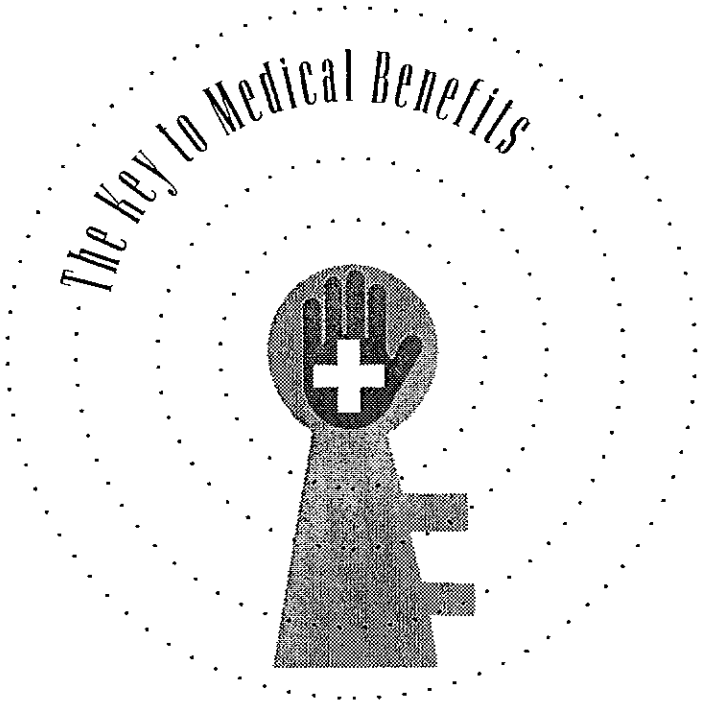
Catastrophic S.P.D.



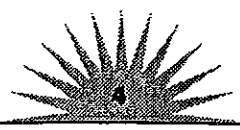
This booklet is a "summary plan description" (SPD) of the Catastrophic Group Health Plan for Salaried Employees Terminated Through a Reduction in Work Force.

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

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

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

Contents



Key Highlights

Medical coverage

WHO IS ELIGIBLE: A salaried employee of the company who has been terminated through a reduction in work force, has been offered this plan and agreed to the terms contained in the Voluntary Separation Agreement. Coverage ends if you become covered under another employer's group health plan as an employee. (See page 7 for more information.)

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

COST TO YOU: You currently pay no premiums. However, you do share in the cost of the treatment you receive by paying deductibles, copayments and a percentage of expenses. What you pay depends on the type of care you receive and where you receive it. (See page 9 for more information.)

The medical plan has a cap, or out-of-pocket maximum, on the amount you pay for most covered expenses. This maximum is $2,500 for one person in one calendar year, and $5,000 combined for all covered family members per calendar year. (See page 16 for more information.)

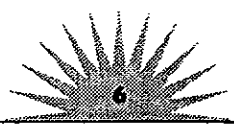
MAXIMUM BENEFIT AMOUNT: In general, the medical plan pays a lifetime maximum benefit of $1 million per covered person as of March 1, 1990. (This is adjusted annually based on the Health Cost Component of the Consumer Price Index. In 1995, the maximum was $1,450,000.) However, additional restrictions apply to hospice care and treatment of mental illness and substance abuse. (See page 17 for more information.)

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

The medical plan includes a Coordinated Care Options program that works with you and your doctor to review your care and avoid unnecessary hospitalization. The purpose of the program is to make sure you receive the most appropriate, cost-effective care for your condition. (See page 11 for more information.)

If you have coverage through your spouse's or dependent's employer, benefits under this plan will be reduced by the benefit amounts you receive from the other plan. (See page 35 for more information.)

Coverage ends if you become covered under another employer's group health plan as an employee. (See page 36 for more information.)



Eligibility and Enrollment

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

- You are terminated through a reduction in work force.
- You have not become covered by another employer's group health plan as an employee.
- You have agreed to the Voluntary Separation Agreement.
- You have not elected to continue coverage under the COBRA continuation of coverage provisions of the Peabody group health plan for salaried employees.

You will be enrolled for medical care and prescription drug benefits after it is certified that you meet the eligibility requirements. The plan currently requires no contributions from you.

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

ELIGIBILITY FOR YOUR DEPENDENTS

Your eligible dependents become covered by the plan at the same time you do. However, this plan covers only those dependents who were eligible on the date your employment terminated, and who do not elect to continue the benefits of the plan for active employees under COBRA.

Your Medical Benefits

"Out-of-area" means you live in an area where no network provider is available.

"Non-network" means you choose not to use a network provider when one is available in your area.

BENEFITS AT A GLANCE	NETWORK AND OUT-OF-AREA	NON-NETWORK
DEDUCTIBLES YOU PAY		
ANNUAL DEDUCTIBLE	$1,500	$1,500
ANNUAL DEDUCTIBLE FAMILY MAXIMUM	$3,000	$3,000
HOSPITAL COPAYMENT (per admission)	$50★	$150
EMERGENCY ROOM COPAYMENT (if not a true emergency)	$50	$50
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE AND HOSPITAL COPAYMENT		
INPATIENT HOSPITAL	100%	80%
INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE	100% UP TO 30 DAYS PER CALENDAR YEAR UP TO $20,000 ANNUAL MAXIMUM	80% UP TO 30 DAYS PER CALENDAR YEAR UP TO $20,000 ANNUAL MAXIMUM
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE		
SPECIAL OUTPATIENT BENEFITS (for same-day surgery, accident if treated within five days, emergency medical care if admitted to the hospital within 24 hours, or pre-admission testing)	100%	80%
SURGERY	100%	80%
HOME HEALTH CARE OR HOSPICE (up to plan limits)	100%	80%
OUTPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE	80% OF THE FIRST $1,000 50% OF THE NEXT $1,500 (NO COVERAGE FOR EXPENSES AFTER $2,500)	
MOST OTHER MEDICAL EXPENSES	80%	60%
ANNUAL OUT-OF-POCKET MAXIMUMS YOU PAY (includes deductible, hospital copayment, coinsurance)		
ANNUAL OUT-OF-POCKET MAXIMUM PER INDIVIDUAL	$2,500	$2,500
ANNUAL OUT-OF-POCKET MAXIMUM PER FAMILY	$5,000	$5,000

