SUMMARY PLAN DESCRIPTION

PEABODY GROUP HEALTH AND LIFE PLAN FOR SALARIED EMPLOYEES

MARCH 1, 1990

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INTRODUCTION

Peabody provides a comprehensive benefits package to its salaried employees for medical care, dental care, vision care, life insurance and accidental death and dismemberment insurance.

These benefits are summarized in this publication. Each benefit has a separate section that provides summary information.

This publication is a summary of the Peabody benefit programs for salaried employees. It is not possible to cover every detail of each benefit. Eligibility for benefits and the actual amount of benefit payments are determined by the legal plan document and laws that govern each benefit plan. If there is any discrepancy between the description in this publication and the benefit to which you are entitled to under the plans, the legal plan documents govern.

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The Plan Administrator will maintain the right to interpret this plan with all interpretations being final and conclusive.

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Peabody intends to maintain a benefit plan for salaried employees indefinitely, but reserves the right to amend or terminate any benefit at any time. This publication is not a guarantee of employment nor an employment contract.

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DEFINITIONS

Certain words, whether or not capitalized, used in this publication have specific meanings. These definitions will help you better understand how the Plan works.

Claim Administrator

The company retained by Peabody on an insured or self-insured basis for granting or denying claims, Provident Life and Accident Insurance Company.

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 with an effective date prior to March 1, 1990 as described in the definitions and Disabled Salaried Employees receiving benefits under the Eastern Gas and Fuel Associates Long Term Disability Plan on March 31, 1987.

NUEAST Mining Corp. (Effective May 1, 1987)
Excluding former salaried Employees of NuEast Mining Corporation who are Retired Employees with an effective date prior to March 1, 1990 as described in the definitions 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)

Disabled Employee

Any Employee who is receiving Company paid salary continuance or receiving benefits under the Peabody Long Term Disability Plan for Salaried Employees.

Employee

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).

Illness

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

Injury

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

Institution of Learning

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

Medicare

The Health Insurance for the Aged and Disabled Program under Title XVIII of the Social Security Act, as amended and currently in effect.

Necessary Care

Treatment recognized as generally accepted medical, dental or vision care practice in the profession or specialty from which care is given, as usual or

customary treatment given at the appropriate level of treatment for an injury or illness and is determined as such by Peabody.

Plan

The Peabody Group Health and Life Plan for Salaried Employees.

Plan Administrator

Peabody Coal Company

Reasonable and Customary

The Reasonable and Customary charge is established using insurance industry standards.

Retired Employee

A former salaried Employee who has separated from service with the Company on account of retirement and begins to receive a retirement benefit under a retirement plan maintained by the Company within thirty-one (31) days following such separation from service. Retirement includes the following provided ten (10) Years of Service has been completed:

1. after the later of attaining age sixty-five (65) or completing ten (10) Years of Service, or

2. after both attaining age fifty-five (55) and completing ten (10) Years of Service, or

3. because of Total and Permanent Disability, in the case of a salaried Employee who has completed 10 Years of Service, but such an Employee shall not become a Retired Employee for this purpose until after the later of six months of such Disability or the date such Disability is established by the Social Security Administration in response to an application for Social Security Disability Benefits. In addition, such an Employee shall remain a Retired Employee only so long as the Total and Permanent Disability continues, which is subject to verification by the Company from time to time until age sixty-five (65). Refusal to cooperate in verifying the continued existence of Total and Permanent Disability will result in the loss of Retired Employee status until such refusal ends and the continued existence of such Disability is verified.

Retirement is considered termination of employment.

Spouse

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

Surviving Spouse

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

Termination of Employment

Shall include:

- Voluntary termination (you leave the Company);
- Involuntary termination;
- Retirement; and
- Death.

Total Disability or Totally Disabled

For your dependent children, total disability means the inability to perform the normal activities, as determined by the Plan Administrator, for someone of his or her age and sex.

CONTINUATION OF COVERAGE

If you, your spouse (including a former spouse) and your children lose health care benefits because of one of the following qualifying events you have the option of continuing your health care benefits for a period of time by paying the required premium. Coverage for you and/or your dependents can be continued for up to 18 months if the following qualifying event occurs:

- if your employment ends for any reason (other than gross misconduct); or
- if your hours are reduced so that you are no longer an eligible employee.

The 18 month coverage continuation period can be extended to 29 months if you become disabled, apply for and are determined to be eligible for Social Security Disability under Title II or Title XVI. This determination for Social Security Disability must be made during the original 18 month coverage continuation period. You must notify the Plan Administrator of the favorable Social Security Disability determination within 60 days after the date of the award, and within 30 days after you are no longer disabled.

Coverage can be continued for up to 36 months if the following qualifying event occurs:

- for your dependents if you die or divorce;
- for your child when that child is no longer considered an eligible dependent under the medical care coverage;
- for your dependents when you become entitled to Medicare; or
- for your dependents in the event the Company files for bankruptcy under Title 11 if you are a retired employee and die after the bankruptcy filing.

Coverage can be continued for life in the event the Company files for bankruptcy under Title 11:

- for a retired employee and his or her dependents; or
- for a retired employee's dependents if the retired employee dies before the bankruptcy filing.

You or your dependents must notify the Company within 60 days when a qualifying event such as: you separate or divorce, or when your dependent child becomes ineligible for health care coverage. After the Plan Administrator is informed, the Company will send enrollment forms within 14 days directly to the person eligible for continuation. Included with the enrollment forms will be information about your rights to continuing coverage and costs of this coverage.

You and/or your covered dependents must pay the full cost as allowed by law for continuing coverage. After notifying the Plan Administrator of your intent to continue coverage, you will have an additional 45-day period to pay the back premium and avoid a loss of coverage. Thereafter, premiums for continuing coverage must be paid by the date specified by the Plan Administrator.

If you and your covered dependents elect coverage continuation due to termination of employment, your covered dependent may elect an additional continuation period of up to 18 months, if during the initial continuation period the following qualifying event occurs:

- you die;
- you divorce;
- your child ceases to qualify for dependent coverage under the terms of the medical coverage; or
- you become entitled to Medicare.

To be eligible for the additional continued coverage, it is your covered dependent's responsibility to notify the Company within 60 days of the occurrence of these events.

Coverage stops before the end of the continuation period if:

- the required premium is not paid;
- you or a dependent becomes covered under another group medical plan unless the new group plan has a pre-existing condition clause that would exclude your condition. You may continue to purchase continued coverage until the pre-existing condition clause in the other group medical plan no longer applies or until you have reached the end of the maximum continuation coverage period;
- you or a dependent becomes entitled to benefits under Medicare; or
- the Company no longer offers medical coverage to its employees.

Within 180 days of the end of your continuation period, the Company will notify you of your right to convert to an individual policy. You will not need to undergo a medical examination. You will have 31 days after plan coverage ends to apply for conversion. However, you do not have the right to convert to an individual policy if your continuation of coverage is cancelled because of failure to make premium payment.

CLAIM PROCEDURES

To File a Claim

To receive medical, dental or vision benefits from the Plan, you must file a claim within one year of the date you incur the expense. Your claim must include itemized bills from your providers. After receipt of the claim and accompanying documentation, the Plan can pay your benefits directly to you or to a provider you designate. You should submit the claims to the following address:

Provident Life and Accident Insurance Co.
1241 Volunteer Parkway, Building 1000
Bristol, TN 37620

If you incur a loss, covered by your life insurance or AD&D benefits, you or your beneficiary should contact the Peabody Benefits Department to file a claim. In the event of death, your beneficiary must provide a certified copy of the death certificate. For an AD&D claim, a medical or coroner report must be supplied.

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

Nonduplication of Benefits

In many families, members may be covered by more than one health care plan. Each plan pays benefits, but the sequence of payments are determined under the nonduplication-of-benefit rules. Under these rules, one group plan has primary responsibility and pays first. The other plan has secondary responsibility and considers any benefits. The secondary plan will not reimburse expenses payable under another group plan which actually covers you or your dependents as their primary plan, but will make up any difference between payments made from another group plan and normal reimbursement covered under the secondary plan.

An example is an employee submits a bill to Provident along with an Explanation of Benefits from his spouse's employer. The office call charge was $20.00. The amount paid by the spouse's insurance was $11.00. Peabody's plan would pay 80% of the $20.00 or $16.00. Since the primary insurance paid $11.00 Peabody will only pay an additional $5.00. Peabody cannot pay over the limits of the Peabody plan.

For those families, whose dependent children are covered by two plans the Birthday Rule will be used. To determine which plan is primary the parent whose birthday falls first in the year will carry the dependent chilren primary

under their coverage and the other parent will carry the children as secondary. For example: John's date of birth is September 12 and Sue's date of birth is March 15. Sue's insurance would be primary on the children and John's insurance would be secondary on the children.

"Allowable expense" means any necessary, reasonable and customary charge for services or treatment covered in whole or in part under at least one of the plans covering the patient.

