* during your leave
covered under the LTD plan

Eastern Coal

Eastern Associated Coal Corp
Keppers Building
Pittsburgh, Pennsylvania 15219

J J Higgins
Vice President
Personnel and Industrial Relations

TO SALARIED EMPLOYEES:

Eastern Associated Coal Corp. has arranged to provide its active salaried employees with the program of group coverage described in this booklet.

The Health Care Plan offers comprehensive coverage for hospital charges, surgical and medical expenses and vision and dental care. As of January 1, 1979, the Company is providing these benefits under an Administrative Services Only (ASO) Agreement with the Provident Life and Accident Insurance Company (the Provident). Under this arrangement, the company is responsible for all the benefits; however, the Provident administers the payment of claims.

The Life Insurance Benefits are provided through a contract with the Provident under Group Policy No. 5942.

This booklet should be read carefully so that you will understand the benefits available to you, and then it should be placed in your Employee Benefits Handbook with your other Summary Plan Descriptions.

J. J. Higgins

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SECTION I - PLAN INFORMATION

A. General Information: The plan disclosure information provided below as well as the information provided in following sections constitute a Summary Plan Description of the Health Care Benefits and Provident Life Insurance Plans for active salaried employees of Eastern Associated Coal Corp. and Subsidiaries, (the Company) as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Sponsor: Eastern Associated Coal Corp.

Plan Number: 501

Employer Identification Number: 25-1125516

Plan Year: The plan's records are kept on a policy year basis ending December 31 each year.

Effective Date: This booklet includes all amendments which have been made to the plan, up to and including amendments effective April 29, 1979.

Type of Plans: The plan is a welfare benefit plan providing Health, Vision, and Dental Care Benefits, and a Life Insurance Program.

Type of Administration: Eastern Associated Coal Corp. is liable for Health, Vision, and Dental care, while the Provident administers payment of claims for these benefits. Provident Life and Accident Insurance Company is liable for all Life Insurance Benefits under Policy No. 5942.

Contributions: Employees contribute a fixed rate per month toward the cost of the Dental Benefit for dependents through payroll deductions. The remainder of the cost of the plan is borne by the Company.

Plan Continuance: The Company expects to continue the program, but reserves the right to terminate, suspend, withdraw, amend or modify the plan in whole or in part at any time.

Plan Document: For simplicity, the plan has been described in a general manner in this booklet. The extent of coverage for each individual is governed at all times by the complete terms of the health plan document and the life insurance contract which are maintained by the Plan Admin[illegible]tor.

Plan Administrator and Agent for Service of Legal Process:
Assistant Vice President - Insurance and Personnel
Eastern Associated Coal Corp.
Koppers Building
Pittsburgh, PA 15219
Tel. Number: 412/288-8100

For further information contact:
Manager—Insurance and Personnel
Eastern Associated Coal Corp.
Koppers Building
Pittsburgh, PA 15219
Tel. Number: 412/288-8100

OR

Manager—Compensation and Benefits
Eastern Associated Coal Corp.
P. O. Box 70
Beckley, WV 25801
Tel. Number: 304/255-0422

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

(1) Examine without charge, at the Plan Administrator's office or through your work location, all documents relating to the plan filed with the U.S. Department of Labor.

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

(3) Receive a summary of the plan's annual financial report.

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

No one may fire you or otherwise discriminate against you in any way solely to prevent you from obtaining a benefit to which you are entitled or from exercising your rights under ERISA.

If your claim for a benefit is denied, you must receive a written explanation of the reasons for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are a number of steps you can take to enforce the above rights:

1) If you request materials from the plan and do not receive them within 30 days, you have the right to file suit in a federal court. The court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials.

2) If you have a claim for benefits which is denied or ignored, you have a right to file suit in a state or federal court.

3) If the people responsible for operating the plan 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 file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful you may not have to pay any court cost or legal fees. If you lose, the court may order you to pay these costs and fees.

