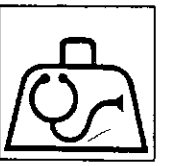
EACC Active Plan . Surv. Sp. 04
. EACC LTD



# THE EACC
# HEALTH CARE PLAN

This plan reimburses you and your family for a large part of your medical expenses. The plan consists of two parts. *Basic Medical Benefits* cover most of your expenses for hospitalization, surgery, maternity and other charges necessary for your care and treatment. *Major Medical Benefits* cover medical expenses above and beyond those provided by the Basic portion of the plan.

## TABLE OF CONTENTS

## ELIGIBILITY

**Employees**

As a full-time active salaried employee, you are eligible for coverage on your date of hire. (If you are not actively at work on the date you would otherwise become eligible, you will be eligible on the date you return to active work.) Coverage also continues under this plan for employees eligible to receive payments from a company-sponsored long-term disability plan.

**Dependents**

Your eligible dependents will become covered at the same time you are. However, if an eligible dependent is hospitalized on the day coverage would normally begin, coverage for that person will begin on the day following the date of discharge. This provision does not apply to a newborn child. Your eligible dependents include:

(1) Your spouse.

(2) Your unmarried children from birth to age 19 (age 23, if a full-time student). "Children" also includes stepchildren, foster children and any other children living with you in a parent-child relationship and dependent on you for support.

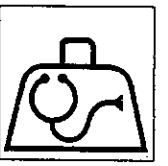
(3) An unmarried dependent child who becomes physically or mentally incapable of earning a living prior to age 19. Coverage will continue for as long as the condition exists, provided you furnish proof of the dependent's condition within 31 days after the dependent reaches the limiting age.

(4) The unmarried spouse and eligible children of a deceased employee whose death occurred on or after December 1, 1969.

## ENROLLMENT

In order to enroll in the Health Care Plan, you must sign an enrollment card for you and your dependents with your Personnel Representative.

If you acquire a dependent after your initial eligibility or if a dependent becomes ineligible, notify the Personnel Office or your Personnel Representative.



## DEFINITIONS

In order to understand how the plan works, the following definitions will be helpful to you:

**Convalescent Facility** — Lawfully operating institution primarily engaged in providing skilled nursing care to patients recovering from injury or illness and which is under the supervision of a physician or registered graduate nurse. This does not include nursing and rest homes.

**Deductible Amount** — The amount which you are required to pay under certain provisions of this plan before the Company begins to share expenses with you.

**Hospital** — An institution legally operating as a hospital that provides medical care and treatment on an inpatient basis at the patient's expense, and which is under the supervision of a staff of physicians, and also provides 24-hour-a-day nursing services by registered graduate nurses. "Hospital" does not include convalescent facilities, nursing or rest homes, or institutions primarily engaged in schooling of its patients.

**Illness** — Sickness or disease which require treatment by a physician, including pregnancy and related conditions, alcoholism, drug abuse, and mental infirmity.

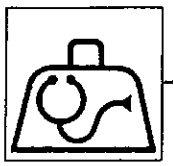
**Injury** — Only bodily injury which requires treatment by a physician.

**Intensive Care Accommodation** — Reserved for critically and seriously ill patients requiring constant observation as prescribed by attending physician, and includes room and board, nursing care, equipment and supplies.

**Optometrist** — Person who is legally licensed to practice Optometry.

**Physician** — Legally qualified physician or surgeon, or a legally qualified dentist.

**Reasonable and Customary Charges** — The maximum benefit payable as determined by the Provident, by considering the usual fee charged by the individual physician and the range of fees usually charged for the same service by physicians in the same area.



## SERVICES NOT COVERED

In addition to the specific exclusions otherwise contained in the Plan, benefits are not provided for the following under any provisions of this plan:

(1) Charges incurred due to occupational injuries or illnesses or any charges covered by Worker's Compensation.

(2) Charges which are subject to reduction in accordance with the provision headed "Coordination of Benefits" described on page 11.

(3) Charges for coverage which could have been obtained upon appropriate application or enrollment under Medicare.

(4) Any amounts exceeding reasonable and customary charges. Reasonable and customary fees are determined by looking at the usual fee charged in the area.

(5) Services and supplies received in a hospital owned or operated by the U.S. Government.

(6) Services or supplies for which no charge is made.

(7) Charges incurred while the coverage under this plan is not in effect.

(8) Acupuncture therapy.