"Plan" means any of the following:

* group, blanket or franchise insured or uninsured coverage;

* group hospital service prepayment plan, group medical service prepayment plan, group practice, or other group prepayment coverage;

* any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; or

* any coverage under governmental programs except Medicare, or any coverage required or provided by any statute, not including individual policies.

The chart below shows which plan is designated as primary or secondary in the case of a husband and wife who work for different companies and also have a child eligible for dependent coverage.

Patient	Primary Plan	Secondary Plan
Husband	Husband's	Wife's
Wife	Wife's	Husband's
Child	Parent whose date of birth is first in the year	Parent whose date of birth is second in the year

If the parents of a dependent child are divorced or legally separated, the plan of the parent who has financial responsibility for that dependent under a court decree will be the primary plan. If there is no decree establishing financial responsibility, the plan that covers the child as a dependent of the parent with custody will be the primary plan. The other parent's plan is secondary.

If there is no financial decree and the parent with custody remarries, that parent's plan remains primary; the stepparent's plan is secondary.

If these rules do not establish the order of payment, the benefit plan that has covered the patient for the longer period of time is primary. Any other plan may pay any remaining benefits up to its maximums.

In certain other circumstances, the plan may be determined to be secondary.

In coordinating your benefits, the Plan Administrator has the right to release or to obtain information from any other organization or person. If another plan

requests claim payment, the Claim Administrator can pay that organization any amount necessary to follow the coordination of benefit rules just described. The Claim Administrator also can recover any amounts this plan has paid in excess of the maximum allowed by this plan based on these rules.

1. If you or a covered family member has group coverage in addition to coverage under this plan, you can expedite claim payments by providing all required information about additional coverage when you enroll and when you submit claims.

2. If this plan is secondary for the claim you are submitting, submit the claim to the patient's primary plan first. Attach the Explanation of Benefits sheet you receive from the primary plan to the claim you submit for this plan.

3. If there is no indication that the claim has been considered by the primary plan, the claim will be denied. Of course, if additional information is later supplied, the claim can be reconsidered.

What to do if Your Claim is Denied

If your claim is denied in whole or in part, you will be notified in writing within 90 days of the receipt of your claim. The written denial will give specific reasons for the denial, reference specific plan provisions on which the denial is based, describe any additional material necessary to approve your claim and explain the plan's claim review procedures.

In special circumstances, a response to your claim may take more than 90 days. If such an extension of time is needed, you will receive written notice before the end of the 90-day period. In no event, will the extension be more than 90 days.

The Plan intends to respond to your claim promptly. The fact that you do not have a response within 90 days does not mean that your claim is being ignored. However, if no response is received within 90 days, allowing reasonable time for mailing, you can assume the claim has been denied and proceed to the claim review stage.

Within 60 days of receiving written notice of claim denial, you or your authorized representatives may submit a written request for reconsideration. In your request for review, state the reasons you believe the claim was improperly denied and submit any additional information, material or comments which you consider appropriate. You may also review any pertinent plan documents.

The Plan Administrator will make a decision on the review within 60 days. If more time is needed, you will be notified within 60 days after receipt of your request for review. In no event will a decision be made more than 120 days after receipt of your request for review.

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

Hold Harmless

In the event a physician, surgeon or dentist attempts to collect charges that either exceed the reasonable and customary level or are not considered medically necessary, the Plan Administrator, with your written consent, shall attempt to resolve the matter either by:

- negotiating a resolution with the provider; or
- defending any legal action that provider may begin.

If the Plan Administrator takes any action, you will not be responsible for any legal fees, settlements, judgements, or other expenses incurred by the Plan Administrator to resolve the matter. The Plan Administrator shall control the manner of defense or negotiation, including determining whether the claim should be settled or whether to appeal any adverse determinations. Nevertheless, you may be liable for any services or supplies rendered by the provider which are not covered by the Plan.

Right to Audit

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

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 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.

Subrogation Third Party Liability

If your illness or injury (or that of one of your dependents) is caused by a third party, you must reserve the right of recovery against the third party by signing a subrogration form. The Plan may ask you to enforce your rights

against the party responsible for the illness or injury. If you receive proceeds from any settlement or judgment, the Plan is entitled to receive an amount up to the benefits paid by the Plan for the illness or injury.

ERISA INFORMATION

Your Rights

As a member of the Peabody Group Health and Life Plan for Salaried Employees, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan members shall be entitled to:

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

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

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

* Obtain a statement telling you whether you have a right to receive a benefit and, if so, what your benefits are under the Plan now. If you do not have a right to a benefit, the statement will tell you how long you have to work to get the right to a benefit. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge.

* In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

* Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

- If you believe that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the U.S. Labor Management Services Administration, Department of Labor.

PLAN INFORMATION

Plan Name:

The Peabody Group Health and Life Plan for Salaried Employees

Type of Plan:

Life insurance, accidental death and dismemberment, medical, dental and vision care benefits

Plan Number:

501

Effective Date:

June 1, 1985

Last Amended:

March 1, 1990

Plan Fiscal Year Ends:

December 31

Plan Sponsor:

The following are Plan sponsors:

Peabody Coal Company	13-2606920
Peabody Holding Company, Inc.	13-2871045
Peabody Development Company	43-1265557
Midco Supply and Equipment Corp.	43-6042249
Eastern Associated Coal Corp.	25-1125516
NuEast Mining Corp.	25-1474206
Mid-America Transportation Co.	43-0730535
Colony Bay Coal Company	55-0604613

However, you may direct correspondence to:

Director-Benefits
Peabody Coal Company
1951 Barrett Court
P.O. Box 1990
Henderson, Kentucky 42420-1990

Plan Administrator:

Peabody Coal Company
1951 Barrett Court
P.O. Box 1990
Henderson, Kentucky 42420-1990

Agent for Service of Legal Process:

The Agent for Service of Legal Process varies by state. You may contact the following to determine the appropriate agent for your location:

Director - Benefits
Peabody Coal Company
1951 Barrett Court
P.O. Box 1990
Henderson, Kentucky 42420-1990

LIFE INSURANCE

DEFINITIONS

Certain words, whether or not capitalized, used in this summary have specific meanings. These definitions will help you better understand how the Plan works:

Basic Annual Salary

The employee's Basic Annual Salary as shown on the Company's records which excludes: overtime, special allowances or salary for foreign service, awards under any special compensation plan or like plans and payments under any other employee benefit plan.

Beneficiary

The person or persons you designate to receive payment of your life insurance benefits.

Survivor

Your spouse.

PLAN ELIGIBILITY

Active Employees

As an employee, you are eligible for life insurance coverage on your date of employment if you have enrolled for coverage. If you are not at work on your date of employment, your coverage becomes effective on the date you are at work and have enrolled for coverage.

Disabled Employees

If you become disabled, are receiving Company-paid salary continuance or benefits under the Peabody Long Term Disability Plan for Salaried Employees and were covered for life insurance benefits immediately before your disability date, you will also remain covered for life insurance benefits. Contributions will be waived for any period you are receiving long term disability benefits.

Reduction in Work Force

If your employment terminates due to a reduction in work force, the Company may provide you with continued benefits in accordance with Company policy No. 120.1 for three (3) calendar months following the end of the last month in which the reduction in work force occurred provided required contributions are made.

Retired Employees

If you are a Retired Employee and had life insurance coverage immediately before your date of retirement, you will remain covered for life insurance benefits as long as the Plan is in effect provided you had ten (10) Years of Service.

Enrollment and Plan Contributions

Your life insurance coverage does not become effective until you have properly enrolled and have authorized contributions to be deducted from your salary. To enroll for life insurance benefits, you must sign an enrollment card within 31 days of your date of hire. The enrollment card authorizes the deduction of required employee contributions from your paycheck.

If you do not want coverage, you must sign a waiver card. However, if you are unsure whether you wish to enroll, you must sign a Memorandum of Understanding stating that you understand that eligibility for benefits is contingent upon your enrollment and that you do not wish to enroll for coverage at that time. If you sign the Memorandum and die within 31 days of your date of hire, no life insurance benefits are payable. At the end of 31 days from your eligibility date, you must sign a waiver card.

If you enroll for life insurance benefits after your initial 31st day on the job, you must complete an Evidence of Insurability form and may be required to take a physical examination at your own expense. Your coverage will become effective after review and approval by the Plan Administrator of your evidence of insurability.

WHEN YOUR COVERAGE ENDS

Termination of Coverage

Your life insurance coverage terminates on the earliest of the following dates:

- termination of the Plan;
- last day of the month in which you made the required contributions;
- the date of your death;
- the last day of the calendar month in which your employment terminates;
- the date you no longer are a member of an eligible class; or
- the date you retire and do not meet the definition of a Retired Employee.

Continuation of Life Insurance for a Disabled Employee

If you are a Disabled Employee who is receiving benefits under the Peabody Long Term Disability Plan for Salaried Employees, your life insurance benefits continue during a disability at no cost to you. If you recover from your disability, benefits will end 31 days after your recovery, unless you return to active work with Peabody. Your benefits will be reduced due to your age or work status as described earlier.