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

SECTI II - HEALTH CARE BENEFITS

A. Eligibility

Employees:

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

Dependents:

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

1) Your spouse.
2) Your unmarried children from birth to age 19 (age 23, if a full-time student). "Children" also includes stepchildren, foster children and any other children living with you in a parent-child relationship and dependent on you for support.
3) An unmarried dependent child who becomes physically or mentally incapable of earning a living prior to age 19. Coverage will continue for as long as the condition exists, provided you furnish proof of the dependent's condition within 31 days after the dependent reaches the limiting age.
4) The unmarried spouse and eligible children of a deceased employee whose death occurred on or after December 1, 1969.

B. Enrollment

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

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

C. Definitions

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

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

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

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

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

Injury - Only bodily injury which requires treatment by a physician.

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

Optometrist - Person who is legally licensed to practice Optometry.

Physician - Legally qualified physician or surgeon, or a legally qualified dentist.

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

D. Services Not Covered

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

1) Charges incurred due to occupational injuries or illnesses or any charges covered by Worker's Compensation.
2) Charges which are subject to reduction in accordance with the provision headed "Coordination with other Medical Care Benefits" described on page 16.
3) Charges for coverage which could have been obtained upon appropriate application or enrollment under Medicare.
4) Any amounts exceeding reasonable and customary charges. Reasonable and customary fees are determined by looking at the usual fee charged in the area.
5) Services and supplies received in a hospital owned or operated by the U.S. Government.
6) Services or supplies for which no charge is made.
7) Charges incurred while the coverage under this plan is not in effect.
8) Acupuncture therapy.
9) Cosmetic surgery, except operations necessary to repair disfigurement from an accident occurring while this insurance is in force, or except for treatment of a birth defect in a child born while the parents are covered under this plan.
10) Treatment of injury or illness which is occasioned by war, declared or undeclared.
11) Telephone conversation with a physician in lieu of an office visit.
12) Charges for writing a prescription, or for medications dispensed from a physician's office. See 33 NC reason
13) Charges for medical summaries and medical invoice preparations.
14) Purchase of hearing aids.
15) Services provided by a relative.
16) Custodial care.

Anything pert to teeth on inpatient or out patient is n/c #32 per T.D

E. Basic Medical Benefits

(1) **Hospital Expense Benefits** - The following benefits are provided for hospital charges incurred during a period of confinement due to illness or injury:

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

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

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

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

1) services and supplies required for treatment.
2) charges for radiology or laboratory services.
3) charges for ambulance service to and from the nearest hospital or medical facility where care and treatment of the injury or illness can be given.

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

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

(2) **Physician's and Surgeon's Fees in the Hospital** - The following benefits are covered in full, up to the reasonable and customary charges:

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

Assistant Surgeons, if required.

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

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

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

(3) Other Covered Charges

(a) *Laboratory and X-Rays*

100% of reasonable and customary charges are provided for:

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

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

(b) *Maternity Benefits* (for dependent wives and female employees)

Maternity benefits are payable for expenses incurred due to pregnancy, childbirth, or miscarriage. Benefits for maternity are identical to those for other illnesses and injuries.

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

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

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

(c) *Emergency Accident and Emergency Illness*

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

(d) *Annual Routine Physical Exam* (employees only)

Benefits are available for one exam per calendar year, for the reasonable and customary fee, not to exceed $50 for the physician's fee. Diagnostic tests are covered in full.

(e) *Physician's Visits*

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

(f) *Prescription Drugs*

The plan pays 80% of covered drug expenses. Covered drugs include all drugs which require a prescription and insulin when prescribed by a physician.

Benefits will not be payable under the plan for:

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

F. Major Medical Benefits

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

(1) Benefit Payments

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

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

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

(2) Covered Charges

- Hospital Care, including room and board at the average semi-private room rate, intensive care, and other hospital services and supplies.
- Convalescent Facility Care, if required following a hospital confinement for at least five days, including room and board and general nursing care at the average semi-private room rate, payable up to 100 days per year.
- Physician's fees for medical and surgical operations.
- Nursing Service, provided by a registered graduate nurse or a practical nurse who is either licensed or registered with an organization approved by the medical profession.
- Artificial limbs or eyes, casts, splints, trusses, braces, crutches.
- Rental of durable equipment for medical or surgical treatment such as wheelchair, iron lungs, etc.
- Anesthetics and their administration.
- Diagnostic laboratory services.
- Services of a physiotherapist or lab technician.
- Use of x-ray, radium and other radioactive substances.
- Oxygen and rental of equipment for administration of oxygen.
- Commercial transportation within the U.S. and Canada, if medically necessary, to an out-of-area hospital or medical facility providing required special treatment.
- Professional psychiatric service.

