Peabody People

How we succeed

APPALACHIA SALARIED EMPLOYEE GUIDE TO

Basic, Supplemental and Dependent Life and Basic AD&D Benefits

JULY 2007

This booklet is a “summary plan description” (SPD) for the life and AD&D plans for eligible employees of Peabody Investments Corp. and designated affiliates and subsidiaries and are working in the Appalachia region in effect July 2007. A complete list of participating employers may be obtained upon written request to the Plan Administrator and may be examined at the principal office of the Plan Administrator and other work sites. This booklet supersedes any booklets previously issued to you.

Eligibility for benefits and the actual amount of benefit payments are determined by the individual insurance plan contracts and laws that govern the plan. This booklet describes the plan in easy-to-read, simplified terms. It cannot cover every detail of the plan. If there is a conflict between the description booklet and the insurance contract, the insurance contract will be followed.

The insurance company maintains the right to interpret the terms of this plan, and its interpretations will be final.

The company intends to maintain this plan for eligible employees, but reserves the right to change or end the plan at any time. This booklet is not a guarantee of employment or an employment contract.

If an employee speaks a language other than English, he or she may contact the local human resources office to request assistance with translating or interpreting the contents of this SPD.

Contents

Life and Accidental Death and Dismemberment Highlights

Basic Life Insurance Highlights

This coverage pays a benefit to your beneficiary in the event that you die. In the case of dependent life insurance, the benefit is paid to you.

WHO IS ELIGIBLE: This plan is made available to employees of certain designated subsidiaries and affiliates of Peabody Investments Corp. If you are classified by a participating employer as a full-time salaried employee working 35 or more hours per week, or a part-time salaried employee working a regular schedule of 20 or more hours per week year round and are working in the Appalachia region, you are eligible to participate in the Peabody Investments Corp. and its designated affiliates Welfare Benefit Plan. A complete list of participating employers may be obtained upon written request to the plan administrator and may be examined at the principal office of the plan administrator and other work sites. Temporary and seasonal employees as well as employees covered by collective bargaining agreement are not eligible.

BASIC LIFE BENEFIT AMOUNT: Your employer provides you with one and one-half times your base annual salary at no cost to you; this is referred to as “basic” life insurance. You may also purchase additional life insurance coverage equal to one, two, three, or four times your base annual salary; this is referred to as “supplemental” life insurance. In addition to basic and supplemental coverage for yourself, you have the option to purchase coverage for your dependents.

COST TO YOU: Your employer pays the full cost of basic life insurance coverage equal to one and one-half times your base annual salary. You pay the full cost of any supplemental life insurance you choose. The premiums will depend on your age, whether or not you use tobacco products and your coverage amount. You also pay the full cost of any dependent life coverage you choose.

IF YOU BECOME DISABLED: Your basic life insurance coverage continues if you meet certain conditions. Your benefit will be reduced at age 65, and again at age 70.

IF YOU RETIRE: If you are at least age 55 with 5 or more years of service (10 years prior to July 1, 2007), a reduced amount of basic life insurance coverage will be continued when you retire. Otherwise, coverage ends.

OTHER IMPORTANT POINTS: If your life insurance ends because your employment ends, or your coverage will be reduced due to your age, you may convert your coverage to an individual policy, with a benefit up to your original amount. You must then pay the entire premium.

Accidental Death and Dismemberment (AD&D) Insurance Highlights

This plan pays a benefit to your beneficiary if you die as a result of a covered accident or to you if you suffer certain injuries as a result of a covered accident. This benefit is paid in addition to any benefit you receive from the basic life insurance plan.

WHO IS ELIGIBLE: This plan is made available to employees of certain designated subsidiaries and affiliates of Peabody Investments Corp. If you are classified by a participating employer as a full-time salaried employee working 35 or more hours per week, or a part-time salaried employee working a regular schedule of 20 or more hours per week year round and are working in the Appalachia region, you are eligible to participate in this plan. A complete list of participating employers may be obtained upon written request to the plan administrator and may be examined at the principal office of the plan administrator and other work sites. Temporary and seasonal employees as well as employees covered by a collective bargaining agreement are not eligible.

COVERED LOSSES: Accidental death, paralysis, coma, loss of hands, feet, thumb and index finger, hearing, speech, or sight.

BENEFIT AMOUNT: Three times your base annual salary. The full amount is paid if you die as the result of a covered accident. All or part of the full amount is paid for other covered losses due to injuries, depending on the loss. Your benefit amount is reduced at certain ages, beginning at age 75.

COST TO YOU: None. The cost of your basic AD&D coverage is paid entirely by your employer.

IF YOU BECOME DISABLED: Coverage will end on the day you become eligible for long-term disability.

IF YOU RETIRE: Coverage will end on the day your employment ends.

OTHER IMPORTANT POINTS: You may continue your AD&D coverage when you are not working for your employer because you are on family or medical leave, if certain conditions are met.

Your employer also offers an optional AD&D plan if you would like to choose additional coverage. See your summary plan description booklet for the optional AD&D plan for more information.

Basic Life Insurance

A basic term life insurance benefit is provided to all eligible employees. Your employer pays the full cost of this coverage.

Eligibility

You are eligible for coverage if you are a full-time salaried employee working 35 or more hours per week, or part-time salaried employee working a regular schedule of 20 hours or more per week year-round of Peabody Investments Corp. or certain designated affiliates and subsidiaries and are working in the Appalachia region. Temporary and seasonal employees are not eligible. You will be automatically enrolled for basic life insurance equal to one times your base annual salary on your first day of employment.

If you are not actively at work due to illness or injury on the date your coverage would otherwise begin, your coverage will not be effective until you return to work.

Certain disabled and retired employees are also eligible, as explained in this section under “Coverage for Disabled Employees” and “Coverage for Retired Employees”.

Your Basic Life Insurance Benefits

If you die while covered by this plan, your beneficiary will receive an amount equal to one and one-half times your base annual salary, rounded to the next $100, to a maximum of $500,000. This is your basic life coverage amount.

When your base annual salary changes, the amount of your basic life insurance also changes. However, if you are not actively at work on the day your life insurance would increase, the additional amount will not be effective until you return to work.

Please note that the IRS requires that the “value” of your basic employee term life insurance coverage in excess of $50,000 be considered taxable income to you. This value is calculated according to an IRS table and will be reflected on the W-2 form that you receive each year.

Naming Your Beneficiary

You may designate anyone as the beneficiary of your basic life insurance. You may change your beneficiary at any time by filling out a form available from the Benefits Department.