Conversion to an Individual Policy

If your life insurance coverage ends because your employment terminates or if your coverage is reduced because of your age as a retired employee, you may buy individual coverage equal to or less than the amount of coverage you had before your termination; you will not need to provide evidence of insurability. If you were covered for survivor income benefits on your termination date, the amount you may convert will include the present value of the survivor income benefits as determined by the Claim Administrator. You may apply for the individual policy within 31 days of your termination or benefit reduction and when you make the required premium payment.

If the Plan is terminated or amended, you can convert your coverage as described in your certificate issued by your insurance carrier.

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

YOUR LIFE INSURANCE BENEFITS

For Active Employees

If you die while covered by this plan, your beneficiary will receive an amount equal to two times your basic annual salary, rounded to the next $100.

For example, if you were earning $20,010 at the time of your death, your beneficiary would receive $40,100.

When your basic annual salary changes, the amount of life insurance also changes on the first day of the calendar month following the date of the change.

- However, if you are away from work due to disability, you will not receive an increase until you actually return to work on a full-time basis.
- Furthermore, your life insurance amount will not decrease even if your basic annual salary decreases.
- And, if you die before the date when your life insurance amount would have increased your beneficiary will receive the amount in effect at the time of your death.

  For example, if your basic annual salary of $20,010 increases to $22,500 on January 1, your life insurance benefit will increase to $45,000 on February 1. However, if you die on January 15, the original amount of $40,100 is payable.

For Disabled Employees

If you are less than age 65, your life insurance benefit is the same amount as described above for active employees.

If you are age 65 or older, your life insurance benefit equals 60 percent of your basic annual salary as of the day you become disabled, subject to a $1,000 minimum.

If you were hired after 1982, upon reaching age 70, your employee life insurance amount is 30 percent of your final basic annual salary on the day before your disability, subject to:

* a minimum benefit of $7,500; and
* a maximum benefit of $30,000.

For Retired Employess

If you are less than age 65, your benefit equals 60 percent of your basic annual salary on the day before you retire, subject to a $1,000 minimum, unless you have filed a written request with Peabody to continue your pre-retirement benefit as described in the Payment Options section and agree to pay the additional contributions.

If you are age 65 or older, your life insurance benefit equals 60 percent of your basic annual salary as of the day before you retire, subject to a $1,000 minimum.

If you were hired after 1982, upon reaching age 70, your employee life insurance amount is 30 percent of your final basic annual salary on the day before your retirement, subject to the following:

* a minimum benefit of $7,500; and
* a maximum benefit of $30,000.

BENEFIT PAYMENTS INFORMATION

Beneficiary

You may designate anyone as the beneficiary of your life insurance benefits. You may change your beneficiary designation at any time by obtaining a form from Peabody and filing the appropriate form with the Plan Administrator. The change will become effective when the form is received and will relate back to the date you signed the request, regardless of whether you are alive at the time Peabody receives the request. Benefits which have been paid prior to the receipt of the change on beneficiary card will not be recovered or repaid.

Assignment of Benefits

You may also assign your life insurance benefits to any individual as a gift. A copy of the assignment request must be filed with Peabody.

Payment of Benefits

All benefit payments will be made automatically to your designated beneficiary. However, if your beneficiary dies before all payments are made, the unpaid

amount will be paid to the beneficiary's executors or administrators, unless you have made a written request stating otherwise. If no beneficiary is designated, benefit payments will be made to your estate.

Survivor Income Benefits Payment Options

As an active employee, you may elect any of the following payment options for your beneficiary:

* Option A - full payment of the benefit upon your death;

* Option B - payment of 50 percent of your basic annual salary in one sum, plus a minimum of 72 monthly installments of 25 percent of your basic monthly salary; or

* Option C - payment of 125 percent of your basic annual salary in one lump sum, plus a minimum of 72 monthly installments of 12 1/2 percent of your basic monthly salary.

If you have elected Option B or C and do not have a survivor at your death, or when you attain age 65 or are eligible for a reduced amount of life insurance, your payment option automatically reverts to Option A (full payment).

You may not elect either Option B or C if you are:

* a retired employee over age 65;

* a retired employee who retired on or before January 1, 1970;

* a retired employee who chose a reduced amount of life insurance at retirement;

* a disabled employee whose coverage continues under the provisions of the Continuation of Life Insurance During Total Disability section and has attained age 65; or

* an employee with no survivor.

Payment Dates

The lump-sum benefits will be payable to your beneficiary. Monthly installments elected under Survivor Income Benefits Payment Options described above can be paid to your surviving spouse for a period of at least 72 months beginning on the first day of the month following your date of death. Subsequent payments will be paid on the first of each month. If your surviving spouse dies before all 72 installments are paid, the remaining payments will be made to your spouse's estate.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

DEFINITIONS

Certain words, whether or not capitalized, used in this summary have specific meanings. These definitions will help you better understand how the Plan works:

Basic Annual Salary

The employee's Basic Annual Salary as shown on the Company's records, which excludes: overtime, special allowances or salary for foreign service, awards under any special compensation plan or like plans and payments under any other employee benefit plan.

Beneficiary

The person or persons you designate to receive payment of your AD&D benefits.

On Company Business

Work, on an assignment by or with authorization of Peabody, that is away from your usual workplace for the purpose of furthering the business of the Company; Company business does not include:

* travel within your usual place of employment;
* regular travel between your home and the place you most frequently report to work; or
* travel while on vacation.

It will always include any time you are temporarily or permanently assigned extra territory including travel to and from your home country, but not within the country as described above.

Loss

Death, loss of your hands and feet by severance through or above the wrist or ankle joints; or the irrecoverable loss of your sight.

PLAN ELIGIBILITY

Active Employees

As an Employee you are eligible for accidental death and dismemberment (AD&D) coverage on your date of employment. If you are not at work on your date of employment, your coverage becomes effective on the date you are at work.

Disabled Employees

If you become disabled, are under age 65, and are receiving Company-paid salary continuance or benefits under the Peabody Long Term Disability Plan for

Salaried Employees, you will also remain covered for accidental death and dismemberment benefits.

Retired Employees

You are eligible for AD&D benefits, if you are a Retired Employee with a retirement date on or after January 1, 1970, and are under age sixty-five (65) provided you had completed ten (10) Years of Service.

Enrollment and Plan Contributions

You are automatically enrolled for accidental death and dismemberment benefits. The Plan currently requires no contributions.

WHEN YOUR COVERAGE ENDS

Termination of Coverage

AD&D coverage terminates on the earliest of the following dates:

* termination of the Plan;
* termination of your employment;
* the date of your death;
* the date you cease to be a disabled employee, unless you return to active employment;
* the date you retire and do not meet the definition of a Retired Employee;
* the date you are no longer a member of an eligible class; or
* the date you attain age 65 unless you are an Active Employee.

YOUR ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

You will receive Accidental Death and Dismemberment Benefits automatically if you sustain a loss within 90 days of an accident. A covered loss is death, loss of your hands and feet by severance through or above the wrist or ankle joints, or irrecoverable loss of your sight.

For Active Employees

The Principal Sum of your AD&D benefits equals three times your basic annual salary, rounded to the next $100. The following schedule shows the percentage of your benefit payable for each type of loss:

For Loss of:	Percentage of Total Benefit Payable
Life	100% of Principal Sum
Both hands or both feet or sight of both eyes	100% of Principal Sum
One hand and one foot	100% of Principal Sum
One hand and sight of one eye	100% of Principal Sum
One foot and sight of one eye	100% of Principal Sum
One hand or one foot	50% of Principal Sum
Sight of one eye	50% of Principal Sum

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

For Disabled and Retired Employees

If you accidentally die or are dismembered while covered by the Plan, your AD&D benefit will equal your benefit in force on the day before your retirement or disablement.

While On Company Business

If you suffer an eligible loss while on Company business, your AD&D benefit will not be less than $50,000.

Exclusions and Limitations

The Plan will not cover any of the following types of losses:

* disease-related losses;
* losses caused by bodily or mental infirmity, disease or medical or surgical treatment, or infection (except pus-forming infections which occur through an accidental cut or wound, botulism and ptomaine poisoning);
* losses caused by any act of war, whether declared or not, or by international armed conflict; and
* losses caused by suicide or attempted suicide, or any intentionally self-inflicted injury.

BENEFIT PAYMENTS INFORMATION

Beneficiary Designation

You may designate anyone as the beneficiary of your AD&D benefits. You may change your beneficiary designation at any time by obtaining a form from Peabody and filing the appropriate form with the Plan Administrator. The change will become effective when the form is received and will be effective as

of the date you signed the request, regardless of whether you are alive at the time Peabody receives the request. Benefits which have been paid prior to the receipt of the change on beneficiary card will not be recovered or repaid.

Payment of Benefits

All benefit payments will be made automatically to your designated beneficiary. If no beneficiary is designated, benefit payments will be made to your estate.

