SUMMARY OF MATERIAL MODIFICATION

(QUICK REFERENCE TO HIGHLIGHTS OF PLAN PROVISIONS)

The Catastrophic Group Health Plan for Salaried Employees
Terminated Through a Reduction in the Work Force
Summary of Material Modification

This notice, called a "Summary of Material Modification" (SMM), advises you of a change in the information presented in your summary plan description (sometimes called an "SPD") with respect to the Plan. Please do three things: (1) Read this summary, and, if you have any questions, contact the Plan Administrator; (2) Keep this summary with your summary plan description; (3) Mark the section of your summary plan description that has been changed so that when you look at that section of your summary plan description, you will be reminded that the change described in this summary has occurred.

The catastrophic plan offers prescription drug benefits and financial protection against major medical care expenses at an affordable cost to you. Enclosed is a summary plan description, and a brochure called *What's New for 1998*, that describe the benefits of the plan. However, special eligibility rules apply if you are terminated through the reduction in the work force occurring during 1998. The special eligibility rules are described in this summary.

When Your Coverage Ends Under the Peabody Group Health Plan for Salaried Employees

If you are a salaried employee who has been terminated through a reduction in the work force, you may continue coverage under the Peabody Group Health Plan for Salaried Employees for three calendar months after the end of the month in which your employment terminates, provided you pay the required contributions. At the end of this three-month period, you may be eligible to purchase a temporary extension of your coverage under the COBRA continuation provisions of the plan. "COBRA" refers to the Consolidated Omnibus Budget Reconciliation Act of 1985; a law containing provisions for certain extensions of employee heath care benefits after employment ends. The catastrophic plan is available as an alternative to COBRA as a means of extending your medical coverage, if you are eligible as described in the following section.

Eligibility and Enrollment (page 7 of the SPD)

As a terminated salaried employee, you are eligible for medical and prescription drug benefits if all of the following apply:

- You are terminated through the reduction in work force occurring in 1998.
- You have agreed to the Voluntary Separation Agreement.
- On the date your employment terminates, you are age 50 or older and have at least 10 years of active service with the company.
- You are not eligible to retire.
- You are not eligible for Medicare.
- You are enrolled for coverage under the Peabody Group Health Plan for Salaried Employees on the date your employment terminates.
- You do not elect to continue coverage under the COBRA continuation-of-coverage provisions of the Peabody Group Health Plan for Salaried Employees.
- You enroll for this plan and pay the required contributions for coverage on a timely basis.

Eligibility for your dependents
You may also obtain coverage for your eligible dependents, if they were covered by the Peabody Group Health Plan for Salaried Employees on the date your employment terminates and they are not eligible for Medicare.

Enrollment
To participate in the catastrophic plan, you must enroll and pay the required contributions within 31 days after the date your coverage ends under the Peabody Group Health Plan for Salaried Employees. If you do not enroll and pay the required contributions within the 31-day period, you will not be able to obtain coverage at any future time.

The cost of your coverage
You will be required to pay a portion of the cost for coverage under the catastrophic plan. Your contribution amount depends on the number of family members you elect to cover. For 1998, the monthly contribution rates are shown on this table:

Coverage Category	***Monthly Rate***
Yourself only	$33.50
Yourself Plus One Dependent	$66.93
Yourself Plus Two or More Dependents	$100.45

You will share in any cost increases in subsequent years.

Contribution payments are due on the first of each month. Your checks should be made payable to Peabody Holding Company, Inc. and submitted to Mary Ellen Moeser at 701 Market Street, Suite 700, St. Louis, Missouri 63101. If your monthly contribution payment is not received by the first day of the month for which it is due, your coverage will end and may not be reinstated.

Coordination of Benefits (page 35 of the SPD)
If you are or become covered under another employer-sponsored group health plan, you may still participate in the catastrophic plan as long as you are otherwise eligible as described above. However, catastrophic plan benefits are reduced by the amount paid by any other medical plan.

When Coverage Ends (page 36 of the SPD)
Your coverage under the catastrophic plan will end on the date the earliest of the following occurs:

- You become eligible to enroll for Medicare.
- You fail to pay the required contributions when due. (Coverage will terminate at the end of the month for which the last contribution was paid on a timely basis).
- The plan is terminated.

If you die while covered by this plan, or your coverage ends because you become eligible for Medicare, your spouse may continue coverage until he or she is eligible to enroll for Medicare as long as the plan is continued and the required contributions are paid.

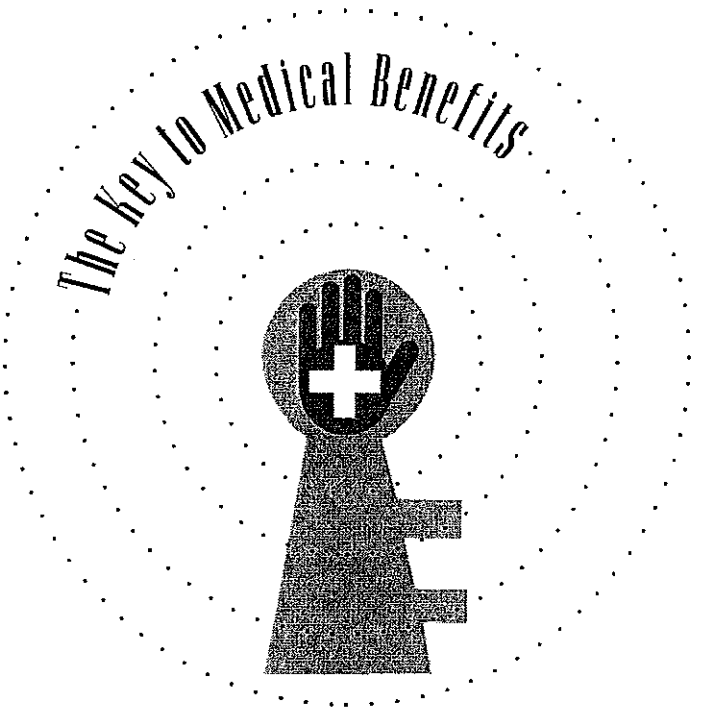
Your dependent children are eligible as long as you or your spouse is covered and they continue to meet the definition of an eligible dependent.