(9) Cosmetic surgery, except operations necessary to repair disfigurement from an accident occurring while this insurance is in force, or except for treatment of a birth defect in a child born while the parents are covered under this plan.

(10) Treatment of injury or illness which is occasioned by war, declared or undeclared.

(11) Telephone conversation with a physician in lieu of an office visit.

(12) Charges for writing a prescription, or for medications dispensed from a physician's office.

(13) Charges for medical summaries and medical invoice preparations.

(14) Purchase of hearing aids.

(15) Services provided by a relative.

(16) Custodial care.

## BASIC MEDICAL BENEFITS

**Hospital Expense Benefits**

The following benefits are provided for hospital charges incurred during a period of confinement due to illness or injury:

(a) *Room and Board:* Covered in full, not to exceed the hospital's average semi-private room charge.

(b) *Intensive Care:* Covered in full, provided the period of confinement is for at least 24 hours.

(c) *Private Room:* Benefits are payable equal to the hospital's average semi-private room charge or payment in full if deemed medically necessary by the attending physician.

(d) *Miscellaneous Hospital Services:* Covered in full, not to exceed reasonable and customary charges. Under this provision, payment will be made for the following:

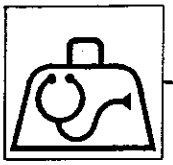
(1) services and supplies required for treatment.

(2) charges for radiology or laboratory services.

(3) charges for ambulance service to and from the nearest hospital or medical facility where care and treatment of the injury or illness can be given.

(e) *Emergency Care/Outpatient Surgery:* Benefits are provided in full for treatment of accidental bodily injuries which are treated within 7 calendar days of an accident, or for outpatient surgery.

(f) *Maximum Benefit:* Hospital Benefits are payable up to 365 days during any one period of confinement. After hospitalization, an employee must return to work for one full day to qualify for a new 365 day maximum benefit or subsequent hospitalization must be due to entirely different and unrelated causes. A dependent's periods of confinement must be separated by at least 3 months to qualify for a new maximum benefit, or subsequent hospitalization must be due to entirely different and unrelated causes.



**Physician's and Surgeon's Fees in the Hospital**

The following benefits are covered in full, up to the reasonable and customary charges:

(a) *Surgical Expenses,* including surgeon's fees for the actual surgical procedure and follow-up surgical care, for either inpatient or outpatient surgery.

(b) *Assistant Surgeons,* if required.

(c) *Physician's Visits,* while you are in the hospital.

(d) *Physician's Consultation,* by a physician certified as a specialist in the medical field, for no more than one consultation during any one period of hospital confinement.

(e) *Anesthetic Expenses:* Benefits will be payable in full for services by a physician or professional anesthetist, other than a salaried employee of the hospital, for administering an anesthetic in connection with a surgical operation or any procedure for which a surgical expense benefit is payable under the plan.

**Other Covered Charges**

(a) *Laboratory and X-Rays*
100% of reasonable and customary charges are provided for:

Diagnostic Laboratory and X-Ray Exams, when performed in a doctor's office, a lab, or on an outpatient basis in a hospital.

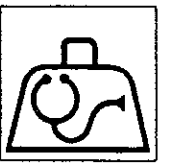
X-Ray and Radiation Therapy, for treatment of a proven malignancy or a non-malignant condition.

(b) *Maternity Benefits* (for dependent wives and female employees)
Maternity benefits are payable for expenses incurred due to pregnancy, childbirth, or miscarriage. Benefits for maternity are identical to those for other illnesses and injuries.

In addition, payment will be made in full for usual and customary nursery care of a newborn child, not to exceed the daily rate charged by the hospital. Benefits are provided for newborn babies, including routine medical care and immunizations to age 6 months.

The physician's fees, including obstetrical procedures and pre-natal and post-natal care up to 6 months after delivery are covered in full. Benefits will also be provided for services performed by a midwife certified by the American College of Midwifery and licensed where such licensure is required.

Benefits are also provided for termination of pregnancy if the procedure is medically necessary, and when certified to and performed by a licensed gynecologist or surgeon.



(c) *Emergency Accident and Emergency Illness*
Benefits are payable in excess of those covered under any other provisions of the plan. The maximum benefit is $100 in connection with any one accident or illness and $500 during any calendar year. The expenses must be incurred within 7 calendar days after accident or illness.

(d) *Annual Routine Physical Exam* (employees only)
Benefits are available for one exam per calendar year, for the reasonable and customary fee, not to exceed $50 for the physician's fee. Diagnostic tests are covered in full.