MEDICAL CARE BENEFITS

DEFINITIONS

Certain words, whether or not capitalized, used in this summary have specific legal meanings. The following definitions will help you better understand how the Plan works:

Ambulatory Surgical Facility

An institution, either freestanding or as part of a hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures in which a patient is admitted and discharged within a brief period. A physician's or dentist's office is not considered to be an ambulatory surgical facility.

Home Health Care

Services provided by either a state licensed, Joint Commission on Accreditation of Healthcare Organizations approved, hospital-based home health care agency or Medicare approved, community home health care agency.

Home Health Care Agency

A Home Health Care Agency is a federally certified public or private agency or organization that:

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

Mental Illness

Neurosis, psychosis, psychiatric, psychoneurosis, psychopathy, mental or emotional disorders including but not limited to depression, anxiety, stress and paranoia.

Oral Dental Surgery

Alveolectomy performed on an outpatient basis or extraction of impacted teeth.

Outpatient Services

Services performed in a physician's office, in a hospital's outpatient department or in an approved Ambulatory Surgical Center.

Physician or Surgeon

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

* a duly licensed dentist operating within the scope of his license for covered dental work or treatment;

* a podiatrist operating within the scope of his license for certain covered podiatry services common to both medicine and podiatry; or

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

Pre-Existing Condition

An injury or illness which you or your covered dependent consulted with a physician, received treatment or took prescribed drugs or medicines within three months prior to your coverage becoming effective or any conditions related to that injury or illness.

Registered Psychologist

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

* If state licensing or certification exists, he or she holds a valid license or certificate as a psychologist.

* If state licensing or certification does not exist, he or she holds a valid, nonstatutory (professional) certification established by that area's recognized psychological association.

* If neither statutory or nonstatutory licensing or certification exists, he or she holds a statement of qualification by a committee established by that area's psychological association; if no committee exists, he or she holds a diploma in the appropriate specialty from the American Board of Examiners in Professional Psychology.

Skilled Nursing Facility

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

* operate legally in the area it is located;

- be accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations;
- be under the full-time supervision of a licensed physician or registered nurse;
- regularly provide room and board;
- provide 24 hour a day skilled nursing care;
- maintain a daily medical record of each patient under the care of a physician; and
- be authorized to administer medications ordered by a physician.

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

PLAN ELIGIBILITY

Active Employees

As an Employee you are eligible for medical benefits on your date of employment. If you are not at work on your date of employment, your coverage becomes effective on the date you are at work.

Reduction in Work Force

If your employment terminates due to a reduction in work force, the Company may provide you with continued benefits in accordance with Company policy No. 120.1 for three (3) calendar months following the end of the last month in which the reduction in work force occurred.

Disabled Employees

If you receive Company-paid salary continuance or benefits under the Peabody Long Term Disability Plan for Salaried Employees, you remain eligible for medical care benefits.

Retired Employees

If you are a Retired Employee with a retirement date on or after January 1, 1970, you and your Dependents are eligible for medical care benefits provided you have completed ten (10) Years of Service.

Dependents

Your eligible dependents become covered by the Plan at the same time you do. However, if an eligible dependent is hospitalized on his or her eligibility date, coverage for that person will become effective on the day after discharge. (This provision does not apply to a newborn child.)

Your eligible dependents include your spouse and any of the following if you regularly provide one-half of their annual support:

* your own natural children, stepchildren and legally adopted children;

* your grandchildren and/or other children who live with you in a regular parent-child relationship and are dependent upon you for support. You are required to have legal guardianship papers for these children;

* your unmarried children of any age who are incapable of supporting themselves due to mental retardation, physical handicap or continuous total disability and are fully dependent upon you for support and maintenance. Mental retardation, physical handicap or total disability must have occurred before age 23 while the child previously satisfied the definition of dependent child. Support also includes living with you or confinement to an institution for care or treatment.

With the exception of children incapable of self-support due to mental retardation, physical handicap or continuous total disability, your unmarried children are eligible as long as they are under age 19, or up to the day they attain age 23 (if attending an Institution of Learning on a full-time basis). In either case, the child must normally reside with you and be financially dependent upon you.

Surviving Spouses and Dependent Children

In the event of your death, your surviving spouse and children may continue coverage as described below:

* If you die while an active or disabled employee who, with proper election immediately preceding death, would have met the definition of a Retired Employee, your surviving spouse's coverage will continue until his or her death or remarriage. Otherwise your surviving spouse's coverage will continue only for the balance of the month of your death plus three (3) additional months. Dependent children are eligible subject to the surviving spouse's eligibility and other requirements of the Plan.

* If you are either a Retired Employee who retired before September 1, 1977 but after Janaury 1, 1970 and made an election of a joint and survivor option or a Retired Employee who retired after August 31, 1977, your surviving spouse's coverage will continue until his or her death or remarriage. Dependent children are eligible subject to the surviving spouse's eligibility and other requirements of the Plan.

Medicare Eligibility

Benefits payable to active employees over age 65 and their covered dependents over age 65, even though participating in Medicare, will be the same as benefits for active employees under age 65. This means this plan remains primary -- pays benefits first. Medicare benefits are secondary.

If an active employee age 65 or over or his or her spouse elects Medicare as his or her primary coverage, his or her coverage under this plan will terminate on the election date or the date the person becomes eligible for Medicare, if later.

For retired employees who are eligible for Medicare and covered dependents, the amount of any Medicare benefits received will be subtracted from the benefits you receive from this plan. This means Medicare is the primary plan, and your medical benefits from Peabody are secondary. You must enroll for Medicare. The Plan treats any covered member eligible for Medicare coverage (usually age 65 or over) as if the member is covered by Medicare (Parts A and B) regardless of whether actually enrolled. Therefore, to be assured of complete coverage, you or a covered dependent must sign up for Medicare when you are first eligible. You and your covered dependent are responsible for all Medicare premiums for both Parts A and B.

Enrollment and Plan Contributions

You are automatically enrolled for medical care benefits. The Plan currently requires no contributions.

WHEN YOUR COVERAGE ENDS

Termination of Coverage

Your coverage for medical care benefits will end on the earliest of the following dates:

* termination of the Plan;
* termination of your employment;
* the date you retire and do not meet the definition of a Retired Employee;
* when you cease to be a disabled employee unless you return to active employment with the Company;
* when your dependents are no longer eligible for coverage;
* when you are no longer a member of an eligible class; or
* your death.

Conversion Privilege

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

The new policy will cover only the medical portion of the Plan. Dependents cannot be added to the individual policy if they were not covered by the Plan at the time your coverage ended.

Furthermore, the benefits available under an individual insurance policy are not necessarily the same as the one offered under this plan. You should examine the new individual policy carefully.

To obtain this coverage, you or your covered dependents do not have to provide proof of insurability. The policy will be in force on the day after your plan coverage terminates if you submit a written application and the first premium payment to the designated insurance company within 31 days of your coverage termination date.

COMPREHENSIVE DEDUCTIBLE

Deductible

There is a $250 annual deductible per individual for covered medical expenses and a $500 annual family deductible. This means that once $500 of deductible has been paid by your family, the remaining members of your family do not have to satisfy their individual deductibles for that year. The deductible will apply to all services including Inpatient Hospital, Outpatient Hospital, Surgical, Medical Benefits, Mental Illness and Substance Abuse and Alternate Care Benefits.

If two or more covered members of your family are injured in the same accident, only one deductible will be charged for their combined covered expenses for that accident.

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

Co-Payments

You pay a $150 co-payment per hospital confinement up to the annual out-of-pocket maximum. A 20% co-payment is also required for Medical Benefits up to the annual Out-of-Pocket Maximum.

If two or more covered members of your family are injured in the same accident, only one co-payment will be charged for their combined covered expenses for that accident. However, all members would still be subject to the 20% co-payment for Medical Benefits up to the annual Out-of-Pocket Maximum.

Out-of-Pocket Maximum

There is an annual $1,250 out-of-pocket maximum per individual which includes: the $250 deductible, hospital co-payments and the 20% co-payment on Medical Benefits. There is an annual $3,000 out-of-pocket family maximum. The out-of-pocket maximum applies to all services and once it is met the Plan pays at 100% of Reasonable and Customary for covered expenses.

Maximum Lifetime Benefits

The Plan pays $1 million in lifetime benefits per individual for all benefits including Inpatient and Outpatient Hospital, Surgical and Medical Benefits. This will be escalated annually by the Health Cost Component of the Consumer Price Index.

On Mental Illness and Subustance Abuse covered expenses there is a $50,000 lifetime maximum per individual. This amount is included in the $1 million lifetime benefit.

On Alternate Care covered expenses there is a $10,000 lifetime maximum per individual. This amount is included in the $1 million lifetime benefit.

Pre-Existing Conditions

If you or your covered dependents have a pre-existing condition, benefits for that condition will be limited to $1,000 until:

- The individual has been continuously covered by the Plan for 12 consecutive months; or
- If you are an active employee and have the pre-existing condition, you have been continuously actively at work and covered by the Plan for six consecutive months.

