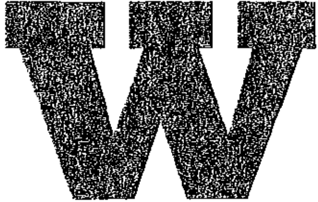
Your Benefit Keys

Everyone must complete the enrollment process!

Enrollment Guide 2005



ELCOME TO YOUR BENEFITS ENROLLMENT GUIDE FOR 2005. DURING THE ENROLLMENT PROCESS, YOU WILL MAKE SELECTIONS FOR THE COMING YEAR FOR MEDICAL, DENTAL, VISION, SUPPLEMENTAL EMPLOYEE TERM LIFE INSURANCE, DEPENDENT TERM LIFE INSURANCE AND OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) COVERAGE, LONG TERM CARE AS WELL AS TAX-FREE REIMBURSEMENT ACCOUNTS.

EACH FALL, YOU HAVE THE OPPORTUNITY TO REVIEW YOUR SELECTIONS AND MAKE ADJUSTMENTS IN YOUR COVERAGE TO MEET YOUR NEEDS FOR THE FOLLOWING YEAR. CAREFULLY CONSIDER YOUR OPTIONS AND COSTS, AND DECIDE WHAT'S BEST FOR YOU AND YOUR FAMILY BASED ON PERSONAL CIRCUMSTANCES AND NEEDS. YOU PAY YOUR SHARE OF THE COSTS THROUGH CONVENIENT PAYROLL DEDUCTIONS. OTHER BENEFITS ARE PAID COMPLETELY BY THE COMPANY.

THIS FALL, EVERYONE MUST COMPLETE THE ENROLLMENT PROCESS BY DECEMBER 3, 2004. FOR NEW HIRES, YOU MUST RETURN A PAPER ENROLLMENT FORM WITHIN 31 DAYS OF YOUR ELIGIBILITY DATE.

YOUR ENROLLMENT GUIDE IS YOUR KEY TO UNLOCKING INFORMATION ABOUT YOUR BENEFITS AND CHANGES TO THE PLANS FOR 2005. IT'S FILLED WITH CHARTS TO MAKE IT EASY FOR YOU TO DETERMINE THE BENEFIT PROGRAM THAT'S RIGHT FOR YOU.

Enrollment Guide

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What You Must Do to Enroll

It's important that you complete the enrollment process during the enrollment period. If you have access to the Peabody intranet, you must complete the online enrollment process by December 3, 2004. Your enrollment packet includes instructions for online enrollment. For employees who do not have online access, a completed enrollment form must be returned to the Peabody Benefits Office in St. Louis no later than December 3, 2004, or if you are a new employee, within 31 days of your eligibility date.

WHAT YOU NEED TO DO NOW

The following table summarizes the steps you need to take depending on your situation.

YOUR SITUATION	WHAT YOU NEED TO DO
You want to keep medical, dental, vision and all other coverage the same for 2005.	You must complete the enrollment process. If you do not, your current medical, dental, vision, supplemental life insurance, and optional AD&D will end on December 31, 2004 and you will forfeit the cash payment for the No Coverage medical option. You also will not be enrolled for the reimbursement accounts.
You want to change your medical coverage to another option, including the new Consumer Choice Option.	Complete the enrollment process indicating your election for 2005. You may choose any available option.
You are currently enrolled in Option 500.	This plan will not be offered in 2005. You must complete the enrollment process indicating your new medical election for 2005.
You want to elect the No Coverage medical option.	You must complete the enrollment process, including providing details on other coverage and completing a "Medical Waiver Statement." (If you do not, you will forfeit the cash payment.) If you decide to enroll in future years, your choice will be limited to Option 1000 unless you have a qualifying change in family status.
You want to enroll for medical or dental coverage for the first time, cancel medical coverage or add or drop a dependent from your coverage.	Complete the enrollment process. Medical benefits may be limited for pre-existing conditions. Dental benefits may also be limited.
You want to cancel dental coverage for 2005.	Complete the enrollment process. If you cancel dental coverage, your benefits will be limited if you decide to re-enroll at the next enrollment period.
You want to cancel optional vision coverage or enroll for optional vision coverage for the first time.	Complete the enrollment process. If you cancel your vision coverage, you will have to wait two years to re-enroll.
You want to change your supplemental life insurance.	Complete the enrollment process. You will be required to furnish evidence of insurability (proof of good health) to enroll or increase your supplemental life insurance.
You want to change your optional AD&D coverage level, or enroll for dependent term life coverage.	Complete the enrollment process indicating your election for 2005.
You want to participate in one or both reimbursement accounts for 2005.	Complete the enrollment process indicating the amount you want to deposit for 2005.

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IF YOU DO NOT ENROLL

Everyone must complete the enrollment process by December 3, 2004. **If you do not complete the enrollment process by the deadline, you will receive only basic life, accidental death and dismemberment, business travel accident and, for full-time employees, disability coverage.**

This means that effective January 1, 2005, all of your other current coverages will end and you will be enrolled for:

- No medical coverage, and you will forfeit the cash payment.
- No dental or vision coverage.
- No supplemental employee term life, dependent term life or optional AD&D coverage.
- No tax-free reimbursement accounts.

If you're a newly hired employee and you do not return an enrollment form within 31 days after your eligibility date, you will have only basic life, basic AD&D and business travel accident coverage. Default coverage for full-time salaried employees also includes eligibility for disability benefits. If you do not complete the enrollment process by the deadline, you will not be eligible to receive the cash payment that comes with the No Coverage election for medical.

YOUR CHOICES ARE BINDING FOR 2005

The choices you make during the enrollment period are binding for 2005. You will not have another opportunity to enroll, cancel or change your options or your dependent coverage choices until the next annual enrollment in the fall of 2005 (with changes effective January 1, 2006), unless you have a qualifying change in family status.

ANY QUESTIONS?

The steps you must take during the enrollment period are spelled out under *What You Must Do to Enroll* on page 3.

If you have questions concerning your 2005 enrollment, you may contact the Peabody Benefits Call Center by calling 1-800-633-9005 or sending an e-mail to **benefits@peabodyenergy.com**.

What's Changing in 2005

For 2005, there will be new choices that are available to you, as well as changes to some provisions within the plans. The changes are summarized below:

- You have a new option for medical coverage, called the Consumer Choice Option. This plan replaces Option 500. See pages 7-34 for details.
- When you select the Consumer Choice Option, you also will have a new tool to help you save for future medical expenses after retirement—the Retiree Choice Account. See pages 23-25.
- Under medical plan Option 250 and Option 1000, the plan will not change for network expenses. However, for non-network expenses, the annual deductible and the out-of-pocket maximum are increasing.
- Also under Option 1000, the special hospital copayment will be eliminated. The regular deductible, however, will still apply before the plan pays its share of covered charges. See page 10.
- You will have access to a new online tool to help guide your health plan enrollment decision. This Web-based tool is designed to help you understand your health care costs and how they affect your health care decisions and your family's finances. See pages 28-29.
- The annual limit to the amount you can elect to deposit to a health care reimbursement account is increasing to $5,000. This account lets you set aside before-tax money from your pay to help cover eligible health care expenses that aren't paid by insurance. See pages 52-54 for details. Also see pages 20-23 to learn more about how the health care reimbursement account can work with the new Consumer Choice Option.
- For 2005, the dental plan annual maximum benefit per person is increasing from $750 to $1,000. See more about the dental plan on pages 35-37.
- For dependent life insurance, a new child coverage option will be added for 2005. You will now be able to choose coverage of $10,000 for each child, or you may still choose the current $5,000 coverage level. See pages 44-45.
- If you become disabled on or after January 1, 2005, medical coverage will be limited to 36 months. This time period includes the time you are covered by short-term disability (STD) as well as long-term disability (LTD). See more about disability coverage on pages 49-51.
- For employees hired on or after January 1, 2005, a disability that begins within the first 12 months of long-term disability (LTD) coverage will not be covered if it is related to a pre-existing condition. A pre-existing condition will now be defined as a medical condition for which treatment, prescriptions or diagnosis was received within 12 months before your eligibility for LTD coverage. See page 50 for details.

Eligibility and Enrollment

If you are a full-time salaried employee, you are eligible for coverage. Part-time employees working a regular schedule of 20 or more hours per week are also eligible for benefits, except disability coverage. Temporary employees are not eligible. Pre-paid retirees are not eligible for disability or business travel accident coverage.

DEPENDENT ELIGIBILITY

You can obtain coverage for your eligible dependents under the medical, dental, vision, dependent term life and optional AD&D plans. Members of your family who are eligible for coverage include:

- Your spouse.
- Your children under age 19.
- Your children ages 19 to 23 if they are full-time students at an accredited school, college or university and depend on you for support (for optional AD&D and dependent term life, students under age 25 are eligible). You must provide proof of full-time student status each semester for your child to remain eligible.
- For participants in the GHP Access HMO (St. Louis only), eligible dependents through age 25 if they are full-time students at an accredited school, college or university and depend on you for support.
- For medical, vision, and optional AD&D coverage (but not dental coverage or dependent term life insurance), your disabled child, regardless of age, provided he or she is permanently incapable of self-support due to a mental or physical disability before the limiting age.

Your married children are not eligible for coverage under the plans. No one may be covered under the plans as both an employee and as a dependent, or as a dependent of more than one employee.

PAYING FOR COVERAGE

If you elect coverage, your contributions for medical, dental and vision will automatically be deducted in equal installments from each paycheck on a before-tax basis. Optional AD&D coverage is also paid on a before-tax basis and will automatically be deducted from each paycheck on the 15th of each month.

Your costs for long term care, supplemental employee term life and dependent term life coverage will be paid with after-tax dollars. Deductions for employee term life and dependent term life coverage will be taken out of your paycheck on the 15th of each month. Long term care will be deducted in equal installments from each paycheck.

Your Medical Keys

During annual enrollment, you choose the medical coverage you need for your family. Below are key features of the various options. See the following pages for details, including out-of-network coverage.

Consumer Choice Option
- High deductible plan paired with a company-provided account to help pay the deductible.
- Option to save money for health expenses during retirement.
- Your share of typical network expenses is 20%.
- Prescription drug benefits through Prescription Solutions (no deductible).
- Same PPO network as Option 250 through BlueCross BlueShield.

Option 250
- $250 annual deductible per person for network expenses.
- Your share of typical network expenses is 20%.
- Prescription drug benefits through Prescription Solutions (no deductible).
- PPO coverage through BlueCross BlueShield network.

Option 1000
- No cost for coverage (for full-time employees only).
- $1,000 annual deductible per person for network expenses.
- Your share of typical network expenses is 30%.
- Prescription drug benefits paid through BlueCross BlueShield of Illinois (subject to deductible).
- Same PPO coverage as other Option choices through BlueCross BlueShield network.

No Coverage
- You receive a $600 cash payment each year ($300 for part-time employees).

To locate providers who participate in the BlueCross BlueShield of Illinois network, go to www.bcbsil.com.

If you are an employee in the St. Louis office, you also have an HMO option available.

COVERAGE CATEGORIES

For any of the Option choices, you can select coverage for:

- Yourself only.
- Yourself plus one dependent.
- Yourself plus two or more dependents.

To cover a dependent for medical, you must also elect the same coverage option for yourself.

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COST FOR COVERAGE

The cost for coverage depends on how many dependents you choose to cover under the plan. The table below shows the 2005 monthly contributions for each dependent coverage level for full-time and part-time employees. The cost of coverage for the HMO plan (if available) is shown on your enrollment form.

The majority of the cost continues to be paid by the company. Active employees will share in any cost increases in subsequent years. For more on your costs after retirement, refer to the *Retiree Medical* section starting on page 56.

Before-Tax Monthly Contributions for Medical Plan Options

	YOURSELF ONLY	YOURSELF PLUS ONE DEPENDENT	YOURSELF PLUS TWO OR MORE DEPENDENTS
CONSUMER CHOICE OPTION			
FULL-TIME EMPLOYEES	$34.36	$137.16	$240.28
PART-TIME EMPLOYEES	$68.70	$274.30	$480.56
OPTION 250			
FULL-TIME EMPLOYEES	$34.36	$137.16	$240.28
PART-TIME EMPLOYEES	$68.70	$274.30	$480.56
OPTION 1000			
FULL-TIME EMPLOYEES		No cost to you	
PART-TIME EMPLOYEES	$0.00	$32.18	$113.46
NO COVERAGE			
FULL-TIME EMPLOYEES	You receive a $600 annual cash payment at the beginning of each year. You must have group health coverage from another source to elect this option.		
PART-TIME EMPLOYEES	You receive a $300 annual cash payment at the beginning of each year. You must have group health coverage from another source to elect this option.		

HOW YOU RECEIVE THE CASH PAYMENT

If you elect No Coverage, the cash payment will be added in a lump sum to a paycheck in January (or as soon as administratively possible). This payment will be subject to the same taxes as your regular pay. If you are a new hire and you elect No Coverage, you will receive a prorated amount of the cash payment based on when you enroll.