If your dependents' coverage ends, they may be eligible to purchase an extension of coverage under the COBRA continuation provisions of the plan. This extension will end 36 months from the earlier of (1) the date of your death, (2) the date you became entitled to Medicare, or (3) the date of the event that caused the loss of coverage. Coverage may terminate on an earlier date as described in the COBRA provisions of the plan booklet.

The benefit plan is operated according to the terms of legal documents. If there is a difference between this summary or the summary plan description booklet and the actual plan document, the plan document will govern. This summary is not a substitute for the official plan documents nor is it an employment contract.

The company reserves the right to amend or terminate the plan in whole ore in part at any time.

This document is a "summary of material modification" and is part of your summary plan description booklet. It should be kept with your other booklets.


The Key to Medical Benefits

This booklet is a "summary plan description" (SPD) of the Catastrophic Group Health Plan for Salaried Employees Terminated Through a Reduction in Work Force.

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

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

The company reserves the right to change or end the plan at any time.

Contents

Key Highlights

Medical coverage

WHO IS ELIGIBLE: A salaried employee of the company who has been terminated through a reduction in work force, has been offered this plan and agreed to the terms contained in the Voluntary Separation Agreement. (See page 7 for more information.)

WHAT IS COVERED: The medical plan covers a wide variety of medical services and supplies. There are special provisions for prescription drugs, home health care, hospice care and treatment of mental illness and substance abuse. (See page 8 for more information.)

COST TO YOU: You will be required to pay a portion of the monthly cost for the plan, according to the terms of the Voluntary Separation Agreement. You also share in the cost of the treatment you receive by paying deductibles, copayments and a percentage of expenses. What you pay depends on the type of care you receive and where you receive it. (See page 8 for more information.)

The medical plan has a cap, or out-of-pocket maximum, on the amount you pay for most covered expenses. For network expenses, this maximum is $4,000 for one person in one calendar year and $8,000 combined for all covered family members per calendar year. (See page 16 for more information.)

MAXIMUM BENEFIT AMOUNT: In general, the medical plan pays a lifetime maximum benefit of $1 million per covered person as of March 1, 1990. (This is adjusted annually based on the Health Cost Component of the Consumer Price Index. In 1999, the maximum was $1.6 million.) However, additional restrictions apply to hospice care and treatment of mental illness and substance abuse. (See page 17 and page 26 for more information.)

OTHER KEY POINTS: You are free to receive your care from any provider you wish, but your share of costs for covered medical expenses will be less if you use providers that are members of the plan's "participating provider" networks. These networks include hospitals, physicians and pharmacies. (See page 9 for more information.)

The medical plan includes a Medical Services Advisory (MSA) program that works with you and your doctor to review your care and avoid unnecessary hospitalization. The purpose of the program is to make sure you receive the most appropriate, cost-effective care for your condition. (See page 10 for more information.)

If you have coverage through another group plan, benefits under this plan will be reduced by the benefit amounts you receive from the other plan. (See page 34 for more information.)

Coverage ends if you reach the end of the maximum coverage period provided in your Voluntary Separation Agreement. (See page 37 for more information.)

Eligibility and Enrollment

As a terminated salaried employee, you are eligible for medical and prescription drug benefits if all of the following apply:

- You are terminated through a reduction in work force.
- You have agreed to the Voluntary Separation Agreement.
- You are not eligible to retire.
- You are enrolled for medical coverage under the Peabody Group Health Plan for Salaried Employees on the date your employment terminates.
- You have not elected to continue coverage under the COBRA continuation of coverage provisions of the Peabody Group Health Plan for Salaried Employees.

Your eligibility period will be based on the amount of time stated in your Voluntary Separation Agreement.

ELIGIBILITY FOR YOUR DEPENDENTS

You may also obtain coverage for your eligible dependents who were enrolled for medical coverage under the Peabody Group Health Plan For Salaried Employees on the date your employment terminated, provided they do not elect to continue the benefits of the plan for active employees under COBRA.

ENROLLMENT

To participate in the catastrophic plan, you must enroll and pay the required contributions within 31 days after the date your coverage ends under the Peabody Group Health Plan for Salaried Employees. If you do not enroll and pay the required contributions within the 31-day period, you will not be able to obtain coverage at any future time.

The cost of your coverage

You will be required to pay a portion of the cost for coverage under the catastrophic plan. Your contribution amount depends on the number of family members you elect to cover.

Contribution payments are due on the first of each month. Your checks should be made payable to Peabody Holding Company, Inc. and submitted to the Benefits Department at the address shown on your enrollment form. If your monthly contribution payment is not received by the first day of the month for which it is due, your coverage will end and may not be reinstated.

Terminated salaried employees are eligible for medical and prescription drug coverage under certain conditions.

Your Medical Benefits

	NETWORK AND OUT-OF-AREA★	NON-NETWORK
DEDUCTIBLES YOU PAY		
Annual Deductible	$1,000	$1,500
Annual Deductible Family Maximum	$2,000	$3,000
Hospital Copayment (per admission)	$200	$300
Emergency Room Copayment (if not true emergency)	$50	$50
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE AND COPAYMENTS		
Inpatient Hospital and Emergency Room★★	70%	50%
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE		
Wellness Benefits (including well-child care, routine physicals and screenings)	70% Up to $250 per calendar year (no deductible)	50%
Most Other Medical Expenses★★	70%	50%
PRESCRIPTION DRUG BENEFITS (AMOUNT THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE★★★)		
Generic Prescription Drugs (Retail or mail order)	70% After deductible	
Brand-Name Prescription Drugs (Retail or mail order)	70% After deductible	
ANNUAL OUT-OF-POCKET MAXIMUMS YOU PAY (includes deductible, hospital copayment, coinsurance, and prescription drugs)		
Individual Out-Of-Pocket Maximum	$4,000	$6,000
Family Out-Of-Pocket Maximum	$8,000	$12,000
LIFETIME MAXIMUM BENEFIT THE PLAN PAYS		
	$1 million Indexed annually for inflation (In 1999, limit was $1.6 million)	

If emergency services meet the requirements of "urgent or emergency care" as defined by the plan, then the covered charges are treated as if they were from a network provider, whether you go to a network or non-network provider.