The change will become effective when the completed form is received by the Benefits Department. It will be effective as of the date you signed the request, regardless of whether you are alive at the time the department receives it. However, any benefits that have been paid before the department receives the change form will remain the property of the person who received them, and will not be paid to the new beneficiary.

Payment of Benefits

Full payment of your coverage amount will be made to your beneficiary (or beneficiaries) upon your death. This payment will be in one lump sum unless your beneficiary chooses another payment option that may be offered by the plan, as explained under “Retained Asset Account”.

If you do not designate a beneficiary, or if your beneficiary dies before receiving your benefit payment, your benefit will be paid to your estate. However, instead of making payment to your estate, the insurance company may, at its option, pay the benefit in the following order:

- To your spouse.
- If you have no living spouse, to your children in equal shares.
- If you have no living children, to your parents in equal shares.
- If you have no living parents, to your brothers and sisters in equal shares.
- If you have no living brothers and sisters, to your estate.

The insurance company may also pay a portion of your benefit to anyone who it determines had assumed primary responsibility for your support or who incurred expenses for your last sickness and up to the time of your death.

If you die, your beneficiary should contact the Benefits Department to file a claim. Your beneficiary must provide a certified copy of the death certificate.

Retained Asset Account

An account called a “retained asset account” is automatically established for each beneficiary receiving a lump-sum benefit payment of $10,000 or more. The payment received by your beneficiary will be placed in this account. Beneficiaries receiving less than $10,000 will receive a single payment by check.

Your beneficiary may withdraw the entire amount from the account at once, or only a portion at a time (minimum of $250), leaving the balance to accumulate interest. Your beneficiary will also receive information about other ways to receive payment if he or she wishes.

Assignment of Benefits

If you wish, you may also “assign” your basic life insurance benefits to any individual as a gift. This is different from designating a beneficiary. The person who is “assigned” benefits then legally owns the insurance policy - you no longer have the right to change beneficiaries - and the benefit is taxed differently. Assignment is usually done for tax purposes. You may want to consult a tax adviser if you wish to learn more about this option.

A copy of the assignment request must be filed with the Benefits Department and approved by the insurance company.

Special Benefit for Terminal Illness

If you become terminally ill, you may choose to receive a portion of your basic life insurance in advance of your death. You can use this amount to help defray the costs associated with your condition.

“Terminal illness” means a medical condition that can be expected to result in death within 12 months.

This special benefit is subject to the following conditions:

- You may choose to receive up to 50% of your basic life insurance amount.
- You must be diagnosed by a physician as having a terminal illness. The insurance company may require a second opinion and examination.
- You may receive this benefit only once in your lifetime. The remaining part of your life insurance will be paid to your beneficiary when you die.
- You may not receive this benefit if you’ve previously made an assignment of benefits or irrevocable beneficiary designation, unless the assignee or beneficiary agrees in writing in a form acceptable to the insurance company.
- This accelerated benefit does not apply if you are required by law to use such benefits to meet the claims of creditors or as a condition of receiving a government entitlement or benefit.

When Your Coverage Ends

Your basic life insurance coverage ends when the earliest of the following occurs:

- The plan is terminated.
- The date of your death.
- The date your employment ends.
- The date you are no longer eligible.
- The date you retire, if you do not meet the plan's specific definition of a retired employee.

You may continue your basic life insurance coverage when you are not working for your employer, under certain circumstances. If your employment ends due to a reduction in the work force, your employer may provide you with continued coverage, according to current policy, for three months after the end of the last month in which the reduction in work force occurred.

Your coverage also will be continued while you are on a leave of absence that's authorized under your employer's family and medical leave policy or any other approved leave of absence program.

Coverage for Disabled Employees

If you become disabled, your coverage will be continued while you are receiving benefits under your employer's disability plan.

Your basic life insurance coverage amount will be equal to the amount that was in effect immediately before the date your disability began (that is, one and one-half times your base annual salary). At age 65, or when you retire, your basic life insurance will be equal to 25% of your base annual salary at the time you became disabled. If this amount is more than $10,000, it will be reduced to $10,000 at age 70.

If your basic life insurance is reduced or discontinued, you may be able to convert these coverage amounts to an individual policy issued by the insurance company. Please see the section called "Converting to an Individual Policy".

Coverage for Retired Employees

If you are at least age 55 and have 5 or more years of service (10 years prior to July 1, 2007) when you retire, you may continue to participate in the plan.

If you are under age 70, your coverage amount is equal to 25% of your base annual salary as of the day before you retire.

If you are age 70 or older, your coverage amount is equal to 25% of your base annual salary as of the day before you retire, or $10,000, whichever is less.

If your basic life insurance is reduced or discontinued, you may continue your coverage under provisions explained under "Converting to an Individual Policy".

Portable Insurance Coverage Option

The portability feature of the plan offers you the option to continue your term life insurance coverage at group rates when you leave your employer, retire or are no longer eligible for the group plan because of a reduction in your work hours.

The portability option is available only if you are not sick or injured when you apply for the option. Sick or injured means you have a medical condition that has a material effect on life expectancy.

You must apply for the portability option and pay the first premium within 31 days after the date that coverage under the group plan ends.

If you are eligible, you may choose portable insurance coverage up to the lesser of the amount of insurance you had while covered under this basic life plan or $750,000. Portable life insurance includes the plan features described under “Special Benefit for Terminal Illness”.

The insurance company will notify you of changes to your premiums for portable life insurance. Your premium will change based upon your age and changes to the insurance company’s rates for portability coverage.

Coverage under the portability option ends when the *earliest* of the following occurs:

- The insurance company no longer offers the portability provision under this plan.
- The required premiums are not paid when due.

If you are not eligible for portable coverage, or portable coverage ends, then you may qualify for conversion coverage, as described in the following section.

Contact the Benefits Department for information on the portability option.

Converting to an Individual Policy

If your basic life insurance coverage ends because your employment ends, or if your coverage is reduced because you are a retired employee or disabled employee at age 65, you may buy individual coverage up to the amount of coverage you had before it ended or was reduced. You will not need to provide evidence of your good health.

You must submit your application for the individual policy to the insurance company and make the required premium payment within 31 days of the date your employment ended or your coverage was reduced.

If your basic life insurance plan is changed or ended, you can convert your coverage under the conditions described in the policy issued by your insurance carrier.

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

Contact the Benefits Department for information about how to convert your coverage.

Supplemental Life Insurance

In addition to the basic term life insurance benefit provided by your employer, eligible employees also have the option of adding supplemental term life coverage. The cost of coverage is determined by the amount of coverage you choose, your age and whether or not you use tobacco products.