In addition, the following rules will apply if you leave the company or change your coverage before the end of the year:

- If you leave the company or retire during the year, you will have to repay a portion of the cash payment, based on when your employment ends. The repayment amount will be deducted from your last paycheck.
- If you elect No Coverage during the year (because you are decreasing your coverage due to a qualifying change in family status), you will receive a prorated amount of the cash payment based on when you elect the lower option.
- If you change your coverage from No Coverage to Consumer Choice Option, Option 250 or Option 1000 (due to a qualifying change in family status), you will have to repay a prorated amount of the cash payment, based on when you upgrade to the higher coverage.

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Comparing Your Options

The table below compares the features of the three medical options available. For St. Louis employees, you will receive more information during the enrollment period about an additional HMO option.

FEATURE	CONSUMER CHOICE OPTION		OPTION 250		OPTION 1000	
	NETWORK*	NON-NETWORK	NETWORK*	NON-NETWORK	NETWORK*	NON-NETWORK
Preventive Care	The plan pays 100% up to $250 per calendar year (no deductible)	The plan pays 60%	The plan pays 100% up to $250 per calendar year (no deductible)	The plan pays 60%	The plan pays 70% up to $250 per calendar year (no deductible)	The plan pays 50%
Primary Deductible	You pay: $250 yourself $500 yourself +1 $750 yourself +2	You pay: $500 yourself $1,000 yourself +1 $1,500 yourself +2	You pay: $250 per person	You pay: $500 per person	You pay: $1,000 per person	You pay: $2,000 per person
Employee Choice Account	The company provides: $750 yourself $1,500 yourself +1 $2,250 yourself +2		N/A	N/A	N/A	N/A
Secondary Deductible	You pay: $350 yourself $700 yourself +1 $1,050 yourself +2	You pay: $700 yourself $1,400 yourself +1 $2,100 yourself +2	N/A	N/A	N/A	N/A
Inpatient Hospital and Emergency Room and Other Medical Expenses**	The plan pays 80%	The plan pays 60%	The plan pays 80%	The plan pays 60%	The plan pays 70%	The plan pays 50%
Coinsurance Maximum (the most you pay each year for your percentage share of covered charges)	$1,100 yourself $1,350 yourself +1 $1,600 yourself +2 *Excludes primary deductible, Employee Choice Account and secondary deductible*	$2,200 yourself $2,700 yourself +1 $3,200 yourself +2	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum (the most you pay out of your pocket each year for your deductibles and your share of covered expenses)	$1,700 yourself $2,550 yourself +1 $3,400 yourself +2 *Includes primary and secondary deductibles and coinsurance maximum*	$3,400 yourself $5,100 yourself +1 $6,800 yourself +2	$1,700 per person $3,400 per family *Includes deductible*	$3,400 per person $6,800 per family	$4,500 per person $9,000 per family *Includes deductible*	$9,000 per person $18,000 per family
Lifetime Maximum Benefit	$1 million indexed annually for inflation (in 2005, limit is $2.2 million)		$1 million indexed annually for inflation (in 2005, limit is $2.2 million)		$1 million indexed annually for inflation (in 2005, limit is $2.2 million)	

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 Medical Services Advisory program. Benefits may be reduced if you don't comply.

* If you or a covered dependent lives outside the network area, benefits will be paid at network rates. Your eligibility records must be adjusted, however, or all claims will be processed as out-of-network. Contact the Peabody Benefits Call Center at 1-800-633-9005 or e-mail **benefits@peabodyenergy.com** for information and forms. ("Out-of-area" does not apply to prescription drugs.)

** Inpatient Mental Health and Substance Abuse benefits are limited to 30 days per calendar year and up to 60 days per lifetime. Outpatient Mental Health and Substance Abuse benefits are limited to 30 visits per calendar year and do not apply toward the out-of-pocket maximum. Emergency room copayment of $50 is required if care was not for a true emergency.

PRESCRIPTION DRUG BENEFITS

The table below shows what the various plans pay toward the cost of prescription drugs. The Consumer Choice Option and Option 250 both have the same prescription drug coverage. If you choose the Consumer Choice Option, you cannot use your Employee Choice Account to pay for prescription drugs. Under both the Consumer Choice Option and Option 250, your copayments do not count toward the annual deductible or the out-of-pocket maximum.

	CONSUMER CHOICE OPTION or OPTION 250		OPTION 1000	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
	Paid Through Prescription Solutions (no deductible or out-of-pocket maximum)		Paid Through BlueCross BlueShield of Illinois[1] (annual deductible and out-of-pocket maximum apply)	
Retail Generic Drugs[4] (30-day supply)	85%[2] $10 minimum copay	70%[2] $10 minimum copay	70% after deductible	
Retail Preferred Brand-Name Drugs[4] (30-day supply)	70%[2][3] $20 minimum copay – $75 maximum	60%[2][3] $20 minimum copay – $100 maximum	70% after deductible	
Retail Non-Preferred Brand-Name Drugs[4] (30-day supply)	50%[2][3] $40 minimum copay – $150 maximum	40%[2][3] $40 minimum copay – $200 maximum	70% after deductible	
Mail Service Pharmacy Generic Drugs[4] (up to a 90-day supply)	85% $10 minimum copay	N/A	N/A	
Mail Service Pharmacy Preferred Brand-Name Drugs[4] (up to a 90-day supply)	70%[3] $50 minimum copay – $200 maximum	N/A	N/A	
Mail Service Pharmacy Non-Preferred Brand-Name Drugs[4] (up to a 90-day supply)	50%[3] $100 minimum copay – $400 maximum	N/A	N/A	

[1] If your prescriptions are filled at a participating BlueScript pharmacy, you will receive discounts, and the pharmacy will file your claims for you. After you meet your annual deductible, BlueCross BlueShield of Illinois will reimburse 70% of the cost of each prescription for the rest of the calendar year (or 100% after you have met the annual out-of-pocket maximum). If you use a non-participating provider, you receive the same level of benefits, but you must file a claim for reimbursement with BlueCross BlueShield of Illinois.

[2] If you receive a maintenance drug from a retail pharmacy instead of using the Prescription Solutions Mail Service pharmacy, you will pay a $10 surcharge in addition to your regular coinsurance/copayment share of the cost.

[3] If you or your doctor requests a brand-name drug when a generic equivalent is available, you will pay the generic coinsurance plus the difference in cost.

[4] Minimum and maximum copays will be indexed for annual Peabody prescription drug inflation.

NEW CONSUMER CHOICE OPTION

For 2005, you have a new option for medical coverage, the Consumer Choice Option. Also referred to as a consumer-driven health plan, this type of plan is designed to engage you more fully in all aspects of your health care. What's more, the Consumer Choice Option also gives you the opportunity to save for health care during retirement.

This option combines a traditional medical plan with two special new accounts, called the Employee Choice Account and the Retiree Choice Account. Through the *Employee* Choice Account, the company provides you with an annual credit to support your health care needs as an active employee. A portion of any unused funds from this account can be rolled over at the end of the year to a *Retiree* Choice Account to be used toward health care expenses during your retirement.

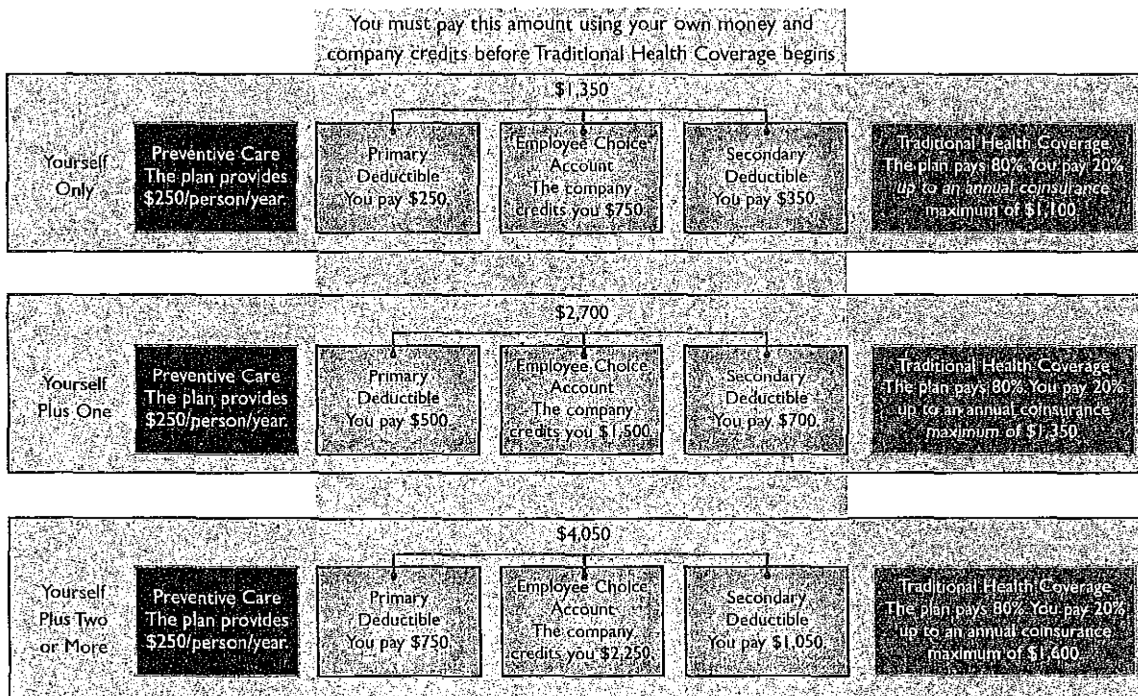
To lay the foundation for understanding this innovative approach to health coverage, begin with these key points:

1. You have the same monthly contributions as for Option 250.
2. You have the option to "save" or "spend" the company-provided credit in your Employee Choice Account each year. You "save" by choosing to use your own money to pay for expenses that would have been paid from the Employee Choice Account. (You also can "save" part of the credit and "spend" part.)
3. You have the opportunity to accumulate funds—tax-free—in your Retiree Choice Account to pay for health care expenses in your retirement. You also pay no taxes on the credit placed in your Employee Choice Account.
4. The Consumer Choice Option supplements your current Medical Premium Reimbursement (MPR) program, which allows you to earn a one-time company credit toward the purchase of your own health care policy when you retire. See page 56 for more details on the MPR program, which is being enhanced starting in 2005.
5. The amount of your deductibles, Employee Choice Account and certain plan maximums vary based on the coverage level you choose (yourself only, yourself plus one dependent, or yourself plus two or more dependents).

Highlights of the Consumer Choice Option

The diagram below summarizes how the Consumer Choice Option works:

CONSUMER CHOICE OPTION COVERAGE LEVELS



Amounts listed are for network services. See page 10 for non-network amounts.

HOW THE CONSUMER CHOICE OPTION WORKS

The diagram above summarizes how the Consumer Choice Option works. Following the diagram, each part of the plan—including the choice you can make to either "save" or "spend"—is described in detail.

Preventive Care: The Consumer Choice Option pays 100% of the cost of preventive care services (which include well-child care, routine physical exams, and related tests and screenings), up to $250 per covered person per calendar year, with no deductible, if you receive them from a BlueCross BlueShield of Illinois network provider. This works the same as Option 250.

Primary Deductible: You must pay a primary deductible before your Employee Choice Account (credited by the company) is available to you. The amount of your primary deductible depends on how many people you are covering, and whether you are using network or non-network providers (see chart on page 10). The primary deductible can be met with a combination of expenses from any or all family members. This is different from Option 250, which requires a separate deductible for each covered person.

Employee Choice Account: After you have met your primary deductible, you gain access to your Employee Choice Account. This account gives you the opportunity to choose how and when the dollars in your account are spent to pay for eligible medical expenses. The amount of credit the company provides each year varies based on how many dependents you are covering (see chart on page 10). The Employee Choice Account gives you the option to save money for the future if you do not need or want to use the money now ("save"). You also have the option to pay for medical needs now ("spend"). Here's a brief summary of how these two paths—"save" vs. "spend" differ.

"SAVE"	"SPEND"
If you choose to save all or a portion of your Employee Choice Account, the plan allows you to roll over the money to the following year, up to plan limits. The excess amount beyond these limits can be invested in an interest-bearing Retiree Choice Account to pay for health expenses during your retirement. See *How to Save* later in this section.	If you choose to spend your account value, you may use the value of your account to pay claims. If you use the entire amount during the year, you then pay for your additional medical expenses out of your pocket until you have met the secondary deductible (see below). See *How to Spend* later in this section.

The two paths are described separately above to help you understand the difference. But keep in mind many people may end up spending *part* of their account and saving the rest.

Secondary Deductible: After you meet your primary deductible and "spend" the money in your Employee Choice Account (or "save" by choosing to use your own money for medical expenses that would have been paid from your Employee Choice Account), you are responsible for paying any additional health care expenses you have until you meet the secondary deductible. It may be helpful to think of the primary deductible, the Employee Choice Account credit and the secondary deductible as one large deductible, as shown in the chart on page 13.

