Eastern Associated Coal Corp.

MEDICAL, VISION, DENTAL, LIFE INSURANCE AND AD&D BENEFITS

For

Salaried employees receiving disability benefits under the Eastern Gas and Fuel Associates Long-Term Disability Plan

Eligible surviving spouses of EACC employees

August 1998

This booklet is a "summary plan description" (SPD) of the medical, vision, dental, life insurance and accidental death and dismemberment (AD&D) plan for salaried employees who are receiving disability benefits under the Eastern Gas and Fuel Associates Long-Term Disability Plan, and for certain surviving spouses of employees of Eastern Associated Coal Corp. (EACC).

Eligibility for benefits and the actual amount of benefit payments are determined by the legal plan documents (including a contract with the insurance company for life and AD&D benefits). This booklet describes the plan in easier-to-read, simplified terms. It cannot cover every detail of the plan. If there is any conflict between the description in this booklet and the legal plan document, the plan document will be followed.

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

The company intends to maintain this plan for salaried employees who are receiving disability benefits under the Eastern Gas and Fuel Associates Long-Term Disability Plan and certain surviving spouses of EACC employees, but reserves the right to change or end the plan at any time. This booklet is not a guarantee of employment or an employment contract.

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Medical Benefits

ELIGIBILITY AND ENROLLMENT FOR MEDICAL BENEFITS

For Disabled Employees

If you are a former salaried employee of Eastern Associated Coal Corp. who began receiving long-term disability benefits under the Eastern Gas and Fuel Associates Long-Term Disability Plan before April 1, 1987, you are eligible for medical coverage. Your coverage began on the date you signed an enrollment card, if you did so within 31 days of the date you became disabled. The plan currently requires no contributions from you.

For Dependents of Disabled Employees

Your eligible dependents became covered by the plan at the same time you did. There is currently no contribution required for you to cover your eligible dependents.

Dependents you acquire after you have been eligible—by marriage or birth, for example—will be covered on the date you acquire them, provided they are enrolled within 31 days of that date.

You may choose not to enroll your dependents for the EACC Health Care Plan because they have other coverage, such as through your spouse's employer. In this situation, you may enroll the dependent in this plan if the other coverage ends because either:

- You or your dependent are no longer eligible for the other coverage.
- Another employer stops making contributions towards the other coverage.
- The coverage was provided under a continuation provision of the law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and the right to this continued coverage has ended.

You must notify your benefits department and complete an enrollment form within 31 days after the other coverage ends. Coverage will be effective on the first day of the month following enrollment.

Your eligible dependents include:

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

Children who are eligible as dependents include:

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

child relationship. However, the plan does *not* cover:

- A child temporarily living in your home.
- A child placed with you in your home by a social service agency that retains control of the child, or whose natural parent may exercise or share parental responsibility and control.
- A child for whom you do not legally claim a federal income tax deduction.

Coverage for your children is provided only while you are covered by the plan. The child must normally reside with you and you must regularly provide one-half of his or her annual support. However, the plan will also cover a child for whom you have been named in a qualified medical child support order.

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

Surviving Spouse Eligibility

In the event of an active or disabled employee's death on or after December 1, 1969, but before April 1, 1987, the surviving spouse may continue coverage, including coverage for eligible dependent children provided the spouse is not eligible for coverage as an employee under this or any other group health plan. This coverage will end on the date that the surviving spouse either dies, remarries, reaches age 65, or becomes eligible for coverage as an employee under this or any other group health plan.

Coverage for the employee's dependent children will end when the surviving spouse is no longer covered or when the child no longer meets the definition of an eligible dependent.

All coverage ends if the plan is terminated. No coverage is provided under this plan if death occurs either before December 1, 1969, or on or after April 1, 1987.

When Coverage Ends for Disabled Employees

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

- The plan is terminated.
- The date of your death.
- The date you cease to be an eligible disabled employee.
- The date you reach age 65 or retire. *For information about health care benefits for retirees, contact your benefits department.*

When Coverage Ends for Your Dependents

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

- The plan is terminated.
- Your spouse or child no longer meet the plan's definition of an eligible dependent or eligible surviving spouse.
- Your coverage ends, except as provided under *Surviving spouse eligibility.*

COVERED EXPENSES

The medical plan will pay benefits only for the services and supplies listed in the following sections. These services and supplies must be prescribed or performed by a physician for the medically necessary treatment of an illness or injury that is not work-related, or pregnancy.

The medical plan provides benefits only for covered expenses that do not exceed the usual, customary and reasonable fees in the geographic area where the services or supplies are provided, as determined by Blue Cross Blue Shield. Participating providers agree to accept these rates, and will not bill you for covered expenses other than the deductible and copayment amounts. For a nonparticipating provider, you must pay any amounts that exceed the usual, customary and reasonable charge, in addition to the deductible and your percentage share of expenses. In this situation, the plan's "hold harmless" provision will apply—see the section called *General provisions for medical, vision and dental benefits.*

A charge is considered to have been incurred on the date the service or supply is received.

HOSPITAL BENEFITS

The plan pays 100% of the usual, customary and reasonable charges for the hospital services listed in this section, while a covered individual is either:

- Confined in a hospital as a bed-patient (after you pay a $100 per confinement deductible).
- Receiving treatment in the outpatient department of a hospital for accidental injuries or emergency illness (treatment must occur within seven calendar days of the accident or onset of the illness), surgery, or 23-hour observation.
- There is a $25 deductible per emergency room visit, which will not apply if the patient is confined to the same hospital through the emergency room.

The expenses that are eligible for hospital benefits are:

- Hospital room and board expenses in a semi-private room, including expenses for intensive care units (if you are confined for at least 24 hours).
- Room and board expenses in a private room, up to the most common daily rate charged by the hospital for a semi-private room.
- Charges by a hospital for miscellaneous services and supplies, other than room and board, required for treatment of the condition.
- Charges by a physician for anesthesiology, radiology or laboratory services.
- Charges for ambulance service to the nearest hospital where care and treatment of the injury or illness can be given, provided transportation by ambulance is medically necessary.

Charges for room and board and miscellaneous services and supplies will not be covered after the 365th day of any one period of confinement. After hospitalization, an employee must return to work for one full day to qualify again for hospital benefits (with a new 365-day maximum), unless subsequent hospitalization is due to entirely unrelated causes. A dependent's periods of

confinement must be separated by at least three months to qualify for a new maximum benefit, unless subsequent hospitalization is due to entirely unrelated causes.

PHYSICIAN'S HOSPITAL VISITS AND SURGERY

The plan pays 100% of the usual, customary and reasonable charges incurred by a covered individual for the following expenses, provided they are medically necessary due to injury or illness.

Surgical Expenses

- The surgeon's usual, customary and reasonable charges for any one operation, including all surgical expenses for the procedure and follow-up surgical care, for either inpatient or outpatient surgery.

- An assistant surgeon's fee up to 25% of the usual, customary and reasonable fee from the operating surgeon.

Physician's Hospital Visits

The plan pays 100% of the physician's charge for visits during inpatient hospital confinement, not to exceed the usual, customary and reasonable fee for each visit.

Physician's Consultation in the Hospital

The plan pays 100% of the usual, customary and reasonable charges for one consultation of a "board certified specialist" during each period of inpatient hospital confinement. The attending physician must request the consultation in connection with diagnosis of an injury or illness.

The term "board certified specialist" means a physician who has been certified by a board within the medical profession as a specialist in his or her field.

No more than one consultation per specialty is covered during any one period of hospital confinement. Usual, customary and reasonable charges for additional consultations are eligible for major medical expense benefits, subject to the deductible.

Anesthetic Expenses

If you or your dependent have been administered an anesthetic by a physician or professional anesthetist in connection with a surgical operation or a procedure for which a surgical expense benefit is paid under the plan, the plan will pay 100% of the usual, customary and reasonable charges for the administration of the anesthetics.