All hospitalization and certain other types of care must be approved under a Medical Services Advisory program. Benefits may be reduced if you don't comply. See the section called Medical Services Advisory (MSA) program and hospital precertification *on page 10.*

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

★★ *Inpatient Mental Health and Substance Abuse benefits are limited to 30 days per calendar year and up to 60 days per lifetime. Outpatient Mental Health and Substance Abuse benefits are limited to 30 visits per calendar year and do not apply toward the out-of-pocket maximum.*

★★★ *If your prescriptions are filled at a participating BlueScript pharmacy, you will receive discounts, and the pharmacy will file your claims for you. After you meet your annual deductible, BlueCross BlueShield of Illinois will reimburse 70% of the cost of each covered prescription for the rest of the calendar year (or 100% after you have met the annual out-of-pocket maximum). If you use a non-participating provider, you receive the same level of benefits, but you must file a claim for reimbursement with BlueCross BlueShield of Illinois.*

BLUECARD NETWORK

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

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

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

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

If you have an emergency

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

In either case, if you are admitted to a hospital, you or someone on your behalf must call Medical Services Advisory (MSA) within two working days of your admission, as described on page 10. If MSA is not notified, your benefits will be reduced.

If the emergency visit meets the requirements of "urgent or emergency care" as defined by the plan, then the covered charges are treated as if they were from a network provider, whether you go to a network or non-network provider.

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

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

You also must call MSA in advance for approval of certain outpatient and extended care services.

If you need care your network doctor can't provide

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

Traveling in the U.S.

If you need emergency medical attention, go immediately to the nearest medical facility. Then follow standard emergency procedures (see *If you have an emergency* on page 9).

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

If you or a dependent lives outside the network area

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

PARTICIPATING PROVIDER PHARMACY PROGRAM

Pharmacies participating in BlueCross BlueShield's pharmacy network, called BlueScript, have agreed to provide discounts for persons covered by the plan. When you fill your prescription at a network retail pharmacy, you pay the full (discounted) cost of the drug and then the network pharmacy will file your claim for reimbursement with BlueCross BlueShield of Illinois. After the deductible is met, BlueCross BlueShield of Illinois will reimburse you 70% of the cost of covered drugs for the rest of the calendar year. After you have met the annual out-of-pocket maximum, the plan will pay 100% of the cost for the rest of the calendar year. A list of participating pharmacies is available from BlueCross BlueShield of Illinois.

If you purchase prescriptions from a non-participating pharmacy, you will receive the same coverage, but you will not receive the network discount and you will have to file your own claim for reimbursement with BlueCross BlueShield of Illinois. The benefits the plan pays for prescription drugs are explained in the section called *Prescription drug benefits* on page 17.

The participating provider networks serve as independent contractors to the company. For this reason, the company cannot guarantee the availability or quality of care and is not liable for any act or omission of any provider.

MEDICAL SERVICES ADVISORY (MSA) PROGRAM AND HOSPITAL PRECERTIFICATION

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

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

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

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

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

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

- Home health care.
- Private-duty nursing.
- Hospice care.
- Skilled nursing facility care.
- Residential treatment facilities.
- Certain surgical procedures (listed on page 21).

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

Precertification for inpatient admissions

To request precertification, simply call the MSA precertification number given in the section called *How to contact Medical Services Advisory* on page 14. Registered professional nurses will carefully evaluate the proposed hospitalization. If the nurse determines that inpatient hospitalization does not meet the guidelines for medical necessity, a consulting physician will be asked to review the case and make a determination.

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

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

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

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

If you do not call MSA before a hospitalization that is not an emergency, your covered hospital charges will be reduced by an additional $200. Even if it's an emergency, you must notify MSA within two working days.

Precertification alone does not guarantee coverage.

Exceptions for maternity admissions

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

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

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

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

Precertification of outpatient and extended care services

You must call MSA for approval of the outpatient services listed on page 11. You must precertify with MSA no later than one day before treatment starts. However, you should precertify as soon as you think you might need treatment. To request precertification, simply call the MSA precertification number given in the section called *How to contact Medical Services Advisory* on page 14. If you don't call, you will pay an additional $200 for each procedure.

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

Precertification alone does not guarantee coverage

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

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

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

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

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

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

Recertification for extending an inpatient stay

When MSA authorizes an inpatient admission, the reviewing nurse may assign the number of days that are commonly needed for inpatient care. If a physician believes it is medically necessary for you to receive inpatient care longer than originally authorized, you are responsible for obtaining approval for the additional days through MSA. (See *How to contact Medical Services Advisory* on page 14.)

If you do not call for recertification

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

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

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

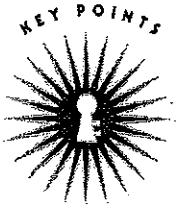
If MSA receives a call requesting approval of additional days of care, and MSA determines that additional inpatient care is not medically necessary, the plan will not provide any benefits for the extra days.

Concurrent review

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

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

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



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

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

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

Retrospective review

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

Managed second surgical opinion

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

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

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

Individual case management

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

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

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

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

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

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

How to contact MSA

When you need to contact MSA, please:

- Call 1-800-325-4705.

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

- Your identification number (from your health plan ID card).
- The name and phone number of the admitting physician.
- The date of admission.
- The name of the hospital or treatment facility.

- The reason for the admission, and how long the doctor expects you to be an inpatient.

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

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

If you disagree with MSA's decision

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

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

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

ANNUAL DEDUCTIBLE

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

The annual deductible depends on whether your expenses are from network or non-network providers. Deductibles are shown in the chart on page 8. However, there are special features and exceptions:

- The deductible may be satisfied with a combination of network and non-network expenses.
- You will pay no more than two times the individual deductible amount in any one calendar year for all your family members combined.
- If two or more covered members of your family are injured in the same accident, you only have to meet one annual deductible for their combined covered expenses for that accident.
- If you have covered expenses in the last three months of a calendar year that apply toward your deductible, they may be applied to the next year's deductible as well.
- No deductible applies to wellness benefits received from network providers, as explained under *Wellness benefits* on page 19.
- Covered expenses already used to satisfy the deductible under the Peabody Group Health Plan for Salaried Employees will be applied towards the current calendar year deductible of this plan.

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

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

HOSPITAL COPAYMENT

Before the plan pays benefits for an inpatient hospital stay, you must pay an additional hospital copayment. The hospital copayments are shown in the chart on page 8.