INPATIENT HOSPITAL BENEFITS

After the deductible and hospital co-payments are met, the Plan pays 100% of the reasonable and customary amount of covered inpatient hospital medical expenses described in this section. Only medically necessary expenses, not specifically excluded from coverage, are covered by the Plan. Expenses must be for treatment of a nonoccupational illness or injury.

The Plan covers only the "reasonable and customary" portion of your hospital medical expenses.

Hospital Pre-Certification

A program has been established to help you with utilization review. The utilization review program (URP) works with you and your doctor to avoid unnecessary hospitalization. And if hospitalization becomes necessary, the URP helps to keep your stay to a minimum. Here's how it works:

If your physician wants to admit you or a covered dependent to the hospital for nonemergency treatment, your doctor must call the URP administrator for preadmission certification. Your doctor can call PROVIEW toll-free Monday through Friday between 8 a.m. and 4 p.m. in all time zones. The toll-free number is 1-800-621-4309. In Tennessee, the number is 1-800-228-6016.

When your doctor calls, he or she will give the physician or nurse taking the call information about your diagnosis, course of treatment and expected length of hospitalization. Shortly after the call is made, the URP administrator will make a determination and advise by phone, and follow up in a letter whether the hospital stay has been certified. If the hospital stay is certified for a specific number of days, this means you can receive full plan benefits for your hospitalization.

If a disagreement over confirmation of your hospitalization arises through PROVIEW, you or your doctor may request a reexamination of your case. PROVIEW is designed to involve you in the decision making process and supports your right to be an informed health consumer.

If you choose to enter the hospital in a nonemergency situation without certification, $200 will be deducted from the reimbursement for your hospital expens-

es. In other words, you will pay an additional $200 of your hospital expenses. Also, the $200 will not be included in the deductible or out-of-pocket maximum portion of the Plan.

After you or a covered dependent is hospitalized, the URP administrator will review your progress with your doctor. A hospitalization is typically approved for a certain number of days based on the procedure and the patient's medical condition. After the initial number of days has elapsed, the URP administrator will check with your doctor to discuss the reasons why the hospitalization is continuing.

In some circumstances, there may be no medical reason for you or a covered dependent to remain hospitalized, and the URP administrator will inform your doctor that continued hospitalization is not certified. If you remain in the hospital anyway, $200 will be deducted from your reimbursement for your hospital expenses and you will pay an additional $200 of your hospital expenses. Also, the $200 will not be included in the deductible or out-of-pocket maximum portion of the Plan.

For more information about the URP, contact the Peabody Benefits office at 502-827-0800. Remember, it is your responsibility to make sure your doctor contacts the URP administrator at the appropriate time.

Emergency Hospitalization Pre-Certification

If you, or a covered dependent, are admitted to a hospital on an emergency basis -- for the treatment of a life-threatening illness or injury or for a condition that requires immediate medical care -- you or your doctor should contact the URP administrator within two working days of the admission. If you do not call, $200 will be deducted from your reimbursement for your hospital expenses.

Covered Services

The Plan covers the following expenses for inpatient hospital services:

* inhospital benefits, which include:

  -- room and board charges in a semiprivate room, including charges for intensive care or coronary care unit services;

  -- special diets;

  -- general nursing care;

  -- use of operating, delivery, recovery, and treatment rooms and equipment;

  -- all drugs and medicines for use in the hospital, and drugs or medicines sent home following hospitalization, up to a 30-day supply;

  -- dressings, ordinary splints and casts;

- -- x-ray examinations, x-ray therapy, radiation therapy and treatment;

- -- laboratory tests;

- -- physical therapy;

- -- anesthesia and its administration;

- -- processing and administering of blood and blood plasma, to the extent it is not donated or replaced;

- -- chemotherapy;

- -- renal dialysis therapy administered according to Medicare regulations;

- -- dental care due to accidental bodily injury or oral dental surgery when a physician, other than a dentist, certifies that hospitalization is necessary to ensure the life or health of a patient because of specified non-dental impairment;

- -- ground transportation in an ambulance to and from the hospital.

The following physician services are covered by the Plan:

* inhospital physician visits up to one visit per day of confinement by the physician in charge of the case up to the day of surgery;

* administration of anesthesia when administered by a certified nurse anesthetist or a physician other than the operating surgeon or assistant surgeon.

A hospital is an institution that:

* is primarily engaged in providing diagnostic and therapeutic facilities for compensation on an inpatient basis for surgical and medical diagnosis under the supervision of a staff of physicians;

* provides 24 hour nursing services by registered nurses;

* is not a rest home, home for the aged, drug or alcohol addiction facility, nursing home, hotel or similar institution; and

* is state licensed and approved by or under the waiting period for accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

The definition of hospital also includes:

* a facility, approved by the Claim Administrator, for inpatient treatment of chemical abuse; and

* psychiatric hospitals classified and accredited by the Joint Commission on Accreditation of Healthcare Organizations.

OUTPATIENT HOSPITAL BENEFITS

After the deductible is met, the Plan pays 100% of reasonable and customary amount of covered outpatient hospital medical expenses described in this section.

* outpatient hospital benefits for services given in a hospital's outpatient department or in an ambulatory surgical facility as follows:

  -- services provided within five days of an accidental injury;

  -- treatment in connection with and on the same day outpatient surgery is performed; and

  -- emergency medical treatment if you are confined to the hospital within 24 hours of medical treatment.

* pre-admission testing for tests required for hospital admission performed within seven days of a scheduled admission.

The following physician services are covered by the Plan:

* administration of anesthesia when administered by a certified nurse anesthetist or a physician other than the operating surgeon or assistant surgeon.

SURGICAL BENEFITS

After the deductible and hospital co-payments are met, the Plan pays 100% of the reasonable and customary amount of covered Surgical expenses described in this section. Only medically necessary expenses, not specifically excluded from coverage, are covered by the Plan. Expenses must be for treatment of a nonoccupational illness or injury.

Mandatory Outpatient Surgery

To enourage the use of outpatient surgery, the Plan requires you to have some surgical procedures done on an outpatient basis. If you do not have the listed procedures performed on an outpatient basis at either a hospital's outpatient department, ambulatory surgical facility or a doctor's office, $200 will be deducted from your plan benefits for the surgery. In other words, you will pay an additional $200 for the cost of the surgery. The $200 will also not count toward the deductible or the out-of-pocket maximum portion of the Plan.

Maximum plan benefits will be paid when the following procedures are performed on an outpatient basis:

* excision of nail and nail matrix;

* blepharoplasty (plastic surgery of the eyelids);

* biopsy of breast or excision of benign tumor;

* muscle biopsy;

* treatment of a closed fracture with or without manipulation;

* repair of foot disorders;

* broncoscopy (inspection of lungs with an illuminating instrument);

* tonsillectomy and/or adenoidectomy (surgical removal of the tonsils and/or adenoids from the nose);

* endoscopy (inspection of the rectum or uterus with an illuminating instrument);

* simple hemorrhoidectomy (simple removal of hemorrhoids);

* biopsy of the liver using a percutaneous needle;

* circumcision, except for a newborn child; (surgical removal of the fore-skin);

* vasectomy (male surgical sterilization);

* culdoscopy or colposcopy;

* biopsy of the cervix using a circumferential cone; (the removal and examination of the cervical tissue);

* dilation and curettage of the uterus;

* tubal ligation (female surgical sterilization);

* laparoscopy (visual examination of the abdomen with an illuminated instrument or sterilization of a woman);

* hysteroscopy (visual examination of the uterus with an illuminated instrument); and

* myringotomy or tympanotomy with or without tubes (surgical incision of the inner ear).

Covered Services

Benefits are provided for the following charges incurred for surgical services:

* surgical procedures, including customary preoperative and postoperative services, performed by a physician or surgeon. The necessary services of an assistant surgeon who actively assists the physician in surgery are included when:

- you or your covered dependent is hospitalized;
- the type of surgery requires assistance; and
- the services of interns, residents or house officers are not available.

Payment for assistant surgeons will be at 20 percent of the primary surgeon's reasonable and customary level;

* medical supplies necessary for surgery in a hospital, a hospital's outpatient department, physician's office or freestanding ambulatory surgical facility;

* when more than one surgical procedure is performed at the same operative session and through the same incision, payment for incidental surgery will be at 50 percent. Incidental surgery is surgery performed in conjunction with primary surgery during the same operating session, same incision and same operating field;

* oral dental surgery due to an accident, impacted teeth or alveolectomy;

* outpatient surgical procedures;

* for managed second and third surgical opinions;

* surgical benefits for the following procedures may be covered, subject to approval by the Plan Administrator:

  - mammoplasty, if medically necessary (not cosmetic);
  - obesity if you or your covered dependent is 160 percent 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
  - cosmetic surgery required for the correction of birth defects or as a result of an injury.

* covered podiatric surgical procedures include minor surgery for:

  - ingrown toenails;
  - flat feet;
  - fallen arches;
  - weak feet; and
  - chronic foot strain;

* major podiatric surgical procedures if performed by a physician in a hospital.