  On an inpatient basis, charges for treatment and convulsive therapy are covered on the same basis as charges for other illness or injury.

  On an outpatient basis, charges are covered up to 50% of the total.

(3) Charges Not Covered

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

G. Vision Care

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

(1) Benefit Payments

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

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

(2) Covered Charges

- One complete visual analysis during a calendar year.
- Lenses, including replacement of contact lenses, dispensing
- One set of frames during any consecutive two year period.
- Verification and fitting. Technical Fee
- Opthalmic materials necessary for fitting of and subsequent evaluation of eyeglasses.

(3) Charges not Covered

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

- Eyeglass repair
- Oversizing (charged separately)
- Protective Tint
- Scratch-coat
- Cleaning
- Polishing

H. Dental Care (includes LTD)

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

(1) Benefit Payments

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

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

(2) Maximum Benefit

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

(3) Enrollment

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

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

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

(4) Covered Charges

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

(5) Cha[illegible]ot Covered

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

I. Termination of Coverage

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

(a) The date the plan is terminated.

(b) The date the plan is amended to terminate the coverage of a class of employees of which you are a member.

(c) The date you are no longer a member of an eligible class of employees.

(d) The date your active employment with the Company is terminated.

(e) The date you are pensioned or retired, except that dental coverage for retirees is continued to age 65. For information about Health Care Benefits for retirees, contact your Personnel Representative.

(f) For employees on layoff, benefits terminate on the date you become eligible to participate in another group plan, or 3 months following the end of the month in which the layoff occurs, whichever is earlier.

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

(a) The date your coverage is terminated for any reason.

(b) The date a dependent ceases to be eligible in accordance with the provision in the "Eligibility" section.

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

J. Extended Benefits After Termination

This does not apply to LTD

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

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

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

For further information, including questions about extension of maternity benefits, contact your Personnel Representative.

K. Conversion to Individual Policy

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

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

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

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

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

L. Coordination with Other Medical Care Benefits

Health Care benefits are designed to help you meet actual expenses for the treatment and care of illnesses and injuries.

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

Allowable expenses as it is used here, is any necessary, reasonable, and customary charge covered at least in part by any one of the plans of which you are a member.

Plan means any of the following:

- Group, blanket or franchise insurance coverage.
- Governmental programs, including Medicare, and any coverage required or provided by any statute.
- Labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans.
- Prepayment plans or group practice coverage, except that for which payment is made directly by the person covered to the organization providing coverage.

M. The Health Maintenance Organization Act of 1973

The Health Maintenance Organization Act of 1973 (HMO act) provides that you have the option of electing membership in a health maintenance organization certified in accordance with federal or state laws in lieu of electing to become covered for the Medical Expense Benefits provided under the group plan.

If you are interested in this option, contact your Personnel Office or Personnel Representative to find out if there is an HMO available in your area. If so, your Personnel Office will provide you with additional information.

SECTION III - LIFE INSURANCE

A. Certificate

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
Chattanooga, Tennessee
(herein called the Provident)

hereby certifies that it has issued Group Policy No. 5942 to

EASTERN ASSOCIATED COAL CORP.

(herein called the Company)

providing the Life Insurance Benefits described on the following pages for certain Employees insured under the Group Policy. This booklet summarizes the principal provisions of the Group Policy which alone constitutes the entire contract between the Provident and the Company.

Employees become eligible for the insured benefits under the plan as provided on a following page. This booklet constitutes the Employee's Certificate of Insurance while covered under the plan.

The benefits and provisions described on the following pages are subject in all respects to the terms and conditions of the Group Policy.

H. Carey Hanlin

President
Provident Life and Accident
Insurance Company

B. Benefit Payments

In the event of the death of an employee from any cause, $5,000 is payable to the beneficiary upon receipt of proof of death. In the event of the death of a dependent from any cause, $1,000 is payable to the employee upon receipt of proof of death.