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

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

EMERGENCY ROOM COPAYMENT

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

OUT-OF-POCKET MAXIMUM

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

For most types of care, you pay a percentage of the covered expenses (called coinsurance) after the deductible and copayments are met. If the amount you have paid in one year for one person's covered medical expenses reaches the out-of-pocket maximum amount shown in the network column in the chart on page 8, (including the deductible, copayments, coinsurance and prescription drugs), the plan will pay 100% of any additional covered network expenses incurred by that person for the rest of that calendar year. If the amount you have paid in one year for one person's covered medical expenses reaches the out-of-pocket maximum amount shown in the non-network column in the chart on page 8, the plan will pay 100% of any additional covered expenses (network and non-network) incurred by that person in that calendar year.

For all covered family members combined, the most you will pay out-of-pocket for covered expenses in one calendar year is the family maximum amount shown in the chart on page 8.

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

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

- Expenses that exceed the plan maximums.

LIFETIME MAXIMUM BENEFIT

For all covered expenses, the medical plan pays a lifetime maximum of $1 million for each covered person, as of March 1, 1990. This amount is increased annually by the Health Cost Component of the Consumer Price Index. In 1999, the lifetime maximum was $1.6 million.

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

PRESCRIPTION DRUG BENEFITS

Covered prescription drugs are reimbursed at 70% after you have met the medical plan deductible each year.

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

How the plan works

Here's how you receive benefits for prescription drugs:

- When you have a prescription filled, you will be required to pay the full cost of the drug up front. If you are using a BlueScript participating pharmacy, your cost will be discounted. Then, the participating pharmacy will file your claim with BlueCross BlueShield of Illinois.
- BlueCross BlueShield will credit the amount you have paid for covered prescriptions, along with your other covered medical expenses, toward your annual medical plan deductible and send you a check in the amount of the benefits payable for your expenses. After you have met the deductible, you will be reimbursed at 70% for all covered prescription drugs for the rest of the calendar year. (If your overall medical costs reach the out-of-pocket maximum in a calendar year, the plan will then pay 100% of eligible prescription drugs for the rest of that year.)
- If you use a non-participating pharmacy, you will not receive the BlueScript discounts and you must file your own claim with BlueCross BlueShield of Illinois. BlueCross BlueShield of Illinois will then reimburse you as described above.
- In any case, you will receive an explanation of benefits from BlueCross BlueShield of Illinois showing the amount that was applied to your deductible and how your benefits were determined.

Mail-order program

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

Prescription drugs are covered at 70% after the annual deductible. Discounts are available through a participating provider pharmacy network called BlueScript.

Certain drugs require prior approval from BlueCross BlueShield of Illinois.

To use the mail-order program:

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

Covered drugs

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. Coverage is limited to drugs that are medically necessary for a specific diagnosis. Dispensing limits may apply.

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.
- Prescriptions for birth control devices or birth control pills (unless these are being used for other than contraceptive purposes, and pre-approval has been given by BlueCross BlueShield of Illinois).

Certain drugs require prior approval from BlueCross BlueShield of Illinois. If your doctor prescribes any of the following, you must call 1-888-873-2227 and receive a prior authorization before the plan will pay benefits for:

- Erectile dysfunction therapy.
- Hair-growth products.
- Contraceptive medication. (Covered only with a specific diagnosis and when medically necessary. Drugs used for birth control are not covered.)
- Smoking-cessation prescriptions in excess of a 90-day program within any 12-month period (over-the-counter products are not eligible).
- Acne therapy medication for participants over age 25.
- Anorectics.
- Growth hormones.
- Fertility drugs.
- Interferon.

- Myeloid stimulants.
- CNS stimulants.
- Migraine therapy.
- Betaseron.
- Erythroid stimulants.

If you have any questions about your prescription drug coverage, you may call BlueCross BlueShield of Illinois directly at 1-888-873-2227.

If you have other group health coverage for prescription drugs—through your spouse's employer, for example—refer to the *Claims procedures* section on page 32 for information about how to submit your claims.

COVERED MEDICAL EXPENSES

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

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

Wellness Benefits

The plan provides benefits for certain wellness and preventive care services. When the care is received from a network provider, the plan will pay 70% of covered wellness expenses up to $250 per person per calendar year with no deductible. Covered expenses in excess of the $250 annual maximum and covered wellness charges by non-network providers will be considered under the regular benefits of the plan (70% for network providers and 50% for non-network providers) after you have paid the applicable deductible.

Covered wellness expenses include:

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

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

The plan provides benefits for certain wellness and preventive care services.

Hospital charges

Covered expenses include the following inpatient and outpatient hospital charges. For an inpatient hospital stay, MSA must approve the hospitalization, as explained on page 11. After the deductible and copayments are met, benefits are payable at 70% for network charges and 50% for non-network charges.

- Room and board expenses in a semi-private room, including expenses for intensive care or coronary care units. The cost of a private room may be eligible if medically necessary.
- Special diets.
- General nursing care.
- Use of operating, delivery, recovery, and treatment rooms and equipment.
- Emergency room care.
- All FDA-approved and appropriately prescribed drugs and medicines for use in the hospital, and covered drugs or medicines sent home following hospitalization, up to a 30-day supply.
- Dressings, ordinary splints and casts.
- X-ray examinations, X-ray therapy and radiation therapy and treatment.
- Laboratory tests.
- Physical therapy.
- Anesthesia and its administration.
- Blood and blood derivatives, to the extent they are not donated without charge or the hospital's supply is not replaced by or for the patient.
- Processing and administering of blood and blood plasma to the extent it is not donated by the patient.
- Chemotherapy.
- Renal dialysis therapy administered according to Medicare regulations.
- Dental care due to accidental bodily injury or oral dental surgery when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition.

Surgical charges

After the deductible is met, the plan pays covered expenses for surgical services described in this section at 70% for network charges or 50% for non-network charges.

Covered expenses include the following surgical services:

- Surgical procedures, including customary preoperative and postoperative services, performed by a physician or surgeon. (Voluntary sterilization surgery is covered but reversal of sterilization surgery is not.)
- The necessary services of an assistant surgeon who actively assists the physician in surgery when:
  - You or your covered dependent is hospitalized.
  - The type of surgery requires assistance.
  - The services of interns, residents or house officers are not available.
  - Payment for assistant surgeons will be at 25% of the primary surgeon's usual, customary and reasonable charge.

