Individual's rights of recovery. In addition, the Plan may reduce the amount of future benefits payable for any other medical expenses incurred by the Participant and/or his Eligible Dependents in order to recover the amount it is entitled to under this provision.

D. The Plan shall be subrogated for any payment by a third party to a Covered Individual for future medical expenses paid pursuant to a judgment, settlement or contract on the following basis:

1. If any amount is awarded by means of a verdict after a full and complete trial and the judgment or verdict form itemizes by separate finding or special interrogatory the amount awarded for future medical expenses, such amount shall be binding on the Plan and the Covered Individual as the amount of future medical expenses to which the Plan is subrogated.

2. If there exists any contract or policy of insurance by which future medical expenses are paid (other than a policy or contract of health care, hospitalization or disability insurance issued to and in the name of such Covered Individual), the Plan shall be subrogated to and deemed secondary or excess insurance to such contract or policy and amounts paid thereby.

3. If any amount is paid to a Covered Individual by means of a settlement or general judgment or verdict which does not itemize components of damage, the Plan Administrator and the Covered Individual shall agree on the amount which is attributable to future medical and dental expenses. In the event that the Plan Administrator and the Covered Individual cannot agree on the amount attributable to future medical expenses, the Plan Administrator, in its sole and absolute discretion, shall determine the amount attributable to future medical expenses.

   In any amount awarded under subsection 1., the total amount of future medical expenses to which the Plan is subrogated shall be reduced by and, in determining the amount to which the Plan is subrogated under subsection 3, consideration may be given to:

   a. the amount of proportionate or comparative fault assessed against the Covered Individual which reduces the amount of total future medical expenses which are paid by the other;

   b. the amount not collectible.

   In addition, in determining the amount of future medical expenses paid under subsection 3. above, consideration shall be given to the percentage of total future medical expenses paid by one who is jointly liable with another, the other remaining liable, any discount for present value of future expenses, and any discount for possibilities of incurring the claimed future medical expenses.

When any amount is paid or payable pursuant to subsections 1., 2. or 3. above, the Covered Individual shall pay all medical expenses incurred in the future for treatment of the Injuries sustained for which the payments under 1., 2. or 3. were made or agreed to be made, and the Plan shall have no responsibility or liability to pay any such future medical expenses, nor shall the amount of any such payment be considered to represent a Covered Expense incurred under this Plan for purposes of satisfying any of the provisions of this Plan with respect to the Deductible or copayment requirements, until the amount under subsection 1., 2. or 3. is fully used.

The subrogation interest of the Plan to payments made under subsections 1., 2. or 3. shall apply to all amounts made under any or all sections.

E. If the Covered Individual's total recovery from all sources does not adequately reimburse him for his expenses and injuries, Plan Administrator, in its sole and absolute discretion, may accept a lesser amount in full satisfaction of its rights. The Plan Administrator shall have sole authority to determine whether a Covered Individual has been adequately reimbursed and whether to accept a lesser amount.

F. The Plan Administrator, in its sole and absolute discretion, may agree to waive the Plan's subrogation rights. Such waiver shall not automatically occur in any matter. Waivers of the subrogation interest of the Plan may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. Waivers of subrogation interests will generally not be granted if the past medical expenses are greater than $500 or if the total judgment or settlement exceeds $5,000.

G. If any portion of this section on subrogation is deemed to conflict with any other provision of the Plan on coordination of benefits of primary-secondary insurance coverage, the other portion of the Plan shall control and the provisions of this section shall supplement such other provisions to the extent not inconsistent.

ARTICLE VIII

## Administration of the Plan

### 8.01 Plan Administrator and Named Fiduciary

Peabody Holding Company, Inc. shall be the Plan Administrator and a named fiduciary of the Plan as that term is defined by the Employee Retirement Income Security Act of 1974 (ERISA). The administration of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

The Plan Administrator shall designate a Claims Administrator and may designate any insurer or other contracting entity as an additional fiduciary of the Plan pursuant to the provisions of ERISA.

Any fiduciary may delegate any of its responsibilities, subject to the approval of the Plan Administrator. Any fiduciary under the Plan may serve in more than one fiduciary capacity. Fiduciaries under the Plan may allocate fiduciary responsibilities among themselves in any reasonable and appropriate fashion, subject to the approval of the Plan Administrator.

### 8.02 Fiduciary Liability

No named fiduciary shall be liable with respect to a breach of fiduciary duty, if such breach was committed before he became a named fiduciary or after he ceases to be a named fiduciary. No fiduciary shall be liable for an act or omission of another person in carrying out any fiduciary responsibility where such fiduciary responsibility is allocated to such other person by the Plan, or where such other person was designated to carry out such fiduciary responsibility in the manner prescribed by the Plan, except to the extent that such fiduciary is in violation of his duty under Section 405(a) or Section 405(c)(2) of ERISA.

The Plan Sponsor agrees to indemnify and hold harmless any present or former employee of the Plan Sponsor to whom Plan administration responsibilities have been delegated, against all claims, demands, rights, liabilities, damages, causes of action, costs and expenses of whatsoever kind and nature (including Plan Administrator-approved attorney's fees and amounts paid in settlement of any claims) which arose through any act or omission to act by such employee or former employee in connection with the Plan, if such act or omission occurred in good faith.

**8.03 Powers and Duties**

The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

A. To establish a funding policy and method consistent with the objectives of the Plan and ERISA.

B. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law.

C. To interpret the Plan, its interpretation in good faith to be final and conclusive on all persons claiming benefits under the Plan.

D. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan.

E. To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan.

F. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, including, but not limited to, delegating certain claims administration duties to the Claims Administrator(s), provided that any such allocation, delegation or designation shall be set out in a written instrument executed by the Plan Administrator and the designated party.

G. To communicate to any insurer or other supplier or administrator of benefits under this Plan in writing all information required to carry out the provisions of the Plan.

H. To notify the Participants in writing of any substantive amendment or termination of the Plan or of a change in benefits available under the Plan.

I. To promulgate written procedures for reviewing and implementing qualified medical child support orders within the meaning of Section 609 of ERISA.

