PLAN TEXT

OF

PEABODY GROUP HEALTH AND LIFE PLAN

FOR

SALARIED EMPLOYEES

As in Effect on and after June 1, 1985

March 9, 1989

Retirement Disability

A. Must have ten years of service with Company
B. Must have disability established by Social Security
C. Proof of disability must be maintained until age 65
D. Benefits
    1. Group Health at no Cost
    2. Group Life at no Cost with reduction at age 65 -
        a. we need to have the amount available at 65 clarified

Early Retirement (prior to age 65)

A. Must have ten years of service
B. Must be at least 55 years of age
C. Benefits
    1. Group Health at no cost - no dental or vision
        a. Medicare becomes primary at age 65
        b. Cobra available for dental until age 65
    2. Life Insurance
        a. Retirement Life Insurance at no cost
            1. 30% of available Option A benefit
        b. Full Life Insurance until age 65
            1. $.21/thousand/month
    3. AD & D until age 65

Normal Retirement (age 65)
A. Must have ten years of service with Company
B. Must be 65 years of age
C. Benefits
    a. Group Health - no dental or vision (COBRA not available) Medicare is primary at age 65
    b. Life Insurance
        1. No cost to retiree - Reduced benefit (must be clarified)

PEABODY GROUP HEALTH AND LIFE PLAN
FOR SALARIED EMPLOYEES

ARTICLE I -- GENERAL INFORMATION

1.1 Intent of the Plan

The intent of the Plan is to set forth the description of the kind and extent of benefits as provided by the Plan for the necessary care and treatment of an Illness or Injury, and the eligibility of each class of Participants to receive such benefits.

1.2 Plan Text

This Plan was established to provide benefits exclusively for Salaried Employees, Disabled Salaried Employees, Retired Salaried Employees of the Company and their Dependents. This text and any amendments hereto constitute the Plan.

1.3 Composition of the Plan

The Plan is composed of:

Article I - General Information
Article II - Definitions
Article III - Eligibility Provisions
Article IV - Life Insurance and Accidental Death and Dismemberment Benefits
Article V - Medical Care Benefits
Article VI - Dental Care Benefits
Article VII - Vision Care Benefits
Article VIII - Claim Procedures
Article IX - Administration of the Plan
Article X - Change or Termination of the Plan
Article XI - Miscellaneous Provisions
Article XII - Eligibility Provisions for Retired Employees

1.4 Gender and Number

Whenever required by the context of any Plan provision, the masculine includes the feminine; the singular includes the plural; and the plural includes the singular.

1.5 Plan Effective Date (Unless otherwise stated in Article II 2.5)

The Plan was effective June 1, 1985, and amended from time to time thereafter.

ARTICLE II -- DEFINITIONS

In General

For purposes of the Plan, the following words and phrases, whether or not capitalized shall have the respective meanings herein provided unless different meanings are plainly indicated by the context.

The definitions set forth in this Article are relative to the Plan in a general sense. The definitions contained in Articles IV, V, VI and VII of this Plan are specifically applicable to those Articles. In the event any definition in the above mentioned Articles conflicts with a definition in this Article II, the definition in Articles IV, V, VI and VII shall govern.

2.1 **"Agent for Service of Legal Process"** shall be:

The Plan Administrator
Peabody Coal Company
P. O. Box 1991
1951 Barrett Court
Henderson, KY 42420

2.2 **"Child" or "Children"** shall include the following persons listed below who are dependent upon the Employee, Disabled Employee, Retired Employee or Surviving Spouse. A person shall be considered dependent if on a regular basis over one-half (1/2) of the annual support of such person is provided by the Employee, Disabled Employee, Retired Employee or Surviving Spouse.

A. The Employee's, Disabled Employee's or Retired Employee's own natural Children, stepchildren and legally adopted Children.

B. Grandchildren and/or other Children who reside in the household of the Employee, Disabled Employee or Retired Employee in a regular parent-child relationship and are dependent upon such individual for support. Children other than those legally adopted or the natural Children of Employees, Disabled Employees or Retired Employees require legal guardianship papers.

C. For medical and vision care eligibility, in addition to the requirements of A. and B. above the following are eligible:

1. Children who are unmarried and under the age of nineteen (19) years or if in full-time attendance at an Institution of Learning, up to the day in which such Child attains age twenty-three (23), and who are financially dependent upon and would normally reside with the Employee, Disabled Employee or Retired Employee; and

2. Unmarried Children of any age who are incapable of self-support due to mental retardation, physical handicap or continuous Total Disability and who are fully dependent upon the Employee, Disabled Employee or Retired Employee for support and maintenance. Mental retardation, physical handicap or continuous Total Disability must occur prior to age twenty-three (23), while said person satisfied the definition of dependent Children under the Plan. Support shall include living in the same household with the Employee, Disabled Employee or Retired Employee or confinement to an institution for care or treatment.

D. For Dental Care eligibility, only unmarried natural Children, stepchildren and legally adopted Children under the age of nineteen (19) who are dependents of an active Employee are eligible.

2.3 **"Claim Administrator"** shall mean the company retained by Peabody Coal Company which functions on an insured or contract administration basis for granting or denying claims.

2.4 **"Company"** The following companies have individually adopted the Plan:

Peabody Holding Company, Inc.
Peabody Development Company
Peabody Coal Company
Midco Supply and Equipment Corporation
Eastern Associated Coal Corp. (Effective May 1, 1987)
Excluding former salaried Employees of Eastern Associated Coal Corp. who are Retired Employees as described in Section 2.25 and Disabled Salaried Employees receiving benefits under the Eastern Gas and Fuel Associates Long Term Disability Plan on March 31, 1987.

NUEAST Mining Corporation (Effective May 1, 1987)
Excluding former salaried Employees of NuEast Mining Corporation who are Retired Employees as described in Section 2.25 and Disabled Salaried Employees receiving benefits under the Eastern Gas and Fuel Associates Long Term Disability Plan on March 31, 1987.
Mid-America Transportation Company
Colony Bay Coal Company (Effective September 1, 1987)

The term "Company" shall mean the company whose name appears on the execution page hereof.

2.5 **"Core Benefits"** shall mean medical benefits only.

2.6 **"Covered Individual" or "Participant"** shall mean a person who has met all requirements of each Article with regard to his or her eligibility, election to participate and contributions required for Plan participation.

2.7 **"Covered Charges" or "Covered Expenses"** shall mean only incurred charges or expenses or portion of such for medical, dental or vision care services or supplies which are eligible under the Plan and are:

A. Medically necessary for the diagnosis or treatment of an accident or Illness, except as indicated;

B. Prescribed by a Physician;

C. Necessary Care recognized as generally accepted practice by the medical, dental or vision care profession which is given at an appropriate level of treatment; and

D. Not in excess of the Reasonable and Customary charges for such supplies or services.

2.8 **"Deductible"** shall mean an amount of Covered Expenses during a calendar year which must be incurred by a Covered Individual before certain benefits under the Plan become payable.

2.9 **"Dependent"** shall mean all Children and the Spouse of the Employee, Disabled Employee or Retired Employee.

2.10 **"Disabled Employee"** shall mean any Employee who is receiving Company paid salary continuance or receiving benefits under the Peabody Long Term Disability Plan for Salaried Employees.

2.11 **"Employee"** shall mean:

Any full-time salaried employee of the Company who is scheduled to work at least thirty (30) hours per week or is considered to be a full-time salaried employee while on vacation, pre-paid retirement or assignment by the Company and who is not a Disabled Employee or Retired Employee.

Excluded from this definition is any part-time or temporary personnel as well as any person who is a non-resident alien and who receives no income from the Company which constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Internal Revenue Code).

2.12 **"ERISA"** shall mean the Employee Retirement Income Security Act of 1974 as same may be amended from time to time and the final regulations issued thereunder by the Secretaries of Labor and the Treasury.

2.13 **"Fiduciary"** shall mean for purposes of ERISA, Peabody Coal Company. Peabody Coal Company may designate any insurer or any other contracting entity as an additional Fiduciary of the Plan.

2.14 **"Illness"** shall mean any disease or disorder of the body or mind and pregnancy. Pregnancy shall include normal delivery, cesarean section, miscarriage, any complications resulting from pregnancy or termination of a pregnancy only if medically necessary, certified and performed by a Physician.

2.15 **"Injury"** shall mean the accidental bodily Injury caused directly and exclusively by sudden, external and violent means.

2.16 **"Institution of Learning"** shall mean any state accredited high school, college or university but including other bonafide educational institution such as nursing schools, trade schools, etc., having an established full-time curriculum for students. Correspondence schools, night schools or schools requiring less than full-time attendance are not acceptable.

2.17 **"Medicare"** shall mean the Health Insurance for the Aged and Disabled Program under Title XVIII of the Social Security Act as amended by the Social Security Amendments of 1965 (Public Law 89-97) and as such program is currently constituted and may be later amended.

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for Salaried Employees

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2.18 **"Necessary Care"** shall mean treatment recognized as generally accepted medical, dental or vision care practice in the profession or specialty from which care is rendered, as usual or customary treatment, given at an appropriate level of treatment for the Participant's Injury or Illness and shall be determined as such by the Plan Administrator.

2.19 **"Non-Core Benefits"** shall mean vision and dental benefits.

2.20 **"Plan"** shall mean Peabody Group Health and Life Plan for Salaried Employees.

2.21 **"Plan Administrator"** shall mean Peabody Coal Company.

2.22 **"Plan Year"** shall mean that period commencing on January 1 of each calendar year and ending on the December 31 of the calendar year.

2.23 **"Pre-existing Conditions"** shall mean an Injury or Illness for which the Covered Individual consulted with a Physician, received treatment or took prescribed drugs or medicines within three (3) months prior to the effective date of such person's participation or any conditions related to such Injury or Illness.

2.24 **"Reasonable and Customary"** shall mean the Reasonable and Customary charge for the procedure which gives rise to the expense as determined by the Plan Administrator.

2.25 **"Retired Employee"** shall mean a former salaried Employee who has separated from service with the Company on account of retirement, begins to receive a retirement benefit under a retirement plan maintained by the Company within thirty-one (31) days following such separation from service, and is described in Section 12.1, but excluding a former salaried Employee who is not described in Section 12.1.

2.26 **"Spouse"** shall mean the legal partner of the Employee, Disabled Employee or Retired Employee in marriage whether the union is by civil or religious ceremony. For purposes of this Plan, common law is not recognized as eligibility for a covered spouse.

2.27 **"Surviving Spouse"** shall mean the Spouse surviving the death of an Employee, Disabled Employee or Retired Employee who at the time of death was living with or supported by the Employee, Disabled Employee or Retired Employee.

2.28 **"Termination of Employment"** shall include:

A. Voluntary termination;
B. Involuntary termination;
C. Retirement; and
D. Death

2.29 **"Total Disability" or "Totally Disabled"** shall mean:

With respect to dependent Children, the inability to perform the normal activities, as determined by the Plan Administrator, for someone of his or her age and sex.

ARTICLE III -- ELIGIBILITY PROVISIONS

3.1 Eligibility

The following persons are eligible for coverage as indicated under the Plan, subject to the provisions of Section 3.2:

A. Life Insurance

1. All Employees.

2. All Retired Employees who had Life Insurance in force immediately preceding the date of retirement.

3. All Disabled Employees who are receiving either Company paid salary continuance or benefits under the Peabody Long Term Disability Plan for Salaried Employees and for which Life Insurance was in effect immediately preceding the date of disability.

4. In the case of an Employee terminated due to a reduction in work force, eligibility for the Employee shall continue through three (3) calendar months following the end of the month in which the reduction in work force occurred.

5. The Employee must enroll for Life Insurance within thirty-one (31) days from date of hire and make the required Employee contributions. If the Employee does not want to enroll for Life Insurance, he or she must sign a waiver card. If he or she wishes to wait the thirty-one (31) day waiting period to decide whether he or she wants to enroll for Life Insurance, a Memorandum of Understanding must be signed. If the Memorandum of Understanding is utilized and death occurs during this thirty-one (31) day sign up period, Life Insurance benefits are not payable.

   If after the thirty-one (31) day waiting period has elapsed, the Employee does want to enroll for Life Insurance he or she will need to complete an Evidence of Insurability Form and may be required to take a physical examination at the Employee's own expense. Life Insurance coverage shall be provided only after review and approval of the Evidence of Insurability.

Employees exempt from making contributions are Employees receiving benefits under the Long Term Disability Plan for Salaried Employees and the Employee who upon retirement took the reduced amount of Life Insurance.

7. Dependents are not eligible for Life Insurance.

B. Accidental Death and Dismemberment

1. All Employees.

2. All Retired Employees who are under age sixty-five (65) with an effective retirement date on or after January 1, 1970.

3. All Disabled Employees under the age of sixty-five (65) who are receiving Company paid salary continuance or benefits under the Peabody Long Term Disability Plan for Salaried Employees.

4. Dependents are not eligible for Accidental Death and Dismemberment coverage.

C. Medical Care

1. All Employees and their Dependents.

2. All Retired Employees with a retirement date on or after January 1, 1970 as described in Section 12.1 and their Dependents.

3. All Disabled Employees receiving Company paid salary continuance or benefits under the Peabody Long Term Disability Plan for Salaried Employees and their Dependents.

4. The unmarried Surviving Spouse of a deceased Employee, Disabled Employee or Retired Employee (Employee who retired prior to September 1, 1977, but after January 1, 1970 must have made an election for a joint and survivor option, or retired on or after September 1, 1977) who at the date of death met the requirements of Section 12.1 or with proper election immediately preceding death would have met the requirements of Section 12.1. Eligibility continues until the death or remarriage of the Surviving Spouse. Dependent Children are eligible subject to the Surviving Spouse's eligibility and any other requirements of the Plan.

5. The unmarried Surviving Spouse of a deceased Employee or Disabled Employee not eligible under C.4. above shall remain eligible for three (3) calendar months following the end of the month in which the date of the Employee's or Disabled Employee's death occurred. Dependent Children are eligible subject to the Surviving Spouse's eligibility and any other requirements of the Plan.

6. In the case of an Employee terminated due to a reduction in work force, eligibility for the Employee and Dependents shall continue through three (3) calendar months following the end of the month in which the reduction in work force occurred.

D. Dental Care

1. All Employees and their Dependents.

2. Disabled Employees on Company paid salary continuance and their Dependents.

E. Vision Care

1. All Employees and their Dependents.

2. Disabled Employees on Company paid salary continuance and their Dependents.

F. The Company reserves the right to require proof or documentation of eligibility.

3.2 Effective Dates of Coverage

A. An Employee shall be eligible under the Plan on the first day of employment provided he or she have reported for work and enrolled in the Plan, subject to the limitations set forth in 3.2 D. and 3.2 E. below.

B. Eligible Dependents of an Employee shall be covered under the Plan on the effective date of the Employee's coverage.

C. Any Child born to an Employee, Disabled Employee or Retired Employee if such Employee, Disabled Employee or Retired Employee has Dependent coverage, hereunder, shall automatically become covered as a Dependent on the date such Child is born.

D. If an Employee is not at work on the date his or her participation would otherwise begin, he or she shall not become a Participant, hereunder, until the day he or she returns to active work.

E. An eligible Individual confined in a Hospital on the date his or her participation would otherwise begin, shall not become covered, hereunder, until he or she is discharged from the Hospital. This requirement shall not apply to a newborn Child otherwise eligible for coverage at birth.

3.3 Cessation of Coverage

A. Life Insurance coverage under this Plan for an Employee, Disabled Employee or a Retired Employee shall cease at the earliest of the following:

1. Discontinuance of the Plan by the Company;

2. The last day of the calendar month for which the Employee, Disabled Employee or Retired Employee shall have made the required contributions;

3. Death of the Employee, Disabled Employee or Retired Employee;

4. Termination of employment except as specifically provided by Subsection 3.1 A. relative to a reduction in work force;

5. Cessation as a member of an eligible class specifically described in Subsection 3.1 A; or

6. The date of separation from service if the Employee or Disabled Employee does not qualify as a Retired Employee as defined at Section 2.25.

B. Accidental Death and Dismemberment (AD&D) coverage under this Plan for an eligible Employee, Disabled Employee or Retired Employee shall cease at the earliest of the following:

1. Discontinuance of the Plan by the Company;

2. Termination of employment;

3. Death of the Employee or Retired Employee;

4. A Disabled Employee ceases to be a Disabled Employee unless he or she returns to active employment with the Company;

5. The date of separation from service if the Employee or Disabled Employee does not qualify as a Retired Employee as defined at Section 2.25;

6. Cessation as a member of an eligible class specifically described in Subsection 3.1 B; or

7. Attainment of age sixty-five (65) unless classified as an Employee.

C. Medical care coverage under this Plan for an Employee, Disabled Employee, or Retired Employee and their Dependents shall cease at the end of the earliest of the following dates:

1. Discontinuance of the Plan by the Company;

2. Death of the Employee, Disabled Employee or Retired Employee except in the case of an unmarried Surviving Spouse and eligible Children as specifically provided by Subsection 3.1 C.;

3. Termination of Employment except as specifically provided by Subsection 3.1 C. relative to a reduction in work force;

4. The date of separation from service if the Employee or Disabled Employee does not qualify as a Retired Employee as defined at Section 2.25;

5. A Dependent ceases to be an eligible Dependent under the Plan;

6. A Disabled Employee ceases to be a Disabled Employee unless he or she returns to active employment with the Company; or

7. Cessation as a member of an eligible class specifically described in Subsection 3.1 C.

D. Vision care coverage under this Plan for an eligible Employee or Disabled Employee receiving Company paid salary continuance and their Dependents shall cease at the earliest of the following dates:

1. Discontinuance of the Plan by the Company;

2. Termination of Employment;

3. The date the Employee becomes a Retired Employee;

4. Death;

5. Qualification of an Employee for benefits under the Peabody Long Term Disability Plan for Salaried Employees;

6. Cessation of a Dependent as an eligible Dependent under the Plan; or

7. Cessation as a member of an eligible class specifically described in Subsection 3.1 E.

E. Dental care coverage under this Plan for an eligible Employee or Disabled Employee receiving Company paid salary continuance and their Dependents shall cease at the earliest of the following dates:

1. Discontinuance of the Plan by the Company;

2. Termination of Employment;

3. The date the Employee becomes a Retired Employee;

4. Death;

5. Attainment of age nineteen (19) for a dependent child;

6. Cessation of a Dependent as an eligible Dependent under the Plan;

7. Cessation as a member of an eligible class specifically described in Subsection 3.1 D.; or

8. Qualification for an Employee for benefits under the Peabody Long Term Disability Plan for Salaried Employees.

F. Covered Individuals whose coverage ceases shall be eligible for an extension of benefits under Dental benefits only if coverage was in effect and covered dental services were incurred prior to the date such coverage ceased, as outlined in Article VI as follows:

1. In the case of appliances or modifications of appliances, if the master impression was taken by a Dentist prior to cessation of coverage and if the appliance is delivered or installed within two (2) calendar months following cessation;

2. In the case of a crown, bridge, inlay, or onlay restorations, if the tooth or teeth were prepared prior to cessation of coverage and if the crown, bridge or cast restoration is installed within two (2) calendar months following cessation;

3. In the case of orthodontic treatment commencing prior to cessation of coverage, coverage will be payable through the end of the month in which cessation occurs based on a proration of any applicable quarterly installment; or

4. In the case of root canal therapy, if the pulp chamber was opened prior to cessation of coverage, benefits will be payable if such root canal therapy is completed within two (2) calendar months after the cessation of coverage.

3.4 Continuation of Coverage

This Section 3.4 applies to all Covered Individuals, who for purposes of this Section 3.4 are qualified beneficiaries.

A. Continuation of Coverage

Coverage under this Plan for Medical Care may be continued upon election and timely payment of any required contributions as indicated below.

The continued coverage shall be on the same basis and in the same amount to which the Covered Individual was entitled immediately prior to the qualifying event as described below. If during the period of any continuation of coverage, the Plan is changed the same changes shall be applied to Covered Individuals participating in this continued coverage. The length of continuation coverage shall be as follows:

1. For a period of thirty-six (36) months from the date of the following qualifying events:

   a. To dependent Children, if he or she fails to satisfy the definition of Dependent;

   b. To the Spouse and/or dependent Children of an Employee, Disabled Employee or Retired Employee if a divorce occurs;

c. To the Spouse and/or dependent Children, if the Employee, Disabled Employee or Retired Employee dies;

d. To the Spouse and/or dependent Children of an Employee due to the Employee, Disabled Employee or Retired Employee becoming entitled to Medicare; or

e. In the event the Company files for bankruptcy under Chapter 11, to the surviving Spouse and/or dependent Children, if the Retired Employee dies after the bankruptcy filing.