- Medical supplies required for surgery in a hospital, a hospital's outpatient department, a physician's office or a freestanding ambulatory surgical facility.
- Administration of anesthesia when administered by a certified nurse anesthetist or a physician other than the surgeon or assistant surgeon.
- When more than one surgical procedure is performed at the same operative session and *through the same incision,* coverage for the secondary procedures will be limited to 50% of the usual, customary and reasonable charge that would apply if the procedures were performed independently. However, additional charges for "incidental surgery" are not covered. Incidental surgery is a procedure that is usually included in the primary surgery charge.
- Oral dental surgery due to an accident, impacted teeth or alveolectomy.
- Surgical benefits for the following procedures may be covered, subject to prior approval by MSA:
  - Surgery for treatment of temporomandibular joint dysfunction (TMJ) if necessary to reorient the joint.
  - Reduction mammoplasty, if medically necessary (not cosmetic).
  - Obesity, if you or your covered dependent is 160% or more of the desirable weight and conservative therapies have been tried and proven unsuccessful, and MSA has given prior authorization for the surgery.
- Cosmetic or reconstructive surgery required for:
  - Repair of defects resulting from an accident.
  - Following a mastectomy, reconstruction of the affected breast and reconstruction of the other breast to create a symmetrical appearance, including services required as a result of complications.
  - Replacement of diseased tissue that was surgically removed.
  - Treatment of a birth defect.

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

Home health care

Covered expenses include home health care that follows inpatient hospital treatment if approved in advance through MSA. (See the section called *How to contact Medical Services Advisory* on page 14.) The home health care must be a necessary alternative to continued hospitalization. After you meet the annual deductible, the plan pays 70% of covered expenses for network charges and 50% for non-network charges.

Eligible expenses from an authorized home health care agency include:

- Part-time or intermittent nursing services.
- Physical, occupational or speech therapy.
- Medical and surgical supplies that would also be covered as a hospital inpatient expense.
- Prescription drugs for IV infusion therapy or injections.

However, the following coverage limitations apply:

- The home health care must be for the continued treatment of the same condition for which the patient has already received inpatient care. It must begin within 21 days after the patient is discharged as an inpatient from a hospital or skilled-nursing facility for treatment that was covered by the plan.
- The home health care must be provided according to a plan of treatment established by the patient's physician and approved through MSA.
- The patient must be homebound for health reasons, but the patient may leave home occasionally to obtain outpatient hospital care that cannot be provided at home, or to obtain care from a licensed health care professional.

Benefits for home health care are not provided for:

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

Hospice care

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

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

After the deductible has been met, the plan pays for covered hospice care expenses at 70% for network charges and 50% for non-network charges.

The following special limitations apply to hospice care:

- All hospice care benefits are limited to a lifetime maximum of $10,000.
- The care must be provided according to a physician's written treatment plan that has been approved in advance by MSA. (See the section called *How to contact Medical Services Advisory* on page 14.)

- Counseling for the family is covered up to a maximum of $200.

Benefits for hospice care are not provided for:

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

Skilled nursing facility

Covered expenses include care from an approved skilled-nursing facility, subject to the following limitations:

- The care must be for the continued treatment of the same condition for which the participant previously received inpatient hospital care, and the patient must have been transferred directly to the skilled-nursing facility from the hospital.
- The care must be provided according to a physician's treatment plan and approved in advance by MSA. (See the section called *How to contact Medical Services Advisory* on page 14.)
- 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.

After the deductible has been met, the plan pays for covered skilled nursing facility expenses at 70% for network charges and 50% for non-network charges.

Other medical services

After the deductible has been met, the plan pays for certain other covered medical services at 70% for network charges and 50% for non-network charges. (Please note this section of the plan does not cover expenses that exceed the maximum benefit described in other sections.)

The following expenses are eligible for benefits under this section of the plan:

- Expenses you incur at your home, a hospital, a clinic or your physician's office for the professional services of a physician or surgeon, including consultations by a qualified specialist.
- Expenses you incur for the services of a physician's assistant or nurse practitioner.
- Expenses incurred for the services of a registered nurse (RN) or licensed practical nurse (LPN), when the skills of an RN or LPN are required.
- The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye.
- The fitting of diaphragms or the insertion or removal of an IUD. (Pharmacy charges for birth control pills or contraceptive devices are not covered.)

- Artificial insemination, when medically diagnosed as an appropriate treatment for infertility. However, the plan will cover artificial insemination for only one of the following, after which the plan will no longer pay benefits:
  - No more than three times within three consecutive cycles.
  - No more than a total of four attempts within a six-month period.

  In vitro fertilization and gamete-transfer procedures are not covered.
- Laboratory tests, radium therapy, X-rays and microscopic tests, including the services of a radiologist and pathologist.
- Professional local ambulance services for transportation to a clinic, medical center, hospital, physician's office or skilled-nursing facility, when medically necessary.

  Air ambulance charges are also covered for:
  - Transportation from a remote area to the first, nearest hospital where treatment can be given.
  - Transportation to a hospital in the event of a life-threatening accidental injury or sudden, life-threatening illness.
- Prosthetic appliances to replace missing or nonfunctioning parts of the body. Covered prosthetic appliances include:
  - Breast prostheses, internal and external (including two surgical brassieres per year), for reconstruction after a mastectomy.
  - Cardiac pacemakers, atomic or electronic.
  - Extraocular and intraocular lenses to replace either surgically removed or congenitally absent crystalline lenses of the eye.
  - Penile prostheses in men suffering impotency resulting from an organic disease or injury.
  - Artificial eyes.
  - Artificial limbs.
  - Colostomy supplies and other equipment directly related to ostomy care.
  - Electronic speech aids after a laryngectomy.
  - Urinary collection and retention systems (Foley catheters, tubes, bags and so forth) in cases of permanent urinary incontinence.