Traditional Health Coverage: After you've met the secondary deductible, the plan will provide coverage for any further expenses, just like a traditional health plan. The plan will pay for 80% of the cost of eligible services received from a network provider. You pay the other 20%, up to an annual "coinsurance maximum." The annual maximum you pay for your share of expenses depends on how many people you are covering, and whether you are using network or non-network providers (see chart on page 10). The primary deductible, secondary deductible, and amounts paid out of the Employee Choice Account *do not count* toward the coinsurance maximum.

HOW TO "SAVE"

If you do not use all the money in your Employee Choice Account in a year, you can roll over a certain amount of it into your Employee Choice Account for next year. This rollover amount will be used to pay for part of your secondary deductible for the following year (you must pay the primary deductible every year, even if you have an existing balance in your Employee Choice Account).

The maximum amount you can roll over from one year's Employee Choice Account to the next is:

- $250 if you have "yourself only" coverage,
- $500 if you have "yourself plus one" coverage, or
- $750 if you have "yourself plus two or more" coverage.

Any amounts remaining in your Employee Choice Account that are less than these amounts will remain in the account and be applied toward the next year's secondary deductible—they cannot be transferred to a Retiree Choice Account, described below.

Investing in a Retiree Choice Account

If you carry over the maximum toward next year's secondary deductible, the remaining amount in your Employee Choice Account will transfer to your Retiree Choice Account. You can use money from your Retiree Choice Account to reimburse yourself for medical expenses you incur during your retirement. Interest will be credited to your Retiree Choice Account based on the rate of interest earned by one-year U.S. Treasury bills. (This rate is subject to change based on business conditions.) See more details about the Retiree Choice Account on page 23.

Building Up Your Employee Choice Account

Each year that you elect coverage under the Consumer Choice Option, the company will credit the full annual amount to your Employee Choice Account. In other words, you will receive a credit of $750 if you have "yourself only" coverage, $1,500 if you have "yourself plus one" coverage, or $2,250 if you have "yourself plus two or more" coverage.

Keep in mind that the limits on the amount you can roll over each year mean that your secondary deductible for the following year will never be *completely* covered. There will be a small "gap" before the traditional coverage steps in. The amount of the gap depends on the coverage level you have chosen: $100 for "yourself only" coverage, $200 if you have "yourself plus one" coverage, or $300 if you have "yourself plus two or more" coverage.

If you enroll in the Consumer Choice Option and then switch to another option in a future enrollment period, you will forfeit any money that remains in your Employee Choice Account. (But you will not lose any money that has already been transferred to your Retiree Choice Account.)

Spending Before-Tax or After-Tax

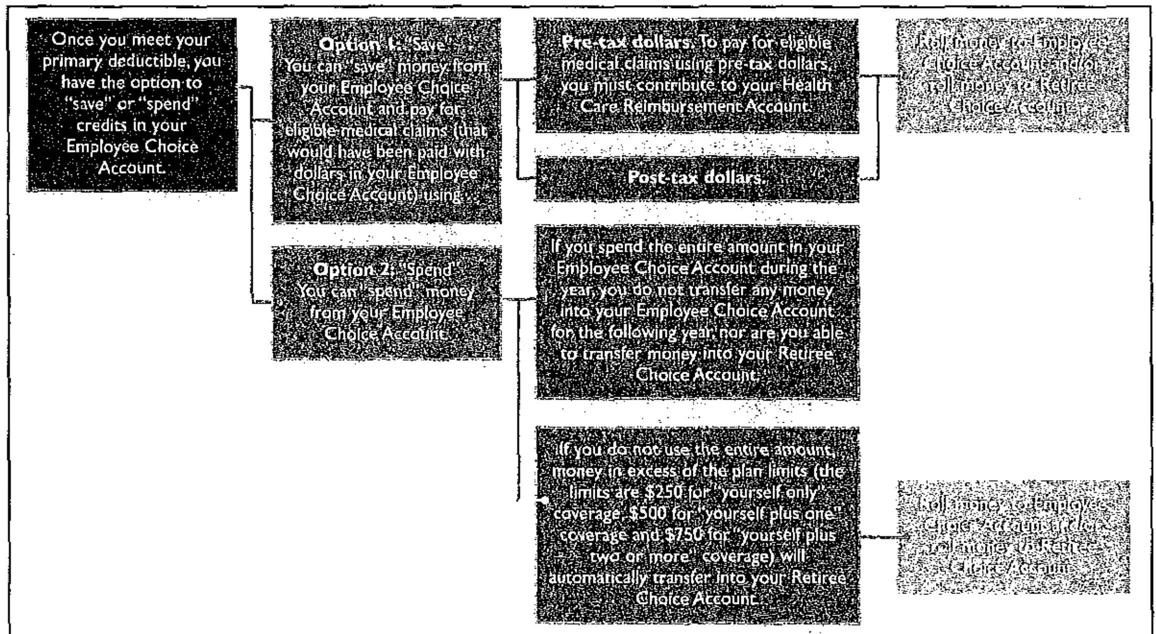
If you are choosing to "save" the money in your company-provided Employee Choice Account, this means you will be paying the full deductible out of your pocket. This full deductible includes the primary deductible, the amount of your Employee Choice Account and the secondary deductible. When you pay "out of pocket" in this manner, you have a choice to spend before-tax or after-tax dollars:

- **Spending before-tax dollars** means you can pay for eligible expenses using tax-free money. To do this, you must elect to contribute to a health care reimbursement account (also known as a "flexible spending account"). The company has offered this account for years, along with a similar version for dependent day care expenses (see page 53). If you use a health care reimbursement account along with the Employee Choice Account, there are several plan rules you'll need to understand. These are explained in more detail on page 20.
- **Spending after-tax dollars** simply means using your own cash. This may make sense if you have the cash flow to cover typical health expenses. In exchange, you have the opportunity to save the company-provided account for your retirement health care needs.

IS THE CONSUMER CHOICE OPTION RIGHT FOR YOU?

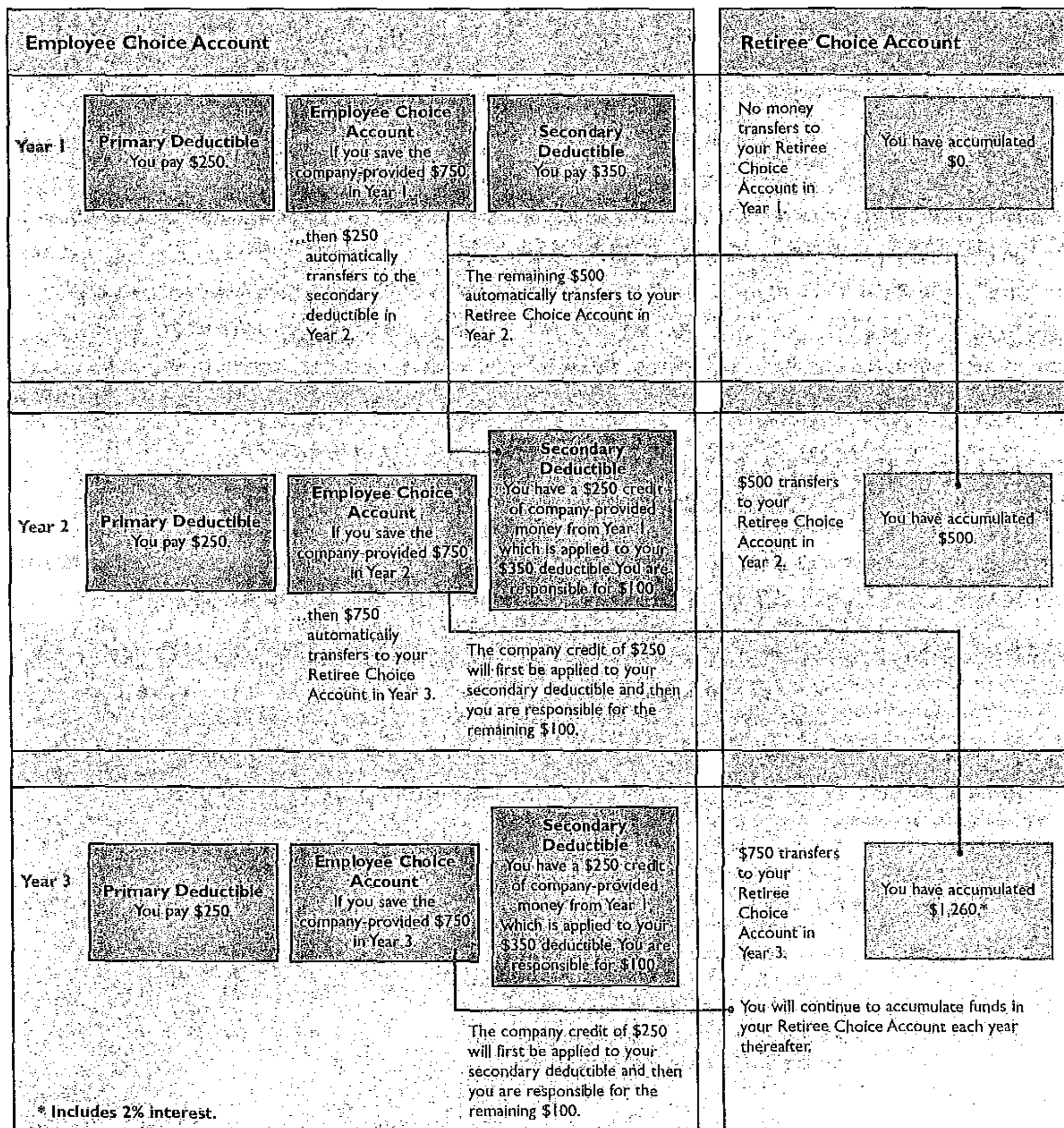
Now that you have a new medical plan option, you need to know if this is the right plan for your personal situation. The following decision tree examples may give you some ideas of how the plan works. This is just a sample—you should base your decision on your own situation.

When you elect the Consumer Choice Option, you choose how to pay for your medical services.



CONSUMER CHOICE OPTION—HOW THE MONEY TRANSFERS YEAR AFTER YEAR

If you think you are likely to follow a "save" strategy for your Employee Choice Account, it's important to understand how the dollars will flow from year to year. The diagrams below show how the transfers can work from Year 1 through Year 3, assuming "yourself only" coverage.



HOW TO "SPEND"

If you want to use your company-provided Employee Choice Account to pay for current medical expenses, you'll be following the "spend" option.

Once you meet your annual primary deductible, you can use money from your Employee Choice Account to pay for eligible medical expenses covered under the medical plan. If you use the entire amount in your Employee Choice Account during the year, you then pay for your additional medical expenses by meeting a secondary deductible. After that, traditional health coverage steps in, and you pay only your coinsurance (20% of charges for network services) until you reach your annual coinsurance maximum (see chart on page 10).

Under this scenario, you may use all of your annual Employee Choice Account credit. When you enroll again for 2006, you will receive another credit to replenish your account. But you could also have some money leftover. If so, you may still "save" a portion for the next year as described under "How to Save" on the previous page. With the Employee Choice Account each year, keep in mind you can only roll over or "save" up to $250 if you have "yourself only" coverage, up to $500 if you have "yourself plus one" coverage, or up to $750 if you have "yourself plus two or more" coverage. Any amounts in excess of these limits will automatically be transferred to a Retiree Choice Account to reimburse yourself for medical expenses during retirement (see details on page 23).

CONSUMER CHOICE OPTION VS. OPTION 250: HOW THE APPROACHES COMPARE

We understand that there's a lot to learn about the new Consumer Choice Option. So it may be helpful to compare it with Option 250 to see how the two plans differ in their fundamental approach.

	CONSUMER CHOICE OPTION	OPTION 250
Focus	The company provides a fixed amount each year, which you can choose to spend or save. This focuses attention on the full cost of health care coverage. It encourages you to seek preventive care and play an active role in managing your spending and/or savings.	After you meet an annual deductible, you pay a share of the cost. This focuses more on the portion of the expense you must pay. This plan also encourages you to seek preventive care.
Philosophy	This option lets you treat plan benefits like they are your own money. Unused amounts in your Employee Choice Account (ECA) can be rolled over to the next year's plan, up to certain limits. Beyond these limits, the extra amount can be shifted to a Retiree Choice Account for use during retirement. In combination with the Medical Premium Reimbursement Program, your savings can help provide health security during retirement.	Many people regret paying for "insurance" they never use. With traditional coverage, if you do not use the plan, you receive no benefit—you cannot build up cash value over time.