2. For a period of eighteen (18) months from the date of the following qualifying events:

a. To the Employee, Disabled Employee or Retired Employee and their Dependents if the Employee is terminated from employment with the Company, (for any reason other than gross misconduct); and

b. To the Employee, Disabled Employee or Retired Employee and their Dependents if the Employee ceases to be a Covered Individual due to a reduction in hours.

3. For life from the date the Company files for bankruptcy under Title 11:

a. To the Retired Employee who is retired before the bankruptcy filing; and

b. To the surviving Spouse and dependent Children of a Retired Employee who died before the bankruptcy filing.

B. Notification

The Covered Individual shall be required to notify the Company if he or she becomes divorced or a dependent Child ceases to satisfy the definition of a Dependent within sixty (60) days of the date such event occurs.

1. The Employee Relations' Department shall notify the Plan Administrator within thirty (30) days if these qualifying events occur:

a. The death of an Employee, Disabled Employee or Retired Employee;

b. The termination of the Employee's, Disabled Employee's or Retired Employee's employment or reduction in hours; or

c. The Employee, Disabled Employee or Retired Employee becomes eligible for Medicare.

2. The Covered Individual is required to notify the Plan Administrator of any additional qualifying events which occur during the initial eighteen (18) month continuation of coverage, within sixty (60) days of such qualifying events.

   In no event shall the continuation period exceed thirty-six (36) months after the initial qualifying event.

3. Upon receiving notice from the Employee Relations Department or from a qualified beneficiary, the Plan Administrator shall notify said qualified beneficiary of his or her rights to continue coverage and the cost to do so.

4. The election period shall begin on the later of the date coverage terminates due to the qualifying event or the date notice is sent from the Company, and shall continue for sixty (60) days.

5. Coverage shall continue to the earliest of:

   a. The end of the benefit period as noted in Subsection 3.4 A. above;

   b. The date the Company discontinues the Plan to all Employees, Disabled Employees or Retired Employees;

   c. The last day of the month for which the qualified beneficiary fails to make the required contribution;

   d. The date the qualified beneficiary becomes covered under any other group health plan; or

   e. The day of the month in which the qualified beneficiary becomes entitled for Medicare.

C. Payment

Initial payment must be made on or before forty-five (45) days from the date of the election date to continue coverage. In the event a qualified beneficiary fails to make subsequent payment within thirty (30) days of the date specified, continuation coverage shall be terminated effective 12:01 a.m. following the last day for which premiums have been paid.

For example, if payments had been received through March 31, but April's premium was not received by April 1, coverage would terminate effective 12:01 a.m. April 1st.

D. Conversion After Continuation of Coverage

After termination of the eighteen (18) or thirty-six (36) month continuation of coverage, the qualified beneficiary is eligible for the Conversion Privilege as described in Section 3.7 below.

3.5 Continuation of Life Insurance Due to Disability

A. The Life Insurance provided for any Disabled Employee who is receiving benefits under the Long Term Disability Plan for Salaried Employees shall be continued in force during the continuance of such disability and no contributions are required provided Life Insurance was in effect immediately preceding the date of the disability.

B. The Life Insurance provided for any Disabled Employee who ceases to be disabled shall automatically terminate thirty-one (31) days after the date of termination of such disability, unless the Employee returns to active employment with the Company.

C. During continuance as described above, any reduction of benefits due to age or at any other specified time shall be reduced in accordance with the Plan.

3.6 Life Insurance Conversion

A. In case of the termination of Life Insurance due to termination of employment, or reduction due to age of Retired Employee such Employee, Disabled Employee or Retired Employee shall be entitled to have issued to him or her by the Claim Administrator without further evidence of insurability an individual

policy of Life Insurance without disability or other supplementary benefits, in an amount equal to or, at the option of the Employee, Disabled Employee or Retired Employee, less than, the amount of such terminated Life Insurance including, if the Employee, Disabled Employee or Retired Employee was covered for Survivor Income Benefits at the date of such termination, the present value of such benefits determined by the Claim Administrator as of such date, and in any one (1) of the forms then customarily issued by the Claim Administrator.

B. The Employee must make:

1. Application to the Claim Administrator within thirty-one (31) days after such termination of Life Insurance at the end of the month; and

2. Payment of the premium applicable to the class of risks to which he or she belongs and to the form and amount of the policy at his or her attained age.

C. Extended Benefit:

In event of the death of the Employee, Disabled Employee or Retired Employee after termination of his or her Life Insurance hereunder and during the thirty-one (31) day period hereunder for making application for an individual policy and before any such individual policy shall have become effective, the amount of insurance for which such Employee, Disabled Employee or Retired Employee shall have been entitled to make application shall be payable as a death benefit hereunder.

3.7 Conversion Privilege for Medical Care Benefits

Upon cessation of coverage for reasons other than termination of the Plan or failure to make required contributions, a Covered Individual shall be entitled to convert to non-group coverage without the necessity of qualifying for such coverage by passing a physical examination.

A. Written application and the first payment of the required contribution must be made to the Claim Administrator within thirty-one (31) days after the date of termination.

B. Such coverage shall include hospitalization benefits of the type customarily issued by the Claim Administrator in conversion of group benefits.

C. The form of the individual insurance policy issued and all other terms and conditions thereof shall be provided by the rules of the Claim Administrator.

D. The coverage, if issued, shall become effective upon the day following the date of cessation of coverage, and subject to the payment of the required premium shall be continued in force for a term of one (1) year. Such policy may be renewed with the consent of the Claim Administrator and at such rates as it may determine for successive terms of one (1) year each.

IV. LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT

4.1 Definitions Relative to Life Insurance and Accidental Death and Dismemberment

For purposes of the Plan, the following terms have the meaning indicated:

A. **"Basic Annual Salary"** shall mean the Employee's Basic Annual Salary as shown on the Company's records, which excludes overtime, special allowances or salary for foreign service, awards, awards under any special compensation plan or like plans and payments under any savings plan or any other employee benefit plan.

B. **"Beneficiary"** shall mean the person or persons designated by the Employee prior to death to receive payment of the Life Insurance benefits.

C. **"On the Business of the Company"** shall mean:

1. Work on an assignment by or with the authorization of the Company away from the Employee's usual place of employment for the purpose of furthering the business of the Company, but not including travel within their usual place of employment; regular travel between the residence of the Employee and the Employee's place of business to which the Employee most frequently reports to work; or any activity of the Employee while on vacation; and

2. At all times during which an Employee is temporarily or permanently assigned extraterritorially including travel to and from the Employee's home country, but not travel within that country except as described in Paragraph C.1. above.

D. **"Loss"** shall mean death or with regard to hands and feet, dismemberment by severance through or above the wrist or ankle joints; with regard to eyes, the entire and irrecoverable loss of sight.

E. **"Survivor"** shall mean the Spouse of the deceased Employee.

4.2 Benefit Provisions

Employees, Disabled Employees and Retired Employees are eligible for the benefits described in this Article IV, as indicated in Subsection 3.1 A. or B. The benefits provided under this Article are insured through the Claim Administrator and the Plan as evidenced by the terms and provisions of the group insurance policy as issued. The terms and provisions of the group insurance policy, and amendments or riders thereto and any policies at any time issued in substitution therefore, shall form a part of the Plan in the same manner as if all the terms and provisions thereof were copied herein.

4.3 Life Insurance

A. The Life Insurance benefits for an Employee shall be an amount equal to two (2) times Basic Annual Salary on the effective date of coverage, taken to the next higher multiple of $100, if the amount is not already a multiple of $100.

1. If the Employee's Basic Annual Salary changes, the amount of Life Insurance shall be predetermined as of the first day of the calendar month next following the date of such increase provided, however:

a. No increase in the amount of Life Insurance shall become effective as to any Employee who is away from work due to disability until the date the Employee actually returns to work on a full-time basis;

b. There shall be no decrease in the scheduled amount of insurance due to a decrease in the Basic Annual Salary; and

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c. No increase in the amount of life insurance shall be effective prior to the effective date of the increase in the Basic Annual Salary.

B. The Life Insurance benefits for a Retired Employee or Disabled Employee only as indicated shall be as follows:

1. For a Retired Employee less than age sixty-five (65), the amount shall be reduced to the amount which would have been applicable as if he or she had retired at age sixty-five (65) as indicated in Subparagraph B.2 below, unless he or she shall have filed prior to the date of retirement with the Company a written request to continue to be insured for the amount in force on the day prior to retirement;

2. For either a Retired Employee or Disabled Employee, age sixty-five (65) and over, the amount of Life Insurance shall be reduced to 60% of the Basic Annual Salary on the day before retirement/ disability, subject to a $1,000 minimum; and

3. For a Retired Employee or Disabled Employee with a hire date on or after January 1, 1983, upon reaching age seventy (70), the amount shall be reduced to 30% of the final Basic Annual Salary on the day before retirement/disability, subject to:

   a. A minimum benefit of $7,500; and

   b. A maximum benefit of $30,000.

C. Each Employee shall have a choice of electing Option A, B or C below:

1. Option A provides payment of the full amount of Life Insurance as indicated in Subsections 4.3 A. and 4.3 B. at the Employee's death;

2. Option B provides payment of 50% of the Employee's Basic Annual Salary of the full amount of Life Insurance as indicated in Subsections 4.3 A. in one (1) sum plus monthly installments in a fixed amount equal to 25% of the Employee's Basic Monthly Salary as further described in Section 4.5 C;

3. Option C provides payment of 125% of the Employee's Basic Annual Salary in one (1) sum plus equal monthly installments payable in a fixed amount equal to 12-1/2% of the Employee's Basic Monthly Salary as further described in Section 4.5 C; and

4. An election of Options B or C is null and void with an automatic conversion to Option A if the Employee is not survived by a Survivor and when the Employee attains age sixty-five (65) or prior thereto if he or she is eligible for a reduced amount of life insurance as described in Subsection 4.3 B.1.

4.4 Death Benefits

Upon receipt of due proof of death of the Employee, Disabled Employee or Retired Employee provided such individual is insured under the Plan in accordance with its terms, provisions and conditions, Peabody shall instruct the Claim Administrator to pay to the Beneficiary the amount of insurance in force on the life of the individual as indicated in Subsections 4.3 A. and 4.3 B. above.

A. Mode of Settlement

Any claim for death benefits shall be paid to the Beneficiary in one (1) amount or as indicated in Paragraph 4.5 D.

In the event of the death of the Beneficiary after the death of the Employee, Disabled Employee or Retired Employee and before payment of the amount of Life Insurance or of all the installments to which the Beneficiary may be entitled, the unpaid amount of the insurance shall be paid to the executors or administrators of the Beneficiary unless the Employee shall have made written request to the contrary in his or her beneficiary designation.

Payment, of any part of the insurance for which there is no Beneficiary either designated or surviving by the Employee, Disabled Employee or Retired Employee, shall be made to the executors or administrators of such person.

B. Beneficiary

Employees may designate the Beneficiary of choice upon enrollment into the Life Insurance and AD&D program.

Employees may designate a new Beneficiary at any time by filing with the Company a written request for such change on forms satisfactory to the Claim Administrator, but such change shall become effec-

tive only upon receipt of such request at the office of the Company where the records of the Life Insurance and AD&D are maintained. Upon receipt by the Company of such request the change shall relate back to and take effect as of the date the Employee, Disabled Employee or Retired Employee signed such request whether or not such individual is living at the time the Company receives such request but without prejudice to the Claim Administrator on account of any payments made by it before such request shall have been received. Benefits which have been paid prior to the receipt of the change on beneficiary card will not be recovered or repaid.

The Beneficiary for the insurance of any Employee, Disabled Employee or Retired Employee insured at the effective date hereof who shall have been insured on the day before such effective date under the former Life Insurance plan shall be duly designated Beneficiary or Beneficiaries of the individual under such former policy until a new Beneficiary is designated by him or her as provided herein, provided such Beneficiary shall survive the individual.

C. Assignment

An Employee, Disabled Employee or Retired Employee shall be permitted to assign his or her interest in his or her Life Insurance under the policy as a gift, but no other form of assignment by any Employee, Disabled Employee or Retired Employee hereunder shall be valid; provided, however, such assignment made as a gift shall not be deemed to have been made thereunder until a copy shall have been filed at the office of the Company where the records of the Life Insurance are maintained. Any assignment made as a gift and filed as provided in the preceding sentence shall be considered to have been made in accordance with the terms of this paragraph, regardless of the effective date of the assignment.

4.5 Survivor Income Benefits

A. Employees have the choice of enrolling in Options B or C as indicated in 4.3 C. above, except the following:

1. Any Retired Employee age sixty-five (65);

2. Any Retired Employee who retired on or before January 1, 1970;

3. Any Retired Employee who took a reduced amount of Life Insurance at retirement is not eligible for Survivor Income Benefits;

4. Any Disabled Employee whose Life Insurance is being continued in force under the provisions of insurance as outlined in Section 3.5 and who has attained age sixty-five (65); and

5. Any Employee who does not have a Survivor.

B. Survivor Benefits

The Claim Administrator shall pay a benefit in accordance with the provisions of Option B or Option C as outlined in subsection 4.5 C., whichever has been selected by the Employee in his or her enrollment for the Life Insurance, upon receipt by the Claim Administrator, within ninety (90) days after the date of death of any Employee or Disabled Employee of written proof that:

1. The death of such Employee or Disabled Employee occurred during continuance of the Life Insurance; and

2. Such Employee or Disabled Employee is survived by a Survivor.

C. Survivor Income Options

1. Option B as described in Paragraph 4.3 C.2.

2. Option C as described in Paragraph 4.3 C.3.

D. Mode of Settlement

1. The one (1) lump sum benefit shall be payable to a Survivor. The monthly benefit installment amounts shall be payable for not less than seventy-two (72) months to a Survivor.

2. If a Survivor dies before seventy-two (72) monthly Survivor benefit payments have been made, any such remaining payments shall be made to the executors or administrators of the Survivor.

3. If a Survivor dies after seventy-two (72) monthly Survivor benefit payments have been made, no further monthly Survivor benefit payments shall be made.

4. If a Survivor remarries while any of the seventy-two (72) monthly Survivor benefits payments are still payable, payments shall continue until seventy-two (72) payments have been made. If a Survivor remarries after seventy-two (72) monthly Survivor benefit payments have been made, no further payments shall be made.

5. The first benefit payment shall become due and payable on the first day of the calendar month next following the date of death of the Employee and subsequent payments on the first day of each calendar month thereafter.

4.6 Accidental Death and Dismemberment (AD&D)

A. The AD&D benefits shall be the Principal Sum which is three (3) times the Basic Annual Salary of the Employee on the effective date of coverage, taken to the next higher multiple of $100, if the amount is not already a multiple of $100 and payable in the amounts indicated below:

For Loss Of

Life	The Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and Sight of One Eye	The Principal Sum
One Foot and Sight of One Eye	The Principal Sum
One Hand or One Foot	1/2 The Principal Sum
Sight of One Eye	1/2 The Principal Sum

Only one (1) of the amounts listed above, the largest, shall be paid for all Injuries resulting from one (1) accident.

The amount of AD&D for a Disabled Employee or Retired Employee shall be equal to the amount in force on the date prior to retirement or Total Disability.

B. AD&D benefits are payable in the event of accidental bodily Injury if any one (1) of the losses listed in Subsection 4.6 A. is incurred within ninety (90) days of the date of accident.

C. For an Injury sustained while On the Business of the Company, the benefit shall not be less than $50,000.

D. Exclusions and Limitations

The AD&D benefits under this Plan shall not cover any of the following:

1. Loss resulting from the contracting of disease;

2. Loss caused or contributed to by bodily or mental infirmity, disease or medical or surgical treatment therefor, or infection (except pus-forming infection which shall occur through an accidental cut or wound, botulism and ptomaine poisoning);

3. Loss caused or contributed to by war or any act of war, whether declared or not, or by any act of international armed conflict, or conflict involving armed forces of any international authority; and

4. Loss resulting from suicide or any attempt thereat (sane), or from intentionally self-inflicted injury.

ARTICLE V -- MEDICAL CARE BENEFITS

5.1 Definitions Relative to Medical Care Benefits

A. Ambulatory Surgical Facility

"Ambulatory Surgical Facility" shall mean an institution, either free-standing or as part of a Hospital, with permanent facilities that is equipped and operated for the primary purpose of performing surgical procedures in which a patient is admitted to and discharged from such facility within a brief period (generally not to exceed twenty-four (24) hours). An office maintained by a Physician for the practice of medicine or an office maintained for the practice of dentistry shall not be considered an Ambulatory Surgical Facility.

B. **"Emergency Admission"** means admission due to a bodily Injury, or conditions, other than bodily Injuries, arising suddenly and requiring immediate care because of danger to the life of the covered Individual.

C. **"Home Health Care"** shall mean services provided by state licensed, Joint Commission on Accreditation of Healthcare Organizations approved, hospital-based home health care agencies or Medicare-approved, community-based home health care agencies.

D. **"Home Health Care Agency"** shall mean only a federally certified public or private agency or organization that meets all of the following criteria or is a Home Health Agency as described by Medicare:

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

2. It has policies established by associated professional personnel, including one (1) or more Physicians and one (1) or more registered nurses (R.N.), to govern the services provided under the supervision of such a Physician or nurse;

3. It maintains medical records on all patients;

4. It is licensed and approved by the state or local law established for such licensing; and

5. It is a Hospital certified by the State Public Health Law to provide Home Health services.

E. **"Hospice Center"** shall mean a state licensed and Joint Commission on Accreditation of Healthcare Organizations approved or Medicare-approved non-curative health care program or facility which provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis of six (6) months or less.

F. **"Hospital"** shall mean an institution which meets fully all the following criteria:

1. It is primarily engaged in providing, for compensation from its patients and on an inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians;

2. It continuously provides twenty-four (24) hour a day nursing service by registered graduate nurses;

3. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, a hotel, or the like; and

4. It is a state licensed facility which is approved by or under the waiting period for accreditation from the Joint Commission of Accreditation of Healthcare Organizations.

Hospital shall also include for inpatient treatment of chemical abuse an approved facility other than a Hospital as defined as determined by the Claim Administrator.

Hospitals classified and accredited as psychiatric Hospitals by the Joint Commission on Accreditation of Healthcare Organizations shall be deemed to be Hospitals for purposes of this Plan.

G. **"Oral Dental Surgery"** shall mean:

1. Extraction of impacted teeth; or

2. Alveolectomy if performed on an Outpatient basis.

H. **"Outpatient"** shall mean services performed:

1. In a Physician's office;

2. In the Outpatient department of a Hospital; or

3. In an approved Ambulatory Surgical Center.

I. **"Physician" or "Surgeon"** shall mean one who is duly licensed to prescribe and administer drugs and medicines or to perform surgery.

Physician shall also include:

1. For covered dental work or dental treatment only, a duly licensed dentist operating within the scope of his or her license;

2. For certain covered podiatry services common to both medicine and podiatry, a podiatrist operating within the scope of his or her license; and

3. A certified and Registered Psychologist when providing psychological services in connection with the diagnosis or treatment of a mental or nervous condition.

J. **"Registered Psychologist"** shall mean a person who provides registered psychological services in connection with the diagnosis or treatment of mental, psychoneurotic or personality disorders, and who qualifies as a psychologist, in any of the following ways, in the jurisdiction (state, District of Columbia, territory or possession of the United States) in which he or she is practicing:

1. If statutory licensure or certification of psychologists exists in the jurisdiction, he or she holds a valid license or certificate of such jurisdiction as a psychologist;

2. If statutory licensure or certification of psychologists does not exist in the jurisdiction, he holds a valid, nonstatutory (professional) certification established by the jurisdiction's recognized psychological association; or

3. If neither statutory nor nonstatutory licensure or certification of psychologists exists in the jurisdiction, he or she holds a statement of qualification by a committee established for the purpose by the jurisdiction's recognized psychological association or, in the absence of such a committee, he or she holds a diploma in the appropriate specialty awarded by the American Board of Examiners in Professional Psychology.