**8.04 Examination of Records**

The Plan Administrator will make available to each Participant such records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

**8.05 Reliance on Tables, etc.**

In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of any of the plans offered within the Plan, or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

**8.06 Nondiscriminatory Exercise of Authority**

Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

**8.07 Standard of Review**

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall interpret all Plan provisions, and make all determinations as to whether any particular Covered Individual is entitled to receive any benefit under the terms of this Plan, which determination shall be made by the Plan Administrator in the exercise of its sole discretion. Any construction of the terms of the Plan that is adopted by the Plan

Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. If any Participating Employer and/or any Eligible Employee who performs services for a Participating Employer that are or may be compensated for in part by benefits payable pursuant to this Plan, such an individual shall be treated as agreeing with and consenting to any decision that the Plan Administrator makes in its sole discretion and further agrees to the limited standard of review described by this Section 8.07 by the acceptance of such benefits.

ARTICLE IX

# Funding Policy

## 9.01 Employer Contributions

A. Each Participating Employer shall contribute to the Plan for each Plan Year such amounts at such times as shall be determined in the sole discretion of the Plan Administrator to be necessary in order to provide benefits to all Covered Individuals and qualified beneficiaries (and their covered dependents) who are entitled to coverage under this Plan by reason of an employment relationship with a Participating Employer.

If a Participant is transferred from one Participating Employer to another Participating Employer, then each of the Participating Employers shall contribute the amount necessary to provide the benefits of such Participant, and any of his Eligible Dependents who are Covered Individuals, which may become payable as a result of expenses that are determined by the Plan Administrator to be Covered Medical Expenses, incurred during the period of time for which the Participant was engaged in Active Work with each such Participating Employer.

B. Each Participating Employer shall be solely responsible for paying the benefits due those individuals who are or were employed by that Participating Employer, such individual's Eligible Dependents, any individual who becomes a qualified beneficiary in accordance with Section 2.09 with respect to a Participating Employer, and any individual covered as a dependent of such a qualified beneficiary.

C. Each Participating Employer may provide for the payment of benefits to any Covered Individual or qualified beneficiary through direct payment, the purchase of insurance, or funding through a trust. Benefits payable to a Covered Individual or qualified beneficiary shall be paid by the insurance purchased for such payment, if any. If no such insurance is currently in force, then the benefits shall be paid with those funds that may be held in a trust for the purpose of such payment, if any. Except for funds which may be held in such a trust, no Covered Individual or qualified beneficiary shall have a claim against the Plan Administrator, or any other Participating Employer, other than

the Participating Employer with respect to whom such individual is a Covered Individual or qualified beneficiary as of the date the Covered Expense for which benefits are being claimed was incurred.

D. Notwithstanding Section 9.01B., in the event an Eligible Employee becomes an Eligible Retiree in accordance with the provisions of Article XIII and is accredited with Years of Service (as that term is defined in Article XIII) by reason of employment with more than one Participating Employer, the cost of the benefits payable under this Plan, in excess of any amount Participant Contribution which may be required from time to time, with respect to such Retiree Participant and each of his Eligible Dependents, if any, may be allocated among all such Participating Employers in proportion to the number of Years of Service credited to such Retiree Participant by each Participating Employer.

The legal and financial obligation of any Participating Employer established under this Section 9.01D. shall survive any termination of this Plan by such a Participating Employer with respect to its Eligible Employees and/or Eligible Retirees and such Participating Employer shall continue to remit amounts necessary to satisfy such obligations to the Plan Administrator, or any other entity designated by the Plan Administrator to receive such funds.

**9.02 Participant Contributions**

A. Each Participant in the Plan shall contribute to the Plan such amounts at such times as shall be determined in the sole discretion of the Plan Administrator.

B. The Plan Administrator reserves the right to require the payment of a higher contribution for coverage for an Eligible Employee who has Eligible Dependents covered under the Plan, than for an Eligible Employee without Eligible Dependents, and to initiate, increase or decrease the amount of the Participant Contributions prescribed for any category of Participants, including, but not limited to, Disabled Participants and their Eligible Dependents and Retired Participants and their Eligible Dependents covered under the Plan in accordance with the provisions of Article XIII.

C. The Plan Administrator may prescribe the method of payment of Participant Contributions, including payroll withholding, and

if necessary, an alternate method for those Participant Contributions that cannot be made by means of payroll withholding because the particular Participant or qualified beneficiary receives no current compensation from a Participating Employer; provided that any Participant Contribution not collected by means of payroll deduction shall be considered timely if received by the Plan Administrator within 30 days after the date when payment is actually due.

D. If an Eligible Employee or an Eligible Retiree enrolls himself and/or any of his Eligible Dependents in the Plan, such enrollment will be treated as an authorization to deduct any necessary Participant Contributions associated with the coverage selected from the salary or pension payments made to such individual by any Participating Employer.

ARTICLE X

## Amendment or Termination of the Plan

### 10.01 Amendment

The Plan Administrator reserves the right at any time and from time to time to modify or amend the Plan, in whole or in part provided that no such amendment shall have the effect of reducing the amount of any benefit to which a Participant is entitled by reason of expenses incurred prior to the date on which such an amendment is adopted. Such action shall be taken through the action of the Plan Administrator's Board of Directors or of its duly-authorized delegate.

### 10.02 Termination

The Plan Administrator reserves the right to terminate the Plan, in part or in its entirety, at any time. Such action shall be taken through the action of the ~~Plan~~ Administrator's Board of Directors or of its duly-authorized delegate.

Coverage under this Plan shall automatically terminate with respect to all individuals who are Eligible Employees, Eligible Retirees, Eligible Dependents of an Eligible Employee or Eligible Retiree or qualified beneficiaries of a Participating Employer as of the date such Participating Employer ceases to be a Participating Employer, except to the extent otherwise provided by the Plan with respect to Eligible Retirees whose participation in the Plan is based on employment with more than one Participating Employer. From and after that date, the Plan Administrator shall have no further obligation to provide any benefits under this Plan to such an individual; and provided further that a Participating Employer that ceases to be a Participating Employer shall be solely responsible to the Plan for any amounts that are determined by the Plan Administrator to be necessary in order to provide any benefits that the Plan has become obligated to pay by reason of Covered Expenses incurred by such a Covered Individual or qualified beneficiary (or a covered dependent) before the date on which it ceased to be a Participating Employer, or any amount that may be due with respect to an Eligible Retiree.

An employee shall not acquire a lifetime right to any Plan benefit or to the continuation of this Plan merely by reason of the fact that such benefit or this Plan is in existence at any time during the employee's employment. Nor shall a retired employee acquire a lifetime right to any Plan benefit or to the continuation of this Plan merely by reason of the fact that such benefit or this Plan is in existence at any time during the retired employee's employment or at the time of the retired employee's retirement. This Plan shall comply with all applicable requirements of the law and shall be amended, if necessary, in order to satisfy any such requirements.