Enrollment Guide

	CONSUMER CHOICE OPTION	OPTION 250
Health Care for Retirement	In combination with the Medical Premium Reimbursement program, your savings can help provide more health security during retirement. You can use up to $5,000 per calendar year to pay for deductibles, coinsurance and copayments. You can also use it to purchase an individual health insurance policy.	You still have access to the Medical Premium Reimbursement program, but that only covers purchase of a policy, not out-of-pocket expenses for health care.
Deductibles	Although the plan has a high deductible before traditional health coverage steps in, you have a company-provided ECA to cover a portion of that deductible (if you choose to spend it). The deductible can be met with a combination of expenses from any or all family members.	The annual deductible is more modest, but it is completely your responsibility. What's more, each covered person meets an individual deductible before the plan pays a percentage of covered charges.
Coinsurance (Your percentage share of covered expenses)	If you spend your ECA for current health expenses, you will have 100% coverage for eligible charges while you are spending your ECA credit. After your credit is used up and you have met the secondary deductible, the plan pays a percentage of covered charges, the same as Option 250.	Until you reach your out-of-pocket maximum, Option 250 will never pay 100% of any expense (except preventive care). You will always have to pay a portion of the covered charge.
Out-of-Pocket Expenses	Traditional health coverage begins after you meet the full deductible (primary + ECA + secondary deductible). After the deductible, both plans pay 80% of covered network expenses while you pay 20%. Your 20% share is capped at a certain level, depending on how many people you are covering. This coinsurance maximum can be met with a combination of expenses from any or all family members. Both plans protect you from runaway health costs with an annual out-of-pocket maximum. See chart on page 10.	Option 250 coverage begins after you meet an annual deductible per person. After the deductible, both plans pay 80% of covered network expenses while you pay 20%. Both plans protect you from runaway health costs with an annual out-of-pocket maximum. See chart on page 10.
Cash Flow	If you choose to "save" your ECA and later have a large health care expense, such as for the birth of a baby or because of a serious accident, you may have to pay the full deductible (primary + ECA + secondary deductible) all at once before the traditional coverage steps in. However, if unexpected expenses arise, you always have the option of changing your mind and spending your ECA instead of saving it. When you are spending your ECA, you have 100% coverage for eligible charges covered by your ECA credit.	Under Option 250, if you have a large health care expense, such as for the birth of a baby or because of a serious accident, you will also have to pay the full deductible for each person before the traditional coverage steps in for that person. However, the smaller deductible required may make it easier to manage for your family's budget.

PRESCRIPTION DRUG BENEFITS

When you choose coverage under the Consumer Choice Option, prescription drugs are covered—but they are treated a little differently than other eligible health care expenses. Prescriptions are covered exactly the same way as under Option 250. For covered drugs, the plan pays a certain percentage, and you pay a certain percentage—subject to a minimum and maximum copayment—as shown in the chart on page 11. You do not pay a deductible for prescription drugs.

You cannot use the Employee Choice Account to pay for prescriptions, and the amounts you pay for prescription drugs do not count toward your primary or secondary deductible, or toward the coinsurance maximum.

ELIGIBLE EXPENSES FOR THE EMPLOYEE CHOICE ACCOUNT

Under the Consumer Choice Option, you can use the Employee Choice Account to pay for the same expenses that are covered under Option 250, *except for prescription drugs* as explained above. Eligible expenses include:

- Physician office visits.
- Emergency room visits.
- Inpatient care and surgery.

In addition to the exclusion for prescription drugs, you cannot use the Employee Choice Account to pay for expenses that are not covered under the medical plan, such as cosmetic surgery.

You cannot use the Employee Choice Account to reimburse yourself for your primary deductible.

THE CONSUMER CHOICE OPTION AND THE HEALTH CARE REIMBURSEMENT ACCOUNT

The health care reimbursement account, described starting on page 52, is not new. These special accounts let you pay yourself back with tax-free money for many out-of-pocket health care expenses. To receive reimbursement, you must submit a claim to Tri-Star Benefit Systems, Inc. (Tri-Star), as shown in the box on page 23. In some ways, the health care reimbursement account may seem similar to the Employee Choice Account: both provide money to reimburse you for eligible health care expenses during the year. But there are some important differences:

- The money in your Employee Choice Account comes from the company. The money in the health care reimbursement account (if you choose to use it) is provided by you, through before-tax payroll deductions from your pay.

* If you don't spend all the money in your health care reimbursement account on eligible expenses you have incurred during the year, under IRS rules you must forfeit any amounts that are leftover. If you have money left in the Employee Choice Account, on the other hand, you can roll it over into an Employee Choice Account for the next year, up to the plan limits—and any amounts over those limits can be transferred into your Retiree Choice Account.

You can choose to use both the Consumer Choice Option's Employee Choice Account and the health care reimbursement account, if you wish. However, you should be aware of some rules that apply if you use them together.

* If you elect the Consumer Choice Option and you contribute to the health care reimbursement account (HCRA), you must first use the money in your HCRA to pay eligible claims before you can use the Employee Choice Account. This is because the HCRA money will be lost if not used by the end of the year (due to IRS rules), while the Employee Choice Account credit can be rolled over to the next year.
* However, you can use the health care reimbursement account to pay for many expenses that aren't eligible to be paid using the Employee Choice Account. These include:
  - Prescription drugs (the portion of the cost not paid by your prescription drug coverage).
  - Dental care not paid for by your dental coverage, such as your percentage share of expenses.
  - Vision care not paid for by your vision coverage, such as Lasik surgery.
  - Over-the-counter medications used to treat an injury or illness, such as allergy medicines, cough and cold medicines, and pain relievers. (Over-the-counter medications used to promote general good health such as nutritional supplements and vitamins, or cosmetic treatments such as teeth whiteners, are not eligible.)
* In addition, you can use the HCRA to reimburse yourself for all or any portion of your full Consumer Choice Option deductible (primary deductible + Employee Choice Account + secondary deductible).

Timing Your Claims if You Participate in the HCRA

With the Consumer Choice Option, you are always in control of the timing and sequence of claims submission or reimbursement by Tri-Star. If you want to use the health care reimbursement account to pay for expenses that are not eligible under the Consumer Choice plan—such as Lasik surgery or over-the-counter medications—you will have to plan carefully. To ensure that you can pay for these expenses with before-tax dollars, you must submit these specific claims (which are not eligible under the medical plan) for reimbursement *prior* to submitting the claims that are eligible for reimbursement from the Employee Choice Account.

For example, let's assume that an employee elects coverage under the Consumer Choice Option. She also sets aside money in her health care reimbursement account to pay for the portion of her children's orthodontia expenses that aren't covered by the dental plan. Then she has an unexpected medical expense for a leg injury before the orthodontia expense is incurred. In this case, her medical expense would be paid out of the health care reimbursement account first. To avoid this and save her reimbursement account money for its original intended purpose, she would need to delay filing her claim for the leg injury until *after* she had submitted the claim for uncovered orthodontia expenses.

FILING A CLAIM FOR THE EMPLOYEE CHOICE ACCOUNT

If you are choosing to "spend" your Employee Choice Account, here's how to receive reimbursement:

1. You or your health care provider must first submit a claim to BlueCross BlueShield of Illinois and allow it to process the claim. You are generally not required to pay the charge until BlueCross has issued an Explanation of Benefits (EOB) form telling you how much of the claim is your responsibility.
2. To file a claim for reimbursement from your Employee Choice Account, you must provide the EOB form from BlueCross showing it has processed an eligible claim. Until you have met your full Consumer Choice Option deductible (primary deductible + Employee Choice Account + secondary deductible) each year, your EOBs will show that the full amount of your claim is "patient responsibility."
3. If you have already met the primary deductible, complete an Employee Choice Account claim form and submit it to Tri-Star. The claim form is available through the Tri-Star Web site at www.tri-starsystems.com. See the box on page 23 for more details.
4. Submit both the EOB and the Employee Choice Account claim form to Tri-Star at the address or fax number on the claim form.
5. Once your claim has been approved, Tri-Star will mail a reimbursement check to your home. This process usually takes approximately one week. For your convenience, you may request direct deposit of your reimbursement by logging on to www.tri-starsystems.com.

All claims for the Employee Choice Account incurred in a given calendar year must be submitted no later than December 31 of the following calendar year.

Remember that if you are using the health care reimbursement account, you must use up the money in that account before using the Employee Choice Account.

More About Tri-Star and Claim Forms

If you have any questions about filing claims for the Employee Choice Account, you may call Tri-Star Benefit Systems, Inc. (Tri-Star) at 314-576-4022 in St. Louis or toll-free at 1-800-727-0182 and ask to speak with a claims representative. Identify yourself as a Peabody employee and provide your Social Security number so the representative can assist you.

To download claim forms, go to www.tri-starsystems.com and log in as an employee. Then access the "Form Download" link in the upper right corner of the home page. Then select the link for Peabody and select the form you need:

- Direct Deposit Request Form
- Reimbursement Account Claim Form (HCRA/DCRA)
- Employee Choice Account (ECA) Form
- Medical Premium Reimbursement for Retirees Claim Form

To submit the completed forms to Tri-Star, you can mail them to:

14323 South Outer 40 Road
Suite 400 North
Chesterfield, MO 63017-5734

Claim forms may be faxed to 314-985-0277.

NEW RETIREE CHOICE ACCOUNT

If you enroll in the new Consumer Choice Option for medical coverage, you also have access to a new tool to help you save for future medical expenses after you retire—the Retiree Choice Account. It can be used in addition to the MPR program.

Who Is Eligible for the Retiree Choice Account

If you are an employee enrolled in the Consumer Choice Option, you are eligible for the Retiree Choice Account. You do not have to be a certain age for money to be put into the account for your retirement.

However, if you leave the company before retirement, you must be at least age 55 before you can take money out of the Retiree Choice Account. You must also have at least five years of service when you leave the company to receive the full amount of your account. If you have fewer than two years of service when you leave the company, you will forfeit any money you have in your Retiree Choice Account. This is explained more fully under *If You Leave The Company Before Retirement.*

How the Retiree Choice Account Works

As explained in the *New Consumer Choice Option* section beginning on page 7, if you are enrolled in the Consumer Choice Option for medical coverage, that option includes a company-provided Employee Choice Account you can use to pay for eligible expenses. If you don't use the entire amount in your Employee Choice Account by the end of the year, you can roll what remains—up to certain limits—into your Employee Choice Account for the following year.

To recap, the maximum amount you can roll over from one year to the next in the Employee Choice Account is $250 if you have "yourself only" coverage, $500 if you have "yourself plus one" coverage, or $750 if you have "yourself plus two or more" coverage.

Here's where the Retiree Choice Account comes in: If you exceed any of these limits, then the excess amount is transferred into your Retiree Choice Account. Over a period of several years, you could have the opportunity to build up a balance in your account.

Earning Interest on Your Retiree Choice Account

Amounts you transfer into your Retiree Choice Account will earn interest. The rate of interest your account earns will equal that paid on current one-year U.S. Treasury bills. The interest will be calculated on the year-end balance that is rolled over to the Retiree Choice Account and will be automatically reinvested in your account tax-free. The rate of interest is subject to change based on business conditions and is not guaranteed.

Eligible Expenses for the Retiree Choice Account

Like the MPR program, you can use the Retiree Choice Account to purchase your own health care policy when you retire. This can be another employer's group health plan, an individual policy, or Peabody Holding Company, Inc.'s Catastrophic Medical Plan or Medicare.

Unlike the MPR program, after you retire you can also use up to $5,000 per year from your Retiree Choice Account to pay for the deductibles, coinsurance or copayments of the health care plan that you purchase.

You can begin taking money out of the Retiree Choice Account after you are age 55 and are no longer an active employee. You may not take money out of the account until you meet both these requirements.

IF YOU LEAVE THE COMPANY BEFORE RETIREMENT

If you leave the company before retirement and have fewer than two years of service, you will forfeit any money in your Retiree Choice Account. (Remember that all the money in your account originally was contributed by the company.)

If you leave the company before retirement with at least five years of service, you will be entitled to the *full amount* in your Retiree Choice Account when you reach age 55. If you leave the company with two to four years of service with the company, you are entitled to a percentage of the money from your Retiree Choice Account when you reach age 55, as summarized in the table below:

YEARS OF SERVICE	PERCENTAGE OF RETIREE CHOICE ACCOUNT YOU ARE ELIGIBLE FOR
Fewer than 2 years	0%
2 years	25%
3 years	50%
4 years	75%
5 or more years	100%

ADDITIONAL DETAILS OF THE EMPLOYEE CHOICE ACCOUNT AND RETIREE CHOICE ACCOUNT

We are providing the following details about the Employee Choice Account so this enrollment guide can serve as a summary of material modification (SMM) for the Consumer Choice Option.

Type of account: The Employee Choice Account and Retiree Choice Account are technically known as health reimbursement arrangements (HRAs). Money in an HRA can be used to reimburse the eligible medical expenses of you and any other family members you have covered, in any combination.

The Employee Choice Account and the Retiree Choice Account represent an "unfunded" plan as defined by federal law. This means the money will be paid out of the company's general assets and has not been placed in a trust or special account. *Money in the Employee Choice Account does not earn interest,* unless it is transferred to the Retiree Choice Account.

The money in your Retiree Choice Account is used to purchase a health care policy after you retire. You can also use the account (up to $5,000 per year) to pay the deductibles, coinsurance or copayments of the health care plan that you purchase. Money in this account earns interest based on the rate of interest earned by one-year U.S. Treasury bills.

Transfers to the Retiree Choice Account: Amounts over the maximum balance allowed in the Employee Choice Account will be transferred to the Retiree Choice Account on January 1 of the following calendar year.