(e) *Physician's Visits*
Payable for attendance at home or in physician's office for the treatment of injury or illness. The plan pays the cost of the visit less a deductible of $5 per visit up to a maximum deductible of $50 per calendar year per family. Benefits are not payable for innoculation or immunizations for prevention of disease.

(f) *Prescription Drugs*
The plan pays 80% of covered drug expenses. Covered drugs include all drugs which require a prescription and insulin, when prescribed by a physician.

Benefits will not be payable under the plan for:

- more than a 30-day supply on any one prescription.
- contraceptives.
- any refill in excess of the number specified by the physician or any refill dispensed more than one year after the date of the original prescription.
- drugs received from an institution owned or operated by the U.S. Government.
- drugs for which no charge is made.

## MAJOR MEDICAL BENEFITS

Major Medical Benefits provide coverage for medical expenses in excess of your Basic Medical Benefits, and many items not covered elsewhere. Covered expenses include hospital, surgical and medical expenses.

**Benefit Payments**

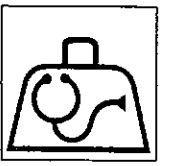
You pay the first $100 (the "deductible"). After the deductible is paid, the plan pays 80% of the remaining covered charges. There is a separate deductible for each covered member, to be met once during each calendar year. However, if two or more members of your family meet their deductible during a calendar year, the remaining members of your family are not subject to the deductible amount.

Also, covered expenses which are incurred in the last three months of a calendar year which apply towards satisfying your deductible, may be carried over into the new year and applied to that year's deductible.

However, if the amount which you pay "out-of-pocket" (not payable by the plan because of the deductible or 80% provision) is in excess of $500 with respect to one covered family member or $1,000 with respect to two or more covered family members during a calendar year, benefits payable by the plan in excess of such amounts will be at the rate of 100%. This means that all Major Medical charges exceeding $2,100 per individual are covered in full.

**Covered Charges**

- Hospital Care, including room and board at the average semi-private room rate, intensive care, and other hospital services and supplies.
- Convalescent Facility Care, if required following a hospital confinement for at least five days, including room and board and general nursing care at the average semi-private room rate, payable up to 100 days per year.
- Physician's fees for medical and surgical operations.
- Nursing Service, provided by a registered graduate nurse or a practical nurse who is either licensed or registered with an organization approved by the medical profession.
- Artificial limbs or eyes, casts, splints, trusses, braces, crutches.
- Rental of durable equipment for medical or surgical treatment such as wheelchair, iron lungs, etc.
- Anesthetics and their administration.
- Diagnostic laboratory services.
- Services of a physiotherapist or lab technician.



- Use of x-ray, radium and other radioactive substances.
- Oxygen and rental of equipment for administration of oxygen.
- Commercial transportation within the U.S. and Canada, if medically necessary, to an out-of-area hospital or medical facility providing required special treatment.
- Professional psychiatric service.
  On an inpatient basis, charges for treatment and convulsive therapy are covered on the same basis as charges for other illness or injury.
  On an outpatient basis, charges are covered up to 50% of the total.

**Charges Not Covered**

- Medical exams not necessary for the treatment of injury or illness.
- Eye refractions, eyeglasses, fitting of eyeglasses.
- Dental care, except tumors and treatment of accidental injury to natural teeth.
- Charges incurred outside U.S. or Canada unless you are a resident of U.S. or Canada and the charges are incurred while traveling.

## VISION CARE

The vision care program pays benefits for services and supplies necessary for treatment of visual defect, injury or disease provided that an optometrist or physician certifies that they are necessary.

**Benefit Payments**

You and your dependents pay the first $10 (the "deductible"). A separate deductible must be met for each covered person once in a calendar year.

After you have paid the deductible, the company pays 80% of the remaining covered charges up to an annual maximum of $75, based on reasonable and customary charges. There is a new $75 maximum for each covered person each year.

**Covered Charges**

- One complete visual analysis during a calendar year.
- Lenses.
- One set of frames during any consecutive two year period.
- Verification and fitting.
- Opthalmic materials necessary for fitting of and subsequent evaluation of eyeglasses.

**Charges not Covered**

- Sunglasses or fitting of sunglasses except prescription sunglasses.
- Surgical or medical care of eye disease or injury.
- Extra charges for photosensitive or anti-reflective lenses.
- Drugs or medications (other than for vision exam).
- Artificial eyes.
- Reading rate and comprehension studies.
- Experimental services or supplies.
- Special procedures, such as orthoptics, vision training, subnormal vision aids, aniselkonic lenses and tonography.