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

All hospitalization and certain other types of care must be approved under a Coordinated Care Options program. Benefits may be reduced if you don't comply. See the section called Coordinated Care Options (CCO) program and hospital precertification *on page 11.*

★ *If you or a covered dependent lives outside the network area, benefits should be paid at network rates, except the hospital copayment, which is $150. Your eligibility records must be adjusted, however, or all claims will be processed as out-of-network. Contact your local benefits department for information and forms.*

PRESCRIPTION DRUGS, AMOUNT THE PLAN PAYS *(no deductible or out-of-pocket maximum)*	
CBN NETWORK PHARMACY	85% ★ BRAND NAME 90% GENERIC
NONPARTICIPATING PROVIDER PHARMACY	80% ★
LIFETIME MAXIMUM BENEFIT THE PLAN PAYS	
	$1,000,000 INDEXED ANNUALLY FOR INFLATION (IN 1995, LIMIT WAS $1,450,000) (NO MORE THAN $50,000 FOR MENTAL HEALTH AND SUBSTANCE ABUSE)

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

Benefits for prescription drugs are provided through a separate program administered by PCS Health Systems, Inc. *See the section called* Prescription drug benefits *on page 20.*

BLUE CROSS BLUE SHIELD NETWORK

The plan offers you the opportunity to obtain health care for yourself and your family through a preferred provider organization, or PPO. (A booklet listing these doctors and hospitals is available from your benefits department.) The PPO has been developed by Blue Cross Blue Shield and is called the Blue Cross Blue Shield PPO, or "network" for short. The network is designed to provide access to comprehensive health care at reasonable costs.

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

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

You may reduce your cost for medical expenses through participating provider arrangements. If you receive care or supplies from certain providers, your cost will be less.

In each state, the name of the network is different. Following are the names of the Blue Cross Blue Shield Networks available to you.

West Virginia:
Super Blue® Plus

Illinois:
PPO Plus Program

Indiana:
Premium Preferred Network

Kentucky:
Option 2000 (for hospitals)
Blue Cross Blue Shield PAR
Plan Network (for physicians)

Missouri:
Alliance Program

Arizona, Colorado, Montana, Nevada, New Mexico and Utah:
Blue Cross Blue Shield PAR
Plan Network

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

If you have an emergency

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

In either case, if you are admitted to a hospital, you or someone on your behalf must call the Coordinated Care Options (CCO) program within two working days of your admission, as described on page 12. If CCO is not notified, your benefits will be reduced.

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

If you need care your network doctor can't provide

If there is no network doctor who provides a certain type of service, you may be able to go to a non-network provider and have your covered expenses paid at network levels. You must call Alliance Blue Cross Blue Shield at 1-800-848-COAL (2625) and select option 1.

Traveling in the U.S.

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

If you are traveling in one of the network states (listed on this page) and you need non-emergency medical attention, call Alliance Blue Cross Blue Shield at 1-800-848-COAL (2625). The Alliance Blue Cross Blue Shield representatives will direct you to a network provider in the area if one is available. If you do not use a network provider when one is available, any covered expenses you have will be paid at non-network levels.

If you or a dependent lives outside the network area

If you or a covered dependent lives outside the network area, benefits may be paid at network rates (except the hospital copayment, which is $150). Your eligibility records must be adjusted, or all claims will be processed as non-network. Contact your local benefits department for information and forms.

PARTICIPATING PROVIDER PHARMACY PROGRAM

Prescription drug benefits are provided through the participating provider pharmacy program. Pharmacies participating in the network have agreed to provide discounts for persons covered by the company medical plan. In addition, the plan pays higher benefits for prescriptions purchased from a participating pharmacy, and you do not have to file a claim. A list of participating pharmacies is available from your benefits department.

If you purchase prescriptions from a non-participating pharmacy, you will still receive your benefits, but you may have to pay the full cost of the drug up front and file a claim for reimbursement. The benefits the plan pays for prescription drugs are explained in the section *Prescription drug benefits* on page 20.

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

COORDINATED CARE OPTIONS (CCO) PROGRAM AND HOSPITAL PRECERTIFICATION

The Coordinated Care Options (CCO) program is administered by Alliance Blue Cross Blue Shield. The program is designed to help you and the company manage costs by reviewing, in advance, the health care services you receive. This allows CCO to "precertify" (authorize in advance as being medically necessary) certain types of care and make sure that it is medically necessary.

If you use a network provider, in most cases the provider will handle precertification for you. However, it's still ultimately your responsibility to precertify by calling CCO at 1-800-848-COAL (2625) before receiving care.

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

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

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

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

- Cardiac rehabilitation.
- Hearing aids (only covered for children under age 13).
- Home health care.
- Magnetic resonance imaging (MRIs).
- Oxygen.
- Private-duty nursing.
- Purchase or rental of durable medical equipment.
- Hospice care.
- Nursing facility care.

The Coordinated Care Options program's goal is to ensure that you receive appropriate, cost-effective, quality care for your condition.

Prescription drug benefits are provided through the participating provider pharmacy program. Pharmacies participating in the network have agreed to provide discounts for persons covered by the company medical plan.

Before all non-emergency hospitalization and certain outpatient services, you must call the Coordinated Care Options (CCO) program for approval. If you don't call first, you must pay a $200 penalty.

Precertification alone does not guarantee coverage.

Precertification for inpatient admissions

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

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

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

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

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

Precertification of outpatient services

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

Also, no benefits are provided for services that are not determined to be medically necessary by CCO.

Precertification alone does not guarantee coverage

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

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

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

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

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

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

Recertification for extending an inpatient stay

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

If you do not call for recertification

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

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

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

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

Concurrent review

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

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

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

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

To contact CCO, call 1-800-848-2625 and select Option 1.