The insurance may be payable in a lump sum or in installments.

C. Eligibility

As a full-time active salaried employee, you and your dependents are eligible for this coverage on your date of hire. Coverage also continues for employees eligible to receive payments from a company - sponsored long-term disability plan.

D. Dependent Coverage

The members of your family eligible for dependent coverage include—

1) your spouse.
2) your unmarried children between 14 days and 19 years of age, or up to age 23 if regular, full-time students. "Children" also includes stepchildren, foster children and any other children living with you in a parent-child relationship and dependent on you for support.

E. Enrollment

You are automatically eligible for enrollment in the Life Insurance Plan on your date of hire. However, you must complete an enrollment card for you and your dependents with your Personnel Representative.

If you are not actively at work on the date coverage would normally begin, your protection will begin on the date you return and complete a full day of work.

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

F. Beneficiary Information

You can name whomever you wish as your beneficiary by filing such designation with your Personnel Representative who will forward it to the Personnel Department. You may change your beneficiary at any time by giving written notice and the change will become effective on the date that you sign the request.

If you designate more than one beneficiary and you do not specify their respective shares, the beneficiaries shall share equally.

If a beneficiary predeceases you, his share shall be payable equally to the surviving beneficiaries, unless you have designated otherwise.

Any amount for which there is no designated beneficiary at your death shall be payable to your estate or as determined equitably by the Plan Administrator. You will be the beneficiary for the insurance protection for the members of your family.

G. Termination of Coverage

1. Your life insurance coverage will terminate on the earliest of the following dates:
   (a) The date the plan is terminated.
   (b) The date the plan is amended to terminate the coverage of a class of employees of which you are a member.
   (c) The date you are no longer a member of an eligible class of employees.
   (d) The date your active employment with the Company is terminated.
   (e) The date you are pensioned or retired.
   (f) The date your lay-off occurs.

2. Your coverage with respect to dependents will terminate on the earliest of the following dates:
   (a) The date your coverage is terminated for any reason.
   (b) The date a dependent ceases to be eligible in accordance with the provisions in the "Eligibility" section.

I. Conversion to Individual Policy

You and your spouse may convert your Group Life Insurance to an individual life insurance policy offered by the Provident Life and Accident Insurance Company if you meet one of the following conditions:

1) You terminate employment with the Company.
2) You cease to be in an eligible class of employees.
3) You have been covered under the plan for at least three years (and the plan has been in effect at least five years,) and the plan terminates or the class of employees of which you are a member ceases to be covered. In this case, only limited types of individual policies may be issued.
4) In the case of your death, conversion will be available to your spouse.

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

The premium for the individual policy will be based on your or your spouse's attained age at the time of application, the class of risk to which either of you belong and the form and amount of policy.

If you or your spouse should die during the 31 day conversion period, the beneficiary will be entitled to the amount of insurance which would have been payable under an individual policy, even if application for the individual policy has not been made.

SECTION IV - CLAIMS PROCEDURE

A. How to File a Claim

(1) For Health Benefits

a) A health benefits identification card will be issued by your employer.

b) When you or one of your dependents requires covered treatment or services, the identification card should be presented to the provider of the services.

c) Contact the Personnel Office or your Personnel Representative to receive a claim form and instructions to bring with you when receiving services.

d) Complete the forms, have the hospital or physician complete the necessary sections, and return them to the Company as soon as possible.

1) When filing your claim, you must submit proof of each charge, so it is extremely important that you secure copies of bills for all charges.
2) Drug store bills for prescription items must include a diagnosis, prescription number, and the name of the person for whom prescribed.

e) The Company will then send your claim to the Insurance Company. The Insurance Company will determine the amount payable under the plan, make the payment, and send you advice of the payment.

(2) For Life Insurance Benefits

All claim forms may be obtained from your Personnel Office or your Personnel Representative and are to be completed according to instructions on the forms. The completed form should be returned to one of the Personnel Offices for proper processing.

What to Do If Your Claim Is Denied

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

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

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