LABORATORY AND X-RAYS

The plan pays 100% of the usual, customary and reasonable charges for laboratory examinations or X-ray examinations, when performed in a doctor's office, lab, or on an outpatient basis in a hospital, provided they are medically necessary due to an injury or illness.

RADIATION AND CHEMOTHERAPY

The plan pays 100% of the usual, customary and reasonable charges for chemotherapy, X-ray or radiation treatment of a proven malignancy or a non-malignant condition.

MATERNITY BENEFITS (FOR DEPENDENT WIVES AND FEMALE EMPLOYEES)

For expenses incurred due to pregnancy, childbirth or miscarriage of an employee or spouse, benefits are identical to those for other illness and injuries.*

In addition, payment will be made in full for reasonable and customary fees for nursery care of a covered newborn child, not to exceed the daily rate charged by the hospital. Benefits are provided for covered

newborn babies, including routine medical care and immunizations to age six months.

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

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

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

Note: Under federal law, group health plans generally may not place restrictions on the length of a hospital stay in connection with childbirth, as far as benefits for the mother or newborn child are concerned, as long as the stay is no more than:

- 48 hours, following a normal vaginal delivery.
- 96 hours, following a cesarean section.

In addition, a group health plan may not require a health care provider to obtain authorization from the plan for prescribing a certain length of stay, as long as it does not exceed these periods.

EMERGENCY ACCIDENT AND EMERGENCY ILLNESS (PHYSICIAN'S SERVICES)

If you or your covered dependents are treated by a physician for an emergency accident or illness, the plan will pay 100% of the usual, customary and reasonable charges, up to $100 for any one accident or illness. There is a maximum benefit of $500 per person for all services provided in one calendar year. The expenses must be incurred within seven calendar days after the accident or illness.

Benefits are not paid for services covered under any other provision of the plan. However, usual, customary and reasonable charges in excess of the maximum benefit under this provision will be eligible for major medical benefits, subject to the deductible.

ANNUAL ROUTINE PHYSICAL EXAM (FOR EMPLOYEES ONLY)

The plan pays 100% of the usual, customary and reasonable charges for one exam per calendar year. Benefits for the physician's examination fee are limited to $50 per exam. (Charges in excess of $50 are not covered under major medical benefits.) X-ray and laboratory tests are not subject to the $50 maximum.

These benefits are provided for the employee only. Your dependents' expenses for preventive or routine services are not covered by the plan, except that well-baby care to age six months is covered under the physician's office visit benefit described in the next section, and routine mammograms and Pap smears for your dependents are eligible for major medical benefits, which the plan pays at 80% after the deductible.

PHYSICIAN'S OFFICE AND HOME VISITS

The plan pays the physician's usual, customary and reasonable charge, after you pay a deductible, for home or office visits for treatment of injury or illness. This benefit is also paid for office visit charges by a doctor of chiropractic (DC). Benefits are not paid for routine checkups, inoculations or immunizations for prevention of disease, except for well-baby care and immunizations for a child under age six months.

You pay a $5 deductible per visit, up to a maximum deductible of $50 per family per calendar year. The $5 deductible is not covered under major medical benefits.

Charges for allergy testing and treatment in the physician's office are covered only under major medical benefits.

THERAPY

The plan pays 100% of covered expenses for the following:

- Physical therapy by a licensed physical therapist that is expected to produce significant improvement within a two-month period. Benefits will no longer be paid when care has become maintenance. When the therapeutic goals of the treatment plan have been achieved and/or when no more measurable progress is expected, benefits will cease. Physical therapy coverage for temporomandibular joint syndrome (TMJ) follows the same guidelines.

- Speech therapy, by a licensed speech therapist, to restore speech that has been impaired as a result of illness, surgery or injury. Speech therapy will also be covered after surgery to correct birth defects. Developmental delays in learning to talk, the perfection of speech and educational services are not covered.

- Occupational therapy for a physical or severe mental disability to restore the ability to perform ordinary tasks of daily living. Benefits will end when the therapeutic goals of a treatment plan have been achieved or when no more measurable progress is expected. Occupational therapy is not covered for most mental and chemical-dependency conditions.

- Cardiac rehabilitation to restore health as much as possible, through exercise, education of the patient and reducing risk factors. To be eligible for benefits, cardiac rehabilitation must be provided within 12 months after one of the following:

  - An acute myocardial infarction (heart attack).

  - Coronary bypass surgery.

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

HOME HEALTH CARE

The plan pays 100% of covered expenses for home health care that follows inpatient hospital treatment. The home health care must be a necessary alternative to continued hospitalization.

Eligible expenses from an authorized home health care agency include:

- Part-time or intermittent nursing services.

- Physical, occupational or speech therapy.

- Medical and surgical supplies that would also be covered as a hospital inpatient expense.

- Prescription drugs for IV infusion therapy or injections.

However, the following coverage limitations apply:

- The home health care must be for the continued treatment of the same condition for which the patient has already received inpatient care. It must begin within 21 days after the patient is discharged as an inpatient from a

hospital or skilled-nursing facility for treatment that was covered by the plan.

- The home health care must be provided according to a plan of treatment established by the patient's physician.
- The patient must be homebound for health reasons, but the patient may leave home occasionally to obtain outpatient hospital care that cannot be provided at home, or to obtain care from a licensed health care professional.

HOSPICE CARE

Hospice care means care that relieves pain and meets the basic life-supporting needs of a covered person who is terminally ill and has a life expectancy of six months or less. The purpose of the service is to provide care for the patient without attempting to prolong his or her life.

A hospice provider is a hospital, home health care agency or other provider that may legally provide hospice care.

After the deductible has been met, the plan pays for covered hospice care expenses at 100%. This is subject to the following special limitations:

- All hospice care benefits are limited to a lifetime maximum of $10,000.
- The care must be provided according to a physician's written treatment plan that has been approved in advance by MSA. (See page 3.)
- Counseling for the family is covered up to a maximum of $200.

Benefits for hospice care are not provided for:

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

SKILLED-NURSING FACILITY

Care from an approved skilled-nursing facility is covered at 100% after the deductible. Benefits are subject to the following limitations:

- The care must be for the continued treatment of the same condition for which the participant previously received inpatient hospital care, and the patient must have been transferred directly to the skilled-nursing facility from the hospital.
- The care must be provided according to a physician's treatment plan and approved in advance by MSA. (See page 3.)
- The care must require the skills of a registered nurse.
- The care must be likely to result in a significant improvement in the patient's condition. (Custodial care is not covered.)
- The degree of care must be more than can be given in the patient's home, but not so much as to require acute hospitalization.

PRESCRIPTION DRUG BENEFITS

All benefits for prescription drugs are provided through a participating provider pharmacy network called the CBN Network. You are free to obtain your prescriptions from pharmacies that are members of the CBN Network, or from non-network pharmacies. However, your benefits are paid through PCS Health Systems, Inc., which pays higher benefits if you use CBN participating pharmacies. No deductible applies, and benefits are paid as described under *CBN Network*.

You can also save money by using generic drugs instead of brand names when possible. When you doctor gives you a prescription, ask if generic substitution is an option.

If you request a brand-name drug when a generic equivalent is available and acceptable to your physician, the plan requires that you also pay the difference in cost.

CBN Network

Pharmacies participating in the CBN Network have agreed to provide discounts for participants in the company medical plan. When you fill a prescription at a CBN participating pharmacy, the plan will pay 90% of the cost of a generic drug, or 85% of the cost of a brand-name drug if a generic equivalent is not available.