# ARTICLE XI

## General Provisions

### 11.01 Gender and Number

Whenever required by the context of any Plan provision, the masculine includes the feminine, the feminine includes the masculine, the singular the plural, and the plural the singular.

### 11.02 Legal Actions

No action at law or in equity shall be brought to recover under the Plan prior to the expiration of 60 days after proof of claim has been filed in accordance with the requirements of the Plan and the Plan's claims procedures, nor shall such action be brought at all unless brought within three years from the expiration of the time within which proof of claim is required in accordance with the Plan's claims procedures.

### 11.03 Not Workers' Compensation Insurance

The coverage provided by the Plan is not in lieu of and does not affect any requirements of coverage by Workers' Compensation insurance.

### 11.04 Assignment of Benefits

All benefits payable for charges by Participating Providers (as defined in Article III) or Participating Dentists (as defined in Article V) are automatically paid to such provider or dentist. Other dental benefits under Article V are automatically paid to the Participant and may not be assigned to the provider. Other medical benefits provided under Article III (except Non-Network prescription drug benefits) are also assigned to the Physician, or other person or institution rendering services or furnishing supplies for which benefits are payable under the Plan, unless the Participant submits satisfactory proof that the charges have been paid. In no event will the Plan pay benefits in excess of the amount that would otherwise be payable in absence of such assignment. The Plan Administrator shall not be required to inquire into the validity of any such assignment, and any payment made in accordance with any such assignment and in good faith by the Plan Administrator shall discharge the obligation of the Plan hereunder to the extent of such payment.

### 11.05 Right of Offset and Recovery

If any benefit is mistakenly paid by the Plan, either in whole or in part, the Plan Administrator reserves the right to offset amounts to be paid in the future as benefits under this Plan, and/or to recover such mistakenly paid amounts from and among any person to, for, or with respect to whom such amounts were paid.

### 11.06 Facility of Payment

If, in the opinion of the Plan Administrator, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Plan Administrator may, at its option, make such payments to the individual or individuals as have, in the Plan Administrator's opinion, assumed the care and principal support of the Covered Individual and are, therefore, equitably entitled thereto. In the event of the death of the Covered Individual prior to such time as all benefit payments due him have been made, the Plan Administrator may, at its sole discretion and option, honor benefit assignments, if any, payment made by the Plan Administrator in accordance with the above provisions shall fully discharge the Plan to the extent of such payments.

### 11.07 Notice of Address

Each person entitled to benefits under this Plan must file with the Plan Administrator, in writing, his Social Security number, his post office address and each change of post office address. Any communications statement, or notice addressed to such person at his latest post office address as filed with the Plan Administrator will be binding on such person for all purposes of the Plan. The Plan Administrator shall not be obliged to search for or to ascertain the whereabouts of any such person.

### 11.08 Actions by Corporation

Whenever under the terms of this Plan a corporation is permitted or required to take some action, such action may be taken by any official of the corporation who has been duly authorized by the board of directors of such corporation.

### 11.09 Rules of Construction

The terms and provisions of this Plan shall be construed according to the principles and in the priority as follows:

First, in accordance with the meaning under, and which will bring the Plan into conformity with, the Internal Revenue Code and with ERISA; and secondly, in accordance with the laws of the State of Missouri.

The Plan shall be deemed to contain the provisions necessary to comply with such laws. If any provision of this Plan shall be held illegal or invalid, the remaining provisions of this Plan shall be construed as if such provision had never been included.

### 11.10 Acts and Omissions of Providers

Neither the Company nor the Claims Administrator shall be liable in any event for any act or omission of any Hospital, Physician, Surgeon, or other provider of service or any officer, employee, servant or agent thereof.

### 11.11 Health, Dental or Vision Care Information

As a condition precedent to the payment of benefits hereunder, each Covered Individual shall authorize any employer, insurance carrier, health services corporation, group prepayment plan (HMO), or any provider of health care services to furnish the Claim Administrator with any and all information and records relating to his or her health condition and history. Such authorization shall be treated as a waiver of all provisions of law forbidding such disclosures.

ARTICLE XII

## Claims Procedures for Medical, Vision and Dental Benefits

### 12.01 Claim Filing Procedure

A. Claims for any Plan benefits shall be submitted to the Claims Administrator. The Plan Administrator will furnish to the participant such forms as are prescribed by the Plan Administrator for filing proof of claim. If such forms are not furnished within 15 days after the Plan Administrator receives notice of claim, the Participant shall be determined to have complied with the requirements of the Plan as to proof of claim upon submitting, within the time limit required below for filing of claim, written proof covering the occurrence, character and extent of the loss for which claim is made, together with information sufficient to identify the person with respect to whom benefits are claims as a Covered Individual.

Notwithstanding the above, effective January 1, 1996, claims for benefits provided under Article IV shall be submitted to Vision Service Plan.

B. The Claims Administrator may require, as part of the proof of claim, additional information which it deems necessary for purposes of determining the applicability of and implementation of the provisions of this Plan. Such information may include, but is not limited to medical records or itemized bills of any hospital or provider of medical services, supplies or treatment. Any such information must be provided to the Claims Administrator within 60 days of the date it is requested by the Claims Administrator.

C. In the event the Participant fails to furnish notice or proof of claim, or any information requested by the Claims Administrator as part of the proof of claim, within the time specified above, his claim shall be denied, unless the Participant advises the Claims Administrator, prior to the expiration of the period, that it is not reasonably possible for him to furnish such notice or proof within such time. A Participant whose claim is denied for failure to furnish notice or proof of claim, or for failure to provide any information requested by the Claims Administrator in a timely manner, may utilize the Claim

Review Procedure set out below and have his claim reconsidered upon showing that it was not reasonably possible for him to have complied with the requirements of Section B above; provided that the Participant provides the required information as soon as it is reasonably possible for him to do so.

D. Notwithstanding the above, in no event will charges submitted more that 12 months after the date on which the expense was incurred be considered for payment.

**12.02 Payment of Claims**

Subject to the provisions of Section 11.04, any benefits due shall be paid to the Participant or to the medical care provider or dental care provider in accordance with the terms set forth in Article III and Article V of the Plan upon receipt of due proof of a valid claim.

Notwithstanding the above, any payment for benefits provided by this Plan pursuant to a qualified medical child support order in reimbursement for expenses paid by either an alternate recipient, as defined in Section 609(a)(2)(C) of ERISA, or by an alternate recipient's custodial parent ~~or~~ legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian. For this purpose, any payments made by the Plan to an official of a State or a political subdivision thereof whose name and address have been substituted for that of an alternate recipient in a QMCSO shall be treated as payment of benefits to the alternate recipient.