Time limit for filing claims: Claims for a given year can be reimbursed up to December 31 of the following calendar year. Claims will not be reimbursed after that limit. If part of your Employee Choice Account is transferred to your Retiree Choice Account before December 31 of the current year (for example, as a result of a change in your family status), or if any of your Employee Choice Account is forfeited before December 31 of the current year, you have 12 months from the date of that event to make a reimbursement claim against the amount being transferred or forfeited.

If you choose a different medical option during the next annual enrollment period: Any amount left unspent in your Employee Choice Account (after eligible transfers to your Retiree Choice Account) will be forfeited, although you will have until December 31 of the following year to submit claims against the amount to be forfeited. (Whatever amount you have transferred to your Retiree Choice Account stays there, subject to the plan's eligibility rules.)

If you are hired (or become eligible for coverage) between annual enrollment periods: When you first enroll in the plan, you receive the entire annual credit that the company normally puts in the Employee Choice Account for the year. At the end of the year, the amount you can roll over into your secondary deductible for the next year (or into your Retiree Choice Account) is reduced based on when you enrolled in the plan. If you joined in the first quarter of the year, your remaining account balance is reduced by 25%; in the second quarter, 50%; in the third quarter, 75%. If you join in the fourth quarter, you will not be able to roll money into your Employee Choice Account for the following year.

If the number of people you cover under the plan changes before the next annual enrollment period: If the change is because a dependent is no longer eligible, the annual credit from the company, and the limits on the amount you can roll over or build up in your Employee Choice Account, will be reduced and will be effective immediately. If the amount you have in your Employee Choice Account exceeds the limits, the excess will be transferred to your Retiree Choice Account. If the change is because you are adding a dependent(s), your coverage level will increase, as appropriate, on the date of the change and an additional amount will be credited to your Employee Choice Account.

If you switch from another medical coverage option to the Consumer Choice Option before the next enrollment period because of a qualifying change in family status: The same rules apply as if you were newly hired or newly eligible for the plan, as described above.

If you switch from the Consumer Choice Option to another medical coverage option before the next enrollment period because of a qualifying change in family status: The same rules apply as if you terminated employment with the company (described below).

If you terminate employment with the company (for any reason): If you choose to continue coverage under the provisions of the law known as COBRA, the plan continues as usual. After COBRA coverage ends, or if you don't elect COBRA continuation, any remaining balance in your Employee Choice Account is forfeited (except for reimbursements you receive for claims filed before the end of the filing time limit). If you have a balance in the Retiree Choice Account, your right to money in that account is subject to the Retiree Choice Account's rules based on years of service (see page 25).

If your covered dependent elects individual coverage under COBRA: The dependent is then treated the same as a new hire.

If you become divorced: Unless there is a court order, divorce decree or other legal instruction stating otherwise, you as the employee have all rights to your Employee Choice Account and/or Retiree Choice Account balances. If there is a change in the number of people you cover, change in family status rules will apply.

If you die while an active employee: If your surviving covered dependents choose to continue coverage under COBRA, the plan continues as usual. After COBRA coverage ends, or if your dependents don't elect COBRA continuation, any remaining balance in your Employee Choice Account is transferred to your Retiree Choice Account. Your surviving dependents may use your Retiree Choice Account immediately, subject to the account's rules based on your years of service (see page 25).

If you take a leave that is covered under the Family and Medical Leave Act: You continue to participate in the plan as if you were actively at work.

When you retire: When you retire, the remaining amount in your Employee Choice Account transfers to your Retiree Choice Account. Your Retiree Choice Account becomes available to you, subject to that account's rules based on years of service (see page 25). The Retiree Choice Account is completely separate from the Medical Premium Reimbursement program (which requires you to be at least age 55 and have 10 years of service), as described starting on page 56.

If you die after you retire: The Retiree Choice Account is immediately available for use by your surviving dependents for eligible expenses, subject to the account's rules based on your years of service (see page 25). If you have no dependents, the Retiree Choice Account is forfeited after all claims have been received within the time limits for filing them.

If you become disabled and receive benefits from the short-term disability plan: You continue to participate in the plan as if you were actively at work.

If you become disabled and receive benefits from the long-term disability plan: You will no longer be eligible for the Consumer Choice Option and you will need to make a new medical election. Your entire Employee Choice Account will roll over into a Retiree Choice Account.

Hardship withdrawal: No withdrawals from the Retiree Choice Account prior to age 55 are permitted.

MAKING THE RIGHT CHOICE

To help you choose the best medical option for your situation, you can use eValuator™, an interactive, online tool. Log on at **www.hr-smart.com/Peabody**.

Your online resource: eValuator™

Introducing eValuator™, an easy-to-use, interactive Web-based modeling tool that helps you make informed health care decisions. eValuator™ is a multi-faceted decision-support tool designed to help you understand your health care costs and assess the financial impact of your health care decisions and actions.

Not sure which medical option is right for your personal health care situation and budget? eValuator™ is designed to help you determine the best medical plan option for you and your family based on your individual circumstances.

Peabody

eValuator™

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Use this tool to assess the "real-life" costs of your medical plan options based on your individual health care needs.

Welcome to the eValuator™

To help you make an informed decision about your health needs, we've put together this suite of decision support tools. By entering some basic completely confidential information about your health care needs and the needs of your family you'll be able to:

- Compare the total cost of coverage for each plan in which you are eligible.
- Estimate how much to contribute to your Health Care Reimbursement Account (also referred to as a Flexible Spending Account) and see the potential tax advantages.
- Compare the costs under your plans with that of your spouse's plan.
- Model your costs if you experience an emergency or unexpected illness

Please note: eValuator™ provides a cost estimate based on national averages and is not intended to provide an exact amount. If you plan to contribute to your Health Care Reimbursement Account, consider your contribution amount carefully. As a reminder, federal law requires you use all your Health Care Reimbursement Account or you lose the remaining funds.

Start

Specifically, eValuator™ enables you to:

- Compare your expected (and unexpected medical emergency) out-of-pocket costs and payroll contributions under each available health plan.

- Compare the cost of having family members covered under your spouse's health plan versus your plan.
- Estimate how much to contribute to your health care reimbursement account (also referred to as a flexible spending account) and see the potential tax advantages.

Note: eValuator™ provides a cost estimate based on national averages and is not intended to provide an exact amount. If you plan to contribute money to your health care reimbursement account, consider your contribution amount carefully. As a reminder, federal law requires that you use all of the money in your health care reimbursement account or you lose the remaining funds.

KEEPING IT ALL STRAIGHT

Our benefits program now includes a number of "accounts" and programs that you can use to pay various expenses. To help you keep them all straight, a table below compares and contrasts the Employee Choice Account, health care reimbursement account, Medical Premium Reimbursement program, and Retiree Choice Account.

The table shows only key highlights of each of these accounts. Each has important rules and limits that you need to understand. Those details are explained elsewhere in this guide.

ACCOUNT/PROGRAM	HOW IT'S FUNDED	HOW IT WORKS	YOUR BEST STRATEGY
Employee Choice Account (ECA)	* Annual credit provided by the company. * Portion of the credit can be rolled to next year's ECA and be applied to your secondary deductible the following year.	* Part of the new Consumer Choice Option. * Available to you after you pay the primary deductible. * To spend the credit for health care, you file a claim for reimbursement to Tri-Star. * You have to use up your HCRA if applicable (see below) before you can use the ECA.	* You can "spend" for current health care needs. * You can "save" for health care during retirement. * You pay no taxes on the value you receive from these accounts.
Retiree Choice Account (RCA)	* Excess savings from the ECA roll over into this account.	* Excess savings accumulate here, tax-free, to cover premiums for health care coverage. * You also use your RCA for deductibles, coinsurance or copayments during retirement, limited to $5,000 a year.	* Works well with the MPR program, which helps cover premium costs for the purchase of a personal health care policy.

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ACCOUNT/PROGRAM	HOW IT'S FUNDED	HOW IT WORKS	YOUR BEST STRATEGY
Medical Premium Reimbursement Program (MPR)	* A one-time credit provided by the company.	* Based on your age and years of service, you earn a one-time credit to help pay premiums associated with a private health insurance policy. * You cannot use this plan to pay out-of-pocket health expenses, such as deductibles, your share of covered charges or charges not covered by insurance.	* You can use this benefit in combination with the new RCA account. * You can increase your MPR benefit the longer you work at the company. * You can use the money towards the purchase of another employer's group plan, a private health policy, COBRA coverage, the Peabody Catastrophic Medical Plan or Medicare.
Health Care Reimbursement Account (HCRA)	* You fund this account with before-tax dollars deducted from your pay.	* You may defer up to $5,000 a year. * Use the money to pay yourself back for health care expenses not paid by insurance (including deductibles). * You file a claim for reimbursement to Tri-Star. * You must use the money each year or lose it (IRS rule). * Note that the IRS calls this a flexible spending account, or FSA.	* You save money in taxes. * You can use this account for items not covered by health insurance, including over-the-counter medicines. * If you wish to "save" all of your ECA for retirement, you can use the HCRA instead. * This account must be used first before claiming reimbursement from your ECA.
Day Care Reimbursement Account (DCRA)	* You fund this account with before-tax dollars deducted from your pay.	* You may defer up to $5,000 a year (or $2,500 if you're married filing separate taxes). * Use the money to pay for day care for children under 13 or dependent adults. * You file a claim for reimbursement to Tri-Star. * You must use the money each year or lose it (IRS rule). * Note that the IRS calls this a flexible spending account, or FSA.	* You save money in taxes. * You cannot use the account for dependent *health care* expenses.

MEDICAL COVERAGE DURING DISABILITY

For disabilities beginning on or after January 1, 2005, disabled employees will remain eligible for group health coverage for a maximum period of 36 months as described below:

- ✳ If you are receiving short-term disability (STD) benefits, you will remain eligible for medical coverage up to a maximum period of 180 days (6 months). Contributions will continue to be deducted on a pay period basis.
- ✳ If you are receiving long-term disability (LTD) benefits, you may elect to continue your medical coverage for a maximum period of 30 months, provided you pay the required contributions.
- ✳ Coverage will end prior to the 36-month maximum if you are no longer receiving LTD benefits.
- ✳ COBRA will not be available at the end of the 36-month period.

IF YOU ENROLL YOURSELF AND YOUR DEPENDENTS UNDER TWO PLANS

If you are thinking about covering yourself and/or your dependents under two plans, be sure you find out how the two plans will coordinate benefits. Your Peabody coverage will always be primary for you as an employee, but Peabody coverage may not necessarily be primary for your children if they are also covered under your spouse's plan. Before making a decision about coverage, you'll want to find out which plan pays first for each dependent and how much the secondary plan pays. For more information, consult the *Coordination of Benefits* section of your medical summary plan description.

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CHANGING YOUR MEDICAL COVERAGE

The choices you make during the annual enrollment period are effective January 1, 2005, and are binding throughout the calendar year. Except in certain cases, you will not be able to enroll, cancel or change your options or your dependent coverage choices until the next annual enrollment period. The options available to you depend on your situation, as shown in the summary below.

YOUR SITUATION	YOUR OPTIONS
You elect Consumer Choice Option, Option 250 or Option 1000.	You can decrease or drop coverage, or switch to an HMO, at any annual enrollment period. If you drop coverage, you must show proof of other coverage.
You elect No Coverage.	You can drop coverage, or enroll in Option 1000 or an HMO (if available), during any annual enrollment period. If you drop coverage, you must show proof of other coverage.
You elect HMO coverage (if available).	You can switch to any Option choice or drop coverage at any annual enrollment period. If you drop coverage, you must show proof of other coverage.
You obtain coverage under another plan due to marriage or a change in your spouse's job, or because your spouse's employer offers annual enrollment at a different time of year than Peabody.	You can drop or decrease Peabody coverage within 31 days of the date your other coverage starts. If you drop coverage, you must show proof of other coverage.
You gain a new dependent through marriage, birth or adoption.	You can change from No Coverage to any Peabody medical option, or add the new dependent to your current Peabody coverage, within 31 days of the qualifying event.
You have coverage from another source and lose it during the plan year for certain reasons.	You can enroll for any Peabody medical option within 31 days of the loss of coverage. (You may not change to an HMO option in this case, unless you had previously elected No Coverage.)

More details about the rules that apply to changing your coverage appear below and on the following page.

During the Annual Enrollment Period

- If you decline coverage now for you and/or your dependents, you may enroll during the next annual enrollment period, but your choice of plans will be limited to Option 1000.
- You may change to or from an HMO (if available) during any annual enrollment period. If you are moving from an HMO, you can choose any other Option.