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

Retrospective review

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

Individual case management

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

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

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

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

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

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

How to contact Coordinated Care Options

When you need to contact CCO, please:

- Call 1-800-848-COAL (2625).
- Select Option 1.

Business hours are 8 a.m. to 6 p.m., Monday through Friday.

When you want to request precertification, be sure to have the following information:

- Your identification number (from your health plan ID card).
- The name and phone number of the admitting physician.
- The date of admission.
- The name of the hospital or treatment facility.
- The reason for the admission, and how long the doctor expects you to be an inpatient.

If you need to contact CCO after business hours, you may either wait until the next business day, or call and leave a message with CCO's answering service. Please be ready to leave your name, your identification number from your health plan ID card and the telephone number at which you can be reached during the day. Be sure to include your area code. Your call will be returned the next business day. Have the other information about your admission ready when your call is returned.

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

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

If you disagree with CCO's decision

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

Coordinated Care Options
National Account Service Center
P.O. Box 66989
St. Louis, MO 63166-6989

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

ANNUAL DEDUCTIBLE

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

The annual deductible is $1,500 for each covered individual per year, and generally applies to all covered expenses. However, there are special features and exceptions:

- The deductible may be satisfied with a combination of network and non-network expenses.
- You will pay no more than $3,000 toward the annual deductible in any one calendar year for all your family members combined.
- If two or more covered members of your family are injured in the same accident, you only have to meet one individual annual deductible for their combined covered expenses for that accident.
- If you have covered expenses in the last three months of a calendar year that apply towards your deductible, they may be applied to the next year's deductible as well.
- Covered expenses already used to satisfy the deductible under the Peabody group health plan for salaried employees will be applied towards the current calendar year deductible of this plan.

The annual deductible is the amount of covered expenses you must pay each calendar year before the medical plan will pay benefits. The annual deductible is $1,500 for each covered individual per year.

Before the plan pays benefits for an inpatient hospital stay, you must also pay a hospital copayment.

For most types of covered medical expenses, the plan pays 100%, 80% or 60% of covered expenses after you've met the deductible and hospital copayments.

For all covered family members combined, the most you will pay out-of-pocket for covered expenses in one calendar year is $5,000. The most you will pay for any one covered person per calendar year is $2,500. This is the plan's out-of-pocket maximum.

- You do not have to meet a deductible for prescription drug benefits, as explained under *Prescription drug benefits* on page 20.

HOSPITAL COPAYMENT

Before the plan pays benefits for an inpatient hospital stay, you must pay an additional hospital copayment of $50 if you are admitted to a Blue Cross Blue Shield network hospital, or $150 for any other hospital (including out-of-area).

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

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

EMERGENCY ROOM COPAYMENT

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

OUT-OF-POCKET MAXIMUM

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

For most types of covered medical expenses, the plan pays 100%, 80% or 60% of covered expenses after you've met the deductible and hospital copayments, if applicable. If your share of covered expenses (including the deductible, hospital copayments and the 20% or 40% you pay) reaches $2,500 for one person in one calendar year, the plan pays 100% of any additional covered expenses incurred by that person for the rest of that year.

For all covered family members combined, the most you will pay out-of-pocket for covered expenses in one calendar year is $5,000.

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

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

- Expenses that exceed the plan maximums (including the special limits on benefits for treatment of mental illness and substance abuse).

LIFETIME MAXIMUM BENEFIT

For all covered expenses, the medical plan pays a lifetime maximum of $1 million for each covered person, as of March 1, 1990. This amount is increased annually by the Health Cost Component of the Consumer Price Index. In 1995, the lifetime maximum was $1,450,000.

For treatment of mental illness and substance abuse, there is a $50,000 lifetime maximum per individual. For hospice care expenses, there is a $10,000 lifetime maximum per individual. These amounts are included in the $1 million lifetime maximum for all benefits.

COVERED MEDICAL EXPENSES

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

The medical plan provides benefits only for covered expenses that do not exceed the usual, customary and reasonable charges in the geographic area where the services or supplies are provided, as determined by Blue Cross Blue Shield. Participating providers agree to accept these rates and will not bill you for covered expenses other than the deductible and copayment amounts. For a nonparticipating provider, you must pay any amounts that exceed the usual, customary and reasonable charge, in addition to the deductible and your percentage share of expenses. In this situation, the plan's "hold harmless" provision will apply—see the section on page 34.

Inpatient hospital benefits

The plan provides benefits for the following covered expenses for an inpatient hospital stay, provided CCO has approved the hospitalization, as explained on page 12. After the deductible and the hospital copayment are met, benefits are payable at 100% for network charges or 80% for non-network charges.

The plan covers charges by a hospital for the following:

- Room and board expenses in a semi-private room, including expenses for intensive care or coronary care units. Charges for a private room may be eligible for reimbursement at 95%, if medically necessary.
- Special diets.
- General nursing care.
- Use of operating, delivery, recovery, and treatment rooms and equipment.
- All FDA-approved and appropriately prescribed drugs and medicines for use in the hospital, and covered drugs or medicines sent home following hospitalization, up to a 30-day supply.
- Dressings, ordinary splints and casts.
- X-ray examinations, X-ray therapy and radiation therapy and treatment.
- Laboratory tests.

For all covered expenses, the medical plan pays a lifetime maximum of $1 million (adjusted annually) for each covered person. However, this includes smaller special limits for treatment of mental illness and substance abuse and for hospice care.

- Physical therapy.
- Anesthesia and its administration.
- Processing and administering of blood and blood plasma to the extent it is not donated or replaced by or for the patient.
- Chemotherapy.
- Renal dialysis therapy administered according to Medicare regulations.
- Dental care due to accidental bodily injury or oral dental surgery when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition.
- Ground transportation in an ambulance to the hospital when medically necessary and when the patient is admitted. Air ambulance charges are also covered for:
  - Transportation from a remote area to the first, nearest hospital where treatment can be given.
  - Transportation to a hospital in the event of a life-threatening accidental injury or sudden, life-threatening illness.