K. **"Skilled Nursing Facility"** shall mean a facility which provides inpatient skilled nursing care, as defined by Medicare, which is qualified to participate in and eligible to receive payments under Medicare and meets all the following requirements:

1. It operates legally in the area it is located;

2. It is accredited as a Skilled Nursing Facility by the Joint Commission on the Accreditation of Hospitals;

3. It is under the full-time supervision of a licensed Physician or registered nurse (R.N.);

4. It regularly provides room and board;

5. It provides twenty-four (24) hour a day skilled nursing care during the convalescent stage of the Injury or Illness;

6. It maintains a daily medical record of each patient under the care of a Physician; and

7. It is authorized to administer medications on the order of a Physician.

Skilled nursing care is covered only in lieu of hospitalization.

L. **"Utilization Review Program"** shall mean the program established by the Company and administered by the Claim Administrator which includes precertification of hospital benefits, mandatory second surgical opinion requirements of listed surgical procedures and required outpatient surgery for certain listed surgical procedures, care review, and case management.

5.2 Benefit Provisions

Only individuals described in Subsection 3.1 C. are eligible for the benefits described in this Article V (Covered Individuals are eligible for the benefits described in this Section 5.2). The benefits set forth are payable for nonoccupational Covered Charges incurred by a Covered Individual on account of accidental bodily Injury or Illness and are subject to the other provisions and limitations set forth below.

There shall be two (2) separate types of health care benefits under the Plan, as follows:

A. Basic benefits; and

B. Major medical benefits.

5.3 Basic Benefits

The Plan pays 100% of the Reasonable and Customary charges for the following medically necessary Covered Expenses, up to the amounts described in this Section 5.3, without satisfaction of the Deductible as follows:

A. Hospitalization

1. In-Hospital Benefits

Precertification of all hospitalizations through the Utilization Review Program is required in order to receive maximum benefits, for each day of confinement:

a. Room and board charges in semi-private accommodations, including charges for intensive care unit services and coronary care unit services;

b. Special diets;

c. General nursing care;

d. Use of operating, delivery, recovery, and treatment rooms and equipment;

e. All recognized drugs and medicines for use in the Hospital and drugs or medicines sent home following hospitalization, not to exceed a thirty (30) day supply;

f. Dressings, ordinary splints and casts;

g. X-ray examinations, X-ray therapy, radiation therapy and treatment;

h. Laboratory tests;

i. Physical therapy;

j. Anesthetics and the administration thereof;

k. Processing and administering of blood and blood plasma, including the supplying of blood or blood plasma to the extent it is not donated or otherwise replaced;

l. Chemotherapy;

m. Renal dialysis therapy if administered in accordance with federal Medicare regulations;

n. Dental care due to accidental bodily Injury, or Oral Dental Surgery when a Physician other than a dentist certifies that hospitalization is necessary to safeguard the life or health of a patient because of the existence of a specified non-dental organic impairment;

o. Treatment for mental Illness by a licensed psychiatrist, psychologist, or a licensed social worker under the direct supervision of a Physician;

p. Treatment for alcoholism and drug abuse for emergency detoxification or any medical treatment required following such detoxification; and

q. Ground transportation in an ambulance to and from the Hospital.

2. Outpatient Hospital Benefits

For services rendered in the outpatient department of a Hospital or in an Ambulatory Surgical Facility:

a. Within five (5) days for an accidental Injury;

b. In connection with and on the same day surgery is performed; or

c. For emergency medical treatment if the Covered Individual is confined to the Hospital within twenty-four (24) hours of the medical treatment. Precertification of Emergency Admissions through the Utilization Review Program is required within two (2) working days following the admission in order to receive maximum benefits.

3. Pre-admission Testing

Tests required for hospital admission performed within seven (7) days prior to a scheduled hospitalization.

B. Surgical Services

The mandatory outpatient surgical requirements as outlined in Appendix V-A and the second surgical opinion requirements as outlined in Appendix V-B of the Utilization Review Program must be met in order to receive maximum benefits.

1. Surgical procedures, including customary pre-operative and post-operative services, performed by a Physician or Surgeon including the necessary services of assistant Surgeons who actively assist the Physician in the performance of the surgical procedure when:

   a. The Covered Individual is hospitalized;

   b. The type of surgical services require assistance; and

   c. The services of interns, residents or house officers are not available.

   Payment for assistant Surgeons shall be at 20% of the Reasonable and Customary charge for the surgery performed.

2. The medical supplies necessary for the surgical services performed in a Hospital, Outpatient department of a Hospital, Physician's office, or a free-standing Ambulatory Surgical Facility.

3. When multiple surgical procedures are performed at the same operative session through the same incision, payment for the incidental surgery shall be at 50% of the Reasonable and Customary charge for the incidental surgery. Incidental surgery is an operative procedure performed in conjunction with a primary surgical procedure, during the same operative session, through the same incision and in the same operative field.

4. Benefits for covered Oral Dental Surgery are payable whether performed in or out of the Hospital.

5. Surgical procedures from the following surgical categories must be performed on an Outpatient basis in order to receive maximum benefits:

   a. Excision of nail and nail matrix;

   b. Blepharoplasty;

   c. Biopsy of breast or excision of benign tumor;

   d. Muscle biopsy;

   e. Treatment of a closed fracture with or without manipulation;

   f. Repair of foot disorders;

   g. Broncoscopy;

   h. Tonsillectomy and/or adenoidectomy;

   i. Endoscopy;

   j. Simply hemorrhoidectomy;

   k. Biopsy of the liver using a percutaneous needle;

   l. Circumcision except for a newborn child;

   m. Vasectomy;

   n. Culdoscopy or colposcopy;

   o. Biopsy of the cervix using a circumferntial cone;

p. Dilation and curettage of the uterus;

q. Tubal ligation;

r. Laparoscopy;

s. Hysteroscopy; and

t. Myringotomy or tympanotomy (with or without tubes).

Appendix V-A contains a detailed listing of all surgical procedures included in the surgical categories as indicated above, their CPT-4 Codes and descriptions of the procedures.

6. The Plan requires a second surgical opinion be received from a board certified specialist when surgery has been recommended by a Surgeon for the following surgical procedures, from the following surgical categories, in order to receive maximum Plan benefits.

a. Blepharophryplasty;

b. Rhytidectony;

c. Mastectomy or mammectomy;

d. Repair of the knee joint;

e. Repair of foot disorders;

f. Surgery on the spinal column and/or the spinal nerves;

g. Revision of the nasal structure;

h. Coronary artery or by-pass surgery;

i. Cholecystostomy;

j. Stomach surgery for obesity;

k. Herniorrhaphy;

l. Tonsillectomy and/or adenoidectomy;

m. Hemorrhoidectomy;

n. Prostatectomy;

o. Hysterectomy;

p. Dilation and curettage of the uterus;

q. Thyroid surgery; and

r. Removal of cataracts.

Appendix V-B contains a detailed listing of all surgical procedures included in the surgical categories as indicated above, their CPT-4 Codes and descriptions of the procedures.

If a third opinion is obtained, it must also be performed by a board certified specialist. No more than three (3) opinions shall be covered by the Plan.

The second and/or third opinion must be performed by a Surgeon that is not a partner in the same office as the Surgeon that performed the first or second opinion.

7. Surgical benefits for the following procedures may be covered subject to approval by the Plan Administrator and the following guidelines:

   a. Mammoplasty, if medically necessary (not cosmetic);

   b. Obesity if the Covered Individual is 160% or more of the desirable weight, and other more conservative therapies have been tried and proven unsuccessful and authorization has been obtained from the Plan Administrator; and

   c. Cosmetic surgery required for the correction of birth defects or as a result of an injury.

8. Covered podiatric surgical procedures include minor surgery for:

   a. Ingrown toenails;

   b. Flat feet;

   c. Fallen arches;

   d. Weak feet; and

   e. Chronic foot strain.

9. Major podiatric surgical procedures are covered only if rendered by a Physician in a Hospital.

C. Physician Services

1. In-Hospital Physician Visits

For each day of confinement, one (1) visit per day by the Physician in charge of the case up to the day of surgery.

2. Administration of Anesthesia

For the administration of anesthesia whether in or out of the Hospital when administered by a certified nurse anesthetist or a Physician other than the operating Surgeon or assistant Surgeon.

D. X-Ray and Laboratory Services - Outpatient

Outpatient x-rays or laboratory tests administered in or out of the Hospital, which are for the diagnosis of an accidental bodily Injury or Illness including expenses for allergy tests and patch tests, subject to a calendar year maximum of $250 for each Covered Individual.

E. Alternate Care Benefits

For Covered Expenses as follows:

1. Home Health Care when rendered from a Home Health Care Agency including:

a. Part-time nursing services for six (6) out of eight (8) hours by a registered nurse (R.N.), licensed vocational nurse, or licensed practical nurse (L.P.N.);

b. Physician fees for treatment;

c. Physical occupational or speech therapy rendered by a licensed therapist;

d. Prescription drugs and other medical supplies;

e. Laboratory and X-ray services; and

f. Four (4) hours of treatment by a home health aide.

The treating Physician must provide a written

Home Health Care plan within seven (7) days after a hospital discharge. Such plan must include an estimate of the treatment's duration and certification that the Home Health Care is in lieu of hospitalization.

The Physician must recertify the need for continued Home Health Care every thirty (30) days.

2. Hospice care when the Covered Individual is diagnosed by an attending Physician as having six (6) months or less to live. A lifetime maximum benefit of $10,000 is available which includes:

   a. Room and board in a free-standing Hospice Center;

   b. General nursing care;

   c. Counseling sessions not to exceed $200 for all sessions with family members prior to the death of the terminally ill patient; and

   d. Charges for homemaker services.

   The treating Physician must submit a plan in writing for home or inpatient hospice care. The plan must meet established standards and care must be rendered in or by an approved Hospice Program.

5.4 Major Medical Benefits

The Plan pays major medical benefits and covered excess basic benefit charges after satisfaction of the Deductible up to 80% of the Reasonable and Customary, medically necessary charges of the first $1,000 of Covered Expenses and 90% of the balance of the Reasonable and Customary, medically necessary charges for Covered Expenses as described in this Subsection 5.4 D. subject to the following:

A. Deductible

The Deductible for one (1) Covered Individual shall be $100 during each calendar year:

1. If two (2) or more members of the same family (including the Employee, Disabled Employee or Retired Employee) incur Covered Expenses which total $200, no Deductible shall be applied to

Covered Expenses incurred by any additional family member during the remainder of that calendar year. Regardless of the make-up of the family (i.e. two (2) Employees and dependents), the family Deductible shall not exceed $200.

2. Covered Expenses incurred during the last three (3) months of a calendar year and used toward satisfying the Deductible in that calendar year may be applied toward satisfying the Deductible for the next calendar year.

3. If two (2) or more covered family members are injured in the same accident, only one (1) Deductible shall be charged to their combined Covered Expenses for that accident in each calendar year.

B. Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum for each Covered Individual shall be $1,000 including the Deductible. Once the Out-of-Pocket Maximum is reached, for the balance of that calendar year, the Plan pays 100% of the Reasonable and Customary charges for covered major medical benefits for that individual as listed in Subsection 5.4 D.

The $1,000 Out-of-Pocket Maximum is met as follows:

	Out-of-Pocket
Deductible	$100.00
Plan Pays 80% of next $1,000 ($800)	200.00
Plan Pays 90% of next $7,000 ($6,300)	700.00
Total	$1,000.00

Once the $1,000 total is reached, the Plan shall pay 100% of Covered Expenses for that individual for the remainder of that calendar year.

C. Pre-existing Conditions

Coverage under the Plan for the pre-existing Conditions of a Covered Individual shall be limited to $1,000 until:

1. Such Covered Individual has been continuously covered under the Plan for twelve (12) consecutive months; or

2. In the case of an Employee, who has been continuously classified as an Employee and covered under the Plan for six (6) consecutive months.

D. Covered Expenses include:

1. Private room and board charges for 50% of the difference between the Hospital's average semi-private rate and the average private rate.

2. Hospital charges not covered as basic benefits.

3. Charges incurred at the Covered Individual's home, in a clinic, or the Physician's office for the professional services of a Physician or Surgeon, including consultations by a qualified specialist when rendered at the request of the attending Physician.

4. Charges for services or supplies for obtaining a second or third surgical opinion which is not required under the Utilization Review Program.

5. Charges incurred for the professional services of a Physician, registered graduate nurse (R.N.) and a licensed practical nurse (L.P.N.), Registered Psychologist, or physiotherapist, other than a professional who ordinarily resides in the Covered Individual's home or is a member of such individual's immediate family.

6. Outpatient Hospital benefits including:

   a. Chemotherapy treatments and radiation therapy;

   b. Physiotherapy prescribed and supervised by a Physician; and

   c. Renal dialysis in accordance with federal Medicare regulations.

7. Routine care for newborns and Children under the age of five (5).

8. Immunizations, allergy desensitization injections, pap smears, screening for hypertension and diabetes, examinations for cancer, blindness, deafness and other screening and diagnostic procedures.

9. Routine physical examinations, excluding examinations required for entrance into a school or for participation in sports.

10. Charges by a licensed physiotherapist, Registered Psychologist, psychiatrist and licensed social worker who is under the supervision of a psychiatrist or psychologist.

11. Voluntary sterilization procedures and Physician charges in connection with the prescription of oral contraceptives, the fitting of diaphragms or the insertion or removal of an IUD.

12. Laboratory tests, radium therapy, X-rays and microscopic tests for diagnostic or treatment of an Injury or Illness in excess of basic benefits.

13. Charges made for the cost and administration of an anesthetic.

14. Professional local ambulance service charges for transportation medically necessary to or from a Hospital, clinic, medical center, Physician's office or Skilled Nursing Facility.

15. Air ambulance when either of the following conditions are met:

    a. Transportation is from a remote area, i.e., inaccessible by any other means, and is to the first local Hospital where treatment is given; and

    b. Condition is a life-threatening accidental Injury or life-threatening sudden and serious Illness.

16. Drugs and medicines requiring a Physician's prescription and dispensed by a licensed pharmacist.

17. Blood and blood derivatives to the extent it is not donated or replaced.

18. Prothesis prescribed by a Physician when required to replace internal or external body parts as the result of an accidental bodily Injury, Illness, congenital deformity or anomaly, including prothesis following breast removal.

19. Rental or purchase of durable medical equipment.

20. Oxygen and the rental of the equipment for its administration, when ordered by the attending Physician for a Covered Individual who has been referred to a designated pulmonary consultant for testing, including submission of a report from the consultant which is submitted to the Claim Administrator with the order for oxygen.

21. Services of an inhalation therapist under the attending Physician's order in the Covered Individual's home.

22. Charges made by a Navajo medicine man certified by the Office of Native Healing Services, the Navajo Health Authority and the Northern Cheyenne and Crow medicine man not to exceed $400 per Covered Individual per calendar year.

23. Orthopedic devices including braces, trusses stump stockings and harnesses when essential for effective use of the artificial limb and upon examination and recommendation by an orthopedic Physician for up to two (2) pairs of surgical stockings per prescription in a six (6) month period when prescribed for such conditions as thrombophlebitis and/or conditions resulting from surgery such as reinligation.

24. Physical therapy prescribed by a Physician and administered by a licensed therapist in a Hospital, Skilled Nursing Facility, Ambulatory Surgical Facility or the Covered Individual's home.

25. Speech therapy when rendered by a licensed therapist for stroke patients or medical conditions, such as a ruptured aneurysm, brain tumors or autism, needed to restore techniques of sound and phonation to express the basic needs of the Covered Individual. Speech therapy is also provided for a Child with a speech impediment.

26. Psychotherapy, psychological testing, counseling, group therapy and Medicare approved alcoholism or drug rehabilitation programs if medically necessary and free care sources are not available.

27. Dental care or treatment due to accidental bodily Injury sustained by a Covered Individual while the Plan is inforce.

E. Maximum Benefits

Benefits for each Covered Individual shall be limited to $250,000 per lifetime.

If a Covered Individual has received benefits under the Plan on the first day of each calendar year, an amount equal to the lesser of:

1. $2,000; or

2. The amount necessary to provide a sum equal to the total maximum amount ($250,000) payable shall be reinstated.

A Covered Individual wishing to reinstate the total maximum amount payable may furnish, without expense to the Plan Administrator, proof of good health satisfactory to the Plan Administrator. If such proof is furnished, the total maximum shall be reinstated for that Covered Individual on the date the Plan Administrator determines proof to be satisfactory.

5.5 Exclusions and Limitations for Medical Care Benefits

The Plan shall provide for the Necessary Care treatment, services and/or supplies of an Illness or Injury.

The Plan shall not cover treatment, services and/or supplies other than those determined by the Claim Administrator to be medically necessary for the treatment of an Illness or Injury, including but not limited to treatments which are of unproven value or of questionable current usefulness; procedures which are redundant when performed with other procedures, or unlikely to provide a Physician with additional information when used repeatedly; procedures not ordered by a Physician or which are not documented in timely fashion in the Covered Individual's medical record.

Institutional care is excluded from coverage when the Covered Individual is not required to be in the inpatient setting to deliver the care or treatment medically effective. Any care which does not require the services of a specially, trained medical professional to be delivered, and care which is determined by the Claim Administrator to be custodial in nature, is excluded from coverage.

Additionally, the following items shall not be covered by the Plan:

A. Basic Hospitalization Benefits

1. Hospitalization for convalescent care, custodial domiciliary or sanitarium care, or rest cures.

2. Benefits for hospitalization shall be reduced by $200 when not precertified by the Utilization Review Program or for Hospital stays longer than the certified period without approval by the Utilization Review Program for the extension.

3. Charges covered under surgical services or laboratory and X-ray services.

4. Charges during a continuous hospital confinement which commenced prior to the effective date of the person's coverage under this Plan.

5. Travel expenses for a Covered Individual or for his or her immediate family.

6. Charges for any services with respect to which there is no legal obligation to pay. For the purpose of this Paragraph 5.5 A.6., any charge which exceeds the charge that would have been made if a person were not covered under this Plan shall, to the extent of such excess, be treated as a charge for which there is no legal obligation to pay; and any charge made by a natural or other person for anything which is normally or customarily furnished by such person without payment from the recipient or user thereof shall also be treated as a charge for which there is no legal obligation to pay.

7. Charges in excess of Reasonable and Customary.

8. Charges for hospital confinement due to abortion unless it is medically necessary.

B. Basic Surgical Services Benefits

1. Charges for cosmetic surgery are payable only to the extent that the service is required to correct accidental bodily Injury occurring while the person is covered under this Plan or to correct congenital deformities or anomalies.

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

3. Benefits for services and supplies relating to surgery shall be reduced by $200 when outpatient requirements for surgical procedures as listed in Appendix V-A and the second surgical opinion requirements of the Utilization Review Program listed in Appendix V-B are not followed.

4. Charges for eye surgery which is correctable with lenses, including but not limited to radial keratotomy, unless, in the opinion of the Plan Administrator, no other treatment is medically acceptable and the surgery is determined by the Plan Administrator to be a generally approved procedure in the medical community as a whole.

5. Charges for an autopsy or post-mortem surgery.

6. Charges in connection with transsexual surgery.

7. Charges for any services with respect to which there is no legal obligation to pay. For the purpose of this Paragraph 5.5 B.7., any charge which exceeds the charge that would have been made if a person were not covered under this Plan shall, to the extent of such excess, be treated as a charge for which there is no legal obligation to pay; and any charge made by a natural or other person for anything which is normally or customarily furnished by such person without payment from the recipient or user thereof shall also be treated as a charge for which there is no legal obligation to pay.

8. Charges in excess of Reasonable and Customary.

9. Charges for surgical services due to abortion unless it is medically necessary.

C. Basic In-Hospital Physician Services Benefits

1. Eye examinations for the purpose of prescribing corrective lenses.

2. Dental treatment except Oral Surgery or that which is necessary for the initial repair of an accidental bodily Injury, occurring to sound, natural teeth.

3. Charges covered under hospitalization, surgical services or laboratory and X-ray services.

4. Charges for any services with respect to which there is no legal obligation to pay. For the purpose of this Paragraph 5.5 C.4., any charge which exceeds the charge that would have been made if a person were not covered under this Plan shall, to the extent of such excess, be treated as a charge for which there is no legal obligation to pay; and any charge made by a natural or other person for anything which is normally or customarily furnished by such person without payment from the recipient or user thereof shall also be treated as a charge for which there is no legal obligation to pay.