Managed Second Surgical Opinion

To reduce the risk of unnecessary surgery, the Plan maintains a Managed Second Surgical Opinion Program. When your doctor recommends surgery, and you call for Hospital Pre-Certification, a counselor will discuss your case with a doctor and a determination will be made as to whether or not a second opinion is recommended.

When a second surgical opinion is recommended, the Plan will pay the Reasonable and Customary cost of the second opinion. Second Surgical opinions are not mandatory.

MEDICAL BENEFITS

The Medical Benefits portion of the Plan includes medical expenses not covered as Inpatient Hospital, Outpatient Hospital or Surgical benefits. Expenses above the maximum coverage allowed under Alternate Care and Mental Illness and Substance Abuse benefits are not covered (e.g., expenses over and above the $50,000 maximum under Mental Illness and Substance Abuse benefits or the $10,000 maximum hospice benefits are not covered). After the individual or family deductible is met, the Plan pays 80 percent of Reasonable and Customary covered charges until the $1,250 individual, or $3,000 family, annual out-of-pocket maximum is reached. Thereafter covered charges will be paid at 100% of R&C.

Covered Expenses

The following charges are covered by the Plan:

* private room and board charges for 50 percent of the difference between the hospital's semiprivate rate and the average private rate;

* hospital charges not covered as Inpatient or Outpatient Hospital Benefits;

* charges incurred at your home, a clinic, or your physician's office for professional services of a physician or surgeon, including consultations, at the request of your attending physician by a qualified specialist;

* charges for services or supplies when obtaining a second or third surgical opinion which is not recommended by the utilization review program;

* charges incurred for the professional services of a physician, registered nurse, licensed practical nurse, registered psychologist, or physiotherapist, except for a professional who ordinarily resides in your home or is a member of your immediate family;

* outpatient hospital benefits including:

  -- chemotherapy treatments and radiation therapy;

  -- physiotherapy prescribed and supervised by a physician; and

  -- renal dialysis according to Medicare regulations;

* routine care for newborns and children under age five;

* immunizations, allergy desensitization injections, pap smears, screening for hypertension and diabetes, examinations for cancer, blindness, deafness, and other screening and diagnostic procedures;

* routine physician examinations, excluding examinations required for entrance into a school or for participation in sports;

* 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;

* laboratory tests, radium therapy, x-rays and microscopic tests;

* charges for the cost and administration of anesthesia;

* professional local ambulance service charges for transportation to or from a hospital, clinic, medical center, physician office or skilled nursing facility;

* air ambulance under either of the following conditions:

  -- transportation from a remote area and to the first local hospital where treatment can be given; or

  -- a life-threatening accidental injury or life-threatening sudden and serious illness.

* drugs and medicines requiring the written prescription of a physician and dispensed by a licensed pharmacist;

* blood and blood derivatives to the extent it is not donated or replaced;

* prosthesis when required to replace internal or external body parts as the result of an accidental bodily injury, illness, congenital deformity or anomaly including prosthesis following breast removal;

* rental or purchase of durable medical equipment;

* 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. Submission of a report from the consultant is required when this report is submitted to the Claim Administrator with the order for oxygen;

* services of an inhalation therapist under the attending physician's order in your or your covered dependent's home;

* 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, up to $400 per covered individual per calendar year;

* orthopedic devices including braces, trusses, stump stockings and harnesses when essential for effective use of an artificial limb; and upon examination and recommendation by an orthopedic physician for up to two pairs of surgical stockings per prescription in a six-month period when prescribed for such conditions as thrombophlebitis and/or conditions resulting from surgery such as reinligation;

* 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;

* 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. Speech therapy is also provided for a child's speech impediment; and

* dental care or treatment due to an accidental bodily injury received while covered under this plan.

MENTAL ILLNESS AND SUBSTANCE ABUSE

After the deductible and hospital co-payments are met, the Plan pays the following benefits for covered Mental Illness and Substance Abuse expenses described in this section.

Inpatient Mental Illness and Substance Abuse

The Plan covers thirty (30) days maximum per individual per year, for inpatient mental illness and substance abuse programs not to exceed $20,000. The $150 hospital co-payment applies to this benefit.

Outpatient Mental Illness and Substance Abuse

The Plan pays 80% of the first $1,000 of covered services after the deductible is met. The Plan pays 50% of the next $1,500 of covered services. Expenses over $2,500 per plan year are not covered.

Lifetime Maximum

There is a lifetime maximum per individual of $50,000 for inpatient and outpatient Mental Illness and Substance Abuse services.

Prescription Drugs

* drugs and medicines requring the written prescription of a physician and dispensed by a licensed pharmacist will be covered under the Medical Benefits portion of this plan and not subject to the limitations of the Mental Illness and Substance Abuse section.

Covered Services

* treatment for mental illness by a licensed physiotherapist, registered psychologist, psychiatrist or licensed social worker who is under the supervision of a psychiatrist or psychologist;

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

* treatment for alcoholism and drug abuse for emergency detoxification or any medical treatment required following detoxification; and

ALTERNATE CARE BENEFITS

To encourage utilization of less costly but equally effective means of treating an illness or injury, the Plan pays for certain types of medical care alternatives to an inpatient hospital setting.

Home Health Care

After the deductible has been met, the Plan pays 100% of the reasonable and customary amount of covered Home Health Care expenses described in this section.

* Home health care when performed by a Home Health Care Agency including:

  -- part-time nursing services for six out of eight hours by a registered nurse, licensed vocational nurse, or licensed practical nurse;

  -- physician fees for treatment;

  -- physical occupational or speech therapy performed by a licensed therapist;

  -- prescription drugs and other medical supplies;

  -- laboratory and x-ray services; and

  -- four hours of treatment by a home health aide.

Your physician must provide a written home health care plan within seven days of a hospital discharge including an estimate of the treatment's duration and certification that the home health care is necessary instead of hospitalization.

Your physician must certify the need for continued home health care every 30 days.

Hospice

After the deductible has been met, the Plan pays 100% of the reasonable and customary amount of covered Hospice Care expenses described in this section.

* Hospice care is covered if you or a covered dependent is diagnosed with a terminal illness. A hospice may be an inpatient or outpatient facility that provides medical care and counseling to help you adjust to your illness and medical care. Hospice care benefits are covered if your physician certifies that your life expectancy is no more than six months.

A lifetime maximum benefit of $10,000 for hospice care includes:

- room and board in a freestanding hospice center which is a state licensed and Joint Commission on Accreditation of Healthcare Organizations approved or Medicare-approved, non-curative health care program or facility providing services in the home or in an outpatient or institutional setting;

- general nursing care;

- counseling sessions up to $200 for all sessions with family members before the death of the terminally ill patient; and

- charges for homemaker services.

Your treating physician must submit a written plan for home or inpatient hospice care which meets established professional standards. An approved hospice program must provide the care.

EXCLUSIONS

Certain charges are not eligible for reimbursement nor can they be used to meet any deductible. You will not receive benefits for the following items under any provision of this plan:

* convalescent care, custodial, domiciliary or sanitarium care, or rest cures;

* charges during a continuous hospital confinement which began before the effective date of the person's coverage under this plan;

* travel expenses for a covered individual or for his or her immediate family;

* charges for any services to which there is no legal obligation to pay;

* charges in excess of reasonable and customary;

* charges for abortion unless considered a medical necessity;

* charges for a reduction in benefits due to failure to precertify an initial admission or hospitalizations exceeding the approved length of stay certified by the utilization review program.

* charges for a reduction in benefits due to failure to have certain surgeries performed on an outpatient basis as required by the utilization review program.

* services in connection with any intentionally self-inflicted injury;

* services for treatment or surgery that are considered experimental, developmental or investigatory according to current medical practices;

* custodial services or supplies in a nursing home, home for the aged or convalescent home;

* Any services provided before the Plan member's effective date or after coverage ends unless otherwise noted;

* services in connection with transsexual surgery;

* accidental bodily injury or illness caused by war or any act of war, whether or not declared, including armed aggression, participating in a riot, or attempted felony or assault;

* accidental bodily injury or illness arising out of the course of employment which is compensable under any Workers' Compensation or Occupational Disease Act or Law;

* charges incurred in a U.S. 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;

* services not recommended and approved by a legally qualified physician or surgeon;

* services in connection with any dental work or dental treatment except as specifically provided under the Plan;

* any medical observation or diagnostic study when no illness or injury is revealed unless satisfactory proof is furnished to the Claim Administrator that:

  -- the claim is in order in all other respects; and

  -- the covered individual had a definite symptomatic condition of illness or injury other than hypochondria.