The Plan shall also pay benefits in accordance with Section 609(b) of ERISA, including requirements to recognize reimbursement and subrogation rights that a state may have with respect to participants and beneficiaries who are eligible for Medicaid benefits under Title XIX of the Social Security Act.

**12.03 Denial of Claims**

A. If a claim is denied in whole or in part, the Participant will be notified in writing by the Claims Administrator within 90 days after receipt of the claim. An additional 90 days may be required for processing the claim if special circumstances are involved. The Participant will be given notice of any such additional time within the first 90-day period. The notice will state the special circumstances involved and the date a decision is expected.

B. The notice of denial will include the following:

1. The specific reason(s) for denial;

2. Specific reference to the provision of the Plan which forms the basis of the denial;

3. A description of additional information, if any, which may enable a Participant to receive the benefits sought and an explanation of why it is needed; and

4. An explanation of the claims review procedure.

C. A Participant who fails to receive a response to his claim within 90 days of submission, allowing reasonable time for mailing, may proceed to the claim review stage set out in D. below.

D. The Participant may file an appeal at any time during the 60-day period following receipt of the notice of denial of the claim. In the case of a Participant who does not receive a timely response to his claim, an appeal may be filed within 150 days of the date that the claim was first filed. The appeal must be made by writing to the Plan Administrator. The Participant, in the course of this appeal, should state the reasons he believes the claim denial was improper and submit any additional information, material or comments which he considers appropriate. He may also review any pertinent documents related to the claim.

E. The Participant will receive a written decision on the appeal which states the specific reason(s) for the decision and specifically references the provision of the Plan on which the decision is based. This decision will be issued within 60 days of the date the appeal was received unless special circumstances require an extension of time. In no event shall the extension of time go beyond 120 days of the date the appeal was received. The Participant will be given notice within the first 60-day period if an extension of time is necessary. The decision of the Plan Administrator shall be final and binding.

**12.04 Hold Harmless**

A. In any case in which a non-network provider of care attempts to collect charges in excess of the Usual, Customary and Reasonable amount or charges for services or supplies not recognized as Medically Necessary, the Plan Administrator may, with the written consent of the Covered Individual attempt to resolve the matter either by:

1. Negotiating a resolution; or

2. Defending any legal action commenced by the provider of care.

B. Whether negotiating a resolution or defending a legal action, the Covered Individual shall not be responsible for any legal fees, settlements, judgments or other expenses in connection with such action.

C. The Plan Administrator shall have sole control over the conduct of the defense or negotiation including the determination of whether the claim should be settled or an adverse determination should be appealed.

D. The Covered Individual may be liable for any services or supplies rendered by the provider of care which are not covered by the Plan.

E. This provision will not apply to expenses incurred in a calendar year prior to the date the Covered Individual has satisfied the Annual Out-of-Pocket Maximum for such calendar year in accordance with Section 3.17, unless the expenses are for services rendered by a non-network provider when a qualified network provider is not available to provide such services.

ARTICLE XIII

## Eligibility Provisions for Retired Employees

### 13.01 Eligibility

For purposes of Article II, a salaried Employee whose employment terminates on or after January 1, 1970 is eligible for coverage as an Eligible Retiree if:

A. His employment terminates on or after the first day of the month coinciding with or next following the date on which he has both completed ten (10) or more years of service and attained age fifty-five (55) and the Employee elects to begin to receive retirement benefits from the Plan Sponsor's retirement plan within 31 days after employment terminates; or

B. His employment terminates prior to January 1, 1998 by reason of permanent and total disability, provided that on the date that such permanent and total disability is established he has completed ten (10) or more years of service and his permanent and total disability has been established by the Social Security Administration in response to an application by such person for a Social Security Disability benefit. A person described in this subparagraph B shall continue to be so described only so long as his permanent and total disability continues. The Plan Administrator shall have the right to verify the continued existence of such person's permanent and total disability at reasonable times from time to time prior to his sixty-fifth (65) birthday. If such person refuses to provide satisfactory evidence of his continuing right to receive a Social Security Disability Benefit such person shall no longer be entitled to the benefits under this Plan until the withdrawal of such refusal, or;

C. He elected to participate in the special early retirement window program offered by the Employing Company between November 17, 1995 and April 1, 1996.

### 13.02 Definitions

Solely and exclusively for purposes of this Article XIII, the following terms shall have the respective meanings set forth below:

A. "Affiliate" means any corporation, trade or business which, at the time in question, is a member of a controlled group of corporations or a

controlled group of trades or businesses within the meaning of subsection 414(b) or (c), respectively, of the Internal Revenue Code of 1986 as amended, which group also includes the Company, but such other corporation, trade or business shall be treated as an Affiliate only during the period that both it and the Company are members of the same controlled group of organizations, trades or businesses. In addition, the term "Affiliate" includes a corporation, trade or business of which more than fifty percent (50%) is owned directly or indirectly by some or all of the same owners which own more than fifty percent (50%) of the Company, but only if the Board of Directors designates such corporation, trade or business as an Affiliate for purposes of this Plan.

B. "Armco List" means the Amended Salaried Employees list referred to in Section 3.1(b) of the Asset Purchase Agreement between Armco, Inc., Big Mountain Coals, Inc. and Peabody Coal Company dated January 20, 1984.

C. "Board of Directors" means the Board of Directors of Peabody Holding Company, Inc. or any successor by merger, purchase or otherwise.

D. "Break in Service" means a period of 365 (366 in a leap year) consecutive days or more during which the person was not employed by an Employing Company. In the case of either (1) an absence (2) a delay in return from layoff, sick leave, salary continuance or approved leave of absence, which absence or delay begins after December 31, 1984, on account of pregnancy or the birth of a child or a person or the placement of child with such person for adoption or the care of such child immediately following birth or placement for adoption, if such person gives timely notice to the Company of the reason for such absence or delay the term "Break in Service" means a period of 730 (731 in a leap year) consecutive days or more during which the person was not employed by an Employing Company.

E. "Eastern" means Eastern Associated Coal Corp., a West Virginia corporation, including its subsidiaries and affiliates if service with such subsidiary or Affiliate was recognized for benefit accrual purposes under the Eastern Plan.