In addition, the medical plan covers the following physician services during inpatient hospitalization:

- Up to one hospital visit per day by the admitting physician, and up to one visit per day by a physician treating another condition, until 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.
- Services of a radiologist or pathologist.

Special outpatient benefits

The plan covers the following services provided by a hospital's outpatient department, in an ambulatory surgical facility or in a physician's office. After the deductible is met, the plan pays 100% of covered expenses for network charges or 80% for non-network charges. This benefit includes:

- Services provided within five days of an accidental injury.
- Treatment in connection with and on the same day that outpatient surgery is performed.
- Emergency medical treatment if you are confined to the hospital within 24 hours of outpatient medical treatment. These services are paid at the network benefit level regardless of the provider you use.
- Pre-admission testing that is required for a hospital admission, if performed within seven days of the scheduled admission.

The plan also covers the following physician services in connection with outpatient care:

- Administration of anesthesia, when administered by a certified nurse anesthetist or a physician other than the operating surgeon or assistant surgeon.

- Services of a radiologist or pathologist.
- Services of an emergency room physician.

Surgical benefits

After the deductible is met, the plan pays covered expenses for the surgical services described in this section at 100% for network charges or 80% for non-network charges. The services must be performed on an outpatient basis or during a hospital stay that has been approved by CCO, as explained on page 12.

- Surgical procedures, including customary preoperative and postoperative services, performed by a physician or surgeon. (Voluntary sterilization surgery is covered but reversal of sterilization surgery is not.)
- The necessary services of an assistant surgeon who actively assists the physician in surgery when:
  - You or your covered dependent is hospitalized.
  - The type of surgery requires assistance.
  - The services of interns, residents or house officers are not available.
  - Payment for assistant surgeons will be at 25% of the primary surgeon's usual, customary and reasonable charge.
- Medical supplies required for surgery in a hospital, a hospital's outpatient department, a physician's office or a freestanding ambulatory surgical facility.
- When more than one surgical procedure is performed at the same operative session and *through the same incision*, payment for the secondary procedures will be limited to 50% of the usual, customary and reasonable charge that would apply if the procedures were performed independently. However, additional charges for "incidental surgery" are not covered. Incidental surgery is a procedure that is usually included in the primary surgery charge.
- Oral dental surgery due to an accident, impacted teeth or alveolectomy.
- Surgical benefits for the following procedures may be covered, subject to approval by CCO:
  - Surgery for treatment of temporomandibular joint dysfunction (TMJ) if necessary to reorient the joint.
  - Reduction mammoplasty, if medically necessary (not cosmetic).
  - Obesity, if you or your covered dependent is 160% or more of the desirable weight and conservative therapies have been tried and proven unsuccessful, and CCO has given prior authorization for the surgery.
  - Cosmetic or reconstructive surgery required for:
    - Repair of defects resulting from an accident that occurred while the patient was covered under the plan.
    - Replacement of diseased tissue that was surgically removed while the patient was covered under the plan.
    - Treatment of a birth defect.

When you fill a prescription at a CBN participating pharmacy, the plan will pay 85% of the cost of a brand-name drug, or 90% of the cost of a generic drug.

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

Managed second surgical opinion

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

If CCO recommends a second surgical opinion, the medical plan will cover 100% of the usual, customary and reasonable charge for the second opinion, after the deductible.

Expenses for a second or third surgical opinion that is not recommended by CCO are covered at 80% after the deductible.

Prescription drug benefits

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

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

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

CBN Network

Pharmacies participating in the CBN Network have agreed to provide discounts for participants in the company medical plan.

When you fill a prescription at a CBN participating pharmacy, the plan will pay 90% of the cost of a generic drug, or 85% of the cost of a brand-name drug if a generic equivalent is not available. Additionally, you may not have to file a claim when using a participating pharmacy —the pharmacy will usually file the claim directly with PCS for reimbursement. Simply show your health plan ID card to the pharmacist, and you will pay only your percentage share that applies to the discounted price for the drug.

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

Nonparticipating pharmacies

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

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

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

Covered drugs

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

The plan does not cover expenses for:

- Cosmetic products (such as topical applications for treatment of acne or wrinkles). If a drug such as Retin-A is prescribed for a person over age 26, you will be required to furnish proof of medical necessity.
- Any drug that is experimental or investigational, or one that is being used for a treatment that has not received final approval from the FDA.
- Any drug covered by workers' compensation.
- Digestive aids (unless they are needed to sustain a patient's life), minerals or other dietary supplements, taken orally or injected, regardless of whether they are prescribed by a physician. However, vitamins prescribed for certain conditions, such as prenatal vitamins, may be eligible if approved by CCO.
- Prescriptions for birth control devices or birth control pills (unless these are being used for other than contraceptive purposes, and pre-approval has been given by CCO).

Certain drugs require prior approval from CCO. If your doctor prescribes any of the following, you must contact CCO at 1-800-848-2625 and receive a prior authorization before the plan will pay benefits for:

- Contraceptive medication. (Covered only with specific diagnosis and when medically necessary. Drugs used for birth control are not covered.)
- Smoking-cessation aids.
- Prescription vitamins.
- Rogaine or Minoxidil.
- Retin-A.
- Anorectics.
- Growth hormones.
- Fertility drugs.

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

If you have any questions about your prescription drug coverage, you may call PCS directly at 1-800-455-5690.

Home health care

The medical plan pays for home health care that follows inpatient hospital treatment if approved in advance through CCO. (See the section called *How to contact Coordinated Care Options* on page 14.) The home health care must be a necessary alternative to continued hospitalization. After you meet the annual deductible, the plan pays 100% of covered expenses for network charges or 80% for non-network charges.

Only prescription medicines and certain diabetic supplies are eligible for prescription drug benefits. Some prescription drugs require prior approval from CCO.