## DENTAL CARE

Benefits are provided under the plan based on reasonable and customary charges, for services certified by the attending physician or dentist to be necessary for the care and treatment of the teeth and gums.

**Benefit Payments**

You and your dependent pay the first $25 (the "deductible"). A separate deductible must be met for each covered person once in a calendar year.

After you have paid the deductible, the company pays 80% of the remaining covered charges up to the maximum annual benefit. Also, covered expenses which are incurred in the last three months of a calendar year, which apply towards satisfying your deductible, may be carried into the new year and applied to that year's deductible.

**Maximum Benefit**

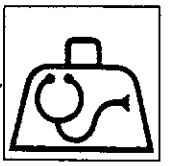
The maximum amount is $800 for orthodontic work during a period of orthodontic treatment and $500 for all other care or treatment during each calendar year. The maximum amount is applied separately to each covered person. A period of orthodontic expense is incurred, and continues for the length of time required by the physician to complete treatment. A period of treatment includes charges for treatment rendered within five years after the end of a previous period of treatment.

**Enrollment**

You are automatically eligible for dental care coverage. However, you must fill out an enrollment card with your Personnel Representative.

Also, dependent coverage is NOT provided automatically upon your enrollment. You must fill out a separate enrollment card for your dependents.

Coverage for dependents is effective immediately if your dependent is enrolled within 31 days of becoming eligible. Otherwise a three month waiting period for benefits will apply.



**Covered Charges**

- Examinations, x-rays, teeth cleaning, emergency treatment of dental pain and equilibration, not including restoration.
- Sodium fluoride treatments.
- Treatment of disease of gums and tissues.
- Tooth extraction, alveolectomies, and post-operative care.
- Root canal.
- Fillings, inlays, and crowns.
- Full and partial dentures and bridge-work, including their replacement and restoration, but not more than one replacement every three years.
- General anesthetics.
- Orthodontic treatments.

**Charges not Covered**

- Oral surgery, except as specified under covered expenses.
- Charges incurred outside the U.S. and Canada unless you or a dependent incurs charges while traveling abroad.
- Services or supplies supplied free of charge.
- Full or partial dentures or bridge-work made to replace teeth extracted before coverage under this plan began. This limitation is dropped after three consecutive years of coverage by the employee or dependent.

## COORDINATION OF BENEFITS

Health Care benefits are designed to help you meet actual medical expenses. If you or your family are eligible for benefits under another plan, benefits from your Health Care Plan will be coordinated with those benefits, so that up to 100% of "allowable expenses" incurred will be paid jointly by all the plans.

Allowable expenses include any necessary, reasonable and customary charges covered at least in part by one of the plans of which you are a member. For dental expenses, allowable expense will include only expenses covered under this plan.

Plan means any of the following:

- Group, blanket or franchise insurance coverage.

- Governmental programs, including Medicare, and any coverage required or provided by any statute.

- Labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans.

- Prepayment plans or group practice coverage, except that for which payment is made directly by the person covered to the organization providing coverage.

The Administrator has the following rights:

- To release to or obtain from any other organization or person any information which is thought to be necessary to administer this provision.

- To pay over to any organization any amounts that it shall determine to be warranted in order to satisfy the intent of this provision. Any amount so paid will discharge liability under the plan to the extent of the payment.

- To recover amounts it has paid in excess of the maximum necessary at any time to satisfy the intent of this provision.

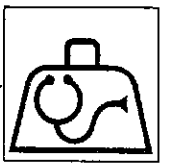
## TERMINATION OF COVERAGE

1. Your Health Care Coverage will terminate on the earliest of the following dates, except as provided in the following section on extended benefits:

(a) The date the plan is terminated.
(b) The date the plan is amended to terminate the coverage of a class of employees of which you are a member.
(c) The date you are no longer a member of an eligible class of employees.
(d) The date your active employment with the Company is terminated.
(e) The date you are pensioned or retired, except that dental coverage for retirees is continued to age 65. For information about Health Care Benefits for retirees, contact your Personnel Representative.
(f) For employees on layoff, benefits terminate on the date you become eligible to participate in another group plan, or 3 months following the end of the month in which the layoff occurs, whichever is earlier.

2. Your coverage with respect to dependents will terminate on the earliest of the following dates:

(a) The date your coverage is terminated for any reason.
(b) The date a dependent ceases to be eligible in accordance with the provision in the "Eligibility" section.