* hearing aids or for their prescription or fitting;

* vision training, eyeglasses and contact lenses or examinations for their prescription or fitting (except the initial pair of eyeglasses after surgery if refractive error is surgically induced, contact lenses as long as the contacts are for the replacement of lens for the eye, or vision training following eye surgery);

* physiotherapy and speech therapy that is educational in nature;

* cosmetic treatment except those required for correction of damage caused by accidental injury sustained while a plan member is covered or to correct congenital deformities or anomalies;

* actual or attempted impregnation or fertilization which involves the covered individual as a surrogate or donor, extrauterine conception or pregnancy of a surrogate mother;

* digestive aids (unless to sustain life), vitamins, minerals or other dietary supplements taken orally or injected regardless of whether such items are prescribed by a physician;

* services or supplies in connection with crowning, wiring or repositioning the teeth for treatment of temporomandibular joint disorders;

* hypnosis and acupuncture;

* routine foot care;

* naturopathic or holistic services;

* home obstetrical delivery;

* charges for telephone conversations with a physician instead of an office visit, for writing a prescription, or for medical summaries and medical invoice preparations;

* medications not dispensed by a licensed pharmacist and that do not require a prescription;

* prescription for birth control pills or birth control devices;

* marriage counseling, encounter or self-improvement group therapy and school related behavioral problems;

* charges incurred as a result of a pregnancy of the daughter of an employee, disabled employee, retired employee, or surviving spouse;

* charges for reversals of sterilization procedures;

* treatment received from an individual who is related to the covered individual or ordinarily resides with that covered individual;

* expenses incurred for services by a licensed chiropractor, whether or not within the chiropractor's license; and

* any charges not determined to be medically necessary for the treatment of an illness or injury, including but not limited to treatments of unproven value or of questionable current usefulness;

* procedures that 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 when the covered individual is not required to be an inpatient to deliver medically effective care;

* any care that does not require the services of a specifically trained medical professional to be delivered; and

* care determined by the Claim Administrator to be custodial in nature.

For inpatient and outpatient service benefits, the following items are not covered:

* eye examinations for prescribing corrective lenses;

* dental treatment except oral dental surgery or treatment necessary for the initial repair of an accidental bodily injury to sound, natural teeth;

* charges covered by any other provisions of the Plan;

For surgical services benefits, the following items are not covered:

* charges for cosmetic surgery unless the service is required to correct accidental bodily injury sustained while covered under this plan or to correct congenital deformities or anomalies;

* routine foot care, including but not limited to, treatment of corns, calluses and bunions;

* 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;

* charges for an autopsy or post-mortem surgery;

For alternate care benefits, the following items are not covered:

* care that is custodial in nature;

* transportation for delivery of home health care;

* eligible hospice services covered by any other provisions of the Plan;

* expenses incurred prior to the date a person is accepted under a hospice care plan;

* expenses incurred by family members in connection with temporary relief away from the patient (respite care); and

* expenses incurred for services by a licensed chiropractor, whether or not within the chiropractor's license.

This is only a partial list of limitations and exclusions; the Plan reserves the right to limit or exclude other services or supplies and their charges.

VISION CARE BENEFITS

PLAN ELIGIBILITY

Active Employees

As an Employee you are eligible for vision benefits on your date of employment. If you are not at work on your date of employment, your coverage becomes effective on the date you are at work.

Disabled Employees

If you receive Company-paid salary continuance, you remain eligible for vision care benefits.

Dependents

Your spouse and eligible dependents are covered by the Plan on your first day of active employment or on your spouse and dependents' first day of eligibility.

Your eligible dependents include your spouse and the following if you regularly provide one-half of their annual support.

* your own natural children, stepchildren and legally adopted children;

* your grandchildren and/or other children who live with you in a regular parent-child relationship and are dependent upon you for support. You are required to have legal guardianship papers for these children; or

* your unmarried children of any age who are incapable of supporting themselves due to mental retardation, physical handicap or continuous total disability and are fully dependent upon you for support and maintenance. Mental retardation, physical handicap or total disability must have occurred before age 23 while the child previously satisfied the definition of dependent child. Support also includes living with you or confinement to an institution for care or treatment.

With the exception of children incapable of self support due to mental retardation, physical handicap or continuous total disability, your unmarried children are eligible as long as they are under age 19, or up to the day they attain age 23 (if attending an Institution of Learning on a full-time basis). In either case, the child must normally reside with you and be financially dependent upon you.

Enrollment and Plan Contributions

You are automatically enrolled for vision care benefits. The Plan currently requires no contributions.

WHEN YOUR COVERAGE ENDS

Termination of Coverage

Coverage for vision care benefits will end on the earliest of the following dates:

* termination of the Plan;
* termination of your employment,
* you qualify for benefits under the Peabody Long Term Disability Plan for Salaried Employees;
* your dependents ceasing to be eligible dependents;
* you are no longer a member of an eligible class;
* your death; or
* the date you become a Retired Employee.

YOUR VISION CARE BENEFITS

The vision care program helps you meet some of your costs for vision care by providing benefits for services and supplies for the necessary treatment of visual defects, injury or disease. Services must be provided by an optometrist, optician or opthalmologist -- any person currently licensed to practice each profession and acting within the scope of the license.

Benefits and Covered Expenses

The Plan pays 100 percent of the scheduled covered expenses. The scheduled covered expenses are limited to charges for services and supplies actually incurred by you or a covered dependent as specified below.

Benefits Covered	Maximum Benefit Payable	Frequency of Service
Vision Examination	$20	Once every 24 months
Lenses	(Per lens)	Once every 24 months
	Maximum of two lenses	
Single Vision	$10	
Bifocal	$15	
Trifocal	$20	

Lenticular	$25	
Contact	$15	
Frames	$14	Once every 24 months

The cost of lenses are not covered unless the new prescription differs from the last one:

* by an axis change of 20 degrees or .50 diopter sphere or cylinder change; and

* the lenses improve visual acuity by at least one line on the standard eye chart.

EXCLUSIONS

The Plan does not cover the following vision care services:

* sunglasses other than tints #1 or #2;

* extra charges for photosensitive or anti-reflective lenses;

* drugs or medications (other than for vision examination, medical or surgical treatment of the eyes;

* special procedures (such as orthoptics);

* vision training;

* subnormal vision aids;

* aniseikonic lenses and tonography;

* experimental, developmental or investigatory services or supplies;

* replacement of lost or broken lenses and/or frames, unless replacement is eligible under the frequency and prescription limitations;

* services or supplies not prescribed as necessary by a licensed physician, optometrist or optician;

* services or supplies for which the covered individual is entitled to benefits under any other plan provision or as provided under a mine safety glass program;

* 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; and

* services or supplies obtained from any governmental agency without cost.

This list of limitations and exclusions is not exhaustive. The Plan reserves the right to limit or exclude other services or supplies and their charges.

DENTAL CARE BENEFITS

DEFINITIONS

Certain words, whether or not capitalized, used in this summary have specific legal meanings. The following definitions will help you better understand how the Plan works.

Dentist

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

Dental Emergency

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

Dental Hygienist

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

Orthodontic Procedures

Movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

PLAN ELIGIBILITY

Active Employees

As an Employee you are eligible for dental benefits on your date of employment. If you are not at work on your date of employment, your coverage becomes effective on the date you are at work.

Disabled Employees

If you become disabled and are receiving Company-paid salary continuance, you remain eligible for dental care benefits.

Dependents

Your spouse and eligible dependents are covered by the Plan on your first day of active employment or on your spouse and dependents first day of eligibility. Dental coverage is only available to dependents of active employees.

Your eligible dependents include your spouse and any of the following if you regularly provide one-half of their annual support:

* your own natural children, stepchildren and legally adopted children if under the age of 19.

Enrollment and Plan Contributions

You are automatically enrolled for dental care benefits. The Plan currently requires no contributions.

WHEN YOUR COVERAGE ENDS

Termination of Coverage

Coverage for dental care benefits will end on the earliest of the following dates:

* termination of the Plan;
* termination of your employment;
* you no longer are a member of an eligible class;
* you qualify for benefits under the Peabody Long Term Disability Plan for Salaried Employees;
* your dependents are no longer eligible for coverage or reach age 19;
* the date you become a Retired Employee; or
* your death.

Extended Dental Benefits if Coverage Terminates

If you or one of your covered dependents has dental work in progress on the date coverage would normally end and the dental treatment began prior to that date, benefits will be extended for:

* appliances or modification of appliances, if the master impression was taken by a dentist before coverage termination and if the appliance is delivered or installed within two calendar months following termination;
* a crown, bridge, inlay, or onlay restorations, if the tooth or teeth were prepared before coverage termination and if the crown, bridge or cast restoration is installed within two calendar months following termination;
* orthodontic treatment, commencing while dental benefits are in force through the end of the month in which termination occurs based on a proration of the applicable quarterly installment; and
* root canal therapy, if the pulp chamber was opened prior to termination of coverage, if such root canal therapy is completed within two calendar months after the termination of coverage.

Payment for Orthodontic Services

Benefits for orthodontic services may be paid in equal quarterly installments over the time period for treatment described in the Orthodontic Treatment plan provided by your dentist. However, the number of quarterly installments will be no more than eight. The first installment becomes payable on the date the Orthodontic appliances are first installed, and subsequent installments become payable at the end of each three month period thereafter.