The medical plan pays for home health care that follows inpatient hospital treatment if approved in advance through CCO.

The plan helps pays for the cost of hospice care or care in a skilled-nursing facility, subject to limitations.

Eligible expenses from an authorized home health care agency include:

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

However, the following coverage limitations apply:

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

Benefits for home health care are not provided for:

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

Hospice care

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

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

After the deductible has been met, the plan pays for covered hospice care expenses at 100% for network charges or 80% for non-network charges. This is subject to the following special limitations:

- All hospice care benefits are limited to a lifetime maximum of $10,000 per individual.
- The care must be provided according to a physician's written treatment plan that has been approved in advance by CCO. (See the section called *How to contact Coordinated Care Options* on page 14.)
- Counseling for the family is covered up to a maximum of $200.

Benefits for hospice care are not provided for:

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

Skilled-nursing facility

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

- The care must be for the continued treatment of the same condition for which the participant previously received inpatient hospital care, and the patient must have been transferred directly to the skilled-nursing facility from the hospital.
- The care must be provided according to a physician's treatment plan and approved in advance by CCO. (See the section called *How to contact Coordinated Care Options* on page 14.)
- The care must require the skills of a registered nurse.
- The care must be likely to result in a significant improvement in the patient's condition. (Custodial care is not covered.)
- The degree of care must be more than can be given in the patient's home, but not so much as to require acute hospitalization.

Pregnancy

Necessary treatment of pregnancy is covered in the same way as an illness or injury for you and (if covered) your spouse. All the provisions and limitations of the plan, including the Coordinated Care Options program, also apply to pregnancy.

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

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

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

Benefits for other medical services

After you've met the deductible, the plan pays for the covered expenses listed in this section at 80% for network charges or 60% for non-network charges. Benefits increase to 100% of covered expenses after the out-of-pocket maximum is reached, as explained in the *Out-of-pocket maximum* section on page 16.

This section of the plan does not cover expenses that exceed the maximums given in other sections. For example, it does not cover expenses over the $50,000

Necessary treatment of pregnancy is covered in the same way as an illness or injury for you and your covered spouse.

maximum for treatment of mental illness and substance abuse, or the $10,000 maximum for hospice care.

The following expenses are eligible for benefits:

- Hospital expenses that aren't covered as inpatient or outpatient hospital benefits, such as chemotherapy, radiation therapy and kidney dialysis.
- Expenses you incur at your home, a clinic or your physician's office for the professional services of a physician or surgeon, including consultations by a qualified specialist.
- Expenses you incur for the services of a physician's assistant or nurse practitioner.
- Expenses incurred for the services of a registered nurse (RN) or licensed practical nurse (LPN), when the skills of an RN or LPN are required.
- The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye.
- Preventive and wellness care services for:
  - Routine care for newborns and children under age 5, including routine immunizations.
  - Pap tests, mammograms, screenings for hypertension and diabetes, and examinations for cancer, blindness and deafness, and other screening and diagnostic procedures.
  - Routine physician examinations, except for examinations required for admission to a school or for participation in sports. Routine immunizations are not covered after age 5, except for influenza vaccines.
- The fitting of diaphragms or the insertion or removal of an IUD. (Pharmacy charges for birth control pills or contraceptive devices are not covered.)
- Artificial insemination, when medically diagnosed as an appropriate treatment for infertility. However, the plan will cover artificial insemination for only one of the following, after which the plan will no longer pay benefits:
  - No more than three times within three consecutive cycles.
  - No more than a total of four attempts within a six-month period.

  In vitro fertilization and gamete-transfer procedures are not covered.
- Laboratory tests, radium therapy, X-rays and microscopic tests.
- Professional local ambulance services for transportation to a clinic, medical center, hospital for outpatient care, physician's office or skilled-nursing facility, when medically necessary.
- Blood and blood derivatives, to the extent they are not donated without charge or the hospital's supply is not replaced by or for the patient.

- Prosthetic appliances to replace missing or nonfunctioning parts of the body. Covered prosthetic appliances include:
  - Breast prostheses, internal and external (including a surgical brassiere, two per year), for reconstruction after a mastectomy.
  - Cardiac pacemakers, atomic or electronic.
  - Extraocular and intraocular lenses to replace either surgically removed or congenitally absent crystalline lenses of the eye.
  - Penile prosthesis in men suffering impotency resulting from an organic disease or injury.
  - Artificial eyes.
  - Artificial limbs.
  - Colostomy supplies and other equipment directly related to ostomy care.
  - Electronic speech aids after a laryngectomy.
  - Urinary collection and retention systems (Foley catheters, tubes, bags and so forth) in cases of permanent urinary incontinence.
  - Hearing aids for children under age 13 when medically necessary.

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

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

- Orthopedic devices, including:
  - Braces and trusses.
  - Custom-made and molded supportive orthotic appliances for the feet, when prescribed by a physician.
  - Custom-made shoes when prescribed by a physician.
  - Up to two pairs of surgical stockings per prescription in a six-month period, when prescribed by a medical physician for such conditions as thrombophlebitis, or conditions resulting from surgery.
- Rental of durable medical equipment for home use, up to its purchase price. CCO, at its option, may instead approve the outright purchase of the equipment if it is for long-term use.

  Home oxygen equipment, including stationary and portable oxygen systems, will be eligible for coverage according to Medicare guidelines up to the purchase price. Liquid oxygen systems, whether stationary or portable, must be approved by CCO in advance.

- Services of an inhalation therapist in the patient's home, under the orders of the attending physician.

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

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

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

- Cardiac rehabilitation for up to 12 weeks to restore health as much as possible, through exercise, education of the patient and reducing risk factors. To be eligible for benefits, cardiac rehabilitation must be provided within 12 months after one of the following:
  - An acute myocardial infarction (heart attack).
  - Coronary bypass surgery.
  - Stable angina pectoris (heart-related chest pains).

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

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

- Dental care for the initial repair of an accidental injury to sound natural teeth that occurs while the patient is covered under this plan.