5. Charges in excess of Reasonable and Customary.

6. Charges for physician services during hospital confinement due to abortion unless it is medically necessary.

D. X-Ray and Laboratory Services - Outpatient

1. Charges for x-ray and laboratory services on an outpatient basis due to abortion unless it is medically necessary.

E. Basic Alternate Care Benefits

1. Care that is custodial in nature.

2. Transportation for delivery of Home Health Care.

3. Eligible hospice services which are covered under any other provisions of the Plan.

4. Expenses incurred prior to the date a person is accepted under a hospice care plan.

5. Expenses incurred by family members in connection with temporary relief away from the patient (Respite Care).

6. Charges incurred by Plan Participants for any services rendered by a licensed chiropractor whether or not within the scope of such chiropractor's license effective July 1, 1988.

F. Major Medical Exclusions

1. Accidental bodily Injury or Illness caused by war or any act of war, declared or undeclared, including armed aggression, or by participating in a riot, or the attempt to commit a felony or assault.

2. Accidental bodily Injury or Illness arising out of or in the course of employment, for which is compensable under any Workers' Compensation or Occupational Disease Act or Law.

3. Charges incurred in a United States government Hospital or in any other Hospital operated by a government unit, except as required by law, or unless a charge is made that the Covered Individual is legally required to pay.

4. Charges incurred which are not recommended and approved by a legally qualified Physician or Surgeon.

5. Charges incurred in connection with any intentionally self-inflicted Injury.

6. Charges for treatment or surgery which in the judgement of the Claim Administrator are generally considered by the medical profession as experimental, developmental or investigatory, unless approved by the Claim Administrator in certain lifesaving situations.

7. Charges for convalescent care, custodial, domiciliary or sanitarium care, or rest cures whether or not in the Hospital.

8. Charges for services or supplies in a nursing home, home for the aged, or convalescent home.

9. Custodial charges for any services rendered to a person prior to the date coverage under this Plan becomes effective or after coverage ends with respect to such person unless otherwise noted.

10. Charges in connection with transsexual surgery.

11. Travel expenses for a Covered Individual or his or her immediate family.

12. Charges for any services with respect to which there is no legal obligation to pay. For the purpose of this Paragraph 5.5 E.12., any charge which exceeds the charge that would have been made if a person were not covered under this Plan shall, to the extent of such excess, be treated as a charge for which there is no legal obligation to pay; and any charge made by a natural or other person for anything which is normally or customarily furnished by such person without payment from the recipient or user thereof shall also be treated as a charge for which there is no legal obligation to pay.

13. Charges in excess of Reasonable and Customary.

14. Charges for or in connection with any dental work or dental treatment except as specifically provided under the Plan.

15. Charges incurred for any medical observation or diagnostic study when no Illness or Injury is revealed, except as indicated, unless proof satisfactory to the Claim Administrator is furnished that:

    a. The claim is in order in all other respects; and

    b. The Covered Individual had a definite symptomatic condition of Illness or Injury other than hypochondria.

16. Charges for hearing aids or for the prescription or fitting thereof.

17. Charges for vision training, eyeglasses and contact lenses or examinations for the prescription or fitting thereof, (except the initial pair of eyeglasses after surgery if refractive error is surgically induced, contact lenses when for the replacement of lens for the eye, or vision training following eye surgery.)

18. Charges for physiotherapy and speech therapy that is educational in nature.

19. Charges for cosmetic treatment except that charges for cosmetic treatment required for correction of damage caused by accidental Injury sustained by the Covered Individual

while this Plan is in force on his or her account or to correct congenital deformities or anomalies shall not be excluded if they otherwise qualify as Covered Expenses.

20. Charges for actual or attempted impregnation or fertilization which involves either a Covered Individual as a surrogate or a donor, extrauterine conception or pregnancy of a surrogate mother.

21. Charges incurred for digestive aids (unless to sustain life), vitamins, minerals or other dietary supplements whether taken orally or injected regardless of whether such items are prescribed by a Physician.

22. Charges for services or supplies in connection with crowning, wiring or repositioning of teeth for treatment of temporomandibular joint disorders.

23. Charges for hypnosis provided for any purpose and charges for acupuncture for any purpose.

24. Charges for routine foot care.

25. Charges for naturopathic or holistic services.

26. Charges for home obstetrical delivery.

27. Charges for telephone conversations with a Physician in lieu of an office visit, for writing a prescription or for medical summaries and medical invoice preparations.

28. Medications which are dispensed by other than a licensed pharmacist and which do not require a prescription by state or federal law.

29. Prescription for birth control for any reason or birth control devices.

30. Charges for marriage counseling, encounter or self-improvement group therapy and school related behavioral problems.

31. Charges incurred which are the result of a pregnancy of the daughter of an Employee, Disabled Employee, Retired Employee or Surviving Spouse.

32. Charges for reversals of sterilization procedures.

33. Alcoholism and drug rehabilitation programs not approved by Medicare or treatment if an advance determination has not been made that the Covered Individual is a good candidate for rehabilitation.

34. Treatment received from an individual who is related to the Covered Individual or ordinarily resides with that Covered Individual.

35. Charges incurred by Plan Participants for any services rendered by a licensed chiropractor whether or not within the scope of such chiropractor's license effective July 1, 1988.

36. Charges for abortion unless considered a medical necessity.

The limitations and exclusions set forth above in Section 5.5 and throughout the Plan are not intended in any way to be exhaustive, and the Plan hereby reserves the right to limit or exclude such other services and supplies and the charges therefore as are determined to be inappropriate in the sound discretion of the Plan Administrator under the terms and conditions as well as the scope and intent of the Plan.

5.6 Persons Eligible for Medicare

Benefits payable for Covered Expenses under this Plan shall be reduced by any benefits payable for the same Covered Expenses under Medicare, except under the following circumstances:

A. Employees age sixty-five (65) and over who are actively working for the Company, an active Employee's Spouse, age sixty-five (65) and over, and active Employees and their dependents who are receiving Social Security disability benefits, are eligible for the same benefits provided by the Plan as Employees or dependents under age sixty-five (65) who are not covered under Medicare, subject to the provisions of Paragraph 5.6 B. below.

An Employee or Spouse is considered to be age sixty-five (65) on the first day of the month in which his or her sixty-fifth birthday occurs, or the month he or she becomes entitled to Part A of Medicare, if later.

B. If an active Employee, age sixty-five (65) and over, or an active Employee's Spouse, age sixty-five (65) and over, elects to have Medicare as his or her primary medical coverage, his or her coverage under the Plan shall terminate on the date of election or the date the Employee or Spouse becomes eligible for benefits under Medicare, if later.

C. Benefit determination under the Plan shall assume Covered Individuals must have applied for both Part A and Part B of Medicare. No reimbursement by the Company for Medicare premium payments shall be made.

5.7 Utilization Review Program

A. Maximum benefits for hospitalization and surgery, as set forth in this Article V, shall be payable only for such periods of covered hospitalization and for such covered surgical procedures as shall also be determined eligible by the Claim Administrator, through the Utilization Review Program.

B. In the event of hospitalization and/or surgery, the Covered Individual and/or the provider shall be responsible for following the procedures established by the Claim Administrator in order to obtain such determinations.

C. Covered hospitalization and/or surgery determined not to be eligible for maximum benefits in accordance with the procedures established by the Claim Administrator shall be reduced from the normal benefit level as set forth in this Section V by $200 (for each associated non-compliance event). The reduction of benefits due to non-compliance events is not included in Deductibles or Out-of-Pocket Maximums.

5.8 Non-Duplication of Benefits

A. Benefit Restriction

All of the benefits in Articles V, VI and VII provided under this Plan are subject to the restrictions in this provision as indicated.

1. Prior to 7/1/88 all benefits as indicated are subject to coordination of benefits as such as specified in the National Association of Insurance Commissions model language.

2. Effective 7/1/88 all benefits as indicated are subject to non-duplication of benefits as provided below.

B. Definitions Related Strictly to This Section 5.8

1. **"Plan"** shall mean any plan providing benefits or services for or by reason of medical, vision or dental care or treatment, which benefits or services are provided by:

   a. Group, blanket or franchise insured or uninsured coverage;

   b. Hospital service prepayment plan on a group basis, medical service prepayment plan on a group basis, group practice or other prepayment coverage on a group basis;

   c. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans; and

   d. Any coverage under governmental programs except Medicare, or any coverage required or provided by any statute, which coverage is not otherwise excluded from the calculation of benefits under the Plan, but the term Plan shall not include any individual policies.

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

2. **"Allowable Expense"** shall mean any medically necessary, Reasonable and Customary items of expense at least a portion of which is covered under at least one (1) of the Plans covering the person for whom claim is made.

   When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

3. **"Claim Determination Period"** shall mean calendar year, except that, if in any calendar year the person is not covered under this Plan for the full calendar year, the Claim Determination Period for that year shall be that portion thereof during which he or she was covered under this Plan.

C. Effect on Benefits

1. This provision shall apply in determining the benefits for a person who is covered under this Plan and who is actually covered under another Plan whose benefits are primary for any Claim Determination Period. For the Allowable Expenses incurred as to such a person during such Claim Determination Period, the Plan shall pay the difference between:

   a. The benefits that would be payable under this Plan in the absence of this provision; and

   b. The benefits that would be payable under all other Plans in the absence therein of this provision.

2. If:

   a. Another Plan which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

   b. The rules set forth in Paragraph C.3. below would require this Plan to determine its benefits before such other Plan, then the benefits of such other Plan shall be ignored for the purposes of determining the benefits under this Plan.

3. For the purposes of Paragraph C.2. above, the rules establishing the order of benefit determination are:

   a. The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a plan which covers such person as a dependent.

b. The benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a Plan which covers such person as a dependent of a female person, except that in the case of a person for whom claim is made as a dependent Child:

1) When the parents are separated or divorced and the parent with custody of the Child has not remarried, the benefits of a Plan which covers the Child as a dependent of the parent with custody of the Child shall be determined before the benefits of a Plan which covers the Child as a dependent of the parent without custody;

2) When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a Plan which covers the Child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a dependent of the stepparent, and the benefits of a Plan which covers that Child as a dependent of the stepparent shall be determined before the benefits of a plan which covers that Child as a dependent of the parent without custody; and

3) Notwithstanding items b.1) and b.2) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the Child who is eligible for coverage under this Plan, the benefits of a Plan which covers the Child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers such Child as a dependent Child.

c. Notwithstanding any of the provisions of Subparagraphs 3.a. and 3.b. above, the benefits of a Plan which covers any of the persons listed in items 1) through 4) below, as an active, retired or laid-off

employee of any employer not participating in this Plan shall be determined before the benefits of this Plan with respect to any claim based on such person's expenses:

1) Any active Employee whose coverage under this Plan had an effective date later than the effective date of his or her coverage as an active, retired or laid-off employee of any employer not participating in this Plan;

2) Any former Employee who is receiving benefits under the Peabody Long Term Disability Plan for Salaried Employees;

3) Any former Employee or Spouse thereof who is receiving extended coverage under this Plan by reason of the provisions of this Plan or any applicable collective bargaining agreement; and

4) Any Spouse or dependent of any active or Retired Employee.

d. When Subparagraphs 3.a., 3.b. and 3.c. above do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

e. If two (2) Employees of the Company are covered under the Plan and are also dependents, benefits shall not be duplicated as described in this Section 5.8, beyond the family Deductible. Non-duplication of benefits as stated shall occur when a Covered Individual is covered by two (2) separate Plans.

D. The Claim Administrator shall not apply these provisions nor investigate other possible coverages with respect to Allowable Expenses which are less than $50. However, if additional liability increases Allowable Expenses to an amount in excess of $50, then the entire liability shall be subject to these provisions.

E. Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the Claim Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Claim Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Claim Administrator such information as may be necessary to implement this provision.

5.9 Subrogation and Third Party Liability

The Plan does not assume primary responsibility for Covered Expenses which another person, party or organization is obligated to pay or which another insurance policy or other medical plan covers. Where there is a dispute between the person, party or organization, the Plan shall, subject to Subsections 5.9 A. and 5.9 B. below, pay for such Covered Expenses but only as a convenience to the Covered Individual eligible for benefits under the Plan and only upon receipt of an appropriate indemnification or subrogation agreement; but the primary and ultimate responsibility for payment shall remain with the other person, party or organization. Obligations to pay benefits on behalf of any Covered Individual shall be conditioned upon:

A. Such Covered Individual taking all steps necessary or desirable to recover the costs thereof from any third party who may be obligated therefore; and

B. Such Covered Individual executing such documents as are reasonably required by the Plan and/or Claim Administrator, including but not limited to, an assignment of rights to receive third party payments, in order to protect and perfect the Plan's right to reimbursement from any such third party.

Additionally, in the event of any payment for such Covered Expenses under this Plan, the Company shall be subrogated to all the rights of recovery of the person for whom such payment is made against any person, party or organization of such payment.

5.10 Right to Audit

The Company reserves the right to derive data from or to inspect, for statistical review and analysis or audit purposes, the claim files held by the Claim Administrator.

APPENDIX A

Surgical procedures which must be performed on an Outpatient basis to receive maximum Plan benefits include:

Surgical Category	CPT-4 Code	Purpose
Excision Nail and Nail Matrix	11750	Excision of nail and nail matrix, partial or complete (e.g., ingrown or deformed nail for permanent removal)
Blepharophryplasty (Surgery on eyelids)	15820	Blepharoplasty, lower eyelid;
	15821	with extensive herniated fat pad
	15822	Blepharoplasty, upper lid;
	15823	with excessive skin weighting down lid
Breast Biopsy, Excision of Benign Tumor	19100	Biopsy of breast; needle (separate procedure)
	19101	incisional
	19120	Excision of cyst, fibroadenoma or other benign tumor, aberrant breast tissue, duct lesion or nipple lesion, male or female, one or more lesions
Muscle Biopsy	20200	Biopsy, muscle; superficial
	20205	deep
Treatment of Closed Fracture, with or without manipulation	23500	Treatment of closed clavicular fracture; without manipulation
	23505	with manipulation
	23570	Treatment of closed scapular fracture, without manipulation
	23575	with manipultion (with or without shoulder joint involvement)
	23600	Treatment of closed humeral (surgical or anatomical neck) fracture; without manipulation
	23605	with manipulation
	24500	Treatment of closed humeral shaft fracture; without manipulation
	24505	with manipulation

Surgical Category	CPT-4 Code	Purpose
Treatment of Closed Fracture, with or without manipulation (continued)	24560	Treatment of closed epicondylar fracture, medial or lateral; without manipulation
	24565	with manipulation
	24576	Treatment of closed condylar fracture, medial or lateral, without manipulation
	24577	with manipulation
	24650	Treatment of closed radial head or neck fracture; without manipulation
	24655	with manipulation
	24670	Treatment of closed ulnar fracture, proximal end (olecranon process); without manipulation
	24675	with manipulation
	25500	Treatment of closed radial shaft fracture; without manipulation
	25505	with manipulation
	25530	Treatment of closed ulnar shaft fracture; without manipulation
	25535	with manipulation
	25560	Treatment of closed radial and ulnar shaft fractures; without manipulation
	25565	with manipulation
	25600	Treatment of closed distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation
	25605	with manipulation
	25622	Treatment of closed carpal schaphoid (navicular) fracture; without manipulation
	25624	with manipulation
	25630	Treatment of closed carpal bone fracture (excluding carpal schaphoid (navicular)); without manipulation, each bone
	25635	with manipulation, each bone

Surgical Category	CPT-4 Code	Purpose
Treatment of Closed Fracture, with or without manipulation (continued)	25650	Treatment of closed ulnar styloid fracture
	26600	Treatment of closed metacarpal fracture, single; without manipulation, each bone
	26605	with manipulation, each bone
	27750	Treatment of closed tibial shaft fracture; without manipulation
	27752	with manipulation
	27760	Treatment of closed distal tibial fracture (medial malleolus); without manipulation
	27762	with manipulation
	27780	Treatment of closed proximal fibula or shaft fracture, without manipulation
	27781	with manipulation
	27786	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation
	27788	with manipulation
	27800	Treatment of closed tibia and fibula fractures, shafts; without manipulation
	27802	with manipulation
	27808	Treatment of closed bimalleolar ankle fracture, (including Potts); without manipulation
	27810	with manipulation
	27816	Treatment of closed trimalleolar ankle fracture; without manipulation
	27818	with manipulation
Repair of foot disorders	28010	Tenotomy, subcutaneous, toe; single
	28011	multiple
	28020	Arthrotomy, with exploration, drainage or removal of loose or foreign body; intertarsal or tarsometatarsal joint
	28022	metatarsophalangeal joint
	28024	interphalangeal joint

Surgical Category	CPT-4 Code	Purpose
Repair of Foot Disorders (continued)	28050	Arthrotomy for synovial biopsy; intertarsal or tarsometatarsal joint
	28052	metatarsophalangeal joint
	28054	interphalangeal joint
	28060	Fasciectomy, excision of plantar fascia; partial (separate procedure)
	28062	radical (separate procedure)
	28070	Synovectomy; intertarsal or tarsometatarsal joint, each
	28072	metatarsophalangeal joint, each
	28080	Excision of Morton neuroma, single, each
	28086	Synovectomy, tendon sheath; flexor
	28088	extensor
	28090	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); foot
	28092	toes
	28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus
	28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
	28111	Ostectomy; complete excision of first metatarsal head
	28112	other metatarsal head (second, third or fourth)
	28113	fifth metatarsal head
	28114	all metatarsal heads with partial proximal phalangectomies (Clayton type procedure)
	28116	Ostectomy, excision of tarsal coalition
	28118	Ostectomy, calcaneus; partial (Cotton scoop type procedure)
	28119	for spur, with or without plantar fascial release

Surgical Category	CPT-4 Code	Purpose
Repair of Foot Disorders (continued)	28120	Partial excision (Craterization, saucerization, sequestrectomy, or diaphysectomy) of bone (e.g., for osteomyelitis), talus or calcaneus;
	28121	with suction irrigation
	28122	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), tarsal or metatarsal bone, except talus or calcaneus
	28123	with suction irrigation
	28124	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g, for osteomyelitis), phalanx
	28126	Condylectomy, phalangeal base, single toe, each
	28130	Talectomy (astragalectomy)
	28135	Calcanectomy
	28140	Metatarsectomy
	28150	Phalangectomy, single, each
	28153	Resection, head of phalanx
	28160	Hemiphalangectomy or interphalangeal joint excision, single each
	28200	Repair of suture of tendon, foot, flexor, single; primary or secondary, without free graft, each tendon
	28202	secondary with free graft, each tendon (includes obtaining graft)
	28208	Repair or suture of tendon, foot, extensor, single; primary or secondary, each tendon
	28210	secondary with free graft, each tendon (includes obtaining graft)
	28220	Tenolysis, flexor; single
	28222	multiple (through same incision), each

Surgical Category	CPT-4 Code	Purpose
Repair of Foot Disorders (continued)	28225	Tenolysis, extensor; single
	28226	multiple (through same incision), each
	28230	Tenotomy, open, flexor; foot, single or multiple (separate procedure)
	28232	toe, single (separate procedure)
	28234	Tenotomy, open, extensor, foot or toe
	28236	Transfer of tendon, anterior tibial into tarsal bone (e.g., Lowman-Young type procedure)
	28238	Advancement of posterior tibial tendon with excision of accessory navicular bone (Kidner type procedure)
	28240	Tenotomy or release, abductor hallucis muscle (McCauley type procedure)
	28250	Division of plantar fascia and muscle ("Steindler stripping") (separate procedure)
	28260	Capsulotomy, midfoot; medial release only (separate procedure)
	28261	with tendon lengthening
	28262	extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity
	28264	Capsulotomy, midtarsal (Heyman type procedure)
	28270	Capsulotomy for contracture; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint (separate procedure)
	28272	interphalangeal joint, single, each joint (separate procedure)
	28280	Webbing operating (create syndactylism of toes) for soft corn (Kelikian type procedure)
	28285	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)
	28286	for cock-up fifth toe with plastic skin closure, (Ruiz-Mora type procedure)