Additionally, you may not have to file a claim when using a participating pharmacy, because the pharmacy will usually file the claim directly with PCS for reimbursement. Simply show your health plan ID card to the pharmacist, and you will pay only your percentage share that applies to the discounted price for the drug.

Note that not all pharmacies that display the PCS logo are included in the CBN Network. You may obtain a list of participating pharmacies from your benefits department.

Nonparticipating Pharmacies

If you purchase prescriptions from a pharmacy that is not a member of the CBN Network, you will have to pay the full cost of the drug up front and file a claim for reimbursement through PCS.

The plan pays 80% of the cost of brand name or generic prescription drugs purchased from a nonparticipating pharmacy. However, you also pay the difference in cost if you request a brand name drug when a generic equivalent is available, so talk to your doctor about using lower-cost generic drugs whenever possible.

You can obtain prescription drug claim forms from your benefits department.

Covered Drugs

Only medications and drugs requiring a written prescription from a physician and dispensed by a licensed pharmacist are covered—plus insulin and diabetic supplies such as syringes, lancets and glucose sticks.

The plan does *not* cover expenses for:

- 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, you will be required to furnish proof of medical necessity.
- Any drug that is experimental or investigational, or one that is being used for a treatment that has not received final approval from the FDA.
- Any drug covered by workers' compensation.

- Digestive aids (unless they are needed to sustain a patient's life), minerals or 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 PCS in advance.

- Prescriptions for birth control devices or birth control pills (unless these are being used for other than contraceptive purposes).

Certain drugs require approval in advance from PCS. If your doctor prescribes any of the following, you must contact PCS at 1-800-455-5690 and receive this approval before the plan will pay benefits for:

- Contraceptive medication. (Covered only with specific diagnosis and when medically necessary. Drugs used for birth control are not covered.)

- Smoking cessation aids.

- Prescription vitamins.

- Rogaine or Minoxidil.

- Retin-A.

- Anorectics.

- Growth hormones

- Fertility drugs.

- Viagra. (Covered only with specific diagnosis and when medically necessary.)

If you have other group health coverage for prescription drugs—through your spouse's employer, for example—refer to *Filing a medical, prescription drug or vision claim* on page 20 for information about how to submit claims.

If you have any questions about your prescription drug coverage, you may call PCS directly at 1-800-455-5690. Have your PCS identification number ready (from your health plan ID card).

MAJOR MEDICAL BENEFITS

"Major medical benefits" are provided for covered medical expenses that are not paid in full under the other provisions of the plan, or not covered by the other provisions at all. After you pay the $100 annual major medical deductible, the plan pays 80% of usual, customary and reasonable charges for covered major medical expenses, until the out-of-pocket maximum is reached.

However, charges for covered outpatient treatment of mental or nervous conditions and substance abuse are paid at 50% of the usual, customary and reasonable fee, after you pay the annual deductible.

Annual Deductible

The annual deductible is the amount of covered major medical expenses you must pay each calendar year before the major medical portion of the plan will pay benefits. This deductible applies only to those benefits described under the section called *Covered major medical expenses.*

The annual deductible is $100 for each covered individual per year, and generally applies to all covered expenses under the major medical portion of the plan. However, there are special features and exceptions:

- If the covered expenses applied to the deductible for you and your covered family members reach $200 in any one calendar year, the deductible

requirement will be considered satisfied for all your family members.

- If you have covered expenses in the last three months of a calendar year that apply towards your deductible, they may be applied to the next year's deductible as well.

The following expenses may *not* be used to satisfy the major medical deductible:

- Deductibles you pay for hospital confinement, emergency room visits, and physician's office visits under the other provisions of the plan.
- Any expenses paid in full under the other provisions of the plan.
- Prescription drug expenses.

Maximum Out-of-Pocket

Once you pay $500 "out-of-pocket" for covered major medical expenses (including your 20% share of expenses and the major medical deductible) for one person in a calendar year, the plan will pay 100% of covered expenses incurred by the person for the remainder of that calendar year.

If you and your covered dependents combined pay $1,000 "out-of-pocket" for covered major medical expenses (including your 20% share of expenses and the major medical deductible) in a calendar year, your benefits will be paid at 100% of the usual, customary and reasonable charge for covered major medical expenses incurred by all covered family members for the remainder of that calendar year.

This plan feature does not apply to outpatient treatment of mental health conditions or substance abuse. Also, prescription drug expenses and deductibles paid for hospital confinement, emergency room visits or physician's office visits under the other provisions of the plan do not count toward the out-of-pocket maximum.

Covered Major Medical Expenses

Covered major medical expenses include the usual, customary and reasonable charges incurred by a covered individual for the services and supplies listed below. These charges must be for services and supplies that the attending physician certifies as necessary for treatment of an illness or injury.

Major medical expenses do not include the amount of the expense that is paid under the other provisions of the plan, deductibles you pay for hospital confinement, emergency room visits or physician's office and home visits under the other provisions of the plan or prescription drug expenses.

The covered major medical expenses are:

- Hospital room and board at the average semi-private room rate, intensive care, and other hospital services and supplies.
- Physicians' fees for medical care and surgical operations.
- Charges of a registered graduate nurse (RN), or a practical nurse (LPN), who is either licensed as a practical nurse or is registered with an organization having the approval of the medical profession, provided the skills of an RN or LPN are required.
- Artificial limbs or eyes, casts, splints, trusses, braces, crutches and other medical supplies.
- Rental of a wheel chair, hospital-type bed, iron lung or other durable equipment used exclusively for

treatment of an injury or illness, up to the purchase price.

- Anesthetics and their administration.
- Diagnostic laboratory services.
- Use of X-ray, radium and other radioactive substances.
- Oxygen and rental of equipment for administration of oxygen, up to the purchase price.
- Commercial transportation within the United States and Canada, if medically necessary, to an out-of-area hospital or medical facility equipped to furnish special treatment for the injury or illness.
- Charges for professional psychiatric treatment or consultation (limited to 50% as an outpatient).

EXCLUSIONS

Benefits will not be paid under any provision of the medical plan for:

- Expenses in connection with work-related injuries.
- Expenses in connection with illnesses covered under any workers' compensation act or similar law.
- Any amounts exceeding the usual, customary and reasonable charges.
- Charges for services or supplies received from or in facilities owned or operated by the United States government, except to the extent required by law.
- Charges for services and supplies for which no charge is made.
- Charges incurred while coverage under this plan was not in effect.
- Acupuncture therapy.
- Cosmetic surgery, except:
  - To repair disfigurement due to an accident, provided the surgery is performed within 12 months after the accident occurs.
  - Treatment of a birth defect in a child, provided the surgery is performed within 12 months after the birth defect occurs.
- Treatment of an injury or illness that is caused by an act of war, declared or undeclared.
- Infertility treatment or reversal of sterilization surgery.
- Termination of pregnancy, unless medically necessary.
- Charges in connection with the pregnancy of a dependent child.
- Telephone conversation with a physician in place of an office visit.
- Charges for writing a prescription.
- Services provided by a relative.
- Transsexual surgery.
- Custodial care.
- Eye refractions, eye glasses or the fitting of eye glasses, except one pair of glasses following cataract surgery, if surgery changes the refractive ability of the eye.

- Hearing aids or the fitting of hearing aids.

- Dental care, except treatment of tumors, surgical removal of fully bone-impacted teeth and treatment of accidental injury to teeth.

- Treatment of temporomandibular joint syndrome (TMJ).

- Charges incurred outside the United States or Canada, unless you or a dependent is a resident of the United States or Canada and the charges are incurred while traveling on business or pleasure.

- Expenses incurred for transportation or lodging, except as may be provided for ambulance transportation under the provisions of this plan.