Eligibility and Enrollment

You are eligible for coverage if you are a full-time salaried employee working 35 or more hours per week, or part-time salaried employee working a regular schedule of 20 hours or more per week year-round of Peabody Investments Corp. or certain designated affiliates and subsidiaries and working in the Appalachia region. Temporary and seasonal employees are not eligible.

If you choose to purchase supplemental life insurance, you must pay the full amount of the insurance premium. Your supplemental life insurance coverage does not become effective until you properly enroll and authorize contributions to be deducted in equal installments from your paycheck on an after-tax basis. Your coverage begins on the date you complete the enrollment process, if you do so within 31 days of the date you're hired.

Your cost for coverage is determined by:

- The amount of supplemental life insurance you choose;
- Your age as of January 1; and
- If you use tobacco products.

Your coverage may not become effective immediately if you are not actively at work due to illness or injury on the date your coverage would otherwise begin, or if your coverage choice requires evidence of good health, as explained in this section under "Requirements for Evidence of Good Health" and "Delayed Effective Date of Coverage".

Disabled and retired employees are not eligible to enroll in the supplemental life plan.

Your Supplemental Life Insurance Benefits

You may choose supplemental life insurance equal to one, two, three or four times your base annual salary, rounded to the next $100, subject to a maximum coverage amount of $500,000.

When your base annual salary changes, the amount of your supplemental life insurance also changes. This change is subject to the provisions under "Delayed Effective Date of Coverage".

Requirements for Evidence of Good Health

You have a wide variety of coverage choices under the supplemental term life insurance plan. However, the insurance company restricts the amount of coverage any one employee can choose without having to provide evidence of good health.

Supplemental life insurance coverage that is more than $300,000 requires evidence of good health.

Coverage in excess of this limit will not be effective until you complete a health questionnaire and the insurance company approves your application.

Changing Your Coverage Amount

If you do not enroll for supplemental life insurance coverage within 31 days after you start work, or if you choose supplemental life insurance coverage and later wish to increase or decrease your coverage amount, you may do so during the annual enrollment period with changes effective January 1, subject to evidence of good health requirements. You may also change your coverage amount if you have a change in family status, provided you submit the proper change forms within 31 days of the event. You may increase your supplemental life insurance subject to the provisions described under “Requirements for Evidence of Good Health” and “Delayed Effective Date of Coverage”. You may decrease your coverage to any level at these times.

Situations that qualify as a change in family status are:

- An employee’s marriage or divorce.
- The birth or adoption of an employee’s child.
- The death of an employee’s spouse or children.
- Relocation by the employee to another site that has a different benefit plan than that available to and chosen by the employee at his or her original location.
- Other events related to family status that are permitted by law.

“Change in family status” does not include termination of employment or a reduction in hours that causes you to lose your eligibility for coverage by the plan.

Delayed Effective Date of Coverage

If you are not actively at work due to illness or injury on the date your coverage would normally begin or be increased, your coverage (or the increase in coverage) will not be effective until you return to work.

Naming Your Beneficiary

You may designate anyone as the beneficiary of your supplemental life insurance. You may change your beneficiary at any time by submitting a written request to the Benefits Department.

The change will become effective when the written request is received by the Benefits Department. It will be effective as of the date you signed the request, regardless of whether you are alive at the time the department receives it. However, any benefits that have been paid before the department receives the change form will remain the property of the person who received them, and will not be paid to the new beneficiary.

Payment of Benefits

Full payment of your coverage amount will be made to your beneficiary (or beneficiaries) upon your death. This payment will be in one lump sum unless your beneficiary chooses another payment option that may be offered by the plan, as explained under “Retained Asset Account”.

If you do not designate a beneficiary, or if your beneficiary dies before receiving your benefit payment, your benefit will be paid to your estate. However, instead of making payments to your estate, the insurance company may, at its option, pay the benefit in the following order:

- To your spouse.
- If you have no living spouse, to your children in equal shares.
- If you have no living children, to your parents in equal shares.

- If you have no living parents, to your brothers and sisters in equal shares.
- If you have no living brothers and sisters, to your estate.

The insurance company may also pay a portion of your benefit to anyone who it determines had assumed primary responsibility for your support or who incurred expenses for your last sickness and death.

If you die, your beneficiary should contact the Benefits Department to file a claim. Your beneficiary must provide a certified copy of the death certificate.

Retained Asset Account

An account called a “retained asset account” is automatically established for each beneficiary receiving a lump-sum benefit payment of $10,000 or more. The payment received by your beneficiary will be placed in this account. Beneficiaries receiving less than $10,000 will receive a single payment by check.

Your beneficiary may withdraw the entire amount of the account at once, or only a portion at a time (minimum of $250), leaving the balance to accumulate interest. Your beneficiary will also receive information about other ways to receive payment if he or she wishes.

Assignment of Benefits

If you wish, you may also “assign” your supplemental life insurance benefits to any individual as a gift. This is different from designating a beneficiary. The person who is “assigned” benefits then legally owns the insurance policy - you no longer have the right to change beneficiaries - and the benefit is taxed differently. Assignment is usually done for tax purposes. You may want to consult a tax adviser if you wish to learn more about this option.

A copy of the assignment request must be filed with the Benefits Department and approved by the insurance company.

Exclusion

To the extent permitted by law, benefits will not be payable if your death results from, or is contributed to by suicide within 24 months after the date your coverage begins. This also applies to increases in your coverage amount.

Special Benefit for Terminal Illness

If you become terminally ill, you may choose to receive a portion of your supplemental life insurance in advance of your death. You can use this amount to help defray the costs associated with your condition.

“Terminal illness” means a medical condition that can be expected to result in death within 12 months.

This special benefit is subject to the following conditions:

- You may choose to receive up to 50% of your supplemental life insurance amount.
- You must be diagnosed by a physician as having a terminal illness. The insurance company may require a second opinion and examination.
- You may receive this benefit only once in your lifetime. The remaining part of your supplemental life insurance will be paid to your beneficiary when you die.
- You must continue to pay premiums on the full original amount of your life insurance.
- You may not receive this benefit if you’ve previously made an assignment of benefits or irrevocable beneficiary designation, unless the assignee or beneficiary agrees in writing in a form acceptable to the insurance company.

- This accelerated benefit does not apply if you are required by law to use such benefits to meet the claims of creditors or as a condition of receiving a government entitlement or benefit.

When Your Coverage Ends

Your supplemental life insurance coverage ends when the earliest of the following occurs:

- The plan is terminated.
- If you stop making required contributions, the last day of the period for which you paid them.
- The date of your death.
- The date you begin receiving benefits under your employer's long-term disability plan.
- The date your employment ends.
- The date you are no longer eligible.
- The date you retire.