Surgical Category	CPT-4 Code	Purpose
Repair of Foot Disorders (continued)	28288	Ostectomy, partial, exostectomy or condylectomy, single, metatarsal head, second through fifth, each metatarsal head (separate procedure)
	28290	Hallux valgus bunion correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)
	28292	Keller, McBride or Mayo type procedure
	28293	resection of joint with implant
	28294	with tendon transplants (Joplin type procedure)
	28296	with metatarsal osteotomy (Mitchell or Lapidus type procedure)
	28298	Hallux valgus bunion correction; by phalanx osteotomy
	28299	by other methods (e.g., double osteotomy)
	28300	Osteotomy; calcaneus (Dwyer or Chambers type procedure), with or without internal fixation
	28302	talus
	28304	Osteotomy, midtarsal bones, other than calcaneus or talus
	28305	with autogenous graft (includes obtaining graft) (Fowler type)
	28306	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal
	28308	other than first metatarsal
	28309	Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure)
	28310	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
	28312	other phalanges, any toe
	28315	Sesamoidectomy, first toe (separate procedure)
	28320	Repair of nounion or malunion; tarsal bones (calcaneus, talus, etc.)
	28322	metatarsal, with or without bone graft (includes obtaining graft)

Surgical Category	CPT-4 Code	Purpose
Repair of Foot Disorders (continued)	28705	Pantalar arthrodesis
	28715	Triple arthrodesis
	28725	Subtalar arthrodesis (includes Grice type procedure)
	28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse
	28735	with osteotomy as for flatfoot correction
	28737	Arthrodesis, midtarsal navicular-cuneiform, with tendon lengthening and advancement (Miller type procedure)
	28740	Arthrodesis, midtarsal or tarsometatarsal, single joint
	28750	Arthrodesis, great toe; metatarsophalangeal joint
	28755	interphalangeal joint
	28760	Arthorodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure)
Broncoscopy	31620	Bronchoscopy; diagnostic, rigid bronchoscope
	31621	diagnostic, fiberoptic bronchoscope (flexible)
	31625	with biopsy, rigid bronchoscope
	31626	with biopsy, fiberoptic bronchoscope (flexible)
	31627	with brushing, fiberoptic bronchoscope (flexible)
	31628	with transbronchial lung biopsy, fiberoptic bronchoscope (flexible) under fluoroscopic guidance
	31630	with tracheal or bronchial dilation or closed reduction of fracture
	31635	with removal of foreign body
	31640	with excision of tumor
	31645	with therapeutic aspiration of tracheobronchial tree, initial
	31646	with therapeutic aspiration of tracheobronchial tree, subsequent
	31650	with drainage of lung abscess or cavity, initial

Surgical Category	CPT-4 Code	Purpose
Broncoscopy (continued)	31651	with drainage of lung abscess or cavity, subsequent
	31656	with injection of contrast material for segmental bronchography (fiberscope only)
	31659	with other bronchoscopic procedures
Tonsillectomy and/or Adenoidectomy	42820	Tonsillectomy and adenoidectomy; under age 12
	42821	age 12 or over
	42825	Tonsillectomy, primary or secondary, under age 12
	42826	age 12 or over
	42830	Adenoidectomy, primary; under age 12
	42831	age 12 or over
	42835	Adenoidectomy, secondary; under age 12
	42836	age 12 or over
Endoscopy	43200	Esophagoscopy, rigid or fiberoptic (specify); diagnostic
	43202	with biopsy and/or collection of specimen by brushing or washing for cytology
	43204	with injection sclerosis of esophageal varices
	43215	with removal of foreign body
	43217	with removal of polyp(s)
	43218	with irrigation
	43219	with insertion of plastic tube or stent
	43220	with dilation, direct
	43225	with repair of hypopharyngeal diverticulum (Dohlman procedure)
	43226	with insertion of wire to guide dilation
	43227	with control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
	43228	with fulguration of muscosal lesion
	43235	Uppergastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic
	43239	with biopsy and/or collection of specimen by burshing or washing for cytology

Surgical Category	CPT-4 Code	Purpose
Endoscopy (continued)	43247	with removal of foreign body
	43251	with removal of polyp(s)
	43255	with control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
	43258	with fulguration of mucosal lesion
	43260	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection for cytology
	43262	with sphincterotomy (Oddi) and/or papillotomy
	43263	with pressure measurement of sphincter of Oddi
	43264	with extraction of stone from common bile duct
	43268	with biliary catheter or stent placement for biliary obstruction (including transnasal or other approach)
	44360	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; diagnostic
	44361	with biopsy and/or collection of specimen by brushing or washing for cytology
	44363	with removal of foreign body
	44364	with removal of polyps
	44366	with control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
	44369	with fulguration of mucosal lesion
	44380	Fiberoptic ileoscopy through stoma
	44382	with biopsy and/or collection of specimen for cytology
	44385	Fiberoptic evaluation of Kock pouch
	44388	Fiberoptic colonoscopy through colostomy
	44389	with biopsy and/or collection of specimen for cytology
	44390	with removal of foreign body
	44391	with control of hemorrhage
	44392	with removal of polypoid lesion(s)
	45300	Proctosigmoidoscopy; diagnostic (separate procedure)

Surgical Category	CPT-4 Code	Purpose
Endoscopy (continued)	45302	with collection of specimen by brushing or washing for cytology
	45303	with dilation, direct, instrumental
	45305	with biopsy
	45307	with removal of foreign body
	45310	with removal of polyp or papilloma
	45315	with removal of multiple excrescences, papillomata or polyps
	45317	with control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
	45319	with retrograde lavage (e.g., water pik)
	45330	Sigmoidoscopy, flexible fiberoptic; diagnostic
	45331	with biopsy
	45332	with removal of foreign body
	45333	with removal of polypoid lesion(s)
	45334	with control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
	45355	Colonscopy, with standard sigmoidoscope, transabdominal via colotomy, single or multiple
	45360	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; diagnostic procedure
	45365	with biopsy and/or collection of specimen for cytology
	45367	with removal of foreign body
	45368	with control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
	45370	with removal of polypoid lesion(s)
	45371	with retrograde lavage (e.g., water pik)
	45378	Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure
	45379	with removal of foreign body
	45380	with biopsy and/or collection of specimen for cytology
	45382	with control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
	45385	with removal of polypoid lesion(s)
	45386	with retrograde lavage (e.g., water pik)

Surgical Category	CPT-4 Code	Purpose
Endoscopy (continued)	46600	Anoscopy; diagnostic (separate procedure)
	46602	with collection of specimen by brushing or washing for cytology
	46604	with dilation, direct instrumental
	46606	with biopsy
	46608	with removal of foreign body
	46610	with removal of polyp
	46612	with multiple poly removal
	46614	with control of hemorrhage
Hemorrhoidectomy	46621	Hemorrhoidectomy, by simple ligature (rubber band)
Live Biopsy, Percutaneous	47000	Biopsy of liver, percutaneous needle
Circumscision, Except Newborn	54152	Except newborn, office
	54161	Except newborn
Vasectomy	55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
Culdoscopy, Colposcopy	57450	Culdoscopy, diagnostic
	57451	Culdoscopy, diagnostic; with biopsy and/or lysis of adhesions or tubal sterilization
	57452	Colposcopy (vaginoscopy); (separate procedure)
	57454	with biopsies, or biopsy of the cervix
Biopsy or Cervic, Circumferential (Cone)	57520	Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair
Dilation and Curettage of Uterus	58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
Tubal Ligation	58600	Ligation of transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

Surgical Category	CPT-4 Code	Purpose
Tubal Ligation (continued)	58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach
Laparoscopy	58980	Laparoscopy for visualization of pelvic viscera
	58982	with fulguration of oviducts (with or without transection)
	58983	with occlusion of oviducts by device (e.g., band, clip or Falope ring)
	58984	with fulguration of ovarian or peritoneal lesions
	58985	with lysis of adhesions
	58986	with biopsy (single or multiple)
	58987	with aspiration (single or multiple)
Hysteroscopy	58990	Hysteroscopy
Myringotomy, Tympanostomy, with or without tubes	69420	Myringotomy including aspiration and/or eustachian tube inflation
	69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral
	69437	bilateral

APPENDIX B

Surgical procedures which requires a second surgical opinion to receive maximum Plan benefits include:

Surgical Category	CPT-4 Code	Purpose
Blepharoplasty (Surgery on Eyelids)	15820 15821	Blepharoplasty, lower eyelid with extensive herniated fat pad
	15822 15823	Blepharoplasty, upper eyelid with excessive skin weighting down lid
Rhytidectomy (Removal of Excessive Skin)	15831	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty)
	15832	thigh
	15833	leg
	15834	hip
	15835	buttock
	15836	arm
	15837	forearm or hand
	15838	submental fat pad
	15839	other area
Mastectomy, Mammoplasty (Breast Surgery)	19160	Mastectomy, partial (quadrectomy or more)
	19182	Mastectomy, subcutaneous
	19318 19325	Reduction mammaplasty with prosthetic implant
Repair of Knee Joint	27310	Arthrotomy, knee, with exploration, drainage or removal of foreign body
	27330	Arthrotomy, knee, for synovial biopsy only
	27331	with joint exploration, with or without biopsy, with or without removal of loose bodies
	27332	Arthrotomy, knee, for excision of semilunar cartilage (meniscectomy); medical OR lateral
	27333	medial AND lateral
	27334	Arthrotomy, knee, for synovectomy; anterior OR posterior
	27335	anterior AND posterior including popliteal area

Surgical Category	CPT-4 Code	Purpose
Repair of Knee Joint (continued)	27373	Arthroscopy, knee, diagnostic (separate procedure)
	27374	Arthroscopy, knee, surgical; debridement with cartilage shaving and/or drilling and/or resection of reactive synovium
	27376	with synovial biopsy
	27377	with removal of loose body
	27378	with meniscectomy
	27379	with plica resection and/or shelf resection
	27436	Arthroscopy, knee, with internal fixation of osteochondral fragment
Repair of Foot Disorders	28010	Tenotomy, subcutaneous, toe; single
	28011	multiple
	28020	Arthrotomy, with exploration, drainage or removal of loose or foreign body; intertarsal or tarsometatarsal joint
	28022	metatarsophalangeal joint
	28024	interphalangeal joint
	28050	Arthrotomy for synovial biopsy; intertarsal or tarsometatarsal joint
	28052	metatarsophalangeal joint
	28054	interphalangeal joint
	28060	Fasciectomy, excision of plantar fascia; partial (separate procedure)
	28062	radical (separate procedure)
	28070	Synovectomy; intertarsal or tarsometatarsal joint, each
	28072	metatarsophalangeal joint, each
	28080	Excision of Morton neuroma, single, each
	28086	Synovectomy, tendon sheath; flexor
	28088	extensor
	28090	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); foot
	28092	toes
	28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus
	28110	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)

Surgical Category	CPT-4 Code	Purpose
Repair of Foot Disorders (continued)	28111	Ostectomy; complete excision of first metatarsal head
	28112	other metatarsal head (second, third or fourth)
	28113	fifth metatarsal head
	28114	all metatarsal heads with partial proximal phalangectomies (Clayton type procedure)
	28116	Ostectomy, excision of tarsal coalition
	28118	Ostectomy, calcaneus; partial (Cotton scoop type procedure)
	28119	for spur, with or without plantar fascial release
	28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) of bone (e.g., for esteomyelitis), talus or calcaneus
	28121	with suction irrigation
	28122	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for esteomyelitis), tarsal or metatarsal bone, except talus or calcaneus
	28123	with suction irrigation
	28124	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for esteomyelitis), phalanx
	28126	Condylectomy, phalangeal, base, single toe, each
	28130	Talectomy (astragalectomy)
	28135	Calcanectomy
	28140	Metatarsectomy
	28150	Phalangectomy, single, each
	28153	Resection, head of phalanx
	28160	Hemiphalangectomy or interphalangeal joint excision, single, each

Surgical Category	CPT-4 Code	Purpose
Repair of Foot Disorders (continued)	28200	Repair or suture of tendon, foot, flexor, single; primary or secondary, without free graft, each tendon
	28202	secondary with free graft, each tendon (includes obtaining graft)
	28208	Repair or suture of tendon, foot, extensor, single; primary or secondary, each tendon
	28210	secondary with free graft, each tendon (includes obtaining graft)
	28220	Tenolysis, flexor; single
	28222	multiple (through same incision), each
	28225	Tenolysis, extensor; single
	28226	multiple (through same incision), each
	28230	Tenotomy, open, flexor; foot, single or multiple (separate procedure)
	28232	toe, single (separate procedure)
	28234	Tenotomy, open, extensor, foot or toe
	28236	Transfer of tendon, anterior tibial into tarsal bone (e.g., Lowman-Young type procedure)
	28238	Advancement of posterior tibial tendon with excision of accessory navicular bone (Kidner type procedure)
	28240	Tenotomy or release, abductor hallucis muscle (McCauley type procedure)
	28250	Division of plantar fascia and muscle ("Steindler stripping") (separate procedure)
	28260	Capsulotomy, midfoot, medial release only (separate procedure)
	28261	with tendon lengthening
	28262	extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity
	28264	Capsulotomy, midtarsal (Heyman type procedure)

Surgical Category	CPT-4 Code	Purpose
Repair of Foot Disorders (continued)	28270	Capsulotomy for contracture; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint (separate procedure)
	28272	interphalangeal joint, single, each joint (separate procedure)
	28280	Webbing operation (create syndactylism of toes) for soft corn (Kelikian type procedure)
	28285	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)
	28286	for cock-up fifth toe with plastic skin closure, (Ruiz-Mora type procedure)
	28288	Ostectomy, partial, exostectomy or condylectomy, single, metatarsal head, second through fifth, each metatarsal head (separate procedure)
	28290	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)
	28292	Keller, McBride or Mayo type procedure
	28293	resection of joint with implant
	28294	with tendon transplants (Joplin type procedure)
	28296	with metatarsal osteotomy (Mitchell or Lapidus type procedure)
	28298	Hallux valgus (bunion) correction; by phalanx osteotomy
	28299	by other methods (e.g., double osteotomy)
	28300	Osteotomy; calcaneus (Dwyer or Chambers type procedure), with or without internal fixation
	28302	talus
	28304	Osteotomy, midtarsal bones, other than calcaneus or talus
	28305	with autogenous graft (includes obtaining graft) (Fowler type)
	28306	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal
	28308	other than first metatarsal

Surgical Category	CPT-4 Code	Purpose
Repair of Foot Disorders (continued)	28309	Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure)
	28310	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
	28312	other phalanges, any toe
	28315	Sesamoidectomy, first toe (separate procedure)
	28320	Repair of nonunion or malunion, tarsal bones (calcaneus, talus, etc.)
	28322	metatarsal, with or without bone graft (includes obtaining graft)
	28705	Pantalar arthrodesis
	28715	Triple arthrodesis
	28725	Subtalar arthrodesis (includes Grice type procedure)
	28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse
	28735	with osteotomy as for flatfoot correction
	28737	Arthrodesis, midtarsal navicular-cuneiform, with tendon lengthening and advancement (Miller type procedure)
	28740	Arthrodesis, midtarsal or tarsometatarsal, single joint
	28750	Arthrodesis, great toe; metatarsophalangeal joint
	28755	interphalangeal joint
	28760	Arthrodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure)
Surgery on the Spinal Column and/or Spinal Nerves	22550	Arthrodesis with diskectomy, cervical posterior approach; local bone graft and/or internal fixation
	22552	with iliac or other autogenous bone graft (includes obtaining graft)

Surgical Category	CPT-4 Code	Purpose
Surgery on the Spinal Column and/or Spinal Nerves (continued)	22555	Arthrodesis with diskectomy, cervical, anterior interbody approach with iliac or other autogenous bone graft (includes obtaining graft)
	22560	Arthrodesis with diskectomy, lumbar or thoracic, posterior posterolateral or posterior interbody approach; local bone graft and/or internal fixation
	22561	with iliac or other autogenous bone graft (includes obtaining graft)
	22565	Arthrodesis with diskectomy, lower lumbar spine, anterior interbody approach, (includes obtaining graft)
	22600	Cervical fusion, posterior approach, below C1 level; local bone graft and/or internal fixation
	22605	with iliac or autogenous bone graft (includes obtaining graft)
	22615	Cervical fusion, anterior approach (C3-T1) with iliac or other autogenous bone graft (includes obtaining graft)
	22617	Atlas-axis fusion (C1-C2 or C3) with iliac or other autogenous bone graft (includes obtaining graft) (posterior or anterior approach)
	22620	Cervicocranial fusion (occiput through C2) with iliac or other autogenous bone graft (includes obtaining graft)
	22640	Thoracic or lumbar fusion, posterior or posterolateral approach; local bone graft and/or internal fixation
	22645	with iliac or other autogenous bone graft (includes obtaining graft)
	22655	Thoracic or lumbar fusion; posterior interbody technique, with iliac or other autogenous bone graft, (includes obtaining graft)
	22670	lateral approach (transverse process to transverse process and/or sacrum) with iliac or other autogenous bone graft and/or internal fixation (includes obtaining graft)

Surgical Category	CPT-4 Code	Purpose
Surgery on the Spinal Column and/or Spinal Nerves (continued)	22680	anterolateral or anterior interbody fusion, transthoracic approach (includes obtaining graft)
	22700	Lumbar spine fusion; anterior interbody fusion (includes obtaining graft)
	22720	posterior approach, Harrington or Knodt rod distraction fusion, with iliac or other autogenous bone graft (includes obtaining graft)
	22730	Arthrodesis, primary or repair of pseudarthrosis; two levels
	22735	more than two levels
	22800	Arthrodesis, primary for scoliosis with or without postoperative case, 6 or less vertebrae; local bone graft
	22801	with iliac or other autogenous bone graft
	22802	Arthrodesis, primary for scoliosis with or without postoperative case, seven or more vertebrae; local bone graft
	22803	with iliac or other autogenous bone graft
	22840	Posterior instrumentation; (e.g., Harrington rod technique)
	22842	segmental wiring (e.g., Luque technique)
	22845	Anterior instrumentation (e.g., Dwyer instrumentation)
	62292	Injection procedure for chemonucleolysis, intervertebral disk, single or multiple levels; lumbar
	62293	cervical
	62295	Laminectomy for exploration of intraspinal canal, one or two segments; cervical
	62296	thoracic
	62297	lumbar
	62299	sacral

Surgical Category	CPT-4 Code	Purpose
Surgery on the Spinal Column and/or Spinal Nerves (continued)	62301	Laminectomy for exploration of intraspinal canal, more than two segments; cervical
	62302	thoracic
	62303	lumbar
	63001	Laminectomy for decompression of spinal cord and/or cauda equina, one or two segments; cervical
	63003	thoracic
	63005	lumbar, except for spondylolisthesis
	63010	lumber for spondylolisthesis (Gill type operation)
	63011	sacral
	63015	Laminectomy for decompression of spinal cord and/or cauda equina, more than two segments; cervical
	63016	thoracic
	63017	lumbar
	63020	Laminotomy (hemilaminectomy), for excision of herniated intervertebral disk, and/or decompression of nerve root, one interspace, cervical, unilateral
	63021	one interspace, cervical, bilateral
	63030	one interspace, lumbar, unilateral
	63031	one interspace, lumbar, bilateral
	63035	additional interspaces, cervical or lumbar
	63040	Laminotomy (hemilaminectomy), for herniated intervertebral disk, and/or decompression of nerve root, any level, extensive or reexploration; cervical
	63041	thoracic
	63042	lumbar
	63060	Hemilaminectomy (laminectomy) for herniated intervertebral disk, thoracic, posterior approach
	63064	Costovertebral approach for herniated intervertebral disk, thoracic
	63065	Transthoracic approach for herniated intervertebral disk or other mass lesion, thoracic spine