- Any expenses that are not medically necessary for the treatment of an illness or injury, such as routine checkups. However, this limitation does *not* apply to the annual routine physical exam benefit (for employees only) described on page 6, routine Pap smears and mammograms for dependents, well-baby care to age six months, or physicians' services for sterilization surgery, prescription of oral contraceptives, fitting of a diaphragm or insertion/removal of IUD. Pharmacy charges for oral contraceptives or devices are not covered.

- Immunizations, other than for a child less than six months old.

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

- Treatment instructions or activities for control or reduction of weight, except:

  - Medical treatment approved by the Medical Services Advisory program (MSA).

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

  To contact MSA, call the toll-free telephone number shown on your medical plan ID card.

Vision Benefits

ELIGIBILITY AND ENROLLMENT FOR VISION BENEFITS

You and your eligible dependents become eligible for vision coverage at the same time you become eligible for medical coverage—the eligibility rules are the same.

Vision coverage begins and ends at the same time that medical coverage does.

VISION PLAN HIGHLIGHTS

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

Expenses	Amount the plan pays
• Vision exam (one per calendar year) • Lenses (one set per 2-year period) • Frames (one set per 2-year period) • Verification, fitting and related materials	80% after $10 calendar-year deductible per person, up to $75 annual maximum benefit per person

You and each of your covered dependents must pay the first $10 of any vision care expenses incurred in a calendar year. This is the annual deductible.

After you have paid the deductible, the plan pays 80% of the remaining usual, customary and reasonable charges, up to a maximum of $75 per person in a calendar year. There is a new $75 maximum for each covered person each year.

COVERED EXPENSES

The following expenses are eligible for these benefits:

- One complete vision exam per calendar year.
- One set of lenses, per any two-year period.
- One set of frames per any two-year period.
- Verification and fitting.
- Ophthalmic materials necessary for fitting of and subsequent evaluation of eyeglasses.

EXCLUSIONS

The following charges are not covered under the vision care plan:

- Sunglasses or fitting of sunglasses, except prescription sunglasses.
- Surgical or medical care of eye diseases or injury. (Medically necessary treatment of this sort is covered by the medical plan.)
- Extra charges for photosensitive or anti-reflective lenses.
- Drugs or medications (other than for a 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 Benefits

ELIGIBILITY AND ENROLLMENT FOR DENTAL BENEFITS

For Disabled Employees Under Age 65

If you are an eligible employee of Eastern Associated Coal Corp. who began receiving long-term disability benefits from the Eastern Gas and Fuel Associates Long-Term Disability Plan before April 1, 1987, and you are under age 65, you are eligible for dental benefits. Your coverage began on the date you signed an enrollment card, if you did so within 31 days of the date you became disabled. The plan currently requires no contributions for your coverage.

For Dependents of Disabled Employees Under Age 65

Your eligible dependents became covered by the plan at the same time you do, provided you enrolled them within 31 days of the date you became disabled.

Dependents you acquire after you have been eligible—by marriage or birth, for example—will be covered on the date you acquire them, provided they are enrolled within 31 days of that date. Otherwise, a three-month waiting period for benefits will apply.

Your eligible dependents include:

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

Children who are eligible as dependents include:

- Your natural child.
- Your stepchild.
- Your legally adopted child, or a child placed with you for adoption.
- Your grandchildren or other children who live with you in a regular parent-child relationship. However, the plan does not cover:
  - A child temporarily living in your home.
  - A child placed with you in your home by a social service agency that retains control of the child, or whose natural parent may exercise or share parental responsibility and control.
  - A child for whom you do not legally claim a federal income tax deduction.

Coverage for your eligible dependent children is available only while you are covered by the plan. The child must normally reside with you and you must regularly provide one-half of his or her annual support. However, the plan will also cover a child for whom you have been named in a qualified medical child support order.

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

Surviving Spouse Eligibility

In the event of an active or disabled employee's death on or after December 1, 1969, but before April 1, 1987, the surviving spouse may continue coverage, including coverage for eligible dependent children provided the spouse is not eligible for coverage as an employee under this or any other group health plan. This coverage will end on the date that the surviving spouse either dies, remarries, reaches age 65, or becomes eligible for coverage as an employee under this or any other group health plan.

Coverage for the employee's dependent children will end when the surviving spouse is no longer covered or when the child no longer meets the definition of an eligible dependent.

All coverage ends if the plan is terminated. No coverage is provided under this plan if death occurs either before December 1, 1969, or on or after April 1, 1987.

When Coverage Ends for Disabled Employees

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

- The plan is terminated.
- The date of your death.
- The date you cease to be an eligible disabled employee.
- The date you retire.
- The date you reach age 65.

When Coverage Ends for Your Dependents

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

- The plan is terminated.
- Your spouse or child no longer satisfy the plan's definition of an eligible dependent or eligible surviving spouse.
- Your coverage ends, except as provided under *Surviving spouse eligibility*.

Refer to the section called *General provisions for medical, vision and dental benefits* for information about other provisions for continuation of coverage.

DENTAL PLAN HIGHLIGHTS

The following chart provides highlights of your dental benefits:

Deductible	$25 per person per calendar year
Plan Pays	80% after the deductible
Maximum Benefits the Plan Pays	$500 maximum per person per calendar year (does not include orthodontia)
Orthodontia Maximum	$800 maximum per period of treatment per person

Coverage is limited to fees charged by the majority of Delta Dental participating dentists (the "allowable charge").

Refer to the following pages for information about conditions and limitations that may apply to these benefits.

DELTA DENTAL PARTICIPATING DENTISTS

Your dental benefits are administered by Delta Dental, a nationally recognized provider of dental care programs. Delta Dental has unique "participating agreements" with the majority of dentists in areas where company employees live. These agreements mean that the participating dentist's fee has been accepted in advance by Delta Dental. All you have to do is present your membership card. Participating dentists will then file your claim for you and Delta will pay them directly. You will have to pay only your deductible and your coinsurance percentage for covered services.

A list of participating dentists is available for your review in the benefits department.

NONPARTICIPATING DENTISTS

If you go to a nonparticipating dentist, you will still receive benefits, but payment will be based on the fee that the majority of participating dentists would charge for the same service. This is called the "allowable charge." For services from a nonparticipating dentist, you will pay the difference between the dentist's fee and the allowable charge, in addition to your deductible and a percentage of the allowable charge, as shown on the *Dental plan highlights* chart.

Also, you are responsible for paying the nonparticipating dentist and filing your own claim. Benefits must be paid directly to you, not to the dentist.

DEDUCTIBLE

The annual deductible is the amount of covered expenses you must pay before the dental plan begins to pay benefits.

The deductible is the first $25 of dental expenses incurred by you and each of your covered dependents during each calendar year.

Covered expenses that are incurred in the last three months of a calendar year and applied to your deductible will be applied to the next year's deductible as well.

AMOUNT THE PLAN PAYS

The plan will pay 80% of covered expenses, up to the plan's maximum benefits.

COVERED EXPENSES

Covered expenses include reasonable and customary charges incurred by a covered individual for the following preventive, basic and major services provided by a dentist or a dental hygienist:

- Examinations and teeth cleaning (twice per year), X-rays, emergency treatment of dental pain and equilibration, not including restoration.
- Sealants for children under age 19, once in any five-year period. This is limited to occlusal services of cavity-free first and second permanent molars.
- Space maintainers for dependent children under age 16, once in a lifetime for the same tooth.
- Sodium fluoride treatments for dependent children under age 19, once per calendar year.
- Treatment of disease of the gums and tissues.
- Tooth extraction, alveolectomies, and post-operative care.
- Root canal.
- Fillings, inlays, and crowns.

- Full and partial dentures and bridgework, including their replacement and restoration, but not more than one replacement every three years.
- General anesthetics.
- Orthodontic treatments.

MAXIMUM BENEFITS

The plan will pay up to $500 for eligible preventive, basic and major care dental expenses for each covered person in a calendar year. Benefits for orthodontic services are limited to $800 per person per period of treatment.