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

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

- Orthopedic devices, including:
  - Braces and trusses.
  - Custom-made and molded supportive orthotic appliances for the feet, when prescribed by a physician.
  - Custom-made shoes when prescribed by a physician.
  - Up to two pairs of surgical stockings per prescription in a six-month period, when prescribed by a medical physician for such conditions as thrombophlebitis or conditions resulting from surgery.
- Rental of durable medical equipment for home use, up to its purchase price. In some cases, MSA may instead approve the outright purchase of the equipment if it is for long-term use.
- Home oxygen equipment, including stationary and portable oxygen systems, will be eligible for coverage according to Medicare guidelines up to the purchase price.
- Services of an inhalation therapist in the patient's home, under the orders of the attending physician.
- Physical therapy by a licensed physical therapist that is expected to produce significant improvement within a two-month period. Benefits will no longer be paid when care has become maintenance. When the therapeutic goals of the treatment plan have been achieved and/or when no more measurable progress is expected, benefits will cease. Physical therapy coverage for temporomandibular joint syndrome (TMJ) follows the same guidelines.
- Speech therapy, by a licensed speech therapist, to restore speech that has been impaired as a result of illness, surgery or injury. Speech therapy will also be covered after surgery to correct birth defects. Developmental delays in learning to talk, the perfection of speech and educational services are not covered.
- Occupational therapy for a physical or severe mental disability to restore the ability to perform ordinary tasks of daily living. Benefits will end when the therapeutic goals of a treatment plan have been achieved or when no more measurable progress is expected. Occupational therapy is not covered for most mental and chemical-dependency conditions.
- Cardiac rehabilitation to restore health as much as possible, through exercise, education of the patient and reducing risk factors. To be eligible for benefits, cardiac rehabilitation must be provided within 12 months after one of the following:
  - An acute myocardial infarction (heart attack).
  - Coronary bypass surgery.

In most cases, necessary treatment of pregnancy is covered in the same way as an illness or injury for you or (if covered) your spouse.

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

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

- Biofeedback therapy, when reasonable and necessary for muscle re-education of specific muscle groups or for treating specific muscle abnormalities. This is not covered for treatment of ordinary muscle tension or for psychosomatic conditions.

- Treatment of temporomandibular joint syndrome (TMJ) to realign the joint, and removable appliances and splints when medically necessary. Services or supplies in connection with crowning, wiring or repositioning the teeth, such as orthodontia, are not covered.

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

- Services of a Navajo medicine man who is certified by the office of Native Healing Services and the Navajo Health Authority, or the services of a Northern Cheyenne or Crow medicine man, up to $400 per covered individual per calendar year.

PREGNANCY

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

- The pre-existing conditions limitation does not apply to pregnancy.

- Precertification is not required for a hospital stay that does not exceed 48 hours for a normal delivery or 96 hours for a cesarean section (see the *Medical Services Advisory (MSA) and Hospital Precertification Program* on page 10 for more information).

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

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

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

MENTAL ILLNESS AND SUBSTANCE ABUSE

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

Inpatient mental illness and substance abuse

The medical plan covers inpatient mental illness and substance abuse programs for up to 30 days per individual per year, not to exceed 60 days per lifetime. After the annual deductible and the hospital copayment are met, covered expenses are paid at 70% for network charges or 50% for non-network charges. Also, the inpatient care must be approved by the Medical Services Advisory program, as explained on page 11.

Outpatient mental illness and substance abuse

The plan covers outpatient treatment of mental illness and substance abuse for up to 30 visits per calendar year. After you've met the annual deductible, covered expenses are paid at 70% for network charges or 50% for non-network charges. Your share of these expenses does not count toward the out-of-pocket maximum.

Covered services

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

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

EXCLUSIONS

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

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

- Convalescent care, custodial, domiciliary or sanitarium care or rest cures.
- Expenses from a continuous hospital confinement that began before a person's coverage under this plan became effective.
- Travel expenses.
- Expenses for any services you have no legal obligation to pay, or for which no charge would be made if you had no medical coverage.
- Expenses in excess of usual, reasonable and customary charges.
- Expenses for the plan's penalties for failure to precertify a hospital admission, or for hospitalizations that exceed the length of stay approved by the Medical Services Advisory program.
- Institutional care, when the covered individual does not have to be an inpatient to receive medically effective care.
- Services or supplies in connection with treatment that the claims administrator determines to be experimental or investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational if any of the following applies:
  - There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.

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

- When required by the FDA, approval has not been granted for marketing.
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.
- The written protocol or written informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

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

- The disease can reasonably be expected to cause death within one year in the absence of effective treatment, and all other, more conventional methods of treatment have been exhausted.
- The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the claims administrator will take into account the results of a review by a panel of independent medical professionals, selected by the claims administrator.

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

- Any expenses that are not medically necessary for the treatment of an illness or injury.
- Procedures that are not needed when performed with other procedures, or unlikely to provide a physician with additional information when used repeatedly.
- Procedures that are not ordered by a physician, or not documented in timely fashion in the patient's medical record.
- Any services provided before the effective date of coverage, or after coverage ends.
- Services in connection with transsexual surgery.
- Accidental bodily injury or illness caused by war or any act of war, whether or not declared, including armed aggression, participation in a riot, or attempted felony or assault.
- Accidental bodily injury or illness that is covered by any workers' compensation or occupational disease law.
- Except as required by law, expenses from a U.S. government hospital or any other hospital operated by a government unit, unless there is an expense that the covered individual is legally required to pay.
- Services in connection with any treatment of the teeth, gums or alveolar process, except:
  - Dental care for the initial repair of an accidental injury to sound natural teeth provided the care is received within 12 months, following the date of the accident.

- Oral dental surgery due to an accident, impacted teeth or alveolectomy.
- Hospital expenses when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition.

- Surgery for the purpose of fitting or wearing dentures or dental implants.
- Any medical observation or diagnostic study when no illness or injury is revealed, unless you provide the claims administrator with satisfactory proof that the covered person had definite symptoms of illness or injury other than hypochondria. This limitation does not apply to benefits for wellness services listed under *Covered medical expenses.*
- Hearing aids, or for their prescription or fitting.
- Vision training, eyeglasses and contact lenses or examinations for their prescription or fitting, except:
  - The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye.
  - Contact lenses, as long as the contacts are for the replacement of the eye's lenses.
  - Vision training following eye surgery.