Special Situations (Changes in Family Status)

* If you have a change in status as a result of marriage, birth, adoption or placement for adoption, you may add the new dependent to your current coverage option. Or, if you previously elected No Coverage, you may enroll yourself, your spouse and any new dependent child in any one of the Option choices (or an HMO alternative, if available). Provided you enroll within 31 days of the event, coverage will begin on the date the person becomes your dependent.
* You may cancel coverage or drop a dependent if you need to because of a divorce, death, or because a dependent is no longer eligible. You must complete a new enrollment form within 31 days of the event.
* If you become covered under another medical plan due to marriage or a change in your spouse's employment, or because your spouse's employer offers annual enrollment at a different time of year than our company, you may cancel coverage or decrease to a lower option if you complete a new enrollment form within 31 days.
* You may decide not to elect medical benefits under a company plan or select a lower plan option because you and/or your dependents have other coverage, such as through your spouse's employer. In this situation, you may enroll in any available option and/or add dependents to your coverage—or upgrade your coverage one level—if (1) the other coverage ends because you or your dependent is no longer eligible for such other coverage; (2) an employer makes a significant change to the cost or benefits of the other coverage; or (3) the other coverage ends because it was provided under a COBRA continuation provision and the right to coverage has been exhausted. You must complete a new enrollment form within 31 days after the other coverage ends. You may be required to provide evidence of loss of coverage.

PRE-EXISTING CONDITIONS LIMITATION

As a reminder, certain limits will continue to apply to pre-existing conditions when you or your dependents are first enrolled for medical coverage or you change from No Coverage to one of the Option choices in the future.

* A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care or treatment (including prescription drugs) was recommended or received within the six-month period ending on the individual's enrollment date. For this purpose, the term "enrollment date" means, for an employee who enrolls when first eligible, the first day of employment as an eligible employee; in all other cases, enrollment date is the date coverage begins.

* Charges related to a pre-existing condition are not covered during the 12-month period starting on the individual's enrollment date, as defined on the previous page.
* The 12-month period will be reduced by the length of time an individual had "creditable coverage" under a previous plan.
* The limit for pre-existing conditions will not apply to pregnancy. It also does not apply to a child enrolled within 31 days of birth or placement for adoption, in most cases.

Your medical summary plan description booklet contains details about the pre-existing conditions limitation.

IMPORTANT INFORMATION ABOUT MEDICAL COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

Under federal law, group health plans that provide medical and surgical benefits for mastectomies must also provide coverage for the following services, which are to be provided in a manner determined in consultation with the attending physician and the patient:

* Reconstruction of the breast on which the mastectomy has been performed.
* Surgery and reconstruction of the other breast to produce a symmetrical appearance.
* Prostheses and physical complications in all stages of the mastectomy, including lymphedemas.

As with other covered services, the usual deductibles, copayments or percentage share of expense you are required to pay will apply.

Your Dental Keys

During annual enrollment you choose the dental coverage you need for your family. You may select the company dental plan, or you may choose No Coverage. Your dental coverage choice is completely separate from your medical election.

COVERAGE CATEGORIES

For dental, you can select coverage for:

- Yourself only.
- Yourself plus one dependent.
- Yourself plus two or more dependents.

To cover a dependent for dental, you must also elect that coverage for yourself.

You will share in any cost increases in subsequent years.

Before-Tax Monthly Contributions for Dental Coverage

	YOURSELF ONLY	YOURSELF PLUS ONE DEPENDENT	YOURSELF PLUS TWO OR MORE DEPENDENTS
FULL-TIME EMPLOYEES	$2.66	$10.66	$18.68
PART-TIME EMPLOYEES	$5.34	$21.36	$37.38

Please note that the annual maximum benefit per person has increased from $750 to $1,000 effective January 1, 2005.

Dental Benefits Summary

	PREVENTIVE	BASIC	MAJOR	ORTHODONTIA
Deductible	$0	$50 (lifetime)	$50 (per calendar year)	$100 (lifetime)
Amount the plan pays	100%*	80%*	60%*	60%*
Maximum benefits	$1,000 (per person per calendar year)			$1,000 (lifetime)

* Coverage limited to allowable fees charged by the majority of Delta Dental participating dentists.

DELTA DENTAL PARTICIPATING DENTISTS

Your dental benefits are administered by Delta Dental, which has unique "participating agreements" with the majority of dentists in areas where our employees live. These agreements mean that the participating dentist's fee has been accepted in advance by Delta Dental. All you have to do is present your membership card. Participating dentists will then file your claim for you and Delta Dental will pay them directly. You will have to pay only your deductible and your coinsurance percentage for covered services.

NON-PARTICIPATING DENTISTS

If you go to a non-participating dentist, you will still receive benefits, but payment will be based on the fee that the majority of participating dentists would charge for the same service. This is called the "allowable charge." For services from a non-participating dentist, you will pay the difference between the dentist's fee and the allowable charge, in addition to your deductible and a percentage of the allowable charge, as shown in the following example.

Example

	DELTA DENTAL PARTICIPATING DENTIST	NON-PARTICIPATING DENTIST
Charge for fillings (basic care)	$60	$65
Allowable charge*	$60	$55
Plan pays (80% assuming deductible is satisfied)	$48	$44
Employee pays (20% plus amount over allowable charge)	$12	$21

* Participating Delta dentists' fees have been accepted in advance. For non-participating dentists, the allowable charge may be lower.

Also, you are responsible for paying the non-participating dentist and filing your own claim. The address for dental claim filing is on your Delta Dental ID card. Benefits will be paid directly to you, and may not be assigned to the dentist.

To find out how your dentist can join the network, call 1-800-392-1167 or go to **www.deltadental.com.**

CHANGING YOUR DENTAL COVERAGE

The choices you make during the annual enrollment period are effective January 1, 2005, and are binding throughout the calendar year. Except in certain cases, you will not be able to enroll, cancel or change your dependent coverage choices until the next annual enrollment period.

The following rules apply to changing your coverage:

During the Annual Enrollment Period

- If you decline coverage now for you and/or your dependents, you may enroll during the next annual enrollment period (for 2006), but your coverage will be limited to preventive care benefits only during the first 12 months of your coverage. This also applies if you did not elect dental coverage for 2004 and now wish to enroll for 2005.

Special Situations (Changes in Family Status)

- If you gain a new dependent through marriage, birth, adoption or placement for adoption, you may add that dependent as long as you do so within 31 days of the date the person becomes your dependent. If you enroll during this 31-day period, coverage will begin on the day you gain the new dependent.
- You may cancel coverage or drop a dependent if you need to because of a divorce, death, or because a dependent is no longer eligible. You must complete a new enrollment form within 31 days of the event.
- If you decide not to enroll in the plan because you and/or your dependents have coverage under your spouse's plan, and then you lose that coverage as the result of a divorce, death or a change in your spouse's employment, you may enroll in the plan at that time. To do so, you must complete an enrollment form within 31 days of the date the other coverage ends.

In these situations, there will be no special restrictions on your dental coverage. However, the plan will not cover treatment already in progress on the date your coverage begins.

Your Vision Keys

During annual enrollment, you choose the vision coverage you need for your family. You may select vision coverage, or you may choose No Coverage. Vision coverage is offered through Vision Service Plan (VSP).

COVERAGE CATEGORIES

For vision, you can select coverage for:

- Yourself only.
- Yourself plus one dependent.
- Yourself plus two or more dependents.

To cover a dependent for vision benefits, you must also elect that coverage for yourself.

Vision Care Benefits Summary

SERVICE	FREQUENCY	NETWORK BENEFIT (VSP Providers)	NON-NETWORK BENEFIT (Maximum Reimbursement)
Eye examination	12 months	100%*	$38*
Eyeglass lenses	24 months		
Single-vision		100%**	$31**
Bifocal		100%**	$51**
Trifocal		100%**	$64**
Frames	24 months	$120	$45
Contact lenses (instead of eyeglasses)	24 months	$105	$105

* You pay a $10 copayment.
** You pay a $15 copayment.

Network Benefits: Lens options (tints, scratch resistance coating, etc.) are available to you at VSP's member preferred pricing. If you choose a frame valued at more than your allowance, you will save 20% on the out-of-pocket costs for your frames.

Before-Tax Monthly Contributions for Optional Vision Care Coverage

	YOURSELF ONLY	YOURSELF PLUS ONE DEPENDENT	YOURSELF PLUS TWO OR MORE DEPENDENTS
Employee Cost*	$6.62	$9.64	$17.22

* The company does not contribute toward the cost of optional vision care coverage.

NETWORK CARE

When glasses or contacts are prescribed by VSP providers, VSP guarantees the quality of the materials, including fittings and adjustments, to ensure the highest level of care and comfort for you and your family.

When you need vision care, all you have to do is call a VSP participating doctor for an appointment and identify yourself as a VSP member. You aren't required to complete any up-front paperwork or obtain a benefit form.

If you need assistance in locating a VSP participating doctor, you may call VSP at 1-800-VSP-7195 (1-800-877-7195) or go to **www.vsp.com** on the Internet.

When you call, the VSP participating doctor will also need to know your identification number (usually the Social Security number), and the organization that provides your benefits (Peabody). You'll need to have this information on hand.

If you obtain services from a VSP network provider, VSP will pay the provider directly. You pay only a $10 copayment for each examination or a $15 copayment for eyeglass lenses (once in any 24-month period). You are responsible for the cost of any additional services such as tints, coated lenses, progressive lenses, etc., or the cost of a frame over the VSP allowance. The majority of frames available are covered. If you purchase contact lenses, you pay the amount of the cost in excess of the VSP allowance shown in the summary chart.

NON-NETWORK CARE

You may obtain vision services from any licensed vision provider, although using non-network providers will affect the claims procedure and the amount of benefits you receive. When you receive your vision care from a non-network provider, you pay the provider's charge at the time of service, and you must file a claim with VSP within six months of the date services were provided. VSP will then reimburse you for the charges (minus the copayments), up to the non-network maximum amount. For example, if you receive an eye examination from a non-network provider who charges $50, you pay the $10 copayment plus $2 (the amount of the remaining charge in excess of the maximum reimbursement of $38).

CHANGING YOUR VISION CARE COVERAGE

You may elect or continue vision coverage for 2005 if:

- You are currently enrolled for vision coverage.
- You are electing vision coverage for the first time.

However, if you dropped your vision coverage during the 2004 enrollment period, you may not enroll for coverage in 2005. (Your next opportunity to enroll will be in the fall of 2005, with coverage effective January 1, 2006.)

You may also drop your vision coverage during the annual enrollment period. However, if you do, you will have to wait two years before you can re-enroll in this coverage.

Your election is binding for 2005. You may add or drop dependents from your coverage during the year if you have a change in family status that justifies a change. In addition, you may change your election during the next annual enrollment period.

Your Employee Term Life Insurance Keys

To help provide your loved ones with financial protection in the event of your death, you have the opportunity to choose from a variety of term life insurance levels.

The company provides a "basic" employee term life insurance benefit equal to one times your annual basic salary at no cost to you. You do not need to make an election for this basic coverage.

In addition to this coverage, you can choose "supplemental" employee term life insurance coverage equal to one, two, three or four times your annual basic salary.

Because there is much in common between these two types of term life insurance coverage, they are discussed together in this section.

HOW YOUR BASIC AND SUPPLEMENTAL COVERAGE WORKS

All eligible employees receive a basic term life insurance benefit equal to one times annual basic salary. The IRS requires that the employer cost of your basic employee term life insurance coverage in excess of $50,000 be considered taxable income to you. Because you do not have to make an election for your basic term life benefit, this coverage will not appear as one of your choices when you enroll for benefits.

In addition to your basic term life insurance benefit, you have the option to purchase supplemental employee term life insurance coverage.

For purposes of both the basic employee term life insurance plan and the supplemental employee term life insurance plan, the coverage amount will be based on your current annual basic salary rounded to the next $100. The coverage amount(s) will automatically be adjusted for salary fluctuations.

If you die, the amount of your term life insurance coverage will be paid to the beneficiary you designate.

Note: When you retire, your term life insurance amount is reduced to 25% of your annual pay in effect immediately before your retirement. At age 70, this amount is further reduced to a maximum of $10,000.

YOUR SUPPLEMENTAL EMPLOYEE TERM LIFE INSURANCE

As you can see from the following chart, supplemental employee term life insurance options are multiples of your annual basic salary rounded to the next $100. For example, if your annual basic salary is $20,000 and you choose Option 2 (two times annual basic salary), your supplemental employee term life insurance benefit is $40,000, and your basic term life insurance benefit is $20,000 (for a total coverage amount of $60,000).

Supplemental Employee Term Life Insurance Coverage Amounts

Option 1	One times annual basic salary
Option 2	Two times annual basic salary
Option 3	Three times annual basic salary
Option 4	Four times annual basic salary

Basic and supplemental employee term life insurance maximum is $500,000 for each policy. However, those employees with more than $500,000 in coverage under either policy on December 31, 2003 may continue that coverage subject to the $1 million maximum for each policy.

Changing Your Coverage

You may enroll or change your supplemental employee life coverage during the annual enrollment period, subject to evidence of insurability (proof of good health) requirements described in the next section. You can decrease your coverage as many levels as you choose.

The only other time you may change your supplemental employee term life insurance coverage is if you have a change in family status that justifies a change. You must submit the proper change forms within 31 days of the event. At that time, you can decrease your coverage to any level or increase your supplemental term life insurance coverage, subject to evidence of insurability, provided the change you make is consistent with the family status event.