If orthodontic services begin within five years after a previous treatment program, all the services will be considered one "period of treatment" and will be subject to the original $800 maximum.

DENTAL TREATMENT PLAN

Before your dentist provides treatment, he or she should submit a form describing the proposed course of treatment if:

- The cost of treatment will total $125 or more (unless it is emergency care).
- The treatment includes orthodontia.

The form should:

- Show the itemized dental services recommended.
- Show the charge to be made for each dental service.
- Be accompanied by supporting preoperative X-rays or other appropriate materials required by the claims administrator.

For orthodontic procedures, the treatment plan must:

- Provide a classification of the malocclusion.
- Recommend and describe the necessary orthodontic treatment.
- Estimate the time period over which treatment will be completed.
- Estimate the total charge for treatment.
- Be accompanied by cephalometric X-rays, study models and other supporting evidence the claims administrator may require.

The claims administrator will review the form that is submitted by your dentist and will determine what is covered so you will know in advance what portion of the cost you must pay. Forms are available from your benefits department. Participating dentists have the forms needed in their offices.

By submitting a form and getting it approved, the plan accepts the course of treatment your dentist has recommended and agrees to consider the expenses covered. If you do not submit a form before treatment begins, the plan has the right to take into account other methods of treatment when determining the amount of expenses it will cover.

ALTERNATIVE COURSE OF TREATMENT

In many cases, there may be more than one way to treat a dental condition. In these situations, the plan will pay benefits only for the least expensive services that:

- Are customarily used in the treatment of the condition.

- Are recognized in the dental profession to be appropriate according to broadly accepted national standards of practice.

You and your dentist may decide you want the more expensive treatment. If so, you pay the difference in cost out of your own pocket. It is important for you to request a predetermination of benefits so you know in advance how much the plan will pay for your treatment.

EXCLUSIONS

The plan does not cover charges for the following:

- Oral surgery that is not specifically listed as a covered expense.
- Charges incurred outside the U.S. and Canada, unless you or a dependent incur charges while traveling abroad.
- Services or supplies that were supplied free of charge.
- Full or partial dentures or bridgework made to replace teeth extracted before coverage under this plan began. This limitation no longer applies after three consecutive years of coverage by the employee or dependent.
- 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.
- Accidental injury or illness arising out of or in the course of employment, or which is compensated under any workers' compensation or occupational disease act or law.
- Charges incurred in connection with any intentionally self-inflicted injury.
- Charges for cosmetic treatment.
- Charges for replacement of lost or stolen appliances.
- Except when required by law, services furnished by or on behalf of any federal, state, county or any other governmental unit.
- Charges covered under the company's medical plan.
- Oral hygiene, dietary or plaque-control instructions and programs.
- Procedures, services or supplies that do not meet accepted standards of dental practice.
- Treatment that began before you were covered under this plan.
- Claims received more than 12 months after the date the services or supplies were received.
- Charges for a missed or broken appointment.

General Provisions for Medical, Vision and Dental Benefits

The following provisions apply to medical, vision and dental benefits provided under this plan.

FILING A MEDICAL, PRESCRIPTION DRUG OR VISION CLAIM

Claims for medical and vision expenses must be filed within one year of the date you received the service. Blue Cross Blue Shield participating providers and CBN participating pharmacies will file their claims directly with the plan. For all other expenses, you must file the claim using these steps.

1. Obtain a claim form and envelope from your benefits department. Be sure to complete your portion of the claim form in full.

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

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

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

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

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

5. Submit medical claims to:

   BlueCross BlueShield of Illinois
   P.O. Box 1220
   Chicago, Illinois 60690-1220

   Submit prescription drug claims to:

   PCS Health Systems, Inc.
   P.O. Box 52116
   Phoenix, AZ 85072-2116

PAYMENT OF MEDICAL AND VISION BENEFITS

If you use a Blue Cross Blue Shield participating provider or a CBN participating pharmacy, the benefit payment will be made directly to the provider. For other expenses, you may either:

- Pay the provider directly, provide proof of such payment in full, and be reimbursed for the eligible charges by the claims administrator.
- Choose to have payment sent directly to your provider.

Once the claims administrator has paid your provider its portion of the eligible charges, you will be responsible for any deductible or copayment amounts that apply.

The plan will not pay more than it would usually pay because you have indicated that it should pay the provider directly. Once

the plan has made a payment in good faith, it is no longer obligated for payment of that claim, even if it turns out the payment was sent to the wrong person or organization.

FILING A DENTAL CLAIM

Ask your dentist if he or she is a Delta Dental participating dentist, or call the Delta Dental office at 1-800-392-1167 and ask.

At a Participating Dentist

If you go to a participating dentist, present your membership card when you arrive for your appointment. If the care you need:

- Costs less than $125 or is emergency care, your dentist will proceed with treatment.

- Costs more than $125 and is not emergency care, your dentist will determine what treatment you need and submit a treatment plan to Delta Dental for predetermination of benefits. This will enable you to know in advance how much of the cost will be paid by your dental coverage and how much you will be responsible for paying.

Participating dentists have the forms needed to submit a claim. You may be asked to fill out part of the form. Your dentist will submit the form for you.

You will be responsible for the deductible amount, the copayment amount and any non-covered charges. Your dentist may request payment at the time of treatment or bill you later.

At a Nonparticipating Dentist

If you go to a nonparticipating dentist, benefits will be based on the fees charged by the majority of participating Delta Dental dentists. Also, you are responsible for paying the dentist and filing your claim.

Obtain a claim form from your benefits department or from Delta Dental before your dental appointment. Fill out spaces 1 through 15 on the form and ask your dentist to complete the rest. Then mail the form to Delta Dental at the address below:

Delta Dental Plan of Missouri
P. O. Box 16921
St. Louis, Missouri 63105-1321

If the treatment will cost more than $125 and is not emergency care, ask your dentist to submit a treatment plan to Delta Dental for predetermination of benefits. This will enable you to know in advance how much of the cost will be paid by your dental coverage and how much you will be responsible for paying.

Claims must be submitted within one year from the date the expense is incurred.

PAYMENT OF DENTAL BENEFITS

Benefits for participating Delta Dental dentists will be paid directly to the dentist. For nonparticipating dentists, benefits will be paid directly to you.

APPEALING A CLAIM

If any part of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things you can do to appeal the decision. Most of your questions can be answered quickly and efficiently by either calling or writing the claims administrator. Formal claim-review procedures are discussed in the *Plan administration information* section of this booklet.

RECOVERY OF EXCESS PAYMENTS

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

THE PLAN'S RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To determine the benefits for your claim, the plan may require additional information such as itemized bills, a statement from your provider, medical or dental care records of anyone making a claim, a medical examination, X-rays, and so forth.

The plan may provide or obtain any information necessary to carry out the plan's provisions, without having to give any person notice or obtain anyone's agreement. When you submit a claim for benefits, you must provide all the information needed to carry out the plan's provisions.

PAYMENT OF BENEFITS TO PERSONS OTHER THAN YOU

Under normal conditions, benefits are paid to you, or to the provider of services. Under conditions where you would normally receive a payment but are incapable of handling your affairs, the plan may pay benefits to any individual or organization that has assumed the costs of your care or financial support.

In the event of your death, the plan may also continue to honor decisions you made about payment of benefits.

Once the plan has made its payments under this provision, the plan is no longer liable to you for benefits.

LEGAL DEFENSE AGAINST EXCESSIVE FEES ("HOLD HARMLESS" PROVISION)

If a provider attempts to collect expenses that either exceed the usual, customary and reasonable level or are not considered medically necessary, the plan administrator may—with your written consent—attempt to resolve the matter by either:

- Negotiating a resolution with the provider.
- Defending you and the plan against any legal action the provider may begin.