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

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

- Actual or attempted impregnation or fertilization that involves the covered individual as a surrogate or donor, or the pregnancy of a surrogate mother.
- Expenses in connection with assisted reproductive technology or "ART." ART means any combination of chemical or mechanical means of obtaining gametes and placing them in a medium (whether internal or external to the human body) to improve the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer or pronuclear state tubal transfer. Artificial insemination is covered by the plan, subject to the limitations described under *Covered medical expenses*.
- Expenses for reversals of sterilization procedures.
- Home obstetrical delivery.
- Expenses for abortion, unless medically necessary to protect the life of the mother.
- Charges for more than one ultrasound test for a normal, uncomplicated pregnancy.
- Adoption expenses.
- Charges incurred as a result of a pregnancy of a dependent child.
- Birth control devices or birth control pills, unless used for other than contraceptive purposes and approved by the plan.
- Hypnosis and acupuncture.
- Naturopathic or holistic services.
- Massage therapy or rolfing.
- Treatment, instructions, or activities for control or reduction of weight, except medical treatment approved by MSA or surgery for morbid obesity as described under *Surgical charges* on page 21.
- Expenses for telephone conversations with a physician in the place of an office visit, for writing a prescription or for medical summaries and preparing medical invoices.
- Marriage counseling, encounter or self-improvement group therapy and school-related behavioral problems.
- Treatment received from a person who is your close relative or ordinarily resides with the patient. A "close relative" means you, your spouse or a person related to you or your spouse as a brother, sister or parent.
- Services by a licensed chiropractor, whether or not the services are covered by the chiropractor's license.
- Any care that does not require the services of a specifically trained medical professional.

- Routine foot care, including but not limited to treatment of corns and calluses, and nonsurgical treatment of bunions.
- Expenses for an autopsy or post-mortem surgery.
- Transportation for delivery of home health care.
- Dentures, replacement of teeth or structures directly supporting teeth.
- Electrical continence aids, anal or urethral.
- Wigs or hairpieces.
- Implants for cosmetic purposes.
- Penile prostheses for psychogenic impotence.
- Personal comfort or service items for use during confinement in a hospital, including but not limited to a radio, television, telephone and guest meals.
- Services or supplies not specifically listed under *Covered medical expenses*, including but not limited to:
  - Air conditioners, humidifiers, dehumidifiers, purifiers or tanning booths.
  - Over-the-counter orthopedic or corrective shoes.
  - Exercise equipment.
- Medical care, services or supplies for any injury that may have been caused by the act or omission of a third party, unless the covered individual has fully complied with the plan's subrogation provision. (See the section called *The plan's right to recover payment from third parties and subrogation* on page 35.)
- Services or supplies related to a pre-existing condition, to the extent that such a condition would have been excluded if you had remained covered under the Peabody Group Health Plan for Salaried Employees.
- Claims received more than 12 months after the date the services or supplies were received.

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

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

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

Claims Procedures

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

1. Obtain a claim form and envelope from the benefits department.

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

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

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

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

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

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

Exceptions apply to maternity admissions, as explained on page 26.

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 the claims administrator at 1-888-873-2227 or writing the plan administrator at the address on page 48. Formal claim-review procedures are also discussed in that section.

PAYMENT OF BENEFITS

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

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

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

RECOVERY OF EXCESS PAYMENTS

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

THE PLAN'S RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

By participating in this plan, you (and your covered dependents) agree that the plan may provide or obtain any information necessary to carry out the plan's provisions without having to give any person notice or obtain anyone's agreement. When you submit a claim for benefits, you must provide all the information needed to carry out the plan's provisions.

PAYMENT OF BENEFITS TO PERSONS OTHER THAN YOU

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

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

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

RIGHT TO AUDIT

The company reserves the right to inspect and analyze, for audit purposes, the claim files held by the claims administrator.

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

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

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

Coordination of Benefits

A coordination of benefits (COB) provision applies if you or your dependents are covered by another group plan such as through your spouse's employer.

If you have coverage under another group plan, the benefits paid by our company plan will be reduced by the amount of the other plan's payment.

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

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

EFFECT OF MEDICARE

If you or your dependent remains eligible for this plan after becoming Medicare eligible, the company plan will coordinate with Medicare benefits. Medicare is the primary plan (it pays benefits first) and the company plan is secondary (it pays benefits second, under the COB provision).

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

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

Your benefits will be reduced in this manner if you are eligible for coverage under Medicare Parts A and B, even if you are not enrolled in both parts of Medicare. The company plan's benefits will still be reduced by the amount that Medicare *would* have paid if the patient had enrolled for coverage and had made a claim under Medicare. *For this reason, you should enroll for Medicare coverage as soon as you are eligible. Medicare provides a special enrollment period for individuals 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.*

Note: These provisions do not apply if your eligibility for the catastrophic plan terminates when you become eligible for Medicare. Refer to your Voluntary Separation Agreement or Summary of Material Modifications to determine whether your coverage may continue after Medicare eligibility.

THE PLAN'S RIGHT TO NECESSARY INFORMATION

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

THE PLAN'S RIGHT TO MAKE PAYMENTS TO OTHER ORGANIZATIONS

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

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

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

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

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

Alternatively, if either you or your dependent obtains any payment from the third party, or any insurance covering the third party or any first-party benefits such as uninsured motorist insurance, the plan is entitled to be paid back in full, "in first priority," for the benefits it paid on your behalf. In other words, the plan must be fully reimbursed *first* from any money you receive as a result of a claim against the third party or other insurance.

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

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

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

- Include the medical expenses in any claim that you or your dependents make against a third party for the injury or condition. You must notify the plan at least 30 days before you settle or compromise any claim.
- Reimburse the plan in full, in first priority, for any benefit payment if you or your dependents receive a settlement with a third party or payment for medical expenses. You must make this reimbursement within 30 days of receiving the settlement.
- Cooperate fully with the plan in asserting its rights to attempt recovery of payments, and supply the plan with any information and fill out any forms needed for this purpose within five days of receiving a request from the plan.

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

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

When Coverage Ends

Your coverage, including coverage for your dependents, will end on the date the earliest of the following occurs:

- You retire and meet the definition of a retired employee.
- You reach the end of your eligibility period as stated in your Voluntary Separation Agreement.
- You fail to make the required contribution (coverage will terminate at the end of the month for which the last contribution was paid on a timely basis).
- The plan is terminated.

If you die or a dependent ceases to be eligible under the plan's rules, your dependents may continue coverage until the end of the dependent eligibility period as given in your Voluntary Separation Agreement.

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

Continuation of Coverage

If your Voluntary Separation Agreement Summary of Material Modification (SMM) provides coverage for dependents to the end of your original maximum period, your dependents may continue coverage only for the balance of the maximum coverage period outlined in your Voluntary Separation Agreement.

For example, if your Voluntary Separation Agreement provides coverage under this plan for a maximum of three months, and you die during that period, your dependents may continue coverage for the balance of the three-month period.

If certain events would cause your dependents to lose coverage before the end of your original maximum coverage period provided under the terms of the Voluntary Separation Agreement, your dependents may continue coverage under COBRA for up to 36 months as described in this section.