Surgical Category	CPT-4 Code	Purpose
Surgery on the Spinal Column and/or Spinal Nerves (continued)	63075	Diskectomy, cervical, anterior approach, including microscope, without arthrodesis, single interspace
	63076	additional interspace
	63210	Laminectomy, one or two segments, for excision of intraspinal lesion; cervical
	63215	thoracic
	63220	lumbar
	63225	sacral
	63240	Laminectomy, more than two segments, for excision of intraspinal lesion; cervical
	63241	thoracic
	63242	lumbar
	63250	Laminectomy for excision or occlusion of arteriovenous malformation of cord; cervical
	63251	thoracic
Revision of Nasal Structure	30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	30420	including major septal repair
	30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	30435	intermediate revision (bony work with osteotomies)
	30450	major revision (nasal tip work and osteotomies)
	30500	Submucous resection nasal septum, classic
	30520	Septoplasty with or without cartilage implant (separate procedure)
	30620	Reconstruction, functional, internal nose (septal or other intranasal dermatoplasty) (does not include obtaining graft)

Surgical Category	CPT-4 Code	Purpose
Coronary Artery Bypass Surgery	33510	Coronary artery bypass, autogenous graft (e.g., saphenous vein or internal mammary artery); single artery
	33511	two coronary arteries
	33512	three coronary arteries
	33513	four coronary arteries
	33514	five coronary arteries
	33516	six or more coronary arteries
	33520	Coronary artery bypass, nonautogenous graft (e.g., synthetic or cadaver); single artery
	33525	two coronary arteries
	33528	three or more coronary arteries
Cholecystectomy (Gallbladder Surgery)	47600	Cholecystectomy
	47605	with cholangiography
	47620	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy of sphincteroplasty, with or without cholangiography
Stomach Surgery for Obesity	43844	Gastric bypass for morbid obesity
	43845	Gastric stapling for morbid obesity
	43846	Gastric bypass with Roux-en-Y gastroenterostomy for morbid obesity
Herniorrhaphy (Hernia Repairs)	49500	Repair inguinal hernia, under age 5 years, with or without hydrocelectomy
	49505	Repair inguinal hernia, age 5 or over
	49510	with orchiectomy, with or without implantation or prosthesis
	49515	with excision of hydrocele or spermatocele
	49520	Repair inguinal hernia, any age; recurrent
	49525	sliding
	49530	incarcerated
	49535	strangulated
	49540	Repair lumbar hernia

Surgical Category	CPT-4 Code	Purpose
Herniorrhaphy (Hernia Repairs) (continued)	49550	Repair femoral hernia, groin incision
	49552	Repair femoral hernia, Henry approach
	49555	Repair femoral hernia, recurrent, any approach
	49560	Repair ventral (incisional) hernia (separate procedure)
	49565	Repair ventral hernia (separate procedure); recurrent
	49570	Repair epigastric hernia, properitioneal fat (separate procedure); simple
	49575	complex
	49580	Repair unbilical hernia; under age 5 years
	49581	age 5 or over
	49590	Repair spigelian hernia
Tonsillectomy and/or Adenoidectomy	42820	Tonsillectomy and adenoidectomy; under age 12
	42821	age 12 or over
	42825	Tonsillectomy, primary or secondary, under age 12
	42826	age 12 or over
	42830	Adenoidectomy; primary; under age 12
	42831	age 12 or over
	42835	Adenoidectomy; secondary; under age 12
	42836	age 12 or over
Hemorrhoidectomy (Removal of Hemorrhoids)	46250	Hemorrhoidectomy, external, complete
	46255	Hemorrhoidectomy, internal and external simple
	46257	with fissurectomy
	46258	with fistulectomy, with or without fissurectomy
	46260	Hemorrhoidectomy internal and external, complex or extensive
	46261	with fissurectomy
	46262	with fistulectomy, with or without fissurectomy

Surgical Category	CPT-4 Code	Purpose
Prostatectomy (Removal of Prostate)	52601	Transurethral resection of prostate, including control of postoperative bleeding during hospitalization, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)
	52612	Transurethral resection of prostate; first stage of two-stage resection (partial resection)
	52614	second stage of two-stage resection (resection completed)
	52650	Transurethral cryosurgical removal of prostate (postoperative irrigations and aspiration of sloughing tissue included)
	55801	Prostatectomy, including control of postoperative bleeding during initial hospitalization, complete vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy are included, perineal, subtotal
	55845	with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
Hysterectomy (Removal and/or Repair of Uterus, Tubes or Ovaries	58150	Total hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
	58152	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type)
	58180	Supracervical hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
	58200	Total hysterectomy, extended, corpus cancer, including partial vaginectomy
	58205	with bilaterial radical pelvic lymphadenectomy
	58210	Total hysterectomy, extended, cervical cancer, with bilateral radical pelvic lymphadenectomy (Wertheim type operation)

Surgical Category	CPT-4 Code	Purpose
Hysterectomy (Removal and/or Repair of Uterus, Tubes or Ovaries) (continued)	58240	Total hysterectomy or cervicectomy, with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof (pelvic exenteration)
	58260	Vaginal hysterectomy
	58265	with plastic repair of vagina, anterior and/or posterior colporrhaphy
	58267	with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type)
	58270	with repair of enterocele
	58275	Vaginal hysterectomy, with total or partial colpectomy
	58280	with repair of enterocele
	58285	Vaginal hysterectomy, radical (Schauta type operation)
Dilation and Curettage of Uterus	58120	Dilation and curretage, diagnostic and/or therapeutic (nonobstetrical)
Thyroid Surgery	60200	Excision of cyst or adenoma of thyroid, or transection of isthmus
	60220	Total thyroid lobectomy, unilateral
	60225	with contralateral subtotal lobectomy including isthmus
	60240	Thyroidectomy, total or complete
	60242	near total
	60245	Thyroidectomy, subtotal or partial
	60246	with removal of substermal thyroid gland, cervical
	60260	Thyroidectomy, secondary; unilateral
	60261	bilateral
	60500	Parathyroidectomy or exploration of parathyroid(s)
	60505	with mediastinal exploration, sternal split or transthoracic approach
	60510	Transplantation of parathyroid gland(s) during thyroidectomy

Surgical Category	CPT-4 Code	Purpose
Removal of Cataract	66830	Removal of secondary membranous cataract ("after cataract"), with corneoscleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
	66840	Removal of lens material; aspiration technique, one or more stages
	66850	phacofragmentation technique (mechanical or ultrasonic, e.g., phacoemulsification), with aspiration
	66915	Expression lens, linear, one or more stages
	66920	Extraction lens with or without iridectomy; intracapsular, with or without enzymes
	66930	intracapsular, for dislocated lens
	66940	extracapsular
	66945	in presence of fistulization bleb and/or by temporal, inferior or inferotemporal route, intracapsular or extracapsular

ARTICLE VI -- DENTAL CARE BENEFITS

6.1 Definitions Relative to Dental Care Benefits

A. **"Dentist"** shall mean a currently duly licensed doctor of dental medicine or doctor of dental surgery acting within the scope of his or her license and any other Physician furnishing any dental services which he or she is licensed to perform.

B. **"Dental Emergency"** shall mean an urgent, unplanned diagnostic visit to a Dentist for alleviation of an acute or unexpected dental condition.

C. **"Dental Hygienist"** shall mean a person who is currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of dental hygiene, and who works under the direct supervision and direction of a Dentist.

D. **"Dental Treatment Plan"** shall mean a Dentist's report, on a form satisfactory to the Claim Administrator, which:

1. Itemizes the dental services recommended by him or her for the dental care of a Covered Individual;

2. Shows the charge to be made for each dental service; and

3. Is accompanied by supporting pre-operative X-rays or other appropriate diagnostic materials as required by the Plan Administrator.

With respect to Orthodontic Procedures such Dental Treatment Plan must:

1. Provide a classification of malocclusion;

2. Recommend and describe necessary treatment by Orthodontic Procedures;

3. Estimate the duration over which treatment will be completed;

4. Estimate the total charge for such treatment; and

5. Be accompanied by cephalometric X-rays, study models and such other supporting evidence as the Plan Administrator may reasonably require.

E. **"Incurred Charges"** shall mean that a dental charge is considered to be incurred for:

1. Appliances or a modification of appliances on the date the master impression is made;

2. A crown, a bridge or inlay or onlay restoration, on the date the tooth or teeth are prepared;

3. Root canal therapy on the date the pulp chamber is opened; or

4. All other charges on the date service is rendered or a supply furnished.

F. **"Orthodontic Procedures"** shall mean movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

6.2 Benefit Provisions

Only individuals described in Subsection 3.1 D. are eligible for the benefits described in this Article VI.

After satisfaction of the Deductible, the Plan pays 100% of the usual and customary Covered Charges as listed as long as they are the lesser of the Reasonable and Customary charge incurred, and are not more than the maximum Covered Charges as listed in Appendix VI-A, subject to the following conditions:

A. Deductible

The schedule for Deductibles shall be as follows:

Preventive Care	None
Basic Services	$50 per Covered Individual per lifetime
Major Services	$50 per Covered Individual per calendar year
Orthodontic Services	$100 per Covered Individual per lifetime

If two (2) or more members of the same family incur Covered Expenses which total $100 for Major Services, no further Deductible for Major Services shall be applied to Covered Expenses incurred by any additional family member during the remainder of that calendar year. Regardless of the make-up of the family (i.e. two (2) Employees and dependents, etc.), the family Deductible shall not exceed $100.

B. Maximum Benefits

Benefits for each Covered Individual shall be limited as indicated below:

1. Preventive care; basic services and major services combined $750 each calendar year.

2. Orthodontic services $500 per lifetime.

C. Charges which are in excess of $150 should be part of a Dental Treatment Plan which has been, before the procedures are performed:

1. Submitted to the Claim Administrator;

2. Reviewed and returned to the Dentist with estimated benefits; and

3. For Orthodontic Procedures a Dental Treatment Plan must:

   a. Provide a classification of the malocclusion;

   b. Describe the recommended treatment;

   c. Estimate the duration over which treatment shall be completed;

   d. Estimate the total charge for such treatment; and

   e. Be accompanied by cephalometric X-rays, study models and other supporting evidence as the Claim Administrator may reasonably require.

Submission of a Dental Treatment Plan is not required if the charges are less than $150 or are incurred as the result of a Dental Emergency, as determined by the Plan Administrator.

D. When a service or supply is proposed, rendered or furnished that has an appropriate alternative that is in accordance with accepted standards of dental practice, the service or supply having the lesser charge shall be considered as being the Covered Expense.

E. Orthodontic services are subject to the following:

1. Any benefit scheduled to be paid for Orthodontic Procedures in accordance with an Orthodontic Treatment Plan may be payable in equal quarterly installments over a period of time equal to the estimated duration of the Orthodontic Treatment Plan, provided, however, that the number of quarterly installments shall in no case exceed eight (8). The first installment shall become payable on the date on which the orthodontic appliances are first installed, and subsequent installments shall become payable at the end of each three (3) month period thereafter.

2. Orthodontic charges are covered only to the extent that they are made in connection with an orthodontic procedure which is required by one (1) or more of the following conditions:

a. Overbite or overjet of at least four millimeters;

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

c. Cross-bite; and

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

3. Orthodontic charges are covered only for Plan Participants if such services commence prior to such individual's attainment of age nineteen (19).

F. Covered Charges are scheduled as indicated in Appendix VI-A, but shall include:

1. Preventive Care Services

a. Clinical oral examination;

b. Prophylaxis and fluoride applications; and

c. Space maintainers, including adjustments within six (6) months after installation, limited to the initial appliance only and for Children under age sixteen (16).

2. Basic Care Services

a. Office visits;

b. X-ray and pathology, including examination and diagnosis, except for Injuries;

c. Oral surgery, including local anesthesia and routine post-operative care;

d. Extractions;

e. Alveolar or gingival contructions;

f. Cysts or neoplasms;

g. Injectable antibiotics;

h. Anesthesia;

i. Periodontics (only procedures 4210-4330 as indicated in Appendix VI-A);

j. Endodontics;

k. Root canals including necessary X-rays and cultures, but not final restoration or treatment of non-vital teeth;

l. Anterior, bicuspid and molar teeth;

m. Restorative dentistry, however multiple restorations in one (1) surface shall be considered a single restoration;

n. Amalgam and synthetic restorations;

o. Pins exclusive of restorative material and used in lieu of cast restoration; and

p. Crowns, full and partial denture repairs, relinings, rebasings, adjustments and recementations.

3. Major Care Services

a. Restorative procedures including cast restorations and crowns, when necessitated

by decay or traumatic Injury and only when the restoration cannot be restored with routine filling material;

b. Prosthodontia including inlays, crowns, pontics and removable bridges;

c. Periodontics;

d. Repairs of crowns and bridges; and

e. Dentures, partial dentures and the repair of such, including the addition of teeth to a partial denture to replace extracted natural teeth.

4. Orthodontic Care Services

a. Preventive treatment procedures, including radiographs;

b. Minor treatment for tooth guidance;

c. Interceptive treatment; and

d. Treatment of transitional and permanent dentition.

Any procedure not listed in Appendix VI-A is excluded, except that, if the procedure is for a condition for which one (1) or more of the listed procedures would be appropriate according to customary dental practice, as determined by the Plan Administrator, the maximum Covered Charge shall be the amount allowable for the lesser charge of such listed procedures.

6.3 Exclusions and Limitations for Dental Care Benefits

The following items shall not be covered by the Plan:

A. Accidental Injury or Illness caused by war or any act of war, declared or undeclared, including armed aggression, or by participating in a riot, or the attempt to commit a felony or assault.

B. Accidental Injury or Illness arising out of or in the course of employment, or which is compensable under any Worker's Compensation or Occupational Disease Act or Law.

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

D. Charges for cosmetic treatment required for correction unless necessitated as a result of accidental Injury sustained by the Covered Individual while this Plan is in force on his or her account. For purposes of these limitations, facings on crown, or pontics, posterior to the second bicuspid shall always be considered cosmetic.

E. Charges for replacement of lost or stolen appliances.

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

G. Charges for services or supplies not usual or Necessary Care or in excess of the scheduled amounts.

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

I. The replacement of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within five (5) years of the date of the last placement of such appliance, crown, inlay or onlay restoration or fixed bridge, unless such replacement is required as a result of accidental bodily Injury.

J. Benefits for orthodontic services shall not be provided for any Orthodontic Procedure in connection with which an active appliance has been installed prior to the day on which the Covered Individual became insured or covered.

K. Charges for orthodontic services which commence after the Covered Individual has attained age nineteen (19).

L. Charges incurred in connection with dental implantology.

M. Charges which are Covered Expenses under the Medical Care benefits of this Plan, as indicated in Article V.

N. A service not furnished by a Dentist, unless the service is performed by a licensed dental hygienist under the supervision of a Dentist or is an x-ray ordered by a Dentist.

The limitations and exclusions set forth above in Section 6.3 and throughout the Plan are not intended in any way to be exhaustive, and the Plan hereby reserves the right to limit or exclude such other services and supplies and the charges therefor as are determined to be inappropriate in the sound discretion of the Plan Administrator under the terms and conditions as well as the scope and intent of the Plan.

APPENDIX A

COVERED DENTAL PROCEDURES

The following is a complete listing of the Covered Expenses for Dental Care Benefits and the scheduled amounts payable under the Plan:

Preventive Care Services

	Procedure Number	Description of Services	Maximum Covered Charge
Clinical Oral Examination	0110	Initial oral examination	$ 15.00
	0120	Periodic oral examination	15.00
	0130	Emergency oral examination	21.00
Prophylaxis and Fluoride Applications	1110	Prophylaxis for individuals age 14 or over, treatments to include scaling and polishing (limited to one treatment every six months)	25.00
	1120	Prophylaxis for children under age 14 (limited to one treatment every six months)	20.00
	1210	Topical application of sodium flouride exlcuding prophylaxis	17.00
	1211	Topical application of sodium flouride including prophylaxis	20.00
	1220	Topical application of stannous flouride excluding prophylaxis	12.00
	1221	Topical application of stannous fluoride, including prophylaxis, per treatment (limited to one treatment per 12 consecutive months for children under age 18	35.00
	1230	Topical application of acid fluoride phosphoric excluding prophylaxis	12.00
	1231	Topical application of acid fluoride phosphoric including prophylaxis	15.00
Space Maintainers	1510	Fixed, unilateral (band or stainless steel crown type)	75.00
	1512	Fixed cast type (distal shoe)	100.00
	1515	Fixed bilateral type	90.00

	Procedure Number	Description of Services	Maximum Covered Charge
	1520	Removable Unilateral type	$100.00
	1525	Removable bilateral type	102.00
	1540	Additional clasps activating wires	8.00
	1550	Recement of space maintainer	15.20
	8210	Removable inhibiting appliance to correct thumbsucking	102.00
	8220	Fixed or cemented inhibiting appliance to correct thumbsucking	128.00
		Basic Services	
Non-Routine Visits	9110	Emergency palliative treatment, per visit	14.00
	9310	Consultation by other than practitioner providing treatment	27.00
	9410	House call	15.20
	9420	Hospital call	15.20
	9430	Office visit during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures)	15.20
	9440	Professional visit after hours (payment will be made on the basis of services rendered or visits, whichever is greater)	20.00
X-Ray and Pathology	0210	Entire denture series consisting of at least 14 films, including bitewings if necessary (limited to once every three years)	27.00
	0220	Single film -- initial	6.00
	0230	Additional films (up to 12), each	5.00

Procedure Number	Description of Services	Maximum Covered Charge
0240	Intra-oral, occlusal view, maxillary or mandibular, each (limited to once every 36 consecutive months)	$7.00
0250	Superior or inferior maxillary, extra oral, one film	15.00
0260	Extra-oral x-ray - additional	4.80
0270	Bitewing single x-ray	4.80
0272	Bitewing films, two including examination (limited to once every 6 months)	9.00
0273	Bitewings - 3 films	8.00
0274	Bitewing films, four including examination (limited to once every 6 months)	14.00
0280	Bitewing x-ray - additional	1.60
0290	Posteranterio & lateral skull x-ray	18.40
0321	Temporo - Mandibular joint x-ray	20.00
0330	Panoramic survey, maxillary and mandibular, single film (considered an entire denture series)	24.00
0390	X-rays - miscellaneous	15.20
0410	Bacteriologic cultures (Pathologic agents)	11.20
0420	Caries susceptibility test	6.40
0460	Pulp vitality tests	4.80
0470	Diagnostic models, in connection with endodontic or periodic treatment	21.00
0470	Diagnostic models, in connection with prosthodontic treatment	11.00

	Procedure Number	Description of Services	Maximum Covered Charge
	0471	Diagnostic photographs, in connection with endodontic or periodontic treatment	$11.20
	7286	Biopsy and examination of oral tissue	14.00
Oral Surgery			
Extractions	7110	Uncomplicated (single)	19.00
	7120	Each additional tooth	18.00
	7210	Surgical removal of erupted tooth (including tissue flap and bone removal)	27.00
	7250	Surgical extraction-root recovery	35.20
	7281	Surgical exposure and erupt	35.20
	7290	Surgical repositioning of teeth	49.60
	9930	Post-operative visit (sutures and complications) after multiple extractions or impactions	17.00
Impacted Teeth	7220	Removal of tooth (soft tissue)	35.20
	7230	Removal of tooth (partially bony)	49.60
	7240	Removal of tooth (completely bony)	75.20
Alveolar or Gingival Reconstructions	7310	Alveolectomy (in addition to removal of teeth), per quadrant	38.00
	7320	Alveolectomy (edentulous) per quadrant	36.80
	7330	Alveoplasty-cuspid to cuspid	30.40
	7340	Alveoplasty with ridge extension, per arch	49.60
	7350	Stomatoplasty, per arch, complicated	169.60
	7410	Radical excision, up to 1/2 inch	49.60

	Procedure Number	Description of Services	Maximum Covered Charge
	7420	Radical excision, over 1/2 inch	$129.60
	7425	Excision of pericoronal gingiva, per tooth	129.60
	7450	Removal odontogenic cyst to 1/2 inch	49.60
	7451	Removal odontogenic cyst over 1/2 inch	129.60
	7470	Removal of palatal torus	88.00
	7471	Removal of mandibular tori, per quadrant	88.00
	7480	Partial Ostectomy	100.00
	7490	Radical Resection of Mandible	400.00
	7970	Excision of hyperplastic tissue, per arch	60.00
Cysts and Neoplasms	7430	Removal of cyst or tumor, up to 1.25 cm	65.00
	7431	Removal of cyst or tumor, over 1.25 cm	85.00
	7510	Incision and drainage of abscess	24.00
Other Surgical Procedures	7260	Closure of oral fistula of maxillary sinus	110.40
	7270	Replantation of tooth or tooth bud	102.00
	7280	Crown exposure for orthodontia	51.00
	7520	Incision/drainage of abscess, extra-oral	40.00
	7530	Removal of foreign body from soft tissue	20.00
	7540	Removal of foreign body from bone (independent procedure)	68.00