(c) Any coverage being continued with respect to the spouse and unmarried children of a deceased employee will terminate on the date the spouse of the deceased employee remarries, attains age 65, or becomes eligible for coverage as an employee under this or any other group plan.

NOT MCelig / as result of d-sal

## EXTENDED BENEFITS AFTER TERMINATION

If you or a dependent are hospitalized at the time your coverage terminates, hospital benefits will continue to apply to that period of hospital confinement.

If you are totally disabled by injury or illness at the time your coverage terminates, your hospital, surgical, laboratory, x-ray examination and x-ray and radiation therapy benefits will be extended during continuation of total disability to cover expenses incurred within three months after termination of coverage.

If you or a dependent are totally disabled by injury or illness at the time your coverage terminates, major medical benefits will be extended for continued treatment of that injury or illness during the continuation of total disability up to 12 months after termination.

For further information, contact your Personnel Representative.

## CONVERSION TO INDIVIDUAL POLICY

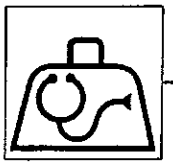
If you leave the company or you are no longer a member of a class of employees covered under this plan, you may apply for an individual hospital and surgical expense insurance policy with the Provident.

Application for the individual policy must be made within 31 days after termination of group coverage. No medical examination will be required.

If you have dependent coverage at the time of termination of group benefits, the individual policy may include certain members of the family.

Conversion to an individual plan shall also be available (i) upon your death, to your surviving spouse with respect to your spouse and eligible dependents or to a child solely for himself because of marriage or attainment of limiting age or (ii) upon the divorce or annulment of your marriage, to your divorced spouse or former spouse.

In no event will an individual plan be issued to cover any person who, at the time of termination of coverage, is eligible for Medicare.



## CLAIMS PROCEDURE

(1) A health benefits identification card will be issued by your employer.
(2) When you or one of your dependents requires covered treatment or services, the identification card should be presented to the provider of the services.
(3) Contact the Personnel Office or your Personnel Representative to obtain a claim form and instructions to take with you when receiving services.
(4) Complete the forms, have the hospital or physician complete the necessary sections, and return them to the Company as soon as possible.
    (a) When filing your claim, you must submit proof of each charge, so it is extremely important that you secure copies of bills for all charges.
    (b) Drug store bills for prescription items must include a diagnosis, prescription number, and the name of the person for whom prescribed.
(5) The company will then send your claim to the Insurance Company. The Insurance Company will determine the amount payable under the plan, make the payment, and send you advice of the payment.

## WHAT TO DO IF YOUR CLAIM IS DENIED

If your claim is denied, you will receive a written notice of the denial within 90 days of the receipt of your claim (except in special cases, where it will be 180 days and you have been so notified). The notice will explain fully the reasons for denial.

In the case of a denial, you have the right to review pertinent documents, to submit additional issues and comments and to request a review of the denial. This appeal must be made in writing within 60 days after you receive a notice of denial.

A final decision of the appeal shall be made no later than 60 days after receipt of your request for review (except in special cases where it will be 120 days and you have been so notified). A notice will be sent to you in writing explaining the reasons for the final decision.

## ADMINISTRATIVE INFORMATION

**Plan Name:** Eastern Associated Coal Corp. Health Care Plan

**Type of Plan:** Health, Vision and Dental Insurance

**Plan Number:** 501

**Effective Date:** December 1, 1951

**Last Amended:** January 1, 1982

**Plan Fiscal Year Ends:** December 31

**Plan Sponsor:**
Eastern Associated Coal Corp.
Koppers Building
Pittsburgh, PA 15219
(412) 288-8100

**Employer Identification Number:** 25-1125516

**Plan Administrator and Agent for Service of Legal Process:**
Vice President–Finance
Eastern Associated Coal Corp.
Koppers Building
Pittsburgh, PA 15219
(412) 288-8100

**Plan Document:** For simplicity, the plan has been described in a general manner in this summary plan description. However, the plan document is always the controlling document in the event of a discrepancy.

All the documents relating to the plan are on file at the offices of the Plan Administrator and the Personnel Administrator.

**Plan Continuation:** The Company hopes and expects to continue the program indefinitely; but necessarily reserves the right to change or discontinue the plan.

**Plan Funding:** The Company is liable for all benefits; however, Provident Life and Accident Insurance Co. administers the payment of claims.