F. "Eastern Plan" means the Eastern Associated Coal Corp. Retirement Plan.

G. "Employee" means any person in the full-time employ of and compensated on a salary basis by a Participating Company on or after January 1, 1976, except, however, that a salaried Employee who becomes represented by a collective bargaining agent and who is

included in a bargaining unit for which an initial collective bargaining agreement has been entered into with such agent shall cease to be considered an "Employee" for purposes of the Plan unless eligibility for his participation in this Plan is provided for by a current Participation Agreement between a Participating Company and such agent. A person on the Armco List shall be considered to be an Employee during the period that he was a salaried Employee of Armco Inc. (or any other corporation which was a member of the controlled group of corporations of which Armco Inc. was a member) until he became a salaried Employee of Peabody Coal Company. A person previously employed by Eastern but who on July 1, 1988, was neither (1) in the employ of and compensated on a salary basis by Eastern or an Employing Company nor (2) absent from Eastern and receiving disability benefits under a disability income plan maintained by either Peabody Holding Company, Inc. or Eastern shall not be considered an Employee hereunder except as otherwise expressly provided herein. When reference is made to "salary," there is meant compensation on a regular and fixed basis (as distinguished from a bonus, hourly, daily, shift, piecework, tonnage, mileage, or any other unit or similar basis).

H. "Employing Company" means: (a) Peabody Holding Company, Inc.; (b) any Affiliate; (c) any predecessor corporation or business; and, (d) North Antelope Coal Company; and (e) any corporation or business which was merged into or consolidated with or a substantial part of whose assets were acquired by Peabody Holding Company, Inc. or any Participating Company and which is designated as an Employing Company by the Board of Directors. In addition, but only with respect to a person who became an Employee on or before June 30, 1977, Kennecott Copper Corporation and each of its subsidiaries ("Kennecott") shall be treated as an Employing Company until July 1, 1977, on and after which date Kennecott shall not be treated as an Employing Company unless thereafter Kennecott is described in the first sentence of this subsection. Gold Fields Mining Corporation shall not be treated as an Employing Company.

I. "Participation Agreement" means the applicable agreement between the Company and a specified collective bargaining agent approving the Plan for Employees in the bargaining unit represented by such collective bargaining agent.

J. "Permanent and Total Disability" means disability by bodily injury or disease which prevents the Employee from engaging in any occupation or employment whatsoever for remuneration or profit, and which disability, in the opinion of a qualified physician appointed by Peabody Holding Company, Inc., will be permanent and continuous

during the remainder of the Employee's lifetime, and which the Plan Administrator shall determine

1. was not contracted, suffered or incurred while the Employee was engaged in, or did not result from his having engaged in, a criminal enterprise; and

2. did not result from his habitual drunkenness or addiction to narcotics, or self-inflicted injury; and

3. did not result from service in the armed forces and for which the Employee receives a military pension.

K. "Years of Service" means, subject to paragraphs 2. and 3. hereof:

1. Years and full months of service determined as follows:

a. The number of days of regular full-time employment in the service or in the interest of an Employing Company through December 31, 1975, plus

b. The number of days of regular full-time employment in the service or in the interest of an Employing Company after December 31, 1975.

c. The sum of a. and b. will be divided by 365 to determine the number of Years of Service. Any remainder will be divided by 30 to determine the number of full months of service, with a remainder of such division of 15 days or more to be considered as an additional full month of service.

d. In the case of a person who performs the duties of cook, oiler, deckhand or barge maintenance aboard or with respect to a vessel owned or operated by an Employing Company, and who is employed by an Employing Company on June 1, 1979, Years of Service shall include those years and full months of service determined under a. through c. above as though his employment by an Employing Company prior to that date had been as an Employee, but this subparagraph d. shall not apply to any employment credited under a. or b. above without regard to this subparagraph d., and shall not apply to any person who is not employed by an Employing Company on June 1, 1979, even though such person previously was so employed and subsequently is so employed.

e. In the case of a person on the Armco List, Years of Service shall include the period that such person was an Employee of Armco, Inc. (or any other corporation which was a member of the controlled group of corporations of which Armco Inc. was a member) until he became a salaried Employee of Peabody Coal Company, and service rendered during such period shall be treated as having been rendered for an Employing Company.

f. Years of Service shall also include all Years of Service credited to a person under the Eastern Plan as of June 30, 1988, and not otherwise credited under subparagraphs a. through e. above, for a person who becomes employed by an Employing Company and, in the case of a person who had no vested interest in an accrued benefit under the Eastern Plan, such employment by an Employing Company occurs before he has incurred five consecutive Breaks in Service under such Plan.

g. In the case of a person who on July 1, 1988, was absent from Eastern and receiving disability benefits under a disability income plan maintained by either Peabody Holding company, Inc. or Eastern, Years of Service shall also include the period during which the disability continues, provided however that no Years of Service shall be credited under this subparagraph g. for any period after the person attains age sixty-five (65).

2. In applying paragraph 1. above:

a. A person shall not receive any credit for years or completed months of employment prior to January 1, 1976, which are prior to his most recent date of employment or reemployment after a Break in Service which began before that date.

b. A person shall not receive any credit for employment prior to his most recent date of reemployment following a Break in Service which began after December 31, 1975, unless, (1) prior to the commencement of such Break in Service he had ten (10) Years of Service or, (2) his reemployment occurs before his consecutive Breaks in Service exceed the greater of (a) the number of years and months of service which he had prior to the commencement of such Break in Service or, (b) five.

c. For purposes of determining a person's Years of Service, he shall receive credit for (1) all days of employment after December 31, 1975, except for such days as are disregarded pursuant to subparagraph b. above and days during a Break in Service and (2), his employment with Eastern, in the case of a person previously employed by an Employing Company, who before July 1, 1988, had become employed by Eastern but had not at that date incurred sufficient Breaks in Service that his prior service with the Employing Company would be disregarded under b. above.

d. A person shall not earn any Years of Service or fractions thereof for employment which is (1) prior to January 1, 1988, if he was first employed by an Employing Company before that date but after the first day of the month following his sixtieth birthday, or (2) after the date on which he attained age sixty-five and before January 1, 1988.

3. In applying paragraphs 1. and 2. above, employment shall include periods of absence by reason of:

a. Retirement on account of Permanent and Total Disability in the case of an Employee who is reemployed.

b. Termination of employment of a person who became or becomes employed by an Employing Company within twelve (12) months of such termination.

c. Termination of employment of a person who, subsequent to May 1, 1940, entered or shall enter the active Armed Forces of the United States (which shall, for the purposes of the Plan, include the Coast Guard and Merchant Marine Services) and who has reemployment rights under applicable laws and complies with the requirements of the law as to reemployment and is reemployed;

d. Layoff, sick leave, conditions entitling salary continuance, except that an Employee shall not receive credit for the portion of any absence for any such cause as is in excess of six (6) months unless both (1) his Employing Company, under rules of general application, deems such absence to be in its interest or in the interest of another Employing Company and (2) the Employee returns to active employment with an Employing Company as soon as permitted by the Employing Company within the terms of his layoff, sick leave, salary continuance or leave of absence.