Procedure Number	Description of Services	Maximum Covered Charge
7550	Sequestrectomy for osteomyelitis or bone abscess, superficial	$100.00
7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	115.20
7640	Condylectomy of temporomandibular joint	350.40
7810	Open reduction of dislocation	375.20
7820	Closed reduction of dislocation	49.60
7830	Manipulation under anesthesia	49.60
7840	Condylectomy	350.40
7850	Menisectomy of tempromandibular joint	350.40
7860	Arthrotomy	235.20
7870	Arthrocentesis	40.00
7871	Injection of sclerosing agent into temporomandibular joint	41.00
7910	Suture of soft tissue injury	30.40
7911	Complicated suturing - up to two inches	110.40
7912	Complicated suturing - over two inches	124.80
7920	Skin grafts	80.00
7930	Treatment of trigeminal neuralgia by injection into second and third divisions	60.00
7931	Avulsion of trigeminal nerve	89.60
7940	Osteoplasty	500.00
7950	Osteoperiosteal	400.00

	Procedure Number	Description of Services	Maximum Covered Charge
	7955	Repair maxillo facial tissue	$44.80
	7960	Frenectomy	58.00
	7970	Excision of hyperplastic tissue	60.00
	7980	Sialolithotomy; removal of salivary calculus	200.00
	7981	Excision of Salivary gland	175.20
	7982	Sialodochoplasty	275.20
	7983	Closure of salivary fistula	300.00
	7984	Dilation of salivary duct	24.00
Drugs -- Injectable Antiobiotics	9610	Injectable antiobiotics	9.00
	9630	Other medicaments	9.00
Anesthesia	9210	Local anesthesia - non-operative	12.00
	9211	Regional block anesthesia	7.00
	9212	Trigeminal division block anesthesia	12.00
	9220	General, in conjunction with surgical procedures only	38.00
Periodontics	4210	Gingivectomy (including post-surgical visits), per quadrant	80.00
	4212	Gingivectomy, treatment per tooth (fewer than six teeth)	17.00
	4220	Subgingival curettage, root planing, per quadrant (not prophylaxis)	24.80
	4240	Gingival flap procedure	104.00
	4250	Mucogingival surgery per quad	104.00

	Procedure Number	Description of Services	Maximum Covered Charge
	4260	Osseous surgery (including post-surgical visits), per quadrant	$200.00
	4270	Muco gingival surgery (pedicle soft tissue graft, sliding horizontal flap)	102.00
	4271	Free soft tissue graft	60.00
	4272	Vestibuloplasty	124.00
	4280	Periodontal pulpal procedures	40.00
	4320	Provisional splinting intracoronal	49.60
	4321	Provisional splinting extracoronal	49.60
	4330	Occlusal adjustment, related to periodontal problems, per quadrant	30.00
	4331	Complete occlusal adjustment	72.00
	4340	Scaling & root planting entire mouth	48.00
	4341	Scaling & root planting - per quadrant	12.00
	4910	Preventive periodontal procedures	24.00
	4920	Unscheduled dressing change	9.60
Endodontics	3110	Pulp capping -- direct, excluding final restoration	14.00
	3120	Pulp cap - indirect	8.00
	3210	Therapeutic apical closure	15.20
	3220	Vital pulpotomy, excluding final restoration	24.00
	3410	Apicoectomy (performed as separate surgical procedure)	88.00

	Procedure Number	Description of Services	Maximum Covered Charge
	3420	Apicoectomy (performed in conjunction with endodontic procedure)	$144.00
	3430	Retrofilling	60.00
	3440	Apical curettage	60.00
	3450	Root amputation	60.00
	3910	Surgical procedure - rubber dam	15.20
	3920	Hemisection	49.60
	3930	Canal and/or pulp chamber enlargement	5.60
	3940	Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only	24.00
	3950	Canal prep fitting dowel post	24.80
	3990	Emergency procedure	15.20
Root Canals			
Anterior Teeth	3305	Medicated paste -- (N-2)	102.00
	3310	Traditional canal therapy	116.00
	3311	Root canal - Sargenti Method one	92.80
Bicuspid Teeth	3315	Medicated paste -- (N-2)	126.00
	3320	Traditional canal therapy	144.00
	3321	Root canal - Sargenti Method two	121.60
Molar Teeth	3325	Medicated paste -- (N-2)	170.00
	3330	Traditional canal therapy	216.00
	3331	Root canal - Sargenti Method three	176.00
	3340	Root canal therapy - four canals	240.00
	3350	Apexification	30.40

	Procedure Number	Description of Services	Maximum Covered Charge
Restorative Dentistry			
Amalgam Restorations	2110	Cavities involving one surface	$14.00
Primary Teeth	2120	Cavities involving two surfaces	21.00
	2130	Cavities involving three or more surfaces	27.00
	2131	Amalgam four or more surfaces	30.40
Amalgam Restorations -- Permanent Teeth	2140	Cavities involving one surface	15.00
	2150	Cavities involving two surfaces	22.00
	2160	Cavities involving three or more surfaces	28.00
	2161	Amalgam four or more surfaces	32.00
Synthetic Restorations	2210	Silicate cement filling	17.00
	2310	Acrylic or plastic filling	22.40
	2320	Acrylic or plastic/incisal angle	28.00
	2330	Composite resin -- one surface	21.00
	2331	Composite resin - two surfaces	31.20
	2332	Composite resin - three surfaces	44.80
	2334	Pin retention Ex composite	9.60
	2335	Composite resin -- involving incisal angle	41.00
	2340	Acid etch for restorations	9.60
Pins	2190	Pin retention -- exclusive of restorative material (used in lieu of cast restoration) -- indicate number of pins (per pin)	11.00

	Procedure Number	Description of Services	Maximum Covered Charge
Crowns	2830	Stainless steel (when tooth cannot be restored with a filling material)	$41.00
Full and Partial Denture Repairs, Acrylic	5610	Broken dentures, no teeth involved	32.00
	5620	Repair broken denture - replace one tooth	36.00
	5630	Repair denture - replace additional tooth	17.60
	5640	Replacing missing or broken teeth, each tooth	21.00
Recementation	2910	Inlay	13.60
	2920	Crown	14.00
	2940	Fillings - sedative	11.20
	2950	Crown buildup - pin retained	51.20
	6930	Bridge	23.20
Denture Relinings and Rebasings	5710	Duplicate upper or lower complete denture -- jump case	96.00
	5720	Duplicate upper or lower partial denture -- jump case	96.00
	5730	Reline upper or lower complete denture -- office/relining	69.60
	5740	Reline upper or lower partial denture -- office/relining	69.60
	5750	Reline complete denture -- laboratory	88.00
	5760	Reline partial denture -- laboratory	88.00

	Procedure Number	Description of Services	Maximum Covered Charge
	5850	Tissue conditioning, per denture (maximum of two treatments per arch) (limited to once per 12 month period). Indicate whether upper or lower	$ 34.00
Denture Adjustments	5410	Adjustment to denture more than six months after installation or if by other than dentist providing appliance	14.00
	5421	Partial denture adjust (upper)	14.00
	5422	Partial denture adjust (lower)	14.00

MAJOR SERVICES

	Procedure Number	Description of Services	Maximum Covered Charge
Restorative	2410	Gold foil restoration - one surface	$ 64.00
	2420	Gold foil restoration - two surfaces	112.00
	2430	Gold foil restoration - three surfaces	128.00
Inlays	2510	One surface	104.00
	2520	Two surfaces	136.00
	2530	Three or more surfaces	166.00
	2540	Onlay, in addition to inlay allowance	23.20
	2610	Porcelain inlay	100.00
	6520	Two surface gold inlay	80.00
	6530	Three or more surface gold inlay	90.00
	6540	Gold inlay (onlaying cusps)	15.00
Crowns	2710	Acrylic	130.00
	2711	Plastic - prefabricated crown	40.00
	2720	Acrylic with gold	188.00
	2721	Crown-plastic/non-precious	164.80
	2722	Acrylic with semi-precious metal	164.00
	2740	Porcelain	176.00
	2750	Porcelain with gold	220.00
	2751	Crown - porcleain/nonprecious	192.00
	2752	Porcelian with semi-precious metal	195.20
	2790	Gold (full cast)	192.00
	2791	Crown - nonprecious - full cast	171.20
	2792	Full cast with semi-precious metal	187.00
	2810	Gold (3/4 cast)	170.00
	2840	Crown - temporary	30.40
	2891	Cast post and core (in addition to crown)	88.00
	2892	Crown - amalgam/composite build up - W.P.	55.20

	Procedure Number	Description of Services	Maximum Covered Charge
Pontics	6210	Cast gold (sanitary)	$143.00
	6211	Bridge pontics - nonprecious	78.00
	6212	Cast with semi-precious metal (sanitary)	150.00
	6220	Slotted facing	109.00
	6230	Slotted pontic	88.00
	6235	Bridge pontic - pin facing	87.00
	6240	Porcelain fused to gold	204.00
	6241	BDG pontic - porc/nonprecious	92.50
	6242	Porcelian fused to semi-precious metal	136.00
	6250	Plastic processed to gold	170.00
	6251	BDG pontic - plastic/nonprecious	136.00
	6252	Plastic processed to semi-precious metal	136.00
Removable Bridge (unilateral)	5280	Unilateral partial denture gold	54.00
	5281	One piece chrome casting clasp attachment (all types), per unit including pontics	54.00
Periodontics	4350	Tooth movement for periodontal purposes	49.60
	4360	Occlusal guards	130.00
Repairs, Crowns and Bridges	6610	Replace broken pin facing with steeles	32.00
	6620	Replace broken facing - post intact	30.40
	6630	Replace broken facing - post broken	40.00
	6640	Replace broken facing - with acrylic	30.40
	6650	Replace broken tru pontic	41.60
	6970	Repairs (covered charge based upon extent and nature of damage and type of materials involved) (individual consideration)	I/C

	Procedure Number	Description of Services	Maximum Covered Charge
Bridge Crowns	6710	Bridge crown - plastic acrylic	$72.50
	6720	Bridge crown - plastic processed to gold	120.00
	6721	BDG - crown - plastic/nonprecious	100.00
	6722	BDG - crown - plastic/semiprecious	105.00
	6740	Bridge crown - porcelain	110.00
	6750	Bridge crown - porcelain fused to gold	137.50
	6751	BDG - crown porcelain/nonprecious	120.00
	6752	BDG - crown porcelain/semiprecious	120.00
	6760	Reverse pin facing and metal	120.00
	6752	BDG - crown porcelain/semiprecious	120.00
	6760	Reverse pin facing and metal	120.00
	6780	Bridge crown - gold/three fourths cast	90.00
	6790	Bridge crown - gold/full cast	100.00
	6791	Bridge crown - nonprecious/full cast	87.50
	6792	Bridge crown - semiprecious/full cast	95.00
Dentures and Partial Dentures	5110	Complete maxillary denture	279.00
	5120	Complete mandibular denture	279.00
	5130	Immediate upper denture	279.00
	5140	Immediate lower denture	279.00
	5211	Uppper partial denture without clasps	169.00
	5212	Lower partial denture without clasps	169.00

Procedure Number	Description of Services	Maximum Covered Charge
5215	PUD 2 gold clasp acrylic base	$272.00
5216	Upper partial, with two chrome clasps with rests, acrylic base	272.00
5217	PLD 2 gold clasp acrylic base	272.00
5218	Lower partial, with two chrome clasps with rests, acrylic base	272.00
5230	PLD gold L/bar/C Acrylic base	272.00
5231	Lower partial with chrome lingual bar and clasps, acrylic base	272.00
5240	PLD gold L/bar 2/C cast base	272.00
5241	PLD chrome L/bar 2/C cast base	272.00
5250	PUD gold P/bar 2/C acrylic base	272.00
5251	Upper partial with chrome palatal bar and clasps, acrylic base	272.00
5260	PUD gold P/bar 2/C cast base	272.00
5261	PUD chrome P/bar 2/C cast base	272.00
5291	PUD full cast 2 gold clasps	272.00
5292	PUD full cast 2 chrome clasps	272.00
5293	PLD full cast 2 gold clasps	272.00
5294	PLD full cast 2 chrome clasps	272.00
5310	Each additional clasp/rest	22.50
5320	Each tooth (applies to 5291-5294 only)	11.00
5820	Temporary PUD (stayplate)	75.00
5821	Temporary PLD (stayplate)	75.00
5822	Stayplate base, temporary denture (front teeth only). (Indicate whether upper or lower, complete or partial denture)	68.00

	Procedure Number	Description of Services	Maximum Covered Charge
	5830	Obturator excised palatal tissue	$212.50
	5840	Obturator/cleft palate	212.50
	6940	Simple stress breakers, extra per unit	34.00
	6960	Bridge dowel pin - metal	37.50
Repairs, Partial Dentures	5611	Partial denture repairs (metal). (Covered charge based upon extent and nature of damage and type of materials involved.) (individual consideration)	I/C
Adding Teeth to Partial Denture to Replace Extracted Natural Teeth	5650	First tooth	44.00
	5660	First tooth with clasp	62.00
	5661	Each additional tooth and clasp	34.00
	5670	Reattaching damage clasp on denture	30.40
	5680	Replace clasp on denture	48.00
	5690	Replace additional clasp on denture	40.00
Miscellaneous Services	9910	Application of desensitizing medicament	9.60
	9930	Unusual omplication	11.20
	9940	Occlusal adjustment, minor	17.60
	9950	Occlusion analysis	60.00

ORTHODONTIC SERVICES

	Procedure Number	Description of Services	Maximum Covered Charge
Preventive Treatment Procedures			
Radiographs	00340	Cephalometric film	$ 17.00
Minor Treatment for Tooth Guidance	08110	Removable appliance therapy	34.00
	08120	Fixed or cemented appliance therapy	43.00
Interceptive Orthodontic Treatment	08360	Removable appliance therapy	34.00
	08370	Fixed appliance therapy	43.00
Treatment of the Transitional Dentition	08460	Class I Malocclusion	340.00
	08470	Class II Malocclusion	340.00
	08480	Class III Malocclusion	340.00
Treatment of the Permanent Dentition	08560	Class I Malocclusion	500.00
	08570	Class II Malocclusion	500.00
	08590	Class III Malocclusion	500.00

ARTICLE VII -- VISION CARE BENEFITS

7.1 Definitions Relative to Vision Care Benefits

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

7.2 Benefit Provisions

Only individuals described in Subsection 3.1 E. are eligible for the benefits described in this Article VII.

A. The Plan pays 100% of the scheduled Covered Expenses subject to the provisions and limitations set forth below:

1. The Covered Expense shall be limited to charges for the services and supplies specified in the schedule below and actually incurred by the Covered Individual upon recommendation and approval of a legally qualified Optician, Optometrist or Opthalmologist; and

2. The maximum amount payable on account of any service or supply shall be the maximum listed below, subject to the frequency limits as indicated below:

Benefits	Maximum Amount Payable	Frequency Limits
Vision Examination	$20	Once every twenty-four (24) months
Per Lens (Maximum two (2))		Once every twenty-four (24) months
Single Vision	10	
Bifocal	15	
Trifocal	20	
Lenticular	25	
Contact	15	

Benefits	Maximum Amount Payable	Frequency Limits
Frames	$14	Once every twenty-four (24) months

Lenses shall not be covered unless the new prescription differs from the most recent one (1) by an axis change of 20. or .50 diopter sphere or cylinder change and the lenses must improve visual acuity by at least one (1) line on the standard chart.

7.3 Exclusions and Limitations for Vision Care Benefits

The following items shall not be covered by the Plan:

A. Sunglasses (other than Tints #1 or #2).

B. Extra charges for photosensitive or anti-reflective lenses.

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

D. Special procedures, such as orthoptics, vision training, subnormal vision aids, aniseikonic lenses and tonography.

E. Experimental, developmental or investigatory services or supplies.

F. Replacement of lost or broken lenses and/or frames unless replacement is eligible under the frequency and prescription limitations.

G. Services or supplies not prescribed as necessary by a licensed Physician, Optometrist or Optician.

H. Services or supplies for which the eligible Covered Individual is entitled to benefits under any other provision of the Plan or as provided under a mine safety glass program.

I. Any services which are covered by any Workers' Compensation laws or employer's liability laws, or services which an employer is required by law to furnish in whole or in part.

J. Services or supplies which are obtained from any governmental agency without cost by compliance with laws or regulations.

The limitations and exclusions set forth above in Section 7.3 and throughout the Plan are not intended in any way to be exhaustive, and the Plan hereby reserves the right to limit or exclude such other services and supplies and the charges therefor as are determined to be inappropriate in the sound discretion of the Claim Administrator under the terms and conditions as well as the scope and intent of the Plan.

ARTICLE VIII -- CLAIM PROCEDURES

8.1 Claim Determination

This Plan text expresses the terms and conditions under which benefits are payable in specific terms. Whenever wording of the Plan is not completely explicit with respect to any claim which arises, the determination of the Plan Administrator shall govern payment.

8.2 Claim Procedure

Claim procedure shall mean the systems, forms, paper flow, etc., utilized with regard to the process of filing, processing and paying claims.

8.3 Procedure for Presenting a Claim

Claims for benefits must be filed on the proper forms provided by the Plan Administrator and/or the Claim Administrator.

8.4 Proof of Claim for Medical Care, Dental Care and Vision Care

In order to be entitled to benefits under the Plan, a claim must be filed within three hundred and sixty-five (365) days after the date of service unless the Plan Administrator shall extend the time.

Written proof of claim for the service or supply for which a claim is made must be furnished to the Plan Administrator. Failure to furnish such proof within the time required by the Plan shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within the required time and that proof was given as soon as was reasonably possible.

The Plan Administrator will also require, as part of the proof of claim, itemized bills of any Hospital, Physician or other provider of services, supplies and treatment, and other pertinent medical, dental or vision records.

8.5 Proof of Claim for Life Insurance, Accidental Death and Dismemberment

A. In order to be entitled to benefits for Life Insurance, the Beneficiary should provide Peabody with a certified copy of the death certificate of the deceased Employee, Disabled Employee or Retired Employee.

Peabody shall then file the claim on the proper form with the Plan Administrator.

B. In order to be entitled to benefits for AD&D, the Beneficiary should provide Peabody with a certified copy of the death certificate of the deceased Employee, Disabled Employee or Retired Employee and a newspaper clipping describing the accident. In the event the accident was work-related, a Workers' Compensation report must be provided.

8.6 Examination

The Plan Administrator shall reserve the right and opportunity to examine the person of the Covered Individual when and so often as it may reasonably require during the pendency of claim hereunder.

8.7 Payment of Claims

Subject to proof of claim satisfactory to the Claim Administrator, all benefits hereunder shall be paid to the Beneficiary, Employee, Disabled Employee, Retired Employee or the health service provider subject to valid assignment of benefits.

8.8 Hold Harmless

A. The Plan Administrator, with the written consent of the Covered Individual, in any case in which a provider of care attempts to collect charges in excess of the Reasonable and Customary amount or for charges for services or supplies not recognized as Necessary Care, shall attempt to resolve the matter either by:

1. Negotiating a resolution; or

2. Defending any legal action commenced by the provider of care.

B. Whether negotiating a resolution or defending a legal action, the Covered Individual shall not be responsible for any legal fees, settlements, judgements or other expenses in connection with the action to collect charges in excess of the Reasonable and Customary amount.

C. The Plan Administrator shall have sole control over the conduct of the defense or negotiation including the determination of whether the claim should be settled or an adverse determination should be appealed.

D. The Covered Individual may be liable for any services or supplies rendered by the provider of care which are not covered by the Plan.

8.9 Notice to Claimant of Claim Denial

The Claim Administrator shall, within ninety (90) days of receipt of the claim, pay the claim or give written notice to any Claimant whose claim for benefits under the Plan has been denied in whole or in part, unless special circumstances require an extension of time for processing the claim. If such an extension of time is required, written notice of this extension shall be forwarded to the Claimant prior to the termination of the ninety (90) day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the final decision may be expected. In no event shall the expected date of final decision be more than ninety (90) days after the end of the initial ninety (90) day period.