COBRA ELIGIBILITY

Your dependents may continue their medical coverage under COBRA 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.

If one of these events would cause your dependents to lose coverage before the end of your original maximum coverage period provided under the terms of the Voluntary Separation Agreement, your dependents may continue coverage under COBRA for up to 36 months as described in this section. The 36-month period of COBRA coverage will be reduced by the length of time your dependents receive continued coverage at the regular contribution rate following a qualifying event under the terms of your Voluntary Separation Agreement.

WHEN COBRA CONTINUED COVERAGE ENDS

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

- The cost of continued coverage is not paid by the date it is due.
- Your dependent 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 Peabody Group Benefits Call Center immediately if your dependent becomes covered under another group health plan.
- Your dependent becomes entitled to Medicare.
- The plan terminates for all employees.
- Thirty-six months have passed since the date of the first event that caused your dependent's loss of coverage.

APPLYING FOR COBRA 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 COBRA 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 COBRA CONTINUED COVERAGE

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

BENEFITS UNDER COBRA CONTINUED COVERAGE

Aside from the special rules that apply specifically to COBRA continuation, continued coverage will be exactly the same health coverage your dependent would have been entitled to if his or her dependent status had not changed.

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

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

Converting Medical Coverage to an Individual Policy

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

Dependents cannot be added to the individual policy if they were not covered by the plan at the time your coverage ended.

Furthermore, the benefits available under an individual insurance policy are not necessarily the same as the benefits offered under the company's medical plan. You should examine the new individual policy carefully.

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

Key Terms

AMBULATORY SURGICAL FACILITY

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

CLAIMS ADMINISTRATOR

The organization retained by the company for granting or denying claims, currently BlueCross BlueShield of Illinois for medical and prescription drug claims.

COMPANY

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

CUSTODIAL CARE

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

DURABLE MEDICAL EQUIPMENT

Equipment that meets all of the following conditions:

- It can withstand repeated use.
- It is primarily and customarily used in the therapeutic treatment of sickness or injury.
- It is generally not useful to a person in the absence of a sickness or injury.
- It is appropriate for use in the home.
- It is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature.
- It is not primarily for the convenience of the person caring for the patient.
- It is not used for exercise or training.

EDUCATIONAL INSTITUTION

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

ELIGIBLE DEPENDENTS

Eligible dependents include:

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

Children who are eligible as dependents include:

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

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

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

ELIGIBLE RETIRED EMPLOYEE

A former salaried employee who has stopped working for the company because of retirement on or after January 1, 1970, and within 31 days of leaving the company begins to receive a retirement benefit from the company's retirement plan.

To be considered a retired employee for the purposes of the medical plan, you must be one of the following:

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

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

EMERGENCY OR URGENT CARE

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

HOME HEALTH CARE

Services provided by either:

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

HOME HEALTH CARE AGENCY

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

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

HOSPITAL

An institution that meets all of the following conditions:

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

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

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

ILLNESS

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

INJURY

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

MEDICALLY NECESSARY

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

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

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

MEDICARE

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

The term "Medicare benefits" will include the following:

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

(b) In the case of a covered individual who has either (1) not enrolled for Medicare Part A and Part B; (2) has enrolled in a Medicare managed care alternative or other Medicare+Choice plan and received reduced Medicare benefits due to failure to comply with managed care rules or use of non-network providers; or (3) received services under a private contract with a provider who has opted out of Medicare, the covered individual shall be deemed to have received Medicare benefits in an amount determined in accordance with the deductible and coinsurance factors then applicable under original Medicare, and in accordance with the covered expense definitions of this plan. The preceding sentence will not apply to benefits under hospital insurance (Part A) of Medicare with respect to an individual whose eligibility for such hospital insurance (Part A) of Medicare requires payment of premium.

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

MENTAL ILLNESS

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

PHYSICIAN OR SURGEON

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

REGISTERED PSYCHOLOGIST

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

- If state licensing or certification exists, he or she must hold a valid license or certificate as a psychologist.
- If state licensing or certification does not exist, he or she must hold a valid, non-statutory (professional) certification established by that area's recognized psychological association.
- If neither statutory or nonstatutory licensing or certification exists, the psychologist must hold a statement of qualification by a committee established by that area's psychological association. If no committee exists, he or she must hold a diploma in the appropriate specialty from the American Board of Examiners in Professional Psychology.

SKILLED NURSING FACILITY

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

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

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

SPOUSE

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

SURVIVING SPOUSE

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

Plan Administration Information

PLAN NAME

The Catastrophic Group Health Plan for Salaried Employees Terminated Through a Reduction in the Work Force.

TYPE OF PLAN

Welfare plan providing medical benefits subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

EMPLOYER IDENTIFICATION NUMBER

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

PLAN NUMBER

518

EFFECTIVE DATE

December 1, 1995

LAST AMENDED

January 1, 2000

PLAN FISCAL YEAR

January 1 to December 31

PLAN SPONSOR

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

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

PLAN ADMINISTRATOR

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

AGENT FOR SERVICE OF LEGAL PROCESS

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

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

FUNDING AND DISBURSEMENTS

The Plan is funded by contributions from Peabody and/or participating employees. Disbursements are made by the applicable Claims Administrator in accordance with the terms of the plan.

Medical and prescription drug benefits are self-insured by Peabody Holding Company, Inc. and are not guaranteed under a policy or contract of insurance.

Your ERISA Rights

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

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and copies of all documents filed by the plan with U.S. Department of Labor, such as detailed annual reports (Form 5500 Series).
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition, if you are a participant in a group health plan, you have the right to:

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Receive a copy of the plan's qualified medical child support procedures without charge from the plan administrator.
- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion or limitation, as described in the summary plan description. Note that this right is available only if you are a participant in a group health plan that is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Under the law, you have certain rights as a participant in this plan.

If your claim is denied or you disagree with the handling of a claim, you have a right to appeal the decision.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington DC 20210.

IF YOUR CLAIM IS DENIED

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

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

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

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

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

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

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

AMENDING THE PLAN

The company reserves the right to terminate the plan, change required contributions, or amend 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 participants to lose all or a portion of their benefits under the plan, but will not affect the right of any participant to be reimbursed for any covered expense that has already been incurred.

This plan will comply with all requirements of the law and will be changed, if necessary, in order to meet any such requirements.