You may continue your coverage while you are on an approved leave of absence including your employer's family and medical leave policy, provided you continue to pay the required contributions. If you choose not to continue your coverage during your leave, you will not be required to provide evidence of good health to reinstate your coverage when you return to work.

Portable Insurance Coverage Option

The portability feature of the plan offers you the option to continue your term life insurance coverage at group rates when you leave your employer, retire or are no longer eligible for the group plan because of a reduction in your work hours.

The portability option is available only if you are not sick or injured when you apply for the option. Sick or injured means you have a medical condition that has a material effect on life expectancy.

You must apply for the portability option and pay the first premium within 31 days after the date that coverage under the group plan ends.

If you are eligible, you may choose portable insurance coverage up to the amount of insurance you had while covered under this supplemental life plan. You may increase your coverage amount (up to the plan's maximum) if you furnish evidence of good health. Portable life insurance includes the plan features described earlier in this section under "Special Benefits for Terminal Illness".

The insurance company will notify you of changes to your premiums for portable life insurance. Your premium will change based upon your age and changes to the insurance company's rates for portability coverage.

Coverage under the portability option ends when the earliest of the following occurs:

- The insurance company no longer offers the portability provision under this plan.
- The required premiums are not paid when due.

If you are not eligible for portable coverage, or portable coverage ends, then you may qualify for conversion coverage, as described in the following section.

Contact the Benefits Department for information on the portability option.

Converting to an Individual Policy

If your supplemental life insurance coverage ends because your employment ends, or because you are a retired or disabled employee, you may buy individual coverage up to the amount of coverage you had before it ended. You will not need to provide evidence of good health.

You must submit your application for the individual policy to the insurance company and make the required premium payment within 31 days of the date your coverage ended.

If the supplemental life insurance plan is changed or ended, you can convert your coverage subject to the conditions described in the policy issued by the insurance carrier.

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

Contact the Benefits Department for information about how to convert your dependent life insurance coverage.

Dependent Life Insurance

In addition to basic and supplemental life insurance, eligible active employees have the option of purchasing life insurance coverage for their dependents.

You must pay the full cost of the coverage. This cost is determined by which dependents you choose to cover and how much life insurance you select.

Eligibility

You are eligible to enroll your dependents for coverage if you are a full-time salaried employee working 35 or more hours per week, or part-time salaried employee working a regular schedule of 20 hours or more per week year-round of Peabody Investments Corp. or certain designated affiliates and subsidiaries and are working in the Appalachia region. Temporary and seasonal employees are not eligible.

The following dependents are eligible for coverage under the dependent life insurance plan:

- Your lawful spouse, including a legally separated spouse. You may cover your spouse as a dependent even if your spouse is enrolled for coverage as an employee.
- Your unmarried dependent children who are under age 19. (Children are eligible from the date of live birth.)
- Your unmarried dependent children who are under age 25 if they are full-time students, enrolled in an accredited school, and dependent on you for principal support and care.

Eligible children include:

- Your natural and adopted children.
- Your stepchildren.

Eligible dependents also include the following. The children listed below must depend upon you for his or her main support and care and must live with you in a parent-child relationship

- Foster children.
- A child placed with you for adoption.
- A child for whom you have been appointed as legal guardian.

No person may be covered as a dependent of more than one employee. A child cannot be covered as an employee under the plan.

Disabled dependents are not eligible for coverage under the plan. Your dependent's coverage will begin on the date your eligible dependent no longer is totally disabled.

Enrollment

If you choose to purchase dependent life insurance, you must pay the full cost of the insurance premium. Your dependent life insurance coverage will not become effective until you properly enroll and authorize contributions to be deducted from your paycheck. Your dependent's coverage begins on the date you sign an enrollment form, if you do so within 31 days of the date you are hired. This is subject to the section called "Delayed Effective Date for Dependent Coverage".

Disabled employees are not eligible to enroll in the dependent life plan. However, employees who become disabled after they enroll may continue their dependent life coverage for six months provided the employee remains covered by the basic life insurance plan.

Your Dependent Life Insurance Benefits

If you select life insurance coverage for your spouse, you have two coverage amount options: $10,000 or $20,000.

If you choose life insurance coverage for your dependent children, you have two coverage amount options: $5,000 or $10,000.

The cost to cover your dependent child(ren) is the same, regardless of the number of children you have.

Your choice of whether you cover your spouse, if any, is separate from your choice of whether to cover your children. You may cover your spouse only, children only, or neither.

If you choose to purchase dependent life insurance, you must pay the full amount of the insurance premium. Your dependent life insurance coverage does not become effective until you properly enroll and authorize contributions to be deducted in equal installments from your paycheck on an after-tax basis. Your coverage begins on the date you complete the enrollment process, if you do so within 31 days of the date you're hired.

Changing Your Coverage Amount

If you do not enroll for dependent life insurance coverage within 31 days after you start work, or if you choose dependent life insurance coverage and later wish to increase or decrease your coverage amount, you may do so only:

- During the annual enrollment period, with changes effective January 1, or
- If you have a change in family status, provided you submit the proper change forms within 31 days of the event causing the change.

You may add, change, or drop dependent life coverage at these times. However, if you are adding coverage for a spouse who was previously eligible but not enrolled in the plan, coverage for your spouse will be limited to the $10,000 option. The option for a dependent will be limited to $5,000. During the following annual enrollment, you may increase the spouse coverage amount to $20,000 and dependent coverage to $10,000 without having to provide evidence of insurability.

Situations that qualify as a change in family status are:

- An employee's marriage or divorce.
- The birth or adoption of an employee's child.

- The death of an employee's spouse or children.
- A change in your spouse's employment.
- Other events related to family status that are permitted by law.

"Change in family status" does not include termination of employment or a reduction in hours that causes you to lose your eligibility for coverage by the plan. Changes to coverage may be delayed as described in the next section, "Delayed Effective Date for Dependent Coverage".

Delayed Effective Date for Dependent Coverage

If you are not actively at work on the date your dependent's coverage would normally begin or increase, such coverage or increase will be delayed until you return to active employment.

If your dependent is totally disabled when coverage would normally begin or increase, such coverage or increase will not start until the date he or she is no longer disabled. *This limitation does not apply to a newborn child, provided you enroll the child for dependent life insurance within 31 days of his or her birth*.

Exclusion

To the extent permitted by law, benefits will not be payable if your spouse or child's death results from, or is contributed to by suicide within 24 months after the date your coverage begins. This also applies to increases in your spouse's or child's coverage amount.