If, within ninety (90) days of receipt of the claim, a Claimant has not been notified of claim payment or denial, the Claimant may elect to assume that the claim has been denied and may proceed to request a claim review as though the claim had been denied.

Written notice to a claimant whose claim for benefits under the Plan has been denied, together with an opinion written in a manner which shall be understandable by such person, shall specify the reasons for denial of claim, refer to the pertinent provisions of the Plan on which denial is based, describe any additional material or information necessary for the claimant to perfect the claim, explain the necessity for same such additional material or information and explain the Plan's claim review procedure.

8.10 Request for Review of Denied Claim

The Plan Administrator, upon receipt of the written request of any Participant or his or her duly authorized representative not more than sixty (60) days after the date of mailing or delivery of written notice of denial of such claim, is required to give such Participant or his or her authorized representative a full and fair review of the claim, the opportunity to review pertinent documents and the opportunity to submit to the Plan Administrator issues and comments in writing. If a Participant does not timely file his or her request for review, the decision of the Plan Administrator shall become final at the expiration of the filing period.

8.11 Decisions on Review

Decisions on review of denied claims by the Plan Administrator shall:

A. Be in writing in a manner which is calculated to be understood by the claimant or the authorized representative;

B. Include specific reasons for the decision and specific references to the pertinent Plan provisions upon which the decision is based; and

C. Be made ordinarily no later than sixty (60) days after the Plan Administrator's receipt of a request for review, unless special circumstances require an extension of time for processing. If such an extension is required, the claimant shall be notified no later than sixty (60) days after receipt of this request for review. The decision on review shall be rendered as soon as possible and not later than one hundred twenty (120) days after receipt of the request for review.

ARTICLE IX -- ADMINISTRATION OF THE PLAN

9.1 Plan Administrator and Named Fiduciary

Peabody Coal Company shall be the Plan Administrator and a named fiduciary of the Plan as that term is defined in the Employee Retirement Income Security Act of 1974 (ERISA). Peabody shall designate a Claim Administrator and may designate any insurer or any other contracting entity as an additional fiduciary of the Plan pursuant to the provisions of ERISA.

Any fiduciary may delegate any of its responsibilities, subject to the approval of Peabody Coal Company. Any fiduciary under the Plan may serve in more than one fiduciary capacity. Fiduciaries under the Plan may allocate fiduciary responsibilities among themselves in any reasonable and appropriate fashion, subject to the approval of Peabody.

9.2 Plan Administrator

The administration of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Plan Administrator shall have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers shall include, but shall not be limited to, the following authority, in addition to all other powers provided by this Plan:

A. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claim procedures that may be required by applicable provisions of law;

B. To interpret the Plan, with its interpretation being final and conclusive on all persons claiming benefits under the Plan;

C. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

D. To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

E. To allocate and delegate any or all of its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

9.3 Indemnification

The Company agrees to indemnify and hold harmless any present or former Company Employee to whom Plan administration responsibilities have been delegated against all claims, demands, rights, liabilities, damages, causes of action, costs and expenses of whatsoever kind and nature (including Plan Administrator approved attorneys' fees and amounts paid in settlement of any claims) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE X -- CHANGE OR TERMINATION OF THE PLAN

10.1 Amendment

The Plan is adopted with the intention that it shall be continued for the benefit of present and future Employees and Retired Employees of the Company; however, the right is reserved by Peabody to terminate, amend, change required contributions, or modify this Plan in whole or in part at any time or for any reason, including changes in any and all of the benefits herein provided. Such termination, amendment, change in required contributions or modification of the Plan may cause Employees and Retired Employees to lose all or a portion of their benefits under the Plan, but shall not affect the right of any Employee or Retired Employee to be reimbursed for any Covered Expense which has already been incurred or to which he or she has already become entitled under the Plan.

This means that an Employee shall not acquire a lifetime right to any Plan benefit or to the continuation of this Plan merely by reason of the fact that such benefit or this Plan is in existence at any time during the Employee's employment. Nor does it mean that a Retired Employee shall acquire a lifetime right to any Plan benefit or to the continuation of this Plan merely by reason of the fact that such benefit or this Plan is in existence at any time during the Retired Employee's employment or at the time of the Retired Employee's retirement. This Plan shall comply with all applicable requirements of the law and shall be amended, if necessary, in order to satisfy any such requirements.

ARTICLE XI -- MISCELLANEOUS PROVISIONS

11.1 Information to be Furnished

Participants shall provide the Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan. Claims shall not be processed without receipt of the proper claim forms and documentation.

11.2 Headings

Section captions and subsection headings have been inserted for convenience of reference only, and such captions and headings shall not be limiting with regard to the interpretation of any provision of the Plan.

11.3 Marginal Notes, Cross Reference or Index

In the publication of the Plan, marginal notes, an index, or bracketed cross-references may be inserted editorially for convenience or reference and the same shall not limit, control, or affect the interpretation of any provision of the Plan.

11.4 Publication of Explanatory Materials

From time to time, the Company may cause to be issued to Participants, and others, Summary Plan Descriptions, commentaries or other materials in connection with an explanation of the provisions of the Plan and its operation. None of such materials shall have the effect of modifying, changing, amending, or altering the provisions of the Plan as adopted and from time to time amended by Peabody, which shall conclusively control the rights of all parties in interest.

11.5 Controlling Law

The Plan shall be governed by and interpreted in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Further, this Plan shall be construed, administered and enforced according to the laws of the state of Missouri, unless exempted under ERISA in whole or in part.

11.6 Overpayments

If any overpayment is made by the Plan for any reason, the Plan shall have the right to recover such overpayment. The Participant shall cooperate fully with the Plan to recover any overpayment and provide any necessary information and required documents. Any overpayments may be deducted from future benefits payable on behalf of the Participant.

11.7 Limitation of Rights

Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, shall be construed as giving to any Participant or other person any legal or equitable right against the Company or Claim Administrator, except as provided herein.

11.8 Acts and Omissions of Providers

Neither the Company nor the Claim Administrator shall be liable in any event for any act or omission of any Hospital, Physician, Surgeon, or other provider of service or any officer, employee, servant or agent thereof.

11.9 No Guarantee of Admission or Service

Neither the Company nor the Claim Administrator guarantees admission to any Hospital or that any specific accommodations or services shall be available from any Hospital, Physician, Surgeon, or other provider of service.

11.10 Health, Dental or Vision Care Information

As a condition precedent to the payment of benefits hereunder, each Participant shall authorize any employer, insurance carrier, health services corporation, group prepayment plan (HMO), or any provider of health care services to furnish the Claim Administrator with any and all information and records relating to his or her health condition and history. Such authorization shall be treated as a waiver of all provisions of law forbidding such disclosure.

11.11 Plan Expenses, Records and Identification Numbers

The expenses of administering the Plan, including the payment of benefits, shall be borne by the Company and the Plan Participants as specified herein.

The Plan and all of its records are kept on a calendar year basis, beginning January 1 and ending December 31 of each year.

The Plan is identified by the following numbers under Internal Revenue Service (IRS) rules:

13-2606920 - assigned by IRS
501 - assigned by Peabody

11.12 Legal Service

Process can be served on the Plan by directing such legal service to the Agent for Service of Legal Process.

ARTICLE XII -- ELIGIBILITY PROVISIONS FOR RETIRED EMPLOYEES

12.1 For purposes of Section 2.25, a person is described in this Section 12.1 if he was a salaried Employee of the Company at the time his employment terminated and:

A. His employment terminated on or after the first day of the month coinciding with or next following the later of his 65th birthday or the completion of ten (10) Years of Service; or

B. His employment terminated on or after the first day of the month coinciding with or next following the date on which he has both completed ten (10) or more Years of Service and attained age fifty-five (55); or

C. His employment terminated by reason of Permanent and Total Disability, but such a person shall be described in this Section 12.1 only as of the later of (i) the first day of the month following the completion of six months of Permanent and Total Disability and (ii) the date that such Permanent and Total Disability is established if he is a person who is Permanently and Totally disabled and has completed ten (10) or more Years of Service and his Permanent and Total Disability has been established by the Social Security Administration in response to an application by such person for a Social Security Disability Benefit. A person described in this subsection C shall continue to be so described only so long as his Permanent and Total Disability continues. The Company shall have the right to verify the continued existence of such person's Permanent and Total Disability at reasonable times from time to time prior to his sixty-fifth (65) birthday. If such person refuses to provide satisfactory evidence of his continuing right to receive a Social Security Disability Benefit such person shall no longer be entitled to the benefits under this Plan until the withdrawal of such refusal.

12.2 Solely and exclusively for purposes of this Article XII, the following terms shall have the respective meanings set forth below:

A. **"Affiliate"** means any corporation, trade or business which, at the time in question, is a member of a controlled group of corporations or a controlled group of trades or businesses within the meaning of

subsection 414(b) or (c), respectively, of the Internal Revenue Code of 1986 as amended, which group also includes the Company, but such other corporation, trade or business shall be treated as an Affiliate only during the period that both it and the Company are members of the same controlled group of organizations, trades or businesses. In addition, the term "Affiliate" includes a corporation, trade or business of which more than fifty percent (50%) is owned directly or indirectly by some or all of the same owners which own more than fifty percent (50%) of the Company, but only if the Board of Directors designates such corporation, trade or business as an Affiliate for purposes of this Plan.

B. **"Armco List"** means the Amended Salaried Employees list referred to in Section 3.1(b) of the Asset Purchase Agreement between Armco, Inc., Big Mountain Coals, Inc. and Peabody Coal Company dated January 20, 1984.

C. **"Board of Directors"** means the Board of Directors of Peabody Holding Company, Inc. or any successor by merger, purchase or otherwise.

D. **"Break in Service"** means a period of 365 (366 in a leap year) consecutive days or more during which the person was not employed by an Employing Company. In the case of either (i) an absence (ii) a delay in return from layoff, sick leave, salary continuance or approved leave of absence, which absence or delay begins after December 31, 1984, on account of pregnancy or the birth of a child or a person or the placement of a child with such person for adoption or the care of such a child immediately following birth or placement for adoption, if such person gives timely notice to the Company of the reason for such absence or delay the term "Break in Service" means a period of 730 (731 in a leap year) consecutive days or more during which the person was not employed by an Employing Company.

E. **"Eastern"** means Eastern Associated Coal Corp., a West Virginia corporation, including its subsidiaries and affiliates if service with such subsidiary or affiliate was recognized for benefit accrual purposes under the Eastern Plan.

F. **"Eastern Plan"** means the Eastern Associated Coal Corp. Retirement Plan.

G. **"Employee"** means any person in the employ of and compensated on a salary basis by a Participating Company on or after January 1, 1976, except, however, that a salaried employee who becomes represented by a collective bargaining agent and who is included in a bargaining unit for which an initial collective bargaining agreement has been entered into with such agent shall cease to be considered an "Employee" for purposes of the Plan unless eligibility for his participation in this Plan is provided for by a current Participation Agreement between a Participating Company and such agent. A person on the Armco List shall be considered to be an Employee during the period that he was a salaried employee of Armco Inc. (or any other corporation which was a member of the controlled group of corporations of which Armco Inc. was a member) until he became a salaried employee of Peabody Coal Company. A person previously employed by Eastern but who on July 1, 1988, was neither (i) in the employ of and compensated on a salary basis by Eastern or an employing Company nor (ii) absent from Eastern and receiving disability benefits under a disability income plan maintained by either Peabody Holding Company, Inc. or Eastern, shall not be considered an Employee hereunder except as otherwise expressly provided herein. When reference is made to "salary", there is meant compensation on a regular and fixed basis (as distinguished from a bonus, hourly, daily, shift, piecework, tonnage, mileage, or any other unit or similar basis).

H. **"Employing Company"** means: (a) Peabody Holding Company, Inc.; (b) any Affiliate; (c) any predecessor corporation or business; and, (d) North Antelope Coal Company; and (e) any corporation or business which was merged into or consolidated with or a substantial part of whose assets were acquired by Peabody Holding Company, Inc. or any Participating Company and which is designated as an Employing Company by the Board of Directors. In addition, but only with respect to a person who became an Employee on or before June 30, 1977, Kennecott Copper Corporation and each of its subsidiaries ("Kennecott") shall be treated as an Employing Company until July 1, 1977, on and after which date Kennecott shall not be treated as an Employing Company unless thereafter Kennecott is described in the first sentence of this Subsection.

I. **"Participation Agreement"** means the applicable agreement between the Company and a specified collective bargaining agent approving the Plan for Employees in the bargaining unit represented by such collective bargaining agent.

J. **"Permanent and Total Disability"** means disability by bodily injury or disease which prevents the Employee from engaging in any occupation or employment whatsoever for remuneration or profit, and which disability, in the opinion of a qualified physician appointed by Peabody Holding Company, Inc., will be permanent and continuous during the remainder of the Employee's lifetime, and which the Plan Administrator shall determine

(i) was not contracted, suffered or incurred while the Employee was engaged in, or did not result from his having engaged in, a criminal enterprise; and

(ii) did not result from his habitual drunkenness or addiction to narcotics, or self-inflicted injury; and

(iii) did not result from service in the armed forces and for which the Employee receives a military pension.

K. **"Years of Service"** means, subject to paragraphs (b) and (c) hereof:

(a) Years and full months of service determined as follows:

(i) The number of days of employment in the service or in the interest of an Employing Company through December 31, 1975, plus

(ii) The number of days of employment in the service or in the interest of an Employing Company after December 31, 1975.

(iii) The sum of (i) and (ii) will be divided by 365 to determine the number of Years of Service. Any remainder will be divided by 30 to determine the number of full months of service, with a remainder of such division of 15 days or more to be considered as an additional full month of service.

(iv) In the case of a person who performs the duties of cook, oiler, deckhand or barge maintenance aboard or with respect to a vessel owned or operated by an Employing Company, and who is employed by an Employing Company on June 1, 1979, Years of Service shall include those years and full months of service determined under (i) through (iii) above as though his employment by an Employing Company prior to that date had been as an Employee, but this subparagraph (iv) shall not apply to any employment credited under (i) or (ii) above without regard to this subpagraph (iv), and shall not apply to any person who is not employed by an Employing Company on June 1, 1979, even though such person previously was so employed and subsequently is so employed.

(v) In the case of a person on the Armco List, Years of Service shall include the period that such person was an employee of Armco, Inc. (or any other corporation which was a member of the controlled group of corporations of which Armco Inc. was a member) until he became a salaried employee of Peabody Coal Company, and service rendered during such period shall be treated as having been rendered for an Employing Company.

(vi) Years of Service shall also include all Years of Service credited to a person under the Eastern Plan as of June 30, 1988, and not otherwise credited under subparagraphs (i) through (v), above, for a person who becomes employed by an Employing Company and, in the case of a person who had no vested interest in an accrued benefit under the Eastern Plan, such employment by an Employing Company occurs before he has incurred five consecutive Breaks in Service under such Plan.

(vii) In the case of a person who on July 1, 1988, was absent from Eastern and receiving disability benefits under a disability income plan maintained by either Peabody Holding Company, Inc. or Eastern, Years of Service shall also include the period during which the disability continues, provided however that no Years of Service shall be credited under this subparagraph (vii) for any period after the person attains age sixty-five (65).

b. In applying paragraph (a) above:

(i) A person shall not receive any credit for years or completed months of employment prior to January 1, 1976, which are prior to his most recent date of employment or reemployment after a Break in Service which began before that date.

(ii) A person shall not receive any credit for employment prior to his most recent date of reemployment following a Break in Service which began after December 31, 1975, unless (A) prior to the commencement of such Break in Service he had ten (10) Years of Service or (B) his reemployment occurs before his consecutive Breaks in Service exceed the greater of (I) the number of years and months of service which he had prior to the commencement of such Break in Service or (II) five.

(iii) For purposes of determining a person's Years of Service, he shall receive credit for (A) all days of employment after December 31, 1975, except for such days as are disregarded pursuant to subparagraph (ii) above and days during a Break in Service and (B), his employment with Eastern, in the case of a person previously employed by an Employing Company, who before July 1, 1988, had become employed by Eastern but had not at that date incurred sufficient Breaks in Service that his prior service with the Employing Company would be disregarded under (ii) above.

(iv) A person shall not earn any Years of Service or fractions thereof for employment which is (A) prior to January 1, 1988, if he was first employed by an Employing Company before that date but after the first day of the month following his sixtieth birthday, or (B) after the date on which he attained age sixty-five 65 and before January 1, 1988.

(c) In applying paragraphs (a) and (b), above, employment shall include periods of absence by reason of:

(i) Retirement on account of Permanent and Total Disability in the case of an Employee who is reemployed.

(ii) Termination of employment of a person who became or becomes employed by an Employing Company within twelve (12) months of such termination.

(iii) Termination of employment of a person who, subsequent to May 1, 1940, entered or shall enter the active Armed Forces of the United States (which shall, for the purposes of the Plan, include the Coast Guard and Merchant Marine Services) and who has reemployment rights under applicable laws and complies with the requirements of the law as to reemployment and is reemployed;

(iv) Layoff, sick leave, conditions entitling salary continuance, except that an Employee shall not receive credit for the portion of any absence for any such cause as is in excess of six (6) months unless both (A) his Employing Company, under rules of general application, deems such absence to be in its interest or in the interest of another Employing Company and (B) the Employee returns to active employment with an Employing Company as soon as permitted by the Employing Company within the terms of his layoff, sick leave, salary continuance or leave of

absence. Credit for an absence due to long term disability shall be provided for up to twenty four (24) months following the end of salary continuance if the Employee returns to employment at or before the end of such twenty four (24) months period.

IN WITNESS WHEREOF, the following company has caused this Plan to be executed in its name and behalf this 30th day of March, 1989, by its officer thereunto duly authorized.

PEABODY COAL COMPANY

By: H W Williams

Attest:

By: Marla C. McKeon

Asst Secy.

IN WITNESS WHEREOF, the following company has caused this Plan to be executed in its name and behalf this 30th day of March, 1989 by its officer thereunto duly authorized.

PEABODY HOLDING COMPANY, INC.

By: F. L. Bailey MAK

Attest:

By: M. N. Nye
Asst. Sec.

IN WITNESS WHEREOF, the following company has caused this Plan to be executed in its name and behalf this 30th day of March, 1989 by its officer thereunto duly authorized.

PEABODY DEVELOPMENT COMPANY, INC.

By: _____

Attest:

By: _____

IN WITNESS WHEREOF, the following company has caused this Plan to be executed in its name and behalf this 30th day of March, 1989 by its officer thereunto duly authorized.

MID-AMERICA TRANSPORTATION COMPANY

By: J. A. Lindsey

Attest:

By: J. D. Russell

IN WITNESS WHEREOF, the following company has caused this Plan to be executed in its name and behalf this 30th day of March, 1989 by its officer thereunto duly authorized.

MIDCO SUPPLY AND EQUIPMENT COMPANY

By: _____

Attest:

By: _____

Asst. Sec.

IN WITNESS WHEREOF, the following company has caused this Plan to be executed in its name and behalf this 30th day of March, 1989 by its officer thereunto duly authorized.

EASTERN ASSOCIATED COAL CORP.
(Effective May 1, 1987) Excluding former salaried Employees of Eastern Associated Coal Corp. who are Retired Employees as described in Section 2.25 and Disabled Salaried Employees receiving benefits under the Eastern Gas and Fuel Associates Long Term Disability Plan on March 31, 1987.

By: H W Williams

Attest:

By: Thomas P Gallagher
ASSISTANT SECRETARY

IN WITNESS WHEREOF, the following company has caused this Plan to be executed in its name and behalf this 30th day of March, 1989 by its officer thereunto duly authorized.

NUEAST MINING CORPORATION
(Effective May 1, 1987) Excluding former salaried Employees of NuEast Mining Corporation who are Retired Employees as described in Section 2.25 and Disabled Salaried Employees receiving benefits under the Eastern Gas and Fuel Associates Long Term Disability Plan on March 31, 1987.

By: H W Williams

mm

Attest:

By: Thomas R Gallagher
ASSISTANT SECRETARY

IN WITNESS WHEREOF, the following company has caused this Plan to be executed in its name and behalf this 30th day of March, 198[illegible] by its officer thereunto duly authorized.

COLONY BAY COAL COMPANY
(Effective September 1, 1987)

By: John E Hull

Attest:

By: [illegible]