You may drop or decrease coverage during any enrollment period.

Evidence of Insurability Requirements

If you elect supplemental life insurance within the initial 31-day enrollment period following your date of hire, you are not required to submit evidence of insurability as long as the amount of your election does not exceed $300,000. Evidence will be required for any coverage requested in excess of $300,000.

If supplemental life insurance coverage is not elected within the initial 31-day enrollment period and you later want to enroll, or if you later wish to increase your coverage during an enrollment period or following a change in family status, you will have to show proof of insurability.

The Evidence of Insurability form required by the insurance company can be found on the Peabody intranet under Human Resources/Benefit Documents/Forms. Complete this form and submit to the insurance company. Your new or higher coverage amount, and the contributions required for the new coverage, will not take effect until the insurance company approves your application. The effective date of coverage will be the approval date designated by the insurance company. Your coverage will also be delayed if you are not actively at work on the date your coverage or an increase in coverage would become effective.

Tobacco Versus Non-Tobacco Rates

Supplemental employee term life insurance rates vary depending whether or not you smoke or use other tobacco products. Any time you have gone at least 12 consecutive months without smoking or using other tobacco products, you are eligible for the lower "Non-Tobacco" rates. If you use tobacco now and elect the "Tobacco" rates but later stop using tobacco, you can change to the "Non-Tobacco" rates after you have been tobacco-free for 12 months.

How to Make the Right Choice

Your premium rates will depend on your age (as of January 1, 2005), your coverage amount and whether or not you use tobacco. For more information about your life coverage options, including information about coverage for retired and disabled employees, refer to your summary plan description booklet.

Your Dependent Term Life Insurance Keys

If you choose, you may also purchase life insurance for your spouse and/or your eligible dependent children. This benefit helps provide you with protection against financial difficulties in the event of a loved one's death.

These are your choices for covering your spouse:

- No spouse coverage.
- Spouse coverage in the amount of $10,000.
- Spouse coverage in the amount of $20,000.

These are your choices for covering your eligible dependent child or children:

- No child coverage.
- Child coverage in the amount of $5,000 per child.
- Child coverage in the amount of $10,000 per child.

The cost of life insurance for your children is the same, regardless of how many children you have.

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

You are automatically the beneficiary of your dependents' life insurance coverage.

If your eligible dependent is totally disabled on the date that coverage would normally begin, his or her coverage will not start until the date he or she is no longer disabled.

After-Tax Monthly Contributions for Dependent Term Life

	COVERAGE AMOUNT	EMPLOYEE COST*
Spouse Coverage Amount	$10,000	$3.50
	$20,000	$7.00
Child Coverage Amount	$5,000	$1.00
	$10,000	$2.00
		(regardless of number of children)

* The company does not contribute toward the cost of dependent term life insurance.

CHANGING YOUR COVERAGE

You may choose dependent life insurance or change the amount of your spouse's coverage during the annual enrollment period. The choices you make during this enrollment period are effective January 1, 2005. However, coverage may be delayed if you are not actively at work, or your coverage choice requires evidence of insurability (proof of good health).

The only other time you may enroll or change your dependent life coverage choices is if you have a change in family status that justifies a change—for example, if you gain a dependent through marriage, birth or adoption, or lose a dependent through divorce or death, or because a child no longer qualifies as an eligible dependent. Your coverage change must be logically consistent with the change in family status, and you must submit the proper change forms within 31 days of the event.

If you do not enroll your dependent within 31 days of when they first become eligible, and then you decide to enroll a dependent later, coverage will be limited to $10,000 for your spouse and $5,000 for each dependent child. During the following annual enrollment, you may choose to increase the spouse coverage amount to $20,000 and the dependent child coverage to $10,000 without having to provide evidence of insurability.

Your Basic Accidental Death & Dismemberment Keys

The company provides all eligible employees with basic accidental death and dismemberment (AD&D) insurance benefits equal to three times your annual basic salary. This coverage pays a benefit to your beneficiary in the event of your death or to you if you sustain certain types of injuries as the result of an accident.

The company will continue to provide a business travel accident insurance benefit equal to five times your annual basic salary ($500,000 maximum).

Because you do not have to make an election for basic AD&D and business travel accident coverage, these benefits will not appear as an option when you enroll for benefits.

Both basic and optional AD&D coverage terminate at retirement.

Your Optional Accidental Death & Dismemberment Keys

You may purchase optional accidental death and dismemberment (AD&D) coverage as a supplement to your basic AD&D coverage. This optional AD&D coverage pays a benefit to your beneficiary in the event of your death, or to you if you sustain certain types of injuries as the result of an accident. The benefits paid by this optional coverage are in addition to benefits paid by your basic employee term life insurance and your basic AD&D coverage. You pay your optional AD&D premiums with before-tax payroll deductions.

OPTIONAL AD&D COVERAGE AMOUNT

You may choose any amount of coverage from $10,000 to $500,000, in multiples of $10,000. However, you may not choose more than $250,000 if that amount is more than 10 times your annual basic salary. The plan pays all or a portion of your benefit amount if you die or sustain certain types of injuries within 365 days of a covered accident. Covered losses include accidental death or paralysis, loss of hands, feet, speech, hearing or sight. There also are several plan features that provide additional benefits to help you and your family recover from the financial losses these injuries may cause. Refer to your summary plan description booklet for details.

FAMILY COVERAGE OPTION

You may also choose AD&D coverage for your spouse and eligible dependent children. If you choose the family coverage option, the plan will pay a benefit to you in the event that a covered accident causes death or certain injuries to one of your covered family members. Benefit amounts will depend on the coverage level you choose for yourself and the family members you have at the time of a covered accident. If you choose to cover your spouse and dependent children, your dependents' coverage amount will equal a percentage of your own amount, as follows:

IF AT THE TIME OF AN ACCIDENT YOUR FAMILY INCLUDES THESE DEPENDENTS	DEPENDENT'S COVERAGE EQUALS THIS PERCENTAGE OF YOUR COVERAGE
Spouse and dependent children	55% spouse, 10% each child*
Spouse, no children	60% spouse
Dependent children, no spouse	20% each child*

* The maximum benefit for each child is $30,000.

COVERAGE AMOUNT AFTER AGE 70

Your optional AD&D coverage amount will be reduced when you or your spouse reach certain ages, as explained in your summary plan description booklet. Your premiums will be based on the original coverage amount, before the reduction.

CHANGING YOUR COVERAGE

Generally, the annual enrollment period is the only time you can enroll in or increase optional AD&D coverage. However, you also can begin or increase your coverage, or choose to cover your spouse and dependent children, within 31 days of either of the following events:

* Your marriage.
* The birth or adoption of your first child.

In either case, your new coverage will become effective the first of the month following the date you complete and return your enrollment form, provided you do so within 31 days of the event.

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 Disability Keys

The company provides short-term and long-term disability coverage under the Disability Plan to all full-time salaried employees. Part-time employees and employees on pre-paid retirement are not eligible for disability benefits. Because you do not have to make an election for disability benefits, these coverages will not appear as an option when you enroll for benefits. Your benefit will be reduced by any additional benefits you are eligible for, such as workers' compensation and Social Security disability.

SHORT-TERM DISABILITY (STD) BENEFITS

For those full-time employees with fewer than five years of service, the plan pays 100% of your daily base pay for the first 30 days of an approved disability and 60% of your daily base pay thereafter, up to a combined total of 180 calendar days of an approved disability. For those full-time employees with five or more years of service, the plan will provide 100% of your daily base pay for up to 180 calendar days of an approved disability. The company currently pays 100% of the cost for this coverage.

LONG-TERM DISABILITY (LTD) BENEFITS

EMPLOYEES WITH FEWER THAN FIVE YEARS OF SERVICE	EMPLOYEES WITH FIVE OR MORE YEARS OF SERVICE
100% of daily base pay for the first 30 days; 60% of daily base pay thereafter, up to a combined total of 180 calendar days.	100% of daily base pay for up to 180 days of disability.

If your approved disability continues after 180 days of STD, the Disability Plan provides LTD benefits equal to 60% of your daily base pay. Your benefit will be reduced by any additional benefits you are eligible for, such as workers' compensation and Social Security disability. LTD benefits may continue until you reach age 65, or longer if you become disabled after age 60.

IF YOU BECOME DISABLED

VPA, our disability claims administrator, will work with employees and the company to help guide you through the disability claim process and to assist you in returning to work as quickly and as safely as possible.

Here's a reminder about how your disability claims will be managed. If you are absent from work due to an illness or injury for seven consecutive calendar days or longer, you must call VPA on the eighth day at 1-800-520-9714 to file an STD claim. VPA will work with you and your doctor to evaluate your claim for benefits. If you do not file a claim, your pay will not continue. VPA will manage your claim for STD and later for LTD, if necessary. If you have a recurrence of a prior disability, you must call VPA immediately.

VPA will:

- Ask you about your condition and medical treatment.
- Ask you to have your physician provide relevant medical information to VPA.
- Review the medical information provided by your doctor.
- Consult with your supervisor about the job requirements.
- Approve your absence, if appropriate.
- Notify you in writing whether benefits will continue to be paid.
- Contact you as needed during your disability.
- Refer and coordinate rehabilitation services when needed.
- Assist you in obtaining Social Security Disability Income, if appropriate.
- Provide assistance in planning your return to work.

After your initial call with VPA, you can call the same toll-free number (1-800-520-9714) or go to **www.vpaweb.com** 24 hours a day, seven days a week, to obtain the status of your claim. If you call during normal business hours, you can discuss your claim with a VPA claims representative.

PRE-EXISTING CONDITIONS LIMIT FOR DISABILITY

For employees hired on or after January 1, 2005, the definition of a pre-existing condition for purposes of disability claims is changing. A disability that begins within the first 12 months of your coverage under this plan is not covered if it is related to a pre-existing condition. Pre-existing conditions are conditions for which you receive any kind of medical treatment, prescription drugs, or diagnostic services within 12 months before your eligibility under the LTD plan begins. This limitation does not apply once you have performed the main duties of your job on a regular basis for at least 12 consecutive months after the effective date of your coverage.

MEDICAL COVERAGE DURING DISABILITY

For disabilities beginning on or after January 1, 2005, disabled employees will remain eligible for group health coverage for a maximum period of 36 months as described below:

* If you are receiving short-term disability (STD) benefits, you will remain eligible for medical coverage up to a maximum period of 180 days (6 months). Contributions will continue to be deducted on a pay period basis.
* If you are receiving long-term disability (LTD) benefits, you may elect to continue your medical coverage for a maximum period of 30 months, provided you pay the required contributions.
* Coverage will end prior to the 36-month maximum if you are no longer receiving LTD benefits.
* COBRA will not be available at the end of the 36-month period.

Your Reimbursement Accounts Keys

You have two reimbursement accounts that allow you to pay for many common expenses using untaxed money deducted from your paycheck: the health care reimbursement account and the day care reimbursement account. Enrollment in these accounts is voluntary—you may decide to use one, both or neither. They are separate accounts, although they have many similar features. The IRS requires that you spend this money by the end of the year or lose it. With a little planning, you can save an amount equal to your tax bracket for many eligible expenses.

You can opt to have your reimbursement checks from either account deposited directly to your bank account. Otherwise, checks will be mailed directly to your home. Direct deposit forms are available by calling Tri-Star Benefit Systems, Inc. (Tri-Star) at 1-800-727-0182 (in St. Louis, 314-576-4022) or visit **www.tri-starsystems.com.** You may also download forms from Tri-Star's Internet site. Go to www.tri-starsystems.com. Then access the "Form Download" link in the upper right corner of the home page. Then select the link for Peabody and select the Direct Deposit Request Form or the Reimbursement Account (HCRA/DCRA) Claim Form.

Please note: If you choose the new Consumer Choice Option for your medical coverage, the health care reimbursement account can be used in combination with your Employee Choice Account. Please see pages 20-23 for details. You will submit claims for both accounts to Tri-Star.

HEALTH CARE REIMBURSEMENT ACCOUNT

The tax-free health care reimbursement account can help you reduce your annual health care expenses. Your monthly health plan contributions automatically will be paid with tax-free payroll deductions. However, you can also save taxes on your deductibles and other out-of-pocket expenses by using the health care reimbursement account. You may now receive reimbursement for certain over-the-counter medications as explained in a following section. Check your summary plan description booklet for details on what other expenses are covered.

You may set aside any amount from $120 to $5,000 a year. This money is deducted from your pay—before it is taxed—in equal installments for each pay period throughout the year and placed in your health care reimbursement account.

You may submit health care expenses for yourself, your spouse or for anyone who is your dependent for federal income tax purposes as defined in Section 152 of the tax code without regard to the otherwise applicable income limitation.

Over-the-Counter (OTC) Drugs

Keep in mind that OTC drugs are eligible for reimbursement through your flexible spending account. To be eligible for reimbursement, a drug must be used for "medical care" which means the drug or service is needed to treat a medical condition.

Items used specifically to promote the general good health of an individual are not reimbursable. This includes items such as OTC drugs purchased for personal or cosmetic reasons such as anti-aging treatments, nutritional supplements and vitamins.