If the plan administrator takes any action, you will not be responsible for any legal fees, settlements, judgments, or other expenses the plan administrator incurs to resolve the matter. (Legally, you are said to be "held harmless" for these responsibilities.)

The plan administrator will control the negotiation or legal defense, including decisions whether to settle the claim or to appeal any legal decisions. However, you may be liable for any services or supplies from the provider that are not covered by the plan.

COORDINATION OF BENEFITS

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

If you or any of your dependents are eligible to receive benefits under more than one group health care plan, our plan's COB provision allows you to receive benefits so that the total amount of benefits paid by all plans can be as much as 100% of the total expense.

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

- Any plan that does not contain a coordination of benefits provision is primary.

- If a plan covers the patient as an employee, that plan is primary and any plan covering the patient as a dependent is secondary.

- If the patient is a dependent child whose parents are not divorced or legally separated, the plan of the parent whose birthday is earlier in the calendar year is primary. The plan of the parent whose birthday falls later in the calendar year will be secondary. If both parents' birthdays are on the same day, the plan which has covered the parent for the longer period of time will be primary.

- If the patient is a dependent child whose parents are divorced or legally separated, the following rules apply:

  - A plan is primary if it covers a child as a dependent of a parent who is required by a court decree to provide health coverage.

  - If there is no court decree that requires one parent to provide health coverage to a dependent child, the plan of the parent who has custody of the child is primary. (The plan of the custodial parent's spouse is secondary and the plan of the other natural parent is third.)

- If a plan covers a person as an active employee, that plan is primary, and any plan that covers that person as a retired or former employee is secondary. If a plan covers a person as a dependent of an active employee, that plan is primary, and any plan that covers that person as a dependent of a retired or former employee is secondary.

- If a plan covers a person because of federal or state continuation-of-coverage laws, that plan is secondary to a plan that covers the person on any other basis.

- If none of the above rules applies, the plan that has covered the individual the longest period of time is primary.

If our plan is secondary, the regular benefits will be reduced so that the amount paid by both plans will not exceed 100% of the expenses incurred as covered under our plan. In other words, after the primary plan pays its benefits, our plan will pay the difference up to 100% of the total expense. In no event will our plan pay more than it would have if there was no other coverage.

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

Effect of Medicare on Benefits

For disabled employees who are eligible for Medicare, as well as their dependents covered under the company plan, Medicare is the primary plan and the company plan is secondary.

If you or any of your dependents are eligible to receive benefits under Medicare, the company plan's benefits will be reduced so that the total amount of benefits paid by both plans will not exceed 100% of the covered expenses. This is the same way the plan coordinates with other group health plans that are primary, as explained at the beginning of the *Coordination of benefits* section.

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

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

The Plan's Right to Necessary Information

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

The Plan's Right to Make Payments to Other Organizations

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

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

The Plan's Subrogation and Reimbursement Rights

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

As a condition to receiving benefits from this plan, you and your dependents agree to transfer to the plan the right to make a claim, sue and recover medical expenses from any money paid or payable as a result of a personal injury claim or reimbursement of medical expenses. This is called "subrogation." The plan may require that you pursue a claim against the third party or other insurance covering the expenses. If you fail or refuse to pursue the claim, the plan is entitled, if it chooses, to pursue the claim itself in order to recover the benefits the plan paid.

Alternatively, if either you or your dependent obtains any payment from the third party, or any insurance covering the third party or any "no-fault" automobile insurance, the plan is entitled to be paid

back in full, "in first priority," for the benefits it paid on your behalf. In other words, the plan must be fully reimbursed *first* from any money you receive as a result of a claim against the third party or other insurance.

You have an obligation to reimburse the plan in full, in first priority, regardless of whether or not you or your dependent is fully reimbursed for the expenses for which a third party is liable, or whether the settlement or judgment requires the third party to pay for medical expenses.

In addition, the plan is not obligated to pay benefits for any medical expenses for which a third party may be liable, unless you or someone legally authorized to act for you promises in writing to:

- Include the medical expenses in any claim that you or your dependents make against a third party for the injury or condition. You must notify the plan at least 30 days before you settle or compromise any claim.

- Reimburse the plan in full, in first priority, for any benefit payment if you or your dependents receive a settlement with a third party or payment for medical expenses. You must make this reimbursement within 30 days of receiving the settlement.

- Cooperate fully with the plan in asserting its rights to attempt recovery of payments, and supply the plan with any information and fill out any forms needed for this purpose within five days of receiving a request from the plan.

You must notify the plan of any personal injury claim or any claim for reimbursement of medical expenses within five days after the date you make the claim.

If you or your dependents do not comply with these provisions, or fail or refuse to complete or sign any document requested by the plan, the plan will no longer be obligated to pay any benefits for the injury or condition. However, the plan's subrogation and reimbursement rights apply whether or not you sign any repayment agreement. In addition, the plan may reduce future benefits paid for any other medical expenses in order to recover the amount it is entitled to under this provision.

CONTINUATION OF COVERAGE UNDER COBRA

Under the law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your eligible dependents may continue company-provided group medical and dental coverage if it ends for certain reasons. To obtain this coverage, you must follow several requirements described by the law.

If you qualify for coverage under COBRA, the law requires the company to continue coverage for certain minimum periods. You may enroll for COBRA coverage only if your coverage has not already been extended for the minimum period under some other plan provision.

Eligibility for Continued Coverage

Your dependents may continue their coverage under this plan for up to 36 months if their coverage ends for any of the following reasons:

- Divorce or legal separation.

- Your death.

- You become entitled to Medicare.

- Your dependent child reaches the age limit or otherwise ceases to qualify as a dependent.

These periods of continued coverage begin on the date of the event that caused the loss of eligibility—for example, on the date of your death, or the date a dependent becomes ineligible.

No more than a total of 36 months of continued coverage will be provided to any individual, even if more than one of these events occur.

When Continued Coverage Ends

Continued coverage ends automatically if any one of the following occurs:

- The cost of continued coverage is not paid by the date it is due.
- A person becomes covered under another group health plan, unless coverage under the other plan is limited due to the individual's pre-existing condition. Please notify the benefits department immediately if you or a dependent becomes covered under another group health plan.
- An individual becomes entitled to Medicare.
- The plan terminates for all employees.
- The applicable maximum coverage period ends.

Applying for Continued Coverage

You or your eligible dependents have the responsibility to inform the benefits department within 60 days in the event of a divorce, legal separation, or when a child no longer qualifies as a covered dependent under the plan.

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

Cost of Continued Coverage

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

Benefits Under Continued Coverage

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

SPECIAL EXTENSIONS OF CERTAIN BENEFITS

If you or a dependent is hospitalized at the time your coverage ends, coverage for hospital benefits will continue to apply to that period of hospital confinement, up to the maximum limits of the plan.

If you are totally disabled by an injury or illness on the date your coverage ends, benefits for your hospital, surgical, laboratory and X-ray examination as well as X-rays and radiation therapy expenses

will be extended. This extension of benefits will continue until three months after your coverage ends or until you are no longer totally disabled, whichever is earlier. In addition, major medical benefits will be extended for treatment of the injury or illness while you remain totally disabled, for up to 12 months after your coverage ends.

If you or one of your covered dependents 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:

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

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

- Orthodontic treatment that began before coverage ended, through the end of the month in which ended. (Benefits may be based on a prorating of the treatment fee—for example, if you paid the cost of the treatment in advance.)

- Root canal therapy, if the pulp chamber was opened before coverage ended, and if the root canal therapy is completed within two months after coverage ended.

For further information about these special extensions of benefits, contact your benefits department.