YOUR DENTAL CARE BENEFITS

This Plan pays you and your family a scheduled benefit for many of your dental expenses. For basic services, the Plan pays the scheduled benefit of the covered expenses after you pay a lifetime deductible. For preventive services, the Plan pays the scheduled benefit of covered expenses. For major services, such as root canals or dentures, the Plan pays the scheduled benefit of the covered expenses after you pay an annual deductible. The Plan also covers some orthodontic expenses after a lifetime deductible is met.

Deductible

You and your dependents pay no deductible for preventive care. However, the following deductibles apply for additional services:

* $50 per person per lifetime for basic services;
* $50 per person per calendar year for major services;
* $100 per person per lifetime for orthodontic services.

A separate deductible must be met for each covered person for each type of service.

If two or more members of your family incur covered expenses totaling $100 in a calendar year, no further deductible for major services will be applied to any other family members.

After the Deductible

After you pay the deductible, the Company pays the scheduled benefit of the covered expenses not to exceed the reasonable and customary charge or the maximum listed in the schedule. Only necessary scheduled expenses, not specifically excluded from coverage, are covered by the Plan. Expenses must be for treatment of a nonoccupational illness or injury.

Maximum Benefits

The Plan will pay up to $750 for eligible preventive, basic and major care dental expenses for each covered person in a calendar year. In other words, each covered family member can receive $750 worth of dental care benefits. Orthodontic services are limited to $500 per person per lifetime. This means the Plan will pay for $500 worth of orthodontic services only.

Dental Treatment Plan

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

* the cost of treatment will total $150 or more; or
* the treatment includes orthodontia;

The form should:

* show the itemized dental services recommended;
* show the charge to be made for each dental service; and
* be accompanied by supporting preoperative x-rays or other appropriate materials required by the Plan Administrator.

For orthodontic procedures, the treatment plan must:

* provide a classification of malocclusion;
* recommend and describe necessary treatment by orthodontic procedures;
* estimate the duration over which treatment will be completed;
* estimate the total charge for treatment; and
* be accompanied by cephalometric x-rays, study models and other supporting evidence the Claim Administrator may require.

The Claim Administrator will review the form submitted by your dentist. The Claim Administrator will determine what is payable so you will know in advance what portion of the cost you must pay. Forms are available from the Peabody Benefits Department.

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

Preventive Care Services

The Plan covers the following preventive care services at the scheduled benefit:

* clinical oral examination;
* prophylaxis and fluoride applications; and
* space maintainers, including adjustments within six months after installation, limited to the initial appliance only and for children under age 16.

Basic Care Services

The Plan covers these basic care services at the scheduled benefit after you pay a $50 lifetime deductible per person:

* office visits;
* x-ray and pathology, including examination and diagnosis, except for injuries;
* oral surgery, including local anesthesia and routine postoperative care;
* extractions;
* alveolar or gingival constructions;
* cysts or neoplasms;
* injectable antibiotics;
* anesthesia;
* periodontics (only procedures 4210-4330 as indicated in the schedule);
* endodontics;
* root canals including necessary x-rays and cultures, but not final restoration or treatment of non-vital teeth;
* anterior, bicuspid and molar teeth;
* restorative dentistry, however multiple restorations in one surface shall be considered a single restoration;
* amalgam and synthetic restorations;
* pins exclusive of restorative material and used in lieu of cast restoration; and
* crowns, full and partial denture repairs, relining, rebasings, adjustments and recementations.

Major Care Services

These major care services are covered at the scheduled benefit after you pay a $50 annual deductible per person:

* restorative procedures including cast restorations and crown, when necessitated by decay or traumatic injury and only when the restoration cannot be restored with routine filling material;

- prostodontia including inlays, crowns, pontics and removable bridges;
- periodontics;
- repairs of crowns and bridges; and
- dentures, partial dentures and denture repairs, including the addition of teeth to a partial denture to replace extracted natural teeth.

Orthodontic Care Services

These orthodontic services are covered at the scheduled benefit after you pay a $100 deductible per person per lifetime:

- preventive treatment procedures, including radiographs;
- minor treatment for tooth guidance;
- interceptive treatment;
- treatment of transitional and permanent dentition; and
- orthodontic charges are covered only if the treatment plan began prior to attainment of age 19.

Orthodontic charges are covered only to the extent they are made in connection with an orthodontic procedure required by one or more of the following conditions:

- overbite or overjet of at least 4 millimeters;
- maxillary (upper) and mandibular (lower) arches in either protrusive or retrusive relation of at least one cusp;
- cross-bite; or
- an arch length discrepancy of more than 4 millimeters in either the upper or lower arch.

EXCLUSIONS

The following charges are not covered by any provisions of this Plan:

- accidental injury or illness caused by war or any act of war, whether or not declared, including armed aggression, or by participating in a riot, or the attempt to commit a felony or assault;
- accidental injury or illness arising out of or in the course of employment, or which is compensable under any Worker's Compensation or Occupational Disease Act or Law;
- charges incurred in connection with any intentionally self-inflicted injury;

* charges for cosmetic treatment required for correction unless necessitated as a result of accidental injury sustained by the covered individual while this Plan is in force. For purposes of these limitations, facings on crowns, or pontics, posterior to the second bicuspid shall always be considered cosmetic;

* charges for replacement of lost or stolen appliances;

* charges for appliances, restorations, or procedures for 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;

* charges for services or supplies not usual or necessary care or in excess of the scheduled amounts;

* a service furnished by or on behalf of any federal, state, county or any other governmental unit unless a charge is made that the covered individual is legally required to pay without regard to existence of Plan coverage;

* the replacement of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within five years of the date of last placement unless the replacement is required as a result of accidental bodily injury;

* any orthodontic procedure in connection with an active appliance that has been installed before the day the covered individual became covered by this Plan;

* charges incurred in connection with dental implantology;

* charges covered under the medical care benefits section;

* charges for orthodontic services which commence after the individual has attained age 19; and

* services not furnished by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or is an x-ray ordered by a dentist.

This list of limitations and exclusions is not exhaustive. The Plan reserves the right to limit or exclude other services or supplies and their charges.

SCHEDULE OF SERVICES

The following schedule of services lists the maximum amount the Plan will pay for each listed service. This means if your dentist or dental care provider charges more than these amounts you will be responsible for paying the difference between the maximum amount and the actual charge.

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 fluoride excluding prophylaxis	17.00
	1211	Topical application of sodium fluoride including prophylaxis	20.00
	1220	Topical application of stannous fluoride 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
	1520	Removable Unilateral type	100.00

	Procedure Number	Description of Services	Maximum Covered Charge
	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
	0240	Intra-oral, occlusal view, maxillary or mandibular, each (limited to once every 36 consecutive months)	7.00

Procedure Number	Description of Services	Maximum Covered Charge
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
0471	Diagnostic photographs, in connection with endodontic or periodontic treatment	11.20

	Procedure Number	Description of Services	Maximum Covered Charge
	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
	7420	Radical excision, over 1/2 inch	129.60

	Procedure Number	Description of Services	Maximum Covered Charge
	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
	7550	Sequestrectomy for osteomyelitis or bone abscess, superficial	100.00

Procedure Number	Description of Services	Maximum Covered Charge
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
7955	Repair maxillo facial tissue	44.80

	Procedure Number	Description of Services	Maximum Covered Charge
	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 Antibiotics	9610	Injectable antibiotics	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
	4260	Osseous surgery (including post-surgical visits), per quadrant	200.00
	4270	Muco gingival surgery (pedicle soft tissue graft, sliding horizontal flap)	102.00

	Procedure Number	Description of Services	Maximum Covered Charge
	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
	3420	Apicoectomy (performed in conjunction with endodontic procedure)	144.00
	3430	Retrofilling	60.00
	3440	Apical curettage	60.00
	3450	Root amputation	60.00

	Procedure Number	Description of Services	Maximum Covered Charge
	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
Restorative Dentistry			
Amalgam Restorations -- Primary Teeth	2110	Cavities involving one surface	14.00
	2120	Cavities involving two surfaces	21.00
	2130	Cavities involving three or more surfaces	27.00
	2131	Amalgam four or more surfaces	30.40

	Procedure Number	Description of Services	Maximum Covered Charge
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
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

	Procedure Number	Description of Services	Maximum Covered Charge
	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
	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			
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

	Procedure Number	Description of Services	Maximum Covered Charge
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

	Procedure Number	Description of Services	Maximum Covered Charge
	2892	Crown - amalgam/composite build up - W.P.	55.20
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	5280	Unilateral partial denture gold	54.00
(unilateral)	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

	Procedure Number	Description of Services	Maximum Covered Charge
	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
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

Procedure Number	Description of Services	Maximum Covered Charge
5130	Immediate upper denture	279.00
5140	Immediate lower denture	279.00
5211	Upper partial denture without clasps	169.00
5212	Lower partial denture without clasps	169.00
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

	Procedure Number	Description of Services	Maximum Covered Charge
	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
	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

	Procedure Number	Description of Services	Maximum Covered Charge
	9940	Occlusal adjustment, minor	17.60
	9950	Occlusion analysis	60.00

ORTHODONTIC SERVICES

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