Covered medicines include items such as:

- Allergy medicines.
- Cough and cold medicines.
- Pain relievers.

However, many OTC medications can be used to both promote general good health and treat a medical condition. These are referred to as "dual use" items and can include such things as medicated shampoos, weight loss drugs, and acne treatment.

To receive reimbursement for OTC medications, you will need to submit the claim form specifying the patient, a receipt (not handwritten) that specifies the name of the drug/supply, the date and the amount paid. For a dual-use product, you will be required to provide a statement from the patient's physician indicating the diagnosis and medical need for the OTC medication.

If you're not sure if an item qualifies or what proof you need to provide, call Tri-Star at 1-800-727-0182 or 314-576-4022. You may also visit www.tri-starsystems.com and click on "FAQs" (frequently asked questions). Then select Flexible Spending Accounts (FSAs). Note that the reimbursement accounts are also referred to as "FSAs" or flexible spending accounts.

DAY CARE REIMBURSEMENT ACCOUNT

You can use the day care reimbursement account to pay the cost of day care for young children or a dependent adult. You decide how much you want to deposit in your account, up to a maximum of $5,000 per year (if you are married and file separate tax returns, the maximum deposit is $2,500). The minimum annual deposit is $120. Check your summary plan description booklet for details on eligible expenses. Be sure to compare the tax advantages of the day care reimbursement account and the federal child care tax credit. In general, if your annual family income is more than $39,000, you will pay less in income and Social Security taxes by using the day care reimbursement account instead of the tax credit.

Also, please note that you may not contribute more than your spouse's current annual income to the account. Under IRS rules, your spouse who is disabled or who is a part-time student is considered to have an earned income of $250 a month if you have one eligible dependent, or $500 a month if you have two or more eligible dependents.

Special Rules for Both Accounts

While the reimbursement accounts provide a good way for you to reduce your taxes, you should be aware of several rules:

- You will lose any money that you put into your accounts and do not use by the end of the plan year. This is an IRS rule. Therefore, you should put aside money only for those expenses that you feel certain you will have.
- If your family status changes because of a birth, death, marriage, divorce or a spouse losing his or her job, you can enroll, cancel or change your monthly deposit for either account subject to the plan rules explained in your summary plan description. Also, you may change your deposits to the day care reimbursement account if you must do so due to a change in day care providers, a change in your need for dependent day care, or a significant increase in your cost for day care (other than a cost increase imposed by a relative). Otherwise, according to IRS rules, you may change your deposits to either account only during annual enrollment.
- Reimbursement under the day care reimbursement account cannot exceed the amount you currently have deposited. Health care reimbursement account claims will be paid as long as they do not exceed the amount of your annual election.
- The deadline for submitting reimbursement expenses incurred during the current calendar year is March 31 of the following year.
- You cannot transfer amounts between your accounts, nor can you use funds from one account to pay expenses eligible under the other account, or vice versa.
- Expenses you incur before becoming a participant, or after participation ends, are not eligible.
- Your salary-related benefits, including your short-term and long-term disability, basic and supplemental term life insurance and basic and optional AD&D, are not affected by the reimbursement accounts. These benefits are based on your total, unreduced pay.
- You cannot fund your monthly medical, dental or vision plan contributions through a reimbursement account. These contributions are automatically deducted on a tax-free basis through separate payroll deductions.
- If you enroll in the Consumer Choice Option medical plan and also participate in a health care reimbursement account, you must submit claims to your health care reimbursement account **first**. When that account is used up, additional claims may be submitted to your Employee Choice Account. See page 21 for details.

Your Long Term Care Keys

Personal long term care (LTC) insurance policies are available at special group rates for you and your family, including spouse, parents and grandparents, siblings and children (who are at least age 18). Current participants do not need to make an election during the annual enrollment period as your benefit will remain in effect until you request to make a change or cancel coverage. If you chose not to enroll for coverage during the initial offering, you may apply for coverage at any time, subject to evidence of insurability (proof of good health).

Today nearly 1.3 million Americans of all ages need assistance with everyday activities, the type of assistance required whether at home or in a nursing facility. It doesn't take long for the costs of a long-term illness or injury to deplete your savings and assets. LTC insurance through the company offers low group rates and convenient payroll deductions.

Newly hired active employees will have a 30-day period from date of hire to enroll. Several of the current options do not require completion of a medical questionnaire when you enroll within this period. If you did not enroll when the coverage was first offered, you will have to complete a medical questionnaire when you apply for coverage. Coverage for any family members will always require a medical questionnaire.

First, request a long term care enrollment kit by calling the Peabody Benefits Call Center at 1-800-633-9005 or by sending an e-mail to **benefits@peabodyenergy.com**. Then, send your completed application to UNUM, along with the completed medical questionnaire (if required) and any other required documentation.

The following options are available and are fully described in the long term care enrollment kit.

BENEFIT DURATION	3 Years	6 Years	Unlimited
MONTHLY BENEFIT AMOUNTS	$2,000 to $6,000	$2,000 to $6,000	$2,000 to $6,000
LIFETIME MAXIMUM	$72,000 to $216,000	$144,000 to $432,000	Unlimited

The premium rates for you and your family members are individually calculated based on age, duration of the policy and the selected monthly benefit. The younger you are when you purchase coverage, the lower the cost. Premiums for you and your spouse will be paid through payroll deduction using after-tax dollars. All other eligible family members will be billed directly by the carrier on a quarterly, semi-annual or an annual basis.

See the long term care enrollment kit for an application, rate sheets and a full description of the various combinations of coverage. You can also access enrollment materials via the UNUM link on My HR Profile.

Retiree Medical

MEDICAL PREMIUM REIMBURSEMENT (MPR) PROGRAM

The MPR program provides a benefit to help you purchase medical coverage after retirement. Under the program, the company will provide an allowance toward the purchase of medical coverage for those retiring on or after January 1, 2003. The dollar amount will be based on your years of service as defined by the plan with Peabody Holding Company, Inc. and selected subsidiaries and affiliates (Peabody). The formula for calculating the dollar amount is improving effective January 1, 2005.

Please note that the MPR program is an unfunded plan as defined by federal law. This means that the money will be paid out of the company's general assets and has not been placed in a trust or special account.

Who Is Eligible for the MPR Program

To be eligible to participate in the MPR program, you must meet both of the following requirements on your last day of employment with the company:

- You are at least age 55.
- You have 10 or more years of service as defined by the plan.

How the MPR Program Works

At the time of termination of employment, your allowance will be based on your age and years of service with Peabody (with years of service rounded up to the next full year) as shown in the table below:

FOR SERVICE:	MEDICAL PREMIUM REIMBURSEMENT ALLOWANCE
Prior to age 50	$1,000 x Years of Service, plus
From age 50-54	$3,000 x Years of Service, plus
At age 55 and beyond	$5,000 x Years of Service

Regardless of your age or service, the maximum allowance you may receive is $65,000. You can view a table on the Peabody intranet to help you determine the level of benefit that will apply based on your own age and years of service. From the Peabody intranet, go to Human Resources/Benefit Documents/ Medical Premium Reimbursement (MPR) Program.

You can use the allowance at any time in the future to request reimbursement for any premiums you pay for medical, dental or vision insurance for you and your eligible dependents (as defined by the plan). This insurance coverage can be through another employer's group health plan, an individual policy, COBRA, Peabody's Catastrophic Medical Plan or Medicare.

If you die before the entire reimbursement allowance is used, your eligible dependents may continue to be reimbursed for such premiums until the allowance is exhausted. You will not be eligible to receive a lump-sum cash payment through the MPR program. If there are no dependents eligible for benefits, the balance of your allowance remaining at the time of your death will be forfeited.

For those who elect not to purchase private medical coverage, eligible employees will be able to use their MPR allowance towards the purchase of basic Catastrophic Medical Plan coverage through Peabody, as described below.

Claims for Reimbursement

At this time, the MPR program is administered by Tri-Star Benefit Systems, Inc. (Tri-Star), a third-party administrator located in St. Louis, Missouri. For reimbursement of premiums for coverage other than the Peabody Catastrophic Medical Plan, you will need to send proof of your paid medical premiums to Tri-Star. Reimbursements will be made once a month for the current month or past month premium payments. Payments will not be made for future dates of coverage.

If you elect coverage under the Catastrophic Medical Plan as described in the following section, you may elect to have your premium payments automatically deducted from your MPR allowance.

PEABODY CATASTROPHIC MEDICAL INSURANCE

Eligible retirees may elect coverage under Peabody's Catastrophic Medical Plan. The plan benefits are identical to the Option 1000 plan design that is described on page 10 of this booklet.

Who Is Eligible for Catastrophic Coverage

The eligibility rules are different than for the MPR program, although the two benefits can work together. To be eligible to participate in the Catastrophic Medical Plan, you must meet all of the following requirements:

- You are at least age 55.
- You have 10 or more years of service as defined by the plan.
- You must begin receiving your retirement benefits from the Peabody Holding Company, Inc. Retirement Plan for Salaried Employees within 31 days of the date your employment ends with the company.
- You must enroll within 31 days after your retirement date unless you elect COBRA coverage or are eligible for coverage through another employer as described in the next section.

Enrollment Guide

Important Plan Provisions

If you have coverage through another employer-sponsored group plan at the time of your retirement or obtain other employer-sponsored group coverage after you commence retirement, you may delay your participation in the Catastrophic Medical Plan. If such employment begins after you retire, you may temporarily suspend participation under the Catastrophic Medical Plan. If you later lose that coverage, you may elect coverage under the Catastrophic Medical Plan as long as you provide proof that you lost the other coverage. This proof must be provided within 31 days of the date coverage was lost, and participation in the Catastrophic Medical Plan must begin immediately thereafter. If you were not a participant in the Peabody medical plan as an active employee because you had coverage through another employer-sponsored group plan, you may elect coverage under the Catastrophic Medical Plan upon retirement. You must provide proof of your other coverage at the time of your election. You may contact the Peabody Benefits Call Center at 1-800-633-9005 for an enrollment form.

Only eligible dependents at the time of retirement can be covered under the Catastrophic Medical Plan; new dependents cannot be added at a later date. If you have a dependent who is covered under another group health plan at the time you elect coverage under the Catastrophic Medical Plan and that dependent later loses the coverage, that dependent can be added within 31 days of the loss of coverage provided they continue to meet the eligibility rules under the plan.

In the event of your death while covered under the Catastrophic Medical Plan, your surviving dependents may continue coverage as long as they remain eligible.

Upon your retirement, you may elect COBRA continuation under the Peabody medical plan you are participating in at the time of your retirement. At the end of your COBRA continuation period, you may then elect coverage under the Catastrophic Medical Plan.

The Cost of Coverage

You will receive an enrollment form for the Catastrophic Medical Plan coverage with your retirement paperwork. The form will include the applicable monthly rates for coverage. You and other participants will be responsible for the full cost of the plan.

Listed below is the cost for Catastrophic Medical Plan coverage in 2005. These costs are subject to change each year. Once enrolled, you may use any of your MPR allowance to offset the cost of Catastrophic Medical Plan coverage.

OPTION 1000	MONTHLY COST
RETIREE ONLY	
Not Medicare Eligible	$357.08
Medicare Eligible	$221.03
RETIREE PLUS ONE DEPENDENT	
Both Not Medicare Eligible	$714.19
Both Medicare Eligible	$442.04
Retiree Medicare Eligible/Dependent Not Medicare Eligible	$578.12
Retiree Not Medicare Eligible/Dependent Medicare Eligible	$578.12
RETIREE PLUS TWO OR MORE DEPENDENTS	
All Not Medicare Eligible	$911.60
Retiree and Spouse Medicare Eligible/Dependent Child Not Medicare Eligible	$736.13
Retiree Medicare Eligible/Spouse and Dependent Child Not Medicare Eligible	$823.87
Spouse Medicare Eligible/Retiree and Dependent Child Not Medicare Eligible	$823.87

Making the Right Choice

Because the Catastrophic Medical Plan provides only a basic level of coverage with high deductibles, you should consider this decision carefully and compare the coverage features and cost with that available in other plans on the market for which you qualify.

When you become eligible for Medicare, you will want to compare the cost and features of Peabody Catastrophic Coverage with Medicare and/or Medigap coverage. (Keep in mind that the MPR program can also reimburse your premiums for Medicare and Medigap coverage, up to your credited allowance.)

Enrollment

This enrollment guide provides highlights of your benefit plans. This is not a complete detailed description. See your summary plan description booklets for more details about the program. The benefit plans are operated according to the terms of legal documents including insurance contracts and plan documents. If there is a difference between this enrollment guide or the summary plan description booklet and the actual plan documents, the plan documents will govern. This enrollment guide is not a substitute for the official plan documents nor is it an employment contract. The company reserves the right to amend or terminate the program in whole or in part at any time. This summary of material modifications is part of your summary plan description and should be kept with your other booklets.

Peabody and Its Affiliates: The use of the words "Peabody," "the company," and "our" relate to Peabody, our subsidiaries and our majority-owned affiliates.