CONVERTING TO AN INDIVIDUAL POLICY

After you (or your dependent's) medical coverage ends, you (or a previously covered dependent) can ask to convert your medical coverage to an individual insurance policy. (This conversion privilege is not available if your coverage ended because the company terminated the plan or you failed to make required contributions.)

Dependents cannot be added to the individual policy if they were not covered by the plan at the time your coverage ended. Furthermore, the benefits available under an individual insurance policy are not necessarily the same as the benefits offered under the company's medical plan. You should examine the new individual policy carefully.

To convert coverage, you must submit a written application and the first premium payment to the designated insurance company within 31 days of the date your coverage ends. You or your covered dependents do not have to provide proof of good health. The policy will be effective on the day after your plan coverage ends.

Please note: You cannot convert your dental or vision coverage to an individual policy.

Life and AD&D Insurance Benefits

The company provides a life insurance plan that pays your family or other beneficiaries a benefit in the event of your death. The company also provides you with an accidental death and dismemberment (AD&D) plan that pays you or your beneficiary a benefit if you are seriously injured or die as a result of a covered accident.

ELIGIBILITY AND ENROLLMENT FOR LIFE AND AD&D BENEFITS

If you are a former salaried employee of Eastern Associated Coal Corp. who began receiving long-term disability benefits under the Eastern Gas and Fuel Associates Long-Term Plan before April 1, 1987, you are eligible for life insurance coverage. Your coverage began on the date you signed an enrollment card, if you did so within 31 days of the date you became disabled. The plan currently requires no contributions from you.

WHEN COVERAGE ENDS

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

- The plan is terminated.
- The date of your death.
- The date you cease to be an eligible disabled employee.
- The date you reach age 65 or retire. *For information about life insurance benefits for retirees, contact your benefits department.*

LIFE INSURANCE BENEFITS

If you die while covered by this plan, your beneficiary will receive an amount equal to two times your basic annual salary that was in effect on February 1 prior to the date you became disabled.

Naming Your Beneficiary

You may designate anyone as the beneficiary of your life insurance benefits. You may change your beneficiary at any time by filling out a form from your benefits department.

The change will become effective when your benefits department receives the completed form. It will be effective as of the date you signed the request, regardless of whether you are alive at the time the benefits department receives it. However, benefits that have been paid before the company receives the change form will remain the property of the person who received them, and will not be paid to the new beneficiary.

Payment of Benefits

Full payment of your coverage amount will be made to your beneficiary (or beneficiaries) upon your death. This payment will be made in one lump sum.

If you do not designate a beneficiary, or if your beneficiary dies before receiving your benefit payment, your benefit will be paid instead in the following manner:

- To your spouse.
- If you have no living spouse, to your children in equal shares.

- If you have no living children, to your parents in equal shares.
- If you have no living parents, to your estate.

If you die, your beneficiary should contact your benefits department to file a claim. Your beneficiary must provide a certified copy of the death certificate.

Benefit Access Account

An account called a "benefit access account" is automatically established for each beneficiary receiving a lump-sum benefit payment of $10,000 or more. The payment received by your beneficiary will be placed in this account. (Beneficiaries receiving less than $10,000 will receive a single payment by check.)

Your beneficiary may withdraw the entire amount of the account at once, or only a portion at a time (with a minimum withdrawal of $500), leaving the balance to accumulate interest. Your beneficiary will also receive information about other ways to receive payment if he or she wishes.

Assignment of Benefits

If you wish, you may also "assign" your life insurance benefits to any individual as a gift. This is different from designating a beneficiary. The person who is "assigned" benefits then legally owns the insurance policy—you no longer have the right to change beneficiaries—and the benefit is taxed differently. Assignment is usually done for tax purposes. You may want to consult a tax adviser if you wish to learn more about this option.

A copy of the assignment request must be filed with your benefits department and approved by the insurance company.

Appealing a Claim

If any part of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things you can do to appeal the decision. Most of your questions can be answered quickly and efficiently by either calling or writing the insurance company. Formal claim-review procedures are discussed in the *Plan administration information* section of this booklet.

Converting to an Individual Policy

If your life insurance ends or is reduced because you are no longer disabled, you reach 65 or you retire, you may buy individual coverage up to the amount that ended or was reduced. You will not need to provide evidence of good health.

You must submit your application for the individual policy to the insurance company and make the required premium payment within 31 days of the date your coverage was reduced.

If the life insurance plan is changed or ended, you can convert your coverage subject to the conditions described in the policy issued by your insurance carrier.

If you die within the 31-day period after your coverage ends but before your individual policy is issued, your benefit will be paid to your beneficiary.

Contact your benefits department for information about how to convert your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

In addition to the life insurance benefit, the plan also provides accidental death and dismemberment (AD&D) coverage. Your AD&D coverage amount is $15,000.

This benefit is paid in addition to the life insurance benefit amount. In other words, if you die as a result of a covered accident, your beneficiary would receive your life insurance benefit amount plus the $15,000 AD&D benefit. The plan also pays all or a portion of your AD&D coverage amount if you suffer certain losses as a result of a covered accident.

Covered Losses

You will receive all or a portion of your AD&D coverage amount if you suffer a covered loss within 365 days of an accident. These benefits are paid in addition to any other amount you receive under the life insurance plan.

The covered losses are:

- Death.
- Loss of a hand by severance through or above the wrist joint.
- Loss of a foot by severance through or above the ankle joint.
- Complete and irrevocable loss of sight.

This table shows the percentage of your AD&D coverage amount that the plan pays for each type of covered loss:

For Loss Of	Percentage of Total Coverage Amount
Life	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and sight of one eye	100%
One foot and sight of one eye	100%
One hand or one foot	50%
Sight of one eye	50%

If you sustain multiple injuries in one accident, only one benefit amount, the largest, will be paid for all of your injuries.

Exclusions

The plan will not cover any losses that are caused by:

- Sickness, disease or infections of any kind (except bacterial infections due to an accidental cut or wound, or botulism and ptomaine poisoning).
- War or act of war (or other international armed conflict), whether declared or not.
- Suicide, attempted suicide or any intentionally self-inflicted injury, while sane.

- Riding as a passenger in (including getting in or out of) any aircraft not intended or licensed for the transportation of passengers.

- Full-time active duty in the armed forces of any country or international authority except the National Guard or organized reserve corps duty.

Naming Your Beneficiary

You may designate anyone as the beneficiary of your AD&D benefits. You may change your beneficiary at any time by filling out a form from your benefits department.

The change will become effective when your benefits department receives the completed form. It will be effective as of the date you signed the request, regardless of whether you are alive at the time the benefits department receives it. However, benefits that have been paid before the company receives the change form will remain the property of the person who received them, and will not be paid to the new beneficiary.

Payment of Benefits

All benefit payments will be made automatically to you or your beneficiary as specifically designated under the group life policy. If you have suffered a covered accidental dismemberment, or loss of sight, the benefit will be paid to you.

If you do not designate a beneficiary, or if your beneficiary dies before receiving your benefit payment, you benefit will be paid instead in the following manner:

- To your spouse.

- If you have no living spouse, to your children in equal shares.

- If you have no living children, to your parents in equal shares.

- If you have no living parents, to your brothers and sisters.

- If you have no brothers and sisters, to your estate.

If you suffer a loss that is covered by the AD&D plan, you should contact your benefits department to file a claim. A medical report must be provided.

If you die, your beneficiary should contact your benefits department to file a claim. Your beneficiary must provide a certified copy of the death certificate, including the coroner's report, if applicable.

The insurance company must be notified of a loss within 20 days or as soon as reasonably possible. Written proof of the loss must be sent to the insurance company within 90 days of the loss or as soon as reasonably possible. In any event, your claim must be submitted within one year of the loss unless you are legally incapable of handling your affairs.

The insurance company has the right to require a physical examination and an examination of records of anyone making a claim.