Special Benefit for Terminal Illness

If your spouse or child is terminally ill, you may choose to receive a portion of their life insurance amount in advance. These provisions are similar to those for your own terminal illness, which are explained in the supplemental life insurance section under "Special Benefit for Terminal Illness".

Beneficiary and Payment of Benefits

You are automatically the beneficiary of your dependent's life insurance under the plan. If one of your covered dependents dies, full payment of his or her coverage amount will be paid to you. This payment will be made in one lump sum.

If you are not living at the time of your dependent's death, the benefit will be paid to your estate. However, instead of making payments to your estate, the insurance company may at its option pay the benefit in the following order:

- To your spouse.
- If you have no living spouse, to your children in equal shares.
- If you have no living children, to your parents in equal shares.
- If you have no living parents, to your brothers and sisters in equal shares.
- If you have no living brothers or sisters, to your estate.

If your dependent dies, you should contact the Benefits Department to file a claim and provide a certified copy of the death certificate.

When Dependent Life Insurance Ends

Your dependent's life insurance will end when the earliest of the following occurs:

- The plan is terminated.
- The date your employment ends.
- If you stop making required contributions, the last day of the period for which you paid them.
- The date of your death.
- Your dependent ceases to satisfy the plan's definition of an eligible dependent.
- The date you retire.
- The date you begin receiving benefits under your employer's long-term disability plan.
- The date you are no longer eligible.

Portable Dependent Life Insurance Option

If you are eligible for the portable insurance coverage option as described in the supplemental life insurance section under "Portable Insurance Coverage Option" (when your life insurance ends under the group plan), you may also be able to continue your dependent's life insurance coverage on an individual basis at group rates. The maximum amount of continued dependent life insurance is based on the amount you select for yourself under the portability option of the basic and supplemental life insurance plan (up to 50% or 100% of your coverage amount, depending on applicable state law). The dependent life portability maximum cannot exceed the amount offered under the group plan. However, if you die while covered under this plan, your spouse may elect to port the amount of dependent life coverage in effect on your death.

The portability option is available only if your dependent(s) are not sick or injured when they apply for the option.

Also, dependent coverage under the portability option ends when your dependent no longer meets the definition of an eligible dependent. Refer to the section called "Portable Insurance Coverage Option" in the supplemental life insurance section for more information about this plan feature.

If your dependent(s) are not eligible for portable coverage, or portable coverage ends, then your dependents may qualify for conversion coverage as described in the following section.

You or your dependent should contact the benefits department for information on the portability option.

Converting Dependent Life Insurance to an Individual Policy

If your dependent's life insurance coverage ends because of any of the following reasons, your dependent may buy individual coverage up to the amount of coverage he or she had before the insurance was terminated:

- You die or your employment ends.
- You are no longer a member of an eligible class.
- Your dependent no longer meets the definition of an eligible dependent.

If the life insurance plan is changed or ended, a dependent can convert coverage subject to the conditions described in the policy issued by the insurance carrier.

Your dependent will not need to provide evidence of good health. Your dependent must submit an application for the individual policy to the insurance company and make the required premium payment

within 31 days of the date coverage ended. If your dependent dies within the 31-day period after coverage ended but before the dependent's individual policy is issued, his or her benefit will be paid.

You or your dependent should contact the Benefits Department for information about how to convert dependent life insurance coverage.

Basic Accidental Death and Dismemberment Insurance

In addition to the basic term life benefit, eligible employees will also receive a basic accidental death and dismemberment (AD&D) benefit. Eligible employees may choose to add additional AD&D coverage, which is covered in a separate summary plan booklet.

Eligibility

You are eligible for coverage if you are a full-time salaried employee working 35 or more hours per week, or part-time salaried employee working a regular schedule of 20 hours or more per week year-round of Peabody Investments Corp. or certain designated affiliates and subsidiaries and are working in the Appalachia region. Temporary and seasonal employees are not eligible. You will be automatically enrolled for AD&D insurance on your first day of employment.

Your employer pays the full cost of this coverage.

If you are not actively at work due to illness or injury on the date your coverage would otherwise begin, your coverage will not be effective until you return to work.

Your Basic AD&D Benefits

Your AD&D coverage amount is three times your base annual salary, rounded up to the next $1,000. For example, if you were to die as a result of a covered accident and were earning $40,010 a year, your beneficiary would receive $121,000. The maximum amount of coverage available is $3,000,000.

When your base annual salary changes, the amount of your AD&D coverage also changes. However, if you are away from work due to a disability, your AD&D coverage will not be increased until you return to work.

Reduction of Coverage at Certain Ages

Your AD&D coverage amount will be reduced when you reach certain ages, according to the following table:

Age	Percentage of Original Coverage Amount
75–79	65%
80–84	45%
85 and older	30%

Covered Losses

You will receive all or a portion of your AD&D coverage amount if you suffer a covered loss within 365 days of an accident. These benefits are paid in addition to any other amount you receive under the life insurance plans.

The covered losses are:

- Death.
- Loss of a foot or hand, actual severance through or above an ankle or wrist joint.
- Actual severance through or above the metacarpophalangeal joint of the thumb or index finger;
- Total and permanent loss of sight;
- Total and permanent loss of speech; or
- Total and permanent loss of hearing.

The table below shows the percentage of your AD&D coverage amount that the plan pays for each type of covered loss.

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

For Loss of	Percentage of Total Coverage Amount
Life	100%
Both hands or both feet	100%
One hand and one foot	100%
One hand or one foot plus the loss of sight of one eye	100%
Sight of both eyes	100%
Speech and hearing	100%
Speech or hearing	50%
One hand, one foot, or sight of one eye	50%
Thumb and index finger of the same hand	25%

Paralysis Benefit

You will receive all or a portion of your AD&D coverage amount if you sustain a covered injury to the spinal chord within 365 days of an accident. The table below shows the percentage of your AD&D coverage amount that the plan pays for each type of covered paralysis.

“Paralysis” means a permanent, complete and irreversible paralysis as determined by a competent medical authority. Proof of total paralysis may be required on a periodic basis. “Arm” means the entire arm, and “leg” means the entire leg.

If you suffer more than one type of paralysis or other injury due to the same accident, only one benefit amount, the largest, will be paid.

Type of Paralysis	Percentage of Total Coverage Amount
Quadriplegia (total paralysis of both arms and both legs)	100%
Triplegia (total paralysis of both legs and one arm or both arms and one leg)	75%
Paraplegia (total paralysis of both legs or both arms)	66%
Uniplegia (total paralysis of one arm or leg)	50%

Exposure and Disappearance

The plan covers loss of life caused by unavoidable exposure to the elements, such as severe weather, just as it does any other accidental loss.