Credit for an absence due to long term disability shall be provided for up to twenty-four (24) months following the end of salary continuance if the Employee returns to employment at or before the end of such twenty-four (24) months period.

**13.03 Termination of Coverage**

Except as provided in Section 2.11, coverage of an Eligible Retiree and any of his Eligible Dependents covered under this Plan will terminate as of midnight on the earliest of the following dates:

A. The Eligible Retiree's date of death, except as provided in Section 2.09.

B. The date on which the Eligible Retiree fails to authorize the withholding of, or to timely make, any required contributions associated with such coverage. Contributions will be considered "timely" if received by the Plan Administrator by the time provided for in Article IX.

C. With respect to any particular type of benefit, the date such benefit is no longer available in accordance with Article III, or the date such benefit is specifically made unavailable with respect to Eligible Retirees and/or their Eligible Dependents, if earlier, even if such benefit is still available to other Eligible Employees and/or their Eligible Dependents.

D. With respect to an Eligible Dependent, the date coverage would otherwise terminate in accordance with the terms of Section 2.08.D.

E. The date on which the Plan is terminated by the Plan Sponsor.

Executed this 8th day of July, 1998, at St. Louis, Missouri

**PEABODY HOLDING COMPANY, INC.**

By: _____

ARTICLE XIV

## Cafeteria Plan Provisions

### 14.01 Purpose and Intent

The purpose of this Article XIV is to provide eligible employees a choice between certain taxable and nontaxable benefits offered under the Peabody Group Health and Life Plan for Salaried Employees and other plans maintained by the Plan Sponsor. The Plan is intended to qualify as a cafeteria plan under Section 125 of the Internal Revenue Code of 1986 and is to be interpreted in a manner consistent with the requirements of that section as it may be amended from time to time.

### 14.02 Definitions

As used herein, the following words and phrases will have the meanings as indicated below unless a different meaning is plainly required by the context.

A. "Benefit Option" means a benefit offered under the Peabody Group Health and Life Plan for Salaried Employees or any other benefits as may be offered by the Plan Sponsor from time to time, provided that such benefit shall be a benefit permitted to be available under a cafeteria plan as defined in Section 125 of the Code.

B. "Component Plan" means a welfare benefit plan maintained by the Employer. Such plans are administered in accordance with the provisions of Articles I through XII of the Peabody Group Health and Life Plan for Salaried Employees or other documents, as applicable.

C. "Election Change" means the revocation of a Participant's election and the making of a new election for the remaining portion of the Plan Year.

D. "Election Form" means the enrollment form or other enrollment process authorized by the Plan Administrator by which a Participant makes his benefits election and by which the Participant may authorize the Participating Employer to reduce his Compensation in order to obtain certain benefits.

E. "Election Period" means the period designated by the Plan Administrator immediately preceding the beginning of each Plan Year during which the Participant must complete his Election Form.

F. "Elective Employer Contributions" means those contributions as described in Section 14.04 of the Plan.

G. "Health Plan" means any of the health plans providing medical, dental and/or vision care, including any HMO plan, that is offered by the Plan Sponsor.

H. "Plan", for purposes of this Article XIV, means the program described in this Article that provides eligible employees the opportunity to choose among taxable and nontaxable Benefit Options.

**14.03 Participation**

A. An Eligible Employee will become a Participant in this Plan on the date he becomes eligible to participate in a Component Plan.

B. A Participant shall cease to be a Participant on the occurrence of earliest of the following events:

1. The date this Plan terminates.

2. The date the individual ceases to be an Eligible Employee,

3. The date with respect to which the Participant ceases to be covered under any Component Plan, if cessation of coverage is due to the Participant's failure to make any required contribution while on an approved leave of absence protected by the Family and Medical Leave Act of 1993, or

4. The date the Plan is discontinued by the Participating Employer then employing the Participant.

C. Coverage under any Benefit Option elected under this Plan shall terminate at the earlier of:

1. The date so specified in the plan document of the Component Plan.

2. The end of each Plan Year. Coverage for subsequent Plan Years can only be obtained in accordance with the election procedures set forth in Section 14.08.

**14.04 Elective Employer Contributions**

A. A Participant may elect to reduce his Compensation for a Plan Year and to use such amounts to purchase one or more Benefit Options. The monetary amount associated with this election constitutes Elective Employer Contributions. Such salary reduction shall be authorized by the Participant on the Election Form.

B. The amount of the reduction in the Participant's Compensation for the Plan Year for coverage under any Benefit Option selected shall equal the Participant's share of the cost of such coverage. If the cost of coverage provided by an independent third party provider increases or decreases during the Plan Year, a corresponding change shall be made in the amount by which a Participant's Compensation is reduced, unless the Plan Administrator exercises its authority under Section 14.11 D. The amount of such change shall be determined by the Plan Administrator.

C. A Participant's election of Elective Employer Contributions under this Plan may be revoked or reduced at any time prior to or during a Plan Year, to the extent necessary to prevent this Plan from being considered discriminatory under Sections 125(b) and 105(h)(2) of the Code.

1. In the case that such reduction affects health benefits, only the elections of Participants who are highly compensated as defined in either Section 105(h) or Section 125(e) of the Code may be reduced.

2. In the case that such reduction affects other qualified benefits, only the elections of Participants who are highly compensated as defined in Section 125(e) of the Code or are otherwise Key Employees as defined in Section 125(b) of the Code may be reduced.

D. If a new employee becomes a Participant after a Plan Year has commenced, the maximum amount of Elective Employer Contributions made available to such Participant for the balance of the Plan Year shall be prorated on the basis of the number of pay periods remaining in such Plan Year.

E. The maximum amount of Elective Employer Contributions for each Plan Year is the sum of the cost of the most expensive of the Benefit Options.

**14.05 Pay Reduction and Payroll Withholding**

A Participant's Compensation for a Plan Year shall be reduced by the amount of the Elective Employer Contributions that the Participant elects for the Plan Year under Section 14.04. Such contributions shall be made only by payroll reduction and shall be authorized by the Participant on the Election Form.