Appealing a Claim

If any part of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things you can do to appeal the decision. Most of your questions can be answered quickly and efficiently by either calling or writing the insurance company. Formal claim-review procedures are discussed in the *Plan administration information* section of this booklet.

Key Terms

Basic annual salary
Twelve times your monthly pay. It does not include overtime, commissions, special allowances or salary for foreign service, awards from any special compensation or similar plan, or payments from any other employee benefit plan.

Beneficiary
The person you designate to receive payment of your life insurance or accidental death benefit.

Claims administrator
The organization retained by the company for granting or denying claims, currently BlueCross BlueShield of Illinois for medical and vision benefits, PCS for prescription drug benefits, and Delta Dental of Missouri for dental benefits.

Company
Eastern Associated Coal Corp.

Convalescent facility
A lawfully operating institution, or a distinct part of an institution, primarily engaged in providing skilled nursing care to patients recovering from injuries or illness and that:

- Is under the resident supervision of a physician or a registered graduate nurse.
- Requires that the health care of every patient be under the supervision of a physician.
- Has a physician available to furnish necessary medical care in emergencies.
- Provides nursing service continuously for 24 hours of every day.
- Provides facilities for the full-time care of five or more patients.
- Maintains clinical records on all patients.
- Is not an institution or part of an institution that is primarily devoted to the care of the aged.

Covered expenses
The items of medical expense for which benefits may be paid.

Dentist
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 that he or she is licensed to perform.

Dental emergency
An urgent, unplanned diagnostic visit to a dentist for alleviation of an acute dental condition caused by an accident.

Dental hygienist
A person currently licensed to practice dental hygiene, who works under the direct supervision of a dentist.

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

Hospital
An institution legally operating as a hospital that is both of the following:

- Primarily engaged in providing, for compensation from its patients, inpatient medical and surgical facilities

for diagnosis and treatment of injury and illness.

- Operated under the supervision of a staff of physicians and continuously provides nursing services by registered graduate nurses for 24 hours of every day.

However, "hospital" does not include:

- Any institution that is operated principally as a rest, nursing or convalescent home or for the care and treatment of drug addicts or alcoholics.
- Any institution or part of an institution that is primarily devoted to the care of the aged.
- Any institution engaged in the schooling of its patients.

Illness
A sickness, disease, mental infirmity or (for the disabled employee or a spouse, but not dependent children) pregnancy that requires treatment by a physician. The term "pregnancy" includes childbirth, miscarriage and complications resulting from pregnancy.

Injury
A bodily injury that requires treatment by a physician caused by accident.

Insurance company
For life insurance:

General American Life Insurance Company
13045 Tesson Ferry Road
St. Louis, Missouri 63128

For accidental death and dismemberment insurance:

AIG Life Insurance Company
One Alico Plaza
Wilmington, Delaware 19801

Intensive care facility
A facility to which all the following apply:

- It is reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending physician.
- It provides room and board, and nursing care by nurses whose duties are confined to care of patients in the intensive care facility.
- It has special equipment or supplies immediately available on a standby basis apart from the rest of the hospital's facilities.

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

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

- It is not experimental, educational or investigational.

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

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

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

Orthodontic procedure
Movement of teeth by means of active appliances to correct the position of malocclused or malpositioned teeth.

Physician
Any of the following:

- A doctor or surgeon of medicine or osteopathy who is legally authorized to practice medicine and surgery by the state in which he or she practices.

- A doctor of chiropractic who is practicing within the scope of his or her license.

- A doctor of dentistry, or of dental or oral surgery, who is legally authorized to practice dentistry in the state in which he or she practices. However, with respect to medical benefits, covered services are limited to:

  - Surgery related to the jaw or any structure contiguous to the jaw.
  - The reduction of any fracture of the jaw or any facial bone.

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

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

Surviving spouse
Your spouse surviving after your death, who at the time of your death was living with you or supported by you.

Usual, customary and reasonable charge or fee
The maximum benefit paid as determined by Blue Cross Blue Shield, taking into consideration:

- The usual fee that is charged for a given service by an individual physician in his or her personal practice.

- The range of usual fees customarily charged by physicians of similar training and experience for the same service within a specific geographic or socio-economic area.

- A reasonable fee that meets the above two criteria or, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of a particular case.

Plan Administration Information

Plan name
Salaried Employee Health Care Insurance.

Type of plan
Medical, vision, dental and life and AD&D insurance benefits.

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

Plan number
501

Plan fiscal year
January 1 to December 31

Plan effective date
April 1, 1987

Plan sponsor
Eastern Associated Coal Corp.
800 Laidley Tower
Charleston, West Virginia 25301

Plan administrator
Peabody Holding Company, Inc.
701 Market Street, Suite 700
St. Louis, Missouri 63101-1826

The plan administrator is responsible for the operation and administration of the plans. The plan administrator, individually or through its delegates, has the full discretionary authority to interpret all provisions of the plans, determine eligibility for benefits and the amount of benefits under the plan, and establish rules for administration of the plan.

Plan funding
Medical, dental and vision benefits are self-insured. The plan administrator has entered into an agreement with the claims administrators to process benefit claims and provide other services under the plan. The plan is funded by direct payments from the plan sponsor's general assets. The claims administrator does not insure these benefits.

The life and AD&D insurance benefits are insured and funded by the payment of premium required by the contracts between the plan sponsor and the insurance companies. Benefits are administered by the insurance companies according to the contracts.

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

Peabody Holding Company, Inc.
701 Market Street, Suite 700
St. Louis, Missouri 63101-1826
(314) 342-3400

Service of legal process may also be made upon the plan administrator.

YOUR ERISA RIGHTS

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

- Examine, without charge, at the plan administrator's office and at other specified locations, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The plan administrator may make a reasonable charge for copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If you believe that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact either:

- The nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory.

- The Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

IF YOUR CLAIM IS DENIED

If any portion of your claim is not paid, or if you do not understand or agree with the handling of a claim, there are several things that you can do to appeal the decision. Most of your questions can be answered quickly and efficiently if you call or write the claims administrator.

If your claim for a plan benefit is denied or reduced, you or your beneficiary will be notified in writing within 90 days after your claim is received. The notice will tell you why additional time is needed and the date you can expect a final decision. This

decision must be made within 90 days after the end of the initial 90-day period. If your claim is denied, you or your beneficiary will receive a form that includes:

- The specific reasons for the denial.
- A specific reference to the plan provisions on which the denial is based.
- A description of any additional material or information necessary for you to substantiate your claim and an explanation of why such material is needed.
- An explanation of the plan's claim review procedures.

The plan intends to respond to claims promptly. However, if you do not receive a response within 90 days, allowing reasonable time for mailing, you may proceed to the claim review stage.

Within 60 days after receiving a written notice that your claim has been denied, or if you do not receive a timely response as described above, you or your authorized representative (such as an attorney) may submit a written request for review. This request should be sent to the plan administrator.

In your request, state the reasons you believe the claim should not have been denied and submit any additional supporting information, material or comments which you consider appropriate. You may review any pertinent plan documents.

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

The decision will be in writing and will include the specific references to the plan provision on which it is based. All decisions by the plan administrator will be final.

AMENDING THE PLAN

The plan is adopted with the intention that it will be continued for the benefit of salaried employees who are eligible for disability benefits under the Eastern Gas and Fuel Associates Long-Term Disability Plan and certain surviving spouses. However, the company reserves the right to terminate the plan, change required contributions, or modify this plan in whole or in part at any time or for any reason, including changes in any and all of the benefits provided. This may cause disabled employees to lose all or a portion of their benefits under the plan, but will not affect the right of any disabled employee to be reimbursed for any covered expense that has already been incurred or to which he or she has already become entitled under the plan.

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