Also, if you disappear because the vehicle in which you were a passenger disappears, sinks or wrecks and your body is not found within one year, you will be considered to have suffered loss of life, and the appropriate AD&D benefits will be paid to your beneficiary.

Coma Benefit

If you are rendered comatose as a result of and within 365 days of a covered accident, and remain in the coma for a period of at least 31 consecutive days, the plan will pay a monthly benefit of 1% of your AD&D coverage amount to your beneficiary. This coma benefit does not apply to the first 31 consecutive days of the coma. This benefit will end on the earliest of the following dates:

- The date you are no longer in a coma that directly resulted from the injury;
- The date you received a monthly coma benefit for 100 months; or
- The date the total payments from the plan equal 100% of your AD&D coverage amount.

For the purposes of this benefit, “comatose” or “coma” means a profound state of unconsciousness from which you cannot be aroused, even by powerful stimulation, as determined by a competent medical authority. In no event shall the total amound paid for all benefits resulting from the accident exceed your insured amount.

Rehabilitation Benefit

If you suffer an injury that causes you to receive an AD&D benefit you are eligible for rehabilitation training. The plan will reimburse you for covered rehabilitative training expenses that you incur within two years after the date of the accident that caused your injury. An additional amount will be paid for the reasonable and customary expenses actually incurred for rehabilitation training in an amount equal to the lesser of:

- The actual expenses that are incurred within two years of the accident;
- $25,000; or
- 10% of the principal amount of your AD&D benefit for all injuries caused by one accident.

Covered rehabilitative expenses are expenses that meet the following conditions:

- Rehabilitation training means a treatment program that is prescribed by a licensed physician acting within the scope of his or her license and is approved by the insurance company prior to rehabilative training services being scheduled.
- Is required as a result of your covered injury; and,
- Prepares you for an occupation that you would not have engaged in except for the injury.
- Reasonable and customary are the common charges for similar treatment, supplies or services in the area where the expense is incurred. If common charges for a service cannot be determined due to the unusual nature of such service, a determination of the amount paid will be made based upon: 1) the complexity involved; 2) the degree of professional skill required; and 3) all other pertinent factors. The insurance company reserves the right to make the final determination of what is reasonable and customary.

Charges that would not have been made if you did not have this insurance are excluded. Additionally, expenses that are paid by workers’ compensation or other similar laws are excluded.

Seat Belt Benefit

If you die as the result of an automobile accident for which an accidental death benefit is payable, and you were wearing a properly fastened, original, factory-installed or manufacturer authorized and installed seat belt or lap and shoulder restraint when the accident occurred, the plan will pay your beneficiary an additional benefit of 10% of the principal sum to a maximum of $50,000. This will be paid in addition to the accidental death and dismemberment benefit for loss of life.

At the time of the accident you must have been driving or riding as a passenger in any private passenger automobile designed for use primarily on private roads.

Verification of the actual use of the seat belt or lap and shoulder restraints must be by an official law enforcement report for the accident, through certification by the investigation officers; or by other reasonable proof, acceptable to the insurance carrier.

Travel Assistance Coverage

The illness coverage provided under the travel assistance coverage applies only to this section.

In addition to paying a benefit for covered losses, the plan also offers you certain assistance services while you are traveling. These special services apply in you are 100 miles or more away from home.

Medical Evacuation

If you become ill or suffer an injury while on a covered trip and are being treated in a hospital, medical facility, clinic or by a medical provider which based upon the insurance company's evaluation cannot provide medical care in accordance with Western Medical Standards, the insurance company will arrange for, and cover the cost for your transport to the nearest hospital or medical facility which can provide such care. The insurance company must be contacted prior to the transport and pre-authorization must be obtained. You must call Zurich Travel Assist in the US and Canada, toll free, 1-800-263-0261. Outside the US and Canada, call collect (416) 977-0277 to pre-authorize transport coverage. No transport coverage will be arranged for and/or covered without the prior recommendation of the attending physician and prior authorization. The insurance company has the sole right to determine the scheduling, mode of transportation and the special equipment and/or personnel which are covered.

Medical Repatriation

If you become injured or ill on a covered trip and have sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to your health, the insurance company will arrange for, and cover the cost for your transport to your principal residence or to your residence in the country where you are currently assigned (at your option). You must call Zurich Travel Assist in the US and Canada, toll free, 1-800-263-0261. Outside the US and Canada, call collect (416) 977-0277 to pre-authorize transport coverage. No transport coverage will be arranged for and/or covered without the prior recommendation of the attending physician and prior authorization. The insurance company has the sole right to determine the scheduling, mode of transportation and the special equipment and/or personnel which are covered.

Non-Medical Repatriation

If you become injured or ill on a covered trip and have sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to your health, the plan will pay for the increase in cost to change the travel date on the return flight and/or for an upgrade in seating to your principal residence or country where you are currently assigned. You must contact the insurance company to pre-authorize transport coverage and to obtain an agreed upon change in travel date and/or upgrade for coverage as recommended by your attending physician. You must call Zurich Travel Assist in the US and Canada, toll free, 1-800-263-0261. Outside the US and Canada, call collect (416) 977-0277 to pre-authorize transport coverage. The upgrade determination will be subject to the insurance company's sole discretion.

Return of Remains

If you die while on a covered trip, the plan will pay and make arrangements for local preparation of the body for transport or cremation, (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. You must call Zurich Travel Assist in the US and Canada call, toll free, 1-800-263-0261. Outside the US and Canada call collect (416)977-0277 to pre-authorize preparation services and transportation of the body for coverage to apply.

Visit to Hospital

If you are scheduled to be hospitalized for more than 7 consecutive days while on a covered trip, the plan will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person you choose to visit while you are hospitalized. You must call Zurich Travel Assist in the US and Canada call, toll free, 1-800-263-0261. Outside the US and Canada call collect (416)977-0277 to pre-authorize transportation of the visitor coverage to apply.

Return of Child

If you are traveling with a child who is under 19 years of age or a child who prior to age 19 became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon you for support and maintenance while on a covered trip and due to your illness or injury your dependent(s) are left unattended, the plan will arrange for, and cover the cost to transport the dependent(s) by a regularly scheduled economy class air flight to the location of your choice and for an attendant, if applicable. You must call Zurich Travel Assist in the US and Canada call, toll free, 1-800-263-0261. Outside the US and Canada call collect (416)977-0277 to pre-authorize transportation of the dependent(s) and attendant, if applicable for coverage to apply.