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

Mental illness and substance abuse

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

Inpatient mental illness and substance abuse

The medical plan covers inpatient mental illness and substance abuse programs for up to 30 days per individual per year, not to exceed $20,000. After the annual deductible and the hospital copayment are met, covered expenses are paid at 100% for network charges or 80% for non-network charges. Also, the inpatient care must be approved by the Coordinated Care Options program, as explained on page 12.

Outpatient mental illness and substance abuse

For the first $1,000 of covered expenses, the medical plan pays 80% 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. Your share of these expenses does not count toward the out-of-pocket maximum.

Lifetime maximum

The plan pays a lifetime maximum per individual of $50,000 for all covered treatment of mental illness and substance abuse (inpatient and outpatient).

Covered services

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

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

EXCLUSIONS

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

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

- Convalescent care, custodial, domiciliary or sanitarium care or rest cures.
- Expenses from a continuous hospital confinement that began before a person's coverage under this plan became effective.
- Travel expenses.
- Expenses for any services you have no legal obligation to pay, or for which no charge would be made if you had no medical coverage.
- Expenses in excess of usual, reasonable and customary charges.
- Expenses for the plan's penalties for failure to precertify a hospital admission, or for hospitalizations that

The plan pays a lifetime maximum per individual of $50,000 for all covered treatment of mental illness and substance abuse (inpatient and outpatient).

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

exceed the length of stay approved by the coordinated care options program.

- Institutional care, when the covered individual does not have to be an inpatient to receive medically effective care.

- Services in connection with any intentionally self-inflicted injury.

- Services or supplies in connection with treatment that the claims administrator determines to be experimental or investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational if any of the following applies:

  - There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.

  - When required by the FDA, approval has not been granted for marketing.

  - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes.

  - The written protocol or written informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

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

  - The disease can reasonably be expected to cause death within one year, in the absence of effective treatment, and all other, more conventional methods of treatment have been exhausted.

  - The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the claims administrator will take into account the results of a review by a panel of independent medical professionals, selected by the claims administrator.

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

- Any expenses that are not medically necessary for the treatment of an illness or injury.

- Procedures that are not needed when performed with other procedures, or unlikely to provide a physician with additional information when used repeatedly.

- Procedures that are not ordered by a physician, or not documented in timely fashion in the patient's medical record.

- Any services provided before the effective date of coverage, or after coverage ends.

- Services in connection with transsexual surgery.

- Accidental bodily injury or illness caused by war or any act of war, whether or not declared, including armed aggression, participation in a riot, or attempted felony or assault.
- Accidental bodily injury or illness that is covered by any workers' compensation or occupational disease law.
- Except as required by law, expenses from a U.S. government hospital or any other hospital operated by a government unit, unless there is an expense that the covered individual is legally required to pay.
- Services in connection with any treatment of the teeth, gums or alveolar process, except:
  - Dental care for the initial repair of an accidental injury to sound natural teeth that occurs while you are covered by this plan.
  - Oral dental surgery due to an accident, impacted teeth or alveolectomy.
  - Hospital expenses when a physician, other than a dentist, certifies that hospitalization is necessary to protect the life or health of a patient because of a specific medical condition.
- Surgery for the purpose of fitting or wearing dentures or dental implants.
- Any medical observation or diagnostic study when no illness or injury is revealed, unless you provide the claims administrator with satisfactory proof that the covered person had definite symptoms of illness or injury other than hypochondria. This limitation does not apply to benefits for preventive care services listed under *Benefits for other medical services.*
- Hearing aids (except for children under age 13), or for their prescription or fitting.
- Vision training, eyeglasses and contact lenses or examinations for their prescription or fitting, except:
  - The initial pair of eyeglasses after surgery, if the surgery changes the refractive ability of the eye.
  - Contact lenses, as long as the contacts are for the replacement of the eye's lenses.
  - Vision training following eye surgery.
- Physical and speech therapy that is educational in nature.
- Supervised exercise programs that are not traditionally medical in nature, such as swimming, horseback riding, etc.
- Cosmetic treatment, except:
  - To repair defects resulting from an accident that occurred while covered under the plan.
  - Replacement of diseased tissue that was surgically removed while covered under the plan.
  - Treatment of a birth defect.

- Actual or attempted impregnation or fertilization that involves the covered individual as a surrogate or donor, or the pregnancy of a surrogate mother.
- Expenses in connection with assisted reproductive technology or "ART." ART means any combination of chemical or mechanical means of obtaining gametes and placing them in a medium (whether internal or external to the human body) to improve the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer or pronuclear state tubal transfer. Artificial insemination is covered by the plan, subject to the limitations described under *Benefits for other medical services.*
- Expenses for reversals of sterilization procedures.
- Home obstetrical delivery.
- Expenses for abortion, unless medically necessary to protect the life of the mother.
- Charges for more than one ultrasound test for a normal, uncomplicated pregnancy.
- Adoption expenses.
- Charges incurred as a result of a pregnancy of a dependent child.
- Birth control devices or birth control pills, unless used for other than contraceptive purposes and approved by the plan.
- Digestive aids (unless they are needed to sustain a patient's life), vitamins, minerals or other dietary supplements, taken orally or injected, regardless of whether they are prescribed by a physician. Vitamins are covered only as described under *Prescription drug benefits.*
- Hypnosis and acupuncture.
- Naturopathic or holistic services.
- Massage therapy or rolfing.
- Treatment, instructions, or activities for control or reduction of weight, except medical treatment approved by CCO or surgery for morbid obesity as described under *Surgical benefits* on page 19.
- Expenses for telephone conversations with a physician in the place of an office visit, for writing a prescription or for medical summaries and preparing medical invoices.
- Marriage counseling, encounter or self-improvement group therapy and school-related behavioral problems.
- Treatment received from a person who is your close relative or ordinarily resides with the patient. A "close relative" means you, your spouse or a person related to you or your spouse as a brother, sister or parent.