**14.06 Contributions by Participants on Approved Leaves of Absence**

A Participant who is on an approved leave of absence and who is otherwise eligible to continue to receive benefits under this Plan while on such leave shall make contributions required to purchase benefits under the Plan as provided below:

A. A Participant who is on paid leave shall have his Compensation reduced in the same manner and in the same amount as if he was not on such leave.

B. A Participant who is on unpaid leave, other than a leave of absence protected by the Family and Medical Leave Act of 1993, shall:

1. Make direct premium payments to the Plan each pay period. Such payments shall be in the amount determined in accordance with the Employer's leave of absence policy.

2. Make contributions to the Plan in such other manner as may be agreed to by the Plan Administrator and the Participant.

C. A Participant who is on an unpaid leave of absence protected by the FMLA may continue his or her coverage under the Plan by making direct contributions to the Plan on the same schedule as contributions would be made if the Participant was not on leave or under any other payment schedule permitted by the Labor Regulations at 29 CFR §825.210(c), as agreed to by the Participant and the Employer. Such contributions may be made on a pre-tax basis to the extent that the contributions are made from taxable compensation that is due the Participant during the leave period.

The Plan Administrator, at its discretion, may also permit a Participant to continue his or her coverage as follows:

1. To pre-pay, prior to the commencement of the FMLA leave period, the amounts due for such leave period. Such contributions may be made on an after-tax basis or may be made pre-tax salary reduction basis from any taxable compensation

received by the Participant that is due the Participant during the FMLA leave period; provided that in the event the period of FMLA leave spans two Plan Years, pre-payment on a salary reduction basis may not be made for the period of FMLA that falls in the subsequent Plan Year, or

2. To make contributions to the Plan under any other method permissible under the Family and Medical Leave Act of 1993.

The Plan Administrator shall provide the Participant with advance written notice of the terms and conditions under which payments are to be made while the Participant is on approved leave.

**14.07 Benefit Options**

Subject to all other provisions of this Plan, a Participant may choose among the following taxable and nontaxable benefits:

A. *Taxable Benefits*. The Participant may elect varying amounts of one the following Benefit Option:

(1) Cash

B. *Nontaxable Benefits*. The Participant may elect one or more of the following Benefit Options:

(1) Medical Benefit Option (varying coverage options)
(2) Dental Benefit Option (varying coverage options)
(3) Vision Benefit Option (varying coverage options)

The Plan Administrator shall determine and set the cost associated with each Benefit Option offered under this Plan. Such cost can be changed at any time at the beginning of, or during, a Plan Year without prior notification to Participants or any Participating Employer.

**14.08 Election Procedures**

A. Prior to the commencement of each Plan Year, the Plan Administrator shall provide an Election Form to each Participant and to each other employee who is eligible to become a Participant at the beginning of the Plan Year. Each Participant shall specify on the Election Form the Benefit Options described in Section 14.07 that are desired for the forthcoming Plan Year and shall also agree to a reduction in his Compensation, if applicable, as provided in Section 14.04. The elections made pursuant to the Election Forms shall be effective as of the first day of the Plan Year. Each Election Form must be completed

and returned to the Plan Administrator on or before such date as the Plan Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's Plan Year's elections will apply.

B. In the event a new Benefit Option becomes available during the Plan Year, each Participant may elect coverage under such Benefit Option for the remainder of the Plan Year. Such Participant shall also agree to an additional reduction in his Compensation, as provided in Section 14.04; provided, however, that in no event may a Participant change his election with respect to any other Benefit Option elected for such Plan Year, except as provided in Section 14.11.

C. If an employee first becomes eligible to be a Participant under this Plan at some time other than at the beginning of a Plan Year, the Plan Administrator will provide such employee with an Election Form. Such employee shall elect one or more of the Benefits Options described in Section 14.07 and so specify on the Election Form. Such Employee shall also agree to a reduction in his Compensation, if applicable, as provided in Section 14.04. The Election Form must be completed and returned to the Plan Administrator on or before such date as the Plan Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's Plan Year's elections will apply.

**14.09 Failure to Make Election**

A. An Employee who fails to return a completed Election Form to the Plan Administrator on or before the specified due date for the Plan Year when initially eligible to participate shall be deemed to have elected to receive his full Compensation in cash and to have elected no nontaxable Benefit Option.

B. A Participant who fails to return an Election Form for any subsequent Plan Year shall be deemed to have: (1) elected to continue whatever Benefit Options he had selected on the Election Form most recently filed with the Plan Administrator; and (2) agreed to have his Compensation reduced by whatever amount is then necessary to purchase such Benefit Options as provided in accordance with Section 14.04 of the Plan. A Participant who had elected HMO coverage on his most recent 1997 Election Form shall be deemed to have elected coverage under the Dental Benefit Option for the 1998 Plan Year for himself and for any dependents who had HMO coverage on the basis of such Election Form.

**14.10 Duration of Elections**

Except as provided in Section 14.11, a Participant's election is irrevocable and shall remain in effect through the last day of the Plan Year, subject further to the conditions set forth in the plan document of the respective Component Plan.

**14.11 Changes in Employee Elections**

A. A Participant may make an Election Change with respect to medical coverage that corresponds with the special enrollment rights provided in Section 9801(f) of the Code, provided the Participant enrolls himself or herself and/or his or her spouse and dependents under a Medical Benefit Option within 31 days of the occurrence of the event giving rise to such special enrollment rights.

B. A Participant may make an Election Change with respect to his or her Health Plan Benefit Option coverage only if such Election Change is on account of and consistent with a Change in Status, is permitted under the terms of the plan documents of the respective Component Plan, and is made within 31 days of the date the Participant experiences the Change in Status for which the Election Change is permitted.

1. A Participant's Election Change with respect to health coverage is consistent with a Change in Status only if as a result of the Change in Status, the Participant and/or the Participant's spouse or dependent: (a) becomes eligible for or loses eligibility for coverage under the cafeteria plan or health plan maintained by the Plan Sponsor or the spouse's or dependent's employer or (b) becomes eligible for or ineligible for coverage under a particular benefit package option under such plan. An Election Change with respect to an individual who becomes eligible for coverage under another plan or benefit package option will be deemed consistent with a Change in Status only if the individual actually enrolls for such coverage.

2. A Participant who revoked his Health Plan Benefit Option or Life Insurance Benefit Option elections upon termination of employment may make new elections with respect to these benefits upon subsequent reemployment during the Plan Year, provided the prior termination of employment was not solely for the purpose of permitting a Participant to make an Election Change. A former Participant who resumes employment within 30 days of the date employment terminated without an intervening event that would otherwise permit an Election

Change under this Section 14.11 shall only be permitted to reinstate the elections in effect as of the date employment terminated.