Return of Companion

If you are traveling with a companion while on a covered trip and if you become ill or injured and you cannot complete the covered trip as scheduled, the plan will pay the lesser of the change fee for the companion's return air flight or a one way economy class flight, whichever is less. You must call Zurich Travel Assist in the US and Canada call, toll free, 1-800-263-0261. Outside the US and Canada call collect (416)977-0277 to pre-authorize such costs for coverage to apply.

Right of Recovery

The insurance company has the right to recover any benefits which have been paid under the plan if you or any covered person recovers any money from a third party for the expenses incurred by the insurance company which were covered under the travel assistance coverage. The insurance company has a right to be reimbursed from such recovery and a lien may be placed against any amount recovered by a third party. The insurance company may recover any benefits paid to you or a covered dependent for transportation services and /or expenses which were not covered under the travel assistance coverage.

Exclusions and Limitations

The plan will not provide benefits for services under the travel assistance coverage for a loss excluded under the "Exclusions and Limitations" section on page 21 or if:

- The covered trip was undertaken for the specific purpose of securing medical treatment.
- The injuries or illness requiring medical services resulted from the covered individual being under the influence of any controlled substance unless the medication was prescribed by a physician and the medication was taken in accordance with the physician's order.
- With respect to medical evacuation, the medical care was not provided consistent with Western medical standards. The insurance company has sole discretion in making that determination.
- In the event of medical evacuation, it must be medically necessary to transport the covered individual to another hospital or medical facility. The insurance company has sole discretion in making that determination.
- Based upon the medical condition of the covered individual and/or local conditions and circumstances, the insurance company determines that medical evacuation or medical repatriation is not appropriate.
- Any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan, the insurance company will be fully and completely excused from performance under the plan.
- The transportation and/or services were not pre-authorized.

The insurance company has the sole authority to determine medical necessity and standards listed above.

Reservation of Rights

The insurance company reserves the right to suspend, curtail or limit coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God, or refusal of authorities to permit the insurance company to provide services in any country for which a travel warning has been issued by the Department of State of the United States of America.

Naming Your Beneficiary

You may designate anyone as the beneficiary of your AD&D benefits, and you may change your beneficiary at any time by obtaining a form from the Benefits Department.

The change will become effective when the Benefits Department receives the completed form. It will be effective as of the date you signed the request, regardless of whether you are alive at the time the benefits department receives it. However, benefits that have been paid before this plan receives the change form will remain the property of the person who received them, and will not be paid to the new beneficiary.

Exclusions and Limitations

The plan will not cover any losses that are caused by contributed to, or resulted from:

- Sickness, disease or infections of any kind, except for pyogenic infections resulting from an injury.
- War or act of war whether declared or not, occurring in certain countries as indicated in the contract.
    - Within the states of the United States of America (including the District of Columbia), Afghanistan, Algeria, Chechnya, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, North Korea, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syria, Turkey, United Arab Emirates, Yemen or the employee's country of residence.
- Suicide, attempted suicide, except while insane.
- Riding as a passenger in (including getting in or out of) any aircraft not intended or licensed for the transportation of passengers.
- Involvement in any type of active military service.
- Purposely self-inflicted wounds.
- Pregnancy, including childbirth, but not including complications resulting from childbirth.
- Travel or flight in certain aircraft or conveyance.
- Travel or flight in covered aircraft or conveyance being used for certain purposes.

Payment of Benefits

All benefit payments will be made automatically to you or your beneficiary.

If you do not designate a beneficiary or if your beneficiary predeceases you or dies at the same time as you, your benefit payment will be made to the beneficiary you named for the group life insurance policy. If there is no beneficiary named for your group life insurance policy or the named beneficiary predeceases you or dies at the same time as you, your benefit payment will be paid in the following order:

- To your legally married spouse.
- If you have no living spouse, to your children in equal shares.
- If you have no living children, to your parents in equal shares.
- If you have no living parents, to your brothers and sisters in equal shares.
- If you have no living brothers and sisters, to your estate.

When Your Coverage Ends

AD&D coverage ends when the earliest of the following occurs:

- The plan is terminated.
- The date of your death.
- The date your employment ends
- The date you retire.
- The date you are no longer eligible.
- The date you begin receiving benefits under your employer's long-term disability plan.

Your coverage will be continued while you are on an approved leave of absence that's authorized under your employer's family and medical leave policy.

Filing Claims

You or your authorized representative must give the Benefits Department written notice of the covered loss within 90 days of such loss. Within 15 days after the Benefits Department receives notice, you or your authorized representative will receive a Proof of Loss Form. If you do not receive the Proof of Loss Form within 15 days after submitting notice, we will accept a detailed written report of the claim and the extent of loss. Failure to furnish acceptable proof of loss within the 90 day time frame will neither invalidate nor reduce any claim if it is not reasonably possible to furnish proof of loss and the proof was provided as soon as reasonably possible.

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

If you die, your beneficiary should contact the Benefits Department to file a claim. Your beneficiary must provide a certified copy of the death certificate, including the coroner's report, if applicable. The insurance company also reserves the right to perform an autopsy unless it is forbidden by law.

Terms and Definitions

Base Annual Salary

The amount you earn each year in base salary according to the company's records, excluding any overtime pay, bonuses, special allowances or salary for foreign service, awards from any special compensation plan or similar plans, payments under any other employee benefit plans or any other company compensation.

Beneficiary

The person you designate to receive payment of your life insurance or accidental death benefit.

For dependent life insurance, the employee has been designated as the beneficiary.

Company

Peabody Investments Corp.

Competent Medical Authority

An individual licensed to diagnose and treat illnesses, prescribe and administer drugs and medicines, or perform surgery.

Employee

Full-time salaried employees of Peabody Investments Corp. or certain designated affiliates and subsidiaries and are working in the Appalachia region 35 or more hours per week, or part-time employees working a regular schedule of 20 hours or more per week year-round. The definition of employee includes any employee while on vacation, or assignment by the company.

This definition does not include any temporary, seasonal or those employees covered by a collective bargaining agreement, or any person who is a non-resident alien and who receives no income from your employer that constitutes income from sources within the United States as defined by Section 861(a)(3) of the Internal Revenue Code.

Disabled Employee

Any employee who is receiving long-term disability benefits under the company's disability plan.

Family and Medical Leave

An approved leave of absence protected under the Family and Medical Leave Act of 1993 (FMLA).

Injury

Bodily injury or injuries directly resulting from a covered accident which is independent of all other causes and which occurs while you are covered under the plan.

Insurance Company

For basic, supplemental and dependent life insurance: UNUM Life Insurance Company of America.