- Services by a licensed chiropractor, whether or not the services are covered by the chiropractor's license.
- Any care that does not require the services of a specifically trained medical professional.
- Routine foot care, including but not limited to treatment of corns and calluses, and nonsurgical treatment of bunions.
- Eye surgery for a condition that could be corrected with lenses instead, including but not limited to radial keratotomy—unless it's the plan administrator's opinion that no other treatment is medically acceptable, and the plan administrator determines that the surgery is a generally approved procedure in the medical community as a whole.
- Expenses for an autopsy or postmortem surgery.
- Transportation for delivery of home health care.
- Dentures, replacement of teeth or structures directly supporting teeth.
- Electrical continence aids, anal or urethral.
- Wigs or hairpieces.
- Implants for cosmetic purposes.
- Penile prostheses for psychogenic impotence.
- Personal comfort or service items for use during confinement in a hospital, including but not limited to a radio, television, telephone and guest meals.
- Services or supplies not specifically listed under *Covered medical expenses*, including but not limited to:
  - Air conditioners, humidifiers, dehumidifiers, purifiers or tanning booths.
  - Over-the-counter orthopedic or corrective shoes.
  - Exercise equipment.
- Medical care, services or supplies for any injury that may have been caused by the act or omission of a third party, unless the covered individual has fully complied with the plan's subrogation provision. (See the section called *The plan's right to recover payment from third parties [subrogation]* on page 35.)
- Services or supplies related to a preexisting condition, to the extent that such a condition would have been excluded if you had remained covered under the Peabody Group Salaried Plan.
- Claims received more than 12 months after the date the services or supplies were received.

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

Claims Procedures

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

Blue Cross Blue Shield participating providers and participating pharmacies will file their claims directly with the plan. For all other providers you must file a claim.

Prescription drug claims must be submitted to PCS at the address shown on the PCS claim form. A separate claim form is required for each family member.

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

1. Obtain a claim form and envelope from your benefits department. Claims for prescription drugs must be filed using the PCS claim form.

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

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

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

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

4. If you or your dependents are also covered by another medical plan through your spouse's or dependent's employer, you must attach a copy of the other plan's explanation of benefits to your bill before submitting it. Refer to the *Coordination of benefits section* for more information.

   Remember—you should keep a copy of all bills you submit.

5. Submit medical claims to the address shown on the medical claim form.

Prescription drug claims must be submitted to PCS at the address shown on the PCS claim form. A separate claim form is required for each family member.

However, if you also have prescription drug coverage through another plan that is your primary plan (as described in the *Coordination of benefits* section), you must submit your claim for secondary benefits from our plan to:

Alliance Blue Cross Blue Shield
P.O. Box 66952
St. Louis, Missouri 63166-6952
Attention: COB Drug Department

It is very important to remember to address your claim to the COB Drug Department in order for it to be processed in a timely manner.

Remember that before any hospital admission, you must call the Coordinated Care Options program (CCO) for precertification. The telephone number is on the back of your ID card. You must also call CCO within two working days of any emergency hospitalization.

If any part of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things you can do to appeal the decision.

Most of your questions can be answered quickly and efficiently by either calling the claims administrator at 1-800-848-COAL (2625) or writing at the address given at the *Plan administration information* section on page 45. Formal claim-review procedures are also discussed in that section.

PAYMENT OF BENEFITS

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

If you use a nonparticipating provider and provide proof that you've paid that provider in full, the benefit payment will be made to you. Otherwise, payment will go directly to your provider.

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

RECOVERY OF EXCESS PAYMENTS

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

THE PLAN'S RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

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

PAYMENT OF BENEFITS TO PERSONS OTHER THAN YOU

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

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

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

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

If you use a nonparticipating provider and provide proof that you've paid that provider in full, the benefit payment will be made to you. Otherwise, payment will go directly to your provider.

The plan may provide or obtain any information necessary to carry out the plan's provisions.

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

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

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

If the plan administrator takes any action, you will not be responsible for any legal fees, settlements, judgments or other expenses the plan administrator incurs to resolve the matter. (Legally, you are said to be "held harmless" for these responsibilities.) The plan administrator will control the negotiation or legal defense, including decisions whether to settle the claim or to appeal any legal decisions. However, you may be liable for any services or supplies from the provider that are not covered by the plan.

The "hold harmless" provision will not apply until you meet your annual out-of-pocket maximum for covered medical expenses. In other words, if you use a non-network provider and are billed more than the usual, customary and reasonable amount, you will be responsible for these charges until you reach the out-of-pocket maximum.

The "hold harmless" provision may apply before you reach the out-of-pocket maximum if you live outside the network area, or if you are treated by a non-network provider because no network provider is available. However, you are responsible for paying those expenses unless you complete a "hold harmless" release form.

If you use a network provider, you do not have to worry about the "hold harmless" provision, because network providers' fees have already been negotiated.

If you go to a network provider and are "balance billed"—meaning you are billed any additional amount beyond the deductible, coinsurance or hospital copayment, or charged the difference between the full amount and the discounted network amount—please call Alliance Blue Cross Blue Shield at 1-800-848 COAL (2625). The Alliance Blue Cross Blue Shield representative will contact the provider.

RIGHT TO AUDIT

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

Coordination of Benefits

All coverage under this plan ends if you become covered under another employer's group health plan as an employee. However, a coordination of benefits (COB) provision applies if you or your dependents are covered by a group plan through your spouse's or dependent's employer.

If you have coverage under a plan provided through your spouse's or dependent's employer, the benefits paid by our company plan will be reduced by the amount of the other plan's payment.

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

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

EFFECT OF MEDICARE

If you or your dependent is eligible for Medicare, the company plan is the primary plan (it pays benefits first) and Medicare is secondary (it pays benefits second, under the COB provision).

THE PLAN'S RIGHT TO NECESSARY INFORMATION

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

THE PLAN'S RIGHT TO MAKE PAYMENTS TO OTHER ORGANIZATIONS

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

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

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

This provision applies if the plan pays benefits because of an injury for which a third party may be liable (such as in an auto accident caused by a third party). In such cases, you have the right to pursue a claim for damages against the third party. If you fail or refuse to pursue the damage claim

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

against the third party, the plan is entitled, if it chooses, to pursue the claim directly against the third party in order to recover the benefits the plan paid.