3. At the Plan Administrator's option, a Participant may elect to increase contributions under the Plan in order to pay for COBRA continuation coverage or state continuation coverage provided under a Health Plan maintained by the Participating Employer when such coverage is elected by the Participant and/or the Participant's spouse or dependents. To be effective, the election to increase contributions must be made within the period of time provided by COBRA or state law, as applicable, for electing continuation coverage.

4. In the event a judgment, decree, or order ("Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in section 609 of ERISA) requires health coverage for a Participant's child, the Plan may:

   a. Change the Participant's election to provide coverage for the child if the Order requires coverage under the plan maintained by the Plan Sponsor, or

   b. Permit the Participant to make an Election Change to cancel coverage for the child if the Order requires the former spouse to provide coverage. To be effective, an Election Change must be made within 31 days of the date the Order is issued to the Participant.

5. If a Participant or the Participant's spouse or dependent covered under a Health Benefit Plan Option enrolls for coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), the Participant may make an Election Change to cancel health coverage with respect to that individual. To be effective, an Election Change must be made within 31 days of the date the individual enrolls for Medicare or Medicaid as described above.

6. A Participant who goes on FMLA Leave may revoke his election under the Health Plan Benefit Option at the onset of such leave, or at any time during such leave. Upon return from FMLA Leave, the Participant may choose to reinstate his or her prior election. A Participant may change his or her election under the Health Plan Benefit Option upon return from FMLA Leave only in accordance with the terms of subsection B. 1. above.

C. In the case of coverage which is provided by an independent third-party provider, if:

1. The Participant's share of the cost of such coverage significantly increases as a result of a significant cost increase by the independent third-party provider, or

2. Such coverage ceases or is significantly curtailed,

the Plan Administrator, in its sole discretion, may permit all Participants electing such coverage for the Plan Year to revoke their elections for the balance of the Plan Year and to receive on a prospective basis, coverage under another Health Plan Benefit Option with similar coverage in lieu thereof.

D. A Participant who experiences a change in employment status may make an Election Change with respect to his benefit elections if: (1) the change in employment status results in an increase or decrease in the Participant Contributions required for such coverage, (2) such change is allowed under the terms of the plan documents of the respective Component Plan and (3) the Election Change is made within 31 days of the date the Participant experiences the change in employment for which the new election is permitted.

**14.12 Effective Date of Election Changes**

Changes in contributions and benefits attributable to an Election Change described in Section 14.11 above shall be effective as of the date the change is effective under the respective Component Plan.

**14.13 No Guarantee of Tax Consequences**

Notwithstanding anything herein to the contrary, the Plan Sponsor neither insures nor makes any commitment or guarantee that any amounts paid to a Participant pursuant to the Plan or any amounts by which a Participant's wages are reduced pursuant to this Article III will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to notify the Plan Administrator if the Participant has reason to believe that any payment made or to be made to the Participant pursuant to the Plan is not excludable from the Participant's gross income for federal, state or local income tax purposes.

# AMENDMENT NUMBER 1
# TO THE
# PEABODY GROUP HEALTH AND LIFE PLAN FOR SALARIED EMPLOYEES

WHEREAS, Peabody Holding Company, Inc., (the "Company") has heretofore established an Employee Welfare Benefit Plan (the "Plan") providing medical and life benefits for employees of Peabody Holding Company and eligible dependents of such employees and has maintained such Plan pursuant to the terms and conditions of the plan document which was amended and restated effective January 1, 1997; and

WHEREAS, the Company now desires to amend the Plan to clarify certain continuation of coverage provisions and to revise the prescription drug benefits of the Plan;

WHEREAS, the Company has the authority to amend the Plan pursuant to Article X;

NOW, THEREFORE, be it resolved that effective January 1, 1999, the Plan be amended as follows:

1. The last paragraph of Section 2.11 E. is replaced with the following:

   To the extent permitted by law, the Plan may charge a Qualified Beneficiary:

   1. 150% of the otherwise applicable cost of coverage for each of the 19th through 29th months of COBRA Continuation Coverage; and

   2. 150% of the otherwise applicable cost of coverage for each of the 30th through 36th months of coverage if such Qualified Beneficiary becomes entitled to an extension of COBRA Continuation Coverage as a result of a second Qualifying Event that occurs during the period of disability extension,

   but only if:

   1. the disabled Qualified Beneficiary is covered during the extension period, and

   2. the coverage would not have been required to have been provided in the absence of a disability extension.

2. Section 3.01 D. 10. is replaced with the following:

10. Prescription Drugs
(Benefits limited in accordance with Section 3.14)

a. Participating Provider Retail Pharmacy (per 30-day supply)

| | |
|---|---|
| Brand name | Lower of 100% less $10 copayment or 85% |
| Generic | Lower of 100% less $5 copayment or 90% |

b. Nonparticipating Retail Pharmacy (per 30-day supply)

| | |
|---|---|
| Brand name | Lower of 100% less $10 copayment or 80% |
| Generic | Lower of 100% less $5 copayment or 80% |

c. Mail-Order Program (per 90-day supply)
(Effective 1/1/98)

| | |
|---|---|
| Brand name | 100% after $15 copayment |
| Generic | 100% after $3 copayment |

3. Section 3.14 A. 2. is revised to add the following subsection j.:

j. Retail prescription drugs in excess of a 30-day supply per prescription or refill.

4. Section 3.14 B. is replaced with the following:

1. With respect to charges made by a Participating Provider retail pharmacy, Covered Expenses are payable in an amount equal to the Covered Portion designated in Section 3.01.D.10.a. Provided, however, no benefits shall be paid by this Plan in the event that the cost of a covered prescription drug is less than the copayment amount specified in Section 3.01.D.10.a.

2. With respect to charges made by any other retail pharmacy, Covered Expenses are payable in an amount equal to the Covered Portion designated in Section 3.10.D.10.b. Provided, however, no benefits shall be paid by this Plan in the event that the cost of a covered prescription drug is less than the copayment amount specified in Section 3.01.D.10.b.

3. With respect to charges made by the Participating Provider mail-order pharmacy, Covered Expenses are payable in an amount equal to the Covered Portion designated in Section 3.01.D.10.c.

IN WITNESS WHEREOF, the Company has caused this Plan to be amended in its name and behalf effective January 1, 1999, by its Officer thereunto duly authorized.

ATTEST

PEABODY HOLDING COMPANY, INC.

_____

By _____