For accidental death and dismemberment insurance: Zurich North American Commercial Insurance Company.

Plan

The Peabody Investments Corp. and its designated affiliates Welfare Benefit Plan.

Retired Employee

A former salaried employee who has separated from service from the employer due to retirement. To be considered a retired employee for the purposes of the plan, you must be age 55 with at least 5 years of service (10 years prior to July 1, 2007).

Surviving Spouse

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

Western Medical Standards

Generally accepted medical standards comparable to those in the United States, Canada or Western Europe.

Plan Administration Information

Plan Name
The Peabody Investments Corp. and its designated affiliates Welfare Benefit Plan.

Type of Plan
Life insurance, accidental death and dismemberment, medical, dental, vision care, flexible spending accounts and disability benefits. Medical, dental, vision, flexible spending accounts, optional AD&D, travel accident life insurance and disability are described in separate summary plan description booklets.

Employer Identification Number
The employer identification number assigned to the company by the Internal Revenue Service is 20-0480084.

Plan Number
501

Plan Fiscal Year
January 1 to December 31

Plan Sponsor
Peabody Investments Corp.
701 Market Street
St. Louis, MO 63101-1826

Plan Administrator
Peabody Investments Corp.
701 Market Street
St. Louis, Missouri 63101-1826
(314) 342-3400

The plan administrator has the responsibility and sole discretion to interpret the plan provisions, to resolve ambiguities and supply omissions, to make factual findings and apply the terms of the plan to specific situations.

With respect to life insurance and accidental death and dismemberment benefits, the plan administrator has delegated this authority to the insurance companies.

Insurance Companies

For basic, supplemental and dependent life insurance:

UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

For basic accidental death and dismemberment insurance:

Zurich North America Commercial
Zurich Towers
1400 American Ln.
Schaumburg, IL 60196

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 Investments Corp.
701 Market Street
St. Louis, MO 63101-1826
(314) 342-2400

Funding and Disbursements
Life and accidental death and dismemberment benefits are fully insured by the insurance companies named above. The plan administrator is not responsible for paying claims. Disbursements are made by the insurance companies in accordance with the terms of the group insurance policies.

Insurance premiums for employees and their families are paid in part by your employer out of general assets and by employee after-tax contributions.

Your ERISA Rights

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

Receive Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

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

Assistance with Questions

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, or if you need assistance in obtaining

documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Claims Procedures

If your claim is based on death or dismemberment the insurance company will make a determination on the claim within a reasonable period of time, but no longer than 90 days after the claim is received unless special circumstances require extra time for processing. If such a time extension is necessary, you will receive written notice before the end of the initial 90 days. This notice will tell you why additional time is needed and the date you can expect a final determination. This determination will be made within 90 days after the end of the initial 90-day period.

If your claim involves a determination as to whether you are disabled, the insurance company will make a determination on your claim within a reasonable period of time, but not later than 45 days after a claim is received. This time period may be extended for an additional 60 days, in the form of two 30-day extensions, when necessary due to matters beyond the control of the insurance company. You will be advised in writing of the need for an extension during the initial 45-day period and you will be notified of the need for a second extension of time before the end of the first extension period. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and any additional information needed to resolve those issues.

If the extension is needed because you failed to submit information necessary to decide the claim, the notice will specifically describe the needed information and you will be allowed 45 days from receipt of the notice to provide the additional information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

If either type of claim is denied in whole or in part, you or your beneficiary will receive a written notice that includes:

- The specific reason for the denial.
- A specific reference to the plan provisions on which the denial is based.
- A description of any additional material or information necessary for you to substantiate your claim and an explanation of why such material is needed.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
  - Your right to submit written comments and have them considered,
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.

In addition, if your claim involves a determination of disability and an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim, the notice will also provide:

- A description of the specific rule, guideline, protocol or criterion relied on, or
- A statement that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request.

Review of Denied Claims

If your claim is denied in whole or in part, you may appeal the denial of your claim to the insurance company.

If your claim involves death or dismemberment, this appeal must be made in writing within 60 days after you receive the written notice from the insurance company that your claim had been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial. If your claim involves waiver of premium, this appeal must be made in writing no more than 180 days after you receive the written notice from the insurance company.

Your written appeal should set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

If Your Claim is Based on Death or Dismemberment

The insurance company will review and decide your appeal within a reasonable period of time but no longer than 60 days after it is submitted. This time period may be extended for an additional 60 days if the insurance company determines that there are special circumstances that require an extension. You will be advised in writing of the need for an extension during the initial 60-day period and a determination will be made no more than 120 days after the date the claim was submitted.

If Your Claim is Based on a Determination of Disability

The insurance company will review and decide your appeal within a reasonable period of time but no longer than 45 days after it is submitted. This time period may be extended for an additional 60 days if the insurance company determines that there are special circumstances that require an extension. You will be advised in writing of the need for an extension during the initial 45-day period and a determination will be made no more than 90 days after the date the claim was submitted. If the extension is needed because you failed to submit information necessary to decide the claim, the period for deciding the appeal shall be tolled from the date on which the insurance company sends you notification of the extension until the date on which you respond to the request for additional information.

The review of each type of appeal will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial determination. In addition, the individual who decides your appeal will not be the same individual who initially decided your claim and will not be that individual's subordinate.

The insurance company may consult with a health professional in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the initial benefit determination nor be a subordinate of the health professional who was involved.

You will be notified in writing of the decision on appeal. If the decision on appeal upholds the initial denial of your claim, the notification will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- A statement of your right to bring a civil action under Section 502 of ERISA.

In addition, if your claim involves a determination of disability and an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim, the notice will also provide:

- A description of the specific rule, guideline, protocol or criterion relied on, or
- A statement that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request.

The decision of the insurance company is final and binding on all individuals dealing with or claiming benefits under the plan.

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. This authorization must be in writing and signed by you. Any reference in these claims procedures to "you" is intended to include your authorized representative.

Amending the Plan

The plan is adopted with the intention that it will be continued for the benefit of present and future employees of the company. However, the company reserves the right to terminate the plan, change required contributions, or to modify this plan in whole or in part at any time or for any reason, including changes in any and all of the benefits provided. This may cause employees to lose all or a portion of their benefits under the plan, but will not affect the right of any employee to be reimbursed for any covered expense that has already been incurred, or to which he or she has already become entitled under the plan.

This means that an employee cannot have a lifetime right to any plan benefit or to the continuation of this plan simply because this plan or a specific benefit is in existence at any time during the employee’s employment. This plan will comply with all requirements of the law and will be changed, if necessary, in order to meet any such requirement.