If either you or the plan obtains payment from the third party, the plan is entitled to be paid back for the benefits it paid on your behalf.

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

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

If you or your dependents fail or refuse to complete or sign any document that would assist the plan in pursuing its subrogation rights when requested by the plan, the plan will not be obligated to pay any benefits for the injury or condition.

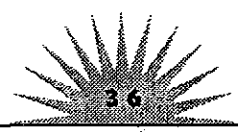
When Coverage Ends

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

- The plan is terminated.
- You retire and meet the definition of a retired employee.
- You (or your family member) become covered under a group health plan provided to you as an employee.
- You reach the end of your eligibility period as stated in your Voluntary Separation Agreement.
- If the plan is ever amended to require participant contributions, the date you fail to make the required contribution.

If you die while covered under this plan, your surviving spouse's coverage will continue until the end of your eligibility period as given in your Voluntary Separation Agreement. Dependent children are eligible as long as your surviving spouse is eligible, and they continue to meet the plan's definition of a dependent child.

Coverage for your dependents will end if they no longer meet the definition of an eligible dependent. However, coverage may be continued under certain conditions described in *Continuation of Coverage*.



Continuation of Coverage

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

- Divorce or legal separation.
- Your death.
- You become entitled to Medicare.
- Your dependent child reaches the age limit or otherwise ceases to qualify as a dependent.

Please note: If you die while covered under this plan, and your surviving dependents receive coverage at no cost until the end of the eligibility period in your Voluntary Separation Agreement (as noted under *When coverage ends*), the period of free coverage also counts toward the 36-month maximum for continued coverage.

WHEN CONTINUED COVERAGE ENDS

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

- The cost of continued coverage is not paid by the date it is due.
- Your dependent becomes covered under another group health plan, unless coverage under the other plan is limited due to the individual's pre-existing condition. Please notify your benefits department immediately if your dependent becomes covered under another group health plan.
- Your dependent becomes entitled to Medicare.
- The plan terminates for all employees.
- Thirty-six months have passed since the date of the event that caused your dependent's loss of coverage.

APPLYING FOR CONTINUED COVERAGE

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

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

COST OF CONTINUED COVERAGE

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

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

BENEFITS UNDER CONTINUED COVERAGE

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

Converting Medical Coverage to an Individual Policy

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

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

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

To convert coverage, you must submit a written application and the first premium payment to the designated insurance company within 31 days of the date your coverage ends. It is your responsibility to file your written application for conversion coverage. If you fail to make a timely application, coverage will be denied.

If you apply for conversion coverage, you or your covered dependents do not have to provide proof of good health. The policy will be effective on the day after your plan coverage ends.

Key Terms

AMBULATORY SURGICAL FACILITY

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

CLAIMS ADMINISTRATOR

The organization retained by the company for granting or denying claims, currently Alliance Blue Cross Blue Shield for medical claims, and PCS Health Systems, Inc., for prescription drug claims.

COMPANY

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

CUSTODIAL CARE

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

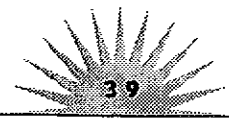
DURABLE MEDICAL EQUIPMENT

Equipment that meets all of the following conditions:

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

EDUCATIONAL INSTITUTION

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



EMERGENCY OR URGENT CARE

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

HOME HEALTH CARE

Services provided by either:

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

HOME HEALTH CARE AGENCY

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

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

HOSPITAL

An institution that meets all of the following conditions:

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

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

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

ILLNESS

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

INJURY

An accidental bodily injury caused directly and exclusively by sudden and violent means, and is not self-inflicted.

MEDICALLY NECESSARY

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

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

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

MEDICARE

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

MENTAL ILLNESS

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

PHYSICIAN OR SURGEON

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

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

PRE-EXISTING CONDITION

An injury or illness for which you or your covered dependent consulted with a physician, received treatment or took prescribed drugs or medicines in the three months before your coverage became effective under the Peabody Group Health and Life Plan for Salaried Employees, or any conditions related to that injury or illness.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

REGISTERED PSYCHOLOGIST

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

- If state licensing or certification exists, he or she must hold a valid license or certificate as a psychologist.
- If state licensing or certification does not exist, he or she must hold a valid, non-statutory (professional) certification established by that area's recognized psychological association.

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

RETIRED EMPLOYEE

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

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

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

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

SKILLED-NURSING FACILITY

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

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

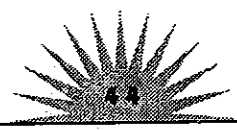
Skilled-nursing care is covered only as an alternative to hospitalization.

SPOUSE

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

SURVIVING SPOUSE

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



Plan Administration Information

PLAN NAME

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

TYPE OF PLAN

Medical coverage and prescription drugs.

EMPLOYER IDENTIFICATION NUMBER

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

PLAN NUMBER

518

EFFECTIVE DATE

December 1, 1995

PLAN FISCAL YEAR

January 1 to December 31

PLAN SPONSOR

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

You may direct correspondence to:
Peabody Holding Company, Inc.
701 Market Street, Suite 700
St. Louis, Missouri 63101-1826

PLAN ADMINISTRATOR

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

AGENT FOR SERVICE OF LEGAL PROCESS

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

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

Your ERISA Rights

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

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

ERISA provides that all plan members shall be entitled to:

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $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.

IF YOUR CLAIM IS DENIED

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

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

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

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

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

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

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

AMENDING THE PLAN

The company reserves the right to terminate the plan, change required contributions, or amend this plan in whole or in part at any time or for any reason, including changes in any and all of the benefits provided. This may cause participants to lose all or a portion of their benefits under the plan, but will not affect the right of any participant to be reimbursed for any covered expense that has already been incurred.

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

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