Benefits Enrollment Guide 2008

Dodge Hill Mining Co., LLC
Hourly Employees

Contents

Welcome to Benefits Enrollment

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, optional accidental death and dismemberment (AD&D) coverage as well as flexible spending 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. You 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.

What You Need to Do for Open Enrollment

If you would like to make a change to your benefit selections or a change to your covered dependent(s) for 2008, you must complete the enrollment process by **November 26, 2007**.

If you do not want to make a change to your benefit selections for 2008 – do nothing! Your 2007 benefits (except for Flexible Spending Account) will carry over to 2008.

If you would like to contribute to a Flexible Spending Account (FSA) in 2008, you must complete the enollment process by **November 26, 2007**. The IRS requires participants to make an election each year.

What You Need to Do if You Are a New Hire

If you are a newly hired employee and you do not return an enrollment form within 31 days of your eligibility date, you will have only basic life, basic AD&D and business travel accident coverage and, for full-time employees, disability coverage.

Your Choices are Binding for 2008

The choices you make during the enrollment period are binding for 2008. 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 2008 (with changes effective January 1, 2009) unless you have a qualifying change in family status.

Any Questions?

If you have questions concerning your 2008 enrollment, you may contact the Patriot Benefits Call Center at 800-633-9005.

What's Changing In 2008

There are, however, a few changes that you will need to be aware of as you prepare to make your benefit elections for the next year. More details on the following changes are located in the applicable section of this enrollment guide.

- Effective January 1, 2008, new retiree medical benefits! You become eligible for retiree medical benefits if you leave the company after age 55 and have at least 5 years of service. Upon retirement, you receive a one-time allowance you can apply toward the purchase of your own health care policy. In addition, you will be eligible to participate in the Patriot Coal Corporation's Catastrophic Medical Plan. See more information in the Retiree Medical Section of this document.
- For Health Care Flexible Spending Account (FSA) participants, the IRS requires participating discount stores and supermarkets to implement a system that allows BeneFLEX VISA Card to identify FSA-eligible items at the checkout. For more information, refer to the FSA section in this enrollment guide or the enclosed BeneFLEX brochure.

Eligibility and Enrollment

If you are a full-time hourly employee, you are immediately eligible for coverage. Temporary employees are not eligible.

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 medical, dental, vision, and optional AD&D (but not dependent term life insurance coverage), your disabled child, regardless of age, provided he or she is permanently incapable of self-support due to a mental or physical disability. The disability must have occurred before age 19.

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 for the optional benefits, your contributions for vision, optional AD&D and the flexible spending accounts will automatically be deducted in equal installments from the first four paychecks of each month on a before tax basis. This means you will not have to pay any federal or state taxes on the amount of your salary used to pay for these plan contributions.

Your costs for supplemental term life insurance and dependent term life insurance will be paid with after-tax dollars. Deductions for employee term life coverage will be automatically taken out in equal installments from the first four paychecks of each month. Deductions for dependent term life coverage will be taken out the first two paychecks each month.

Medical Benefits

During annual enrollment, you choose the medical coverage you need for your family.

Coverage Categories

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 coverage for yourself.

The Cost for Coverage

There is currently no cost for coverage.

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 employer coverage will always be primary for you as an employee, but your employer 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.

Changing Your Medical Coverage

The choices you make during the annual enrollment period are effective January 1, 2008 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 except under special situations.

- 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. You must 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 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 if you complete a new enrollment form within 31 days.
- You may decide not to elect medical under the company plan because you and/or your dependents have other coverage, such as through your spouse's employer. In this situation, you may enroll and/or add dependents to your coverage if the other coverage ends because you or your dependents are no longer eligible for such other coverage; an employer makes a significant change to the cost or benefits of the other coverage, or 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

Certain limits will apply to pre-existing conditions when you or your dependents are first enrolled for medical coverage.

- 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 in the previous paragraph.
- 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.

Medical Claims Administrator

The medical claims are administered by BlueCross BlueShield of Illinois.

What is the BlueCross BlueShield Network?

The BlueCross BlueShield network is a health care system established by BlueCross BlueShield. The network brings together doctors, hospitals, and other providers to offer you health care at an affordable cost. The network helps control health care costs because providers in the network agree to accept negotiated fees for the care they deliver to you. Before joining the network, health care providers must submit to a credentialing process by BlueCross BlueShield. Only licensed health care providers are considered.

The Advantages of Using the Network

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

- If you use a network provider, your share of the cost is less. If you choose an out-of-network provider, you may pay more out of your own pocket for certain expenses.
- Because the providers who participate in the network have agreed to prearranged fees, you don't have to worry about being charged more for your medical care than what's considered a usual, customary, and reasonable fee. When you get care outside the network, and the fee is above what's usual, customary, and reasonable, you will have to pay the difference.
- In most cases, you don't have to fill out claim forms when you use the network. That saves you time and effort. Simply present your health plan ID card when you visit a network provider. Your claims will be filed automatically and BlueCross BlueShield will pay the benefits directly to the provider. For out-of-network providers and other expenses, you will submit your claims to BlueCross BlueShield of Illinois, if the provider does not submit the claim on your behalf. In addition, claims for secondary benefits from the company group medical plan, should go directly to BlueCross BlueShield of Illinois.

For a list of participating doctors and hospitals, you may call 1-800-810-2583 or 1-888-873-2227, or visit the web site at *www.bcbsil.com*.

Blue Care Connection (BCC) Program and Hospital Precertification

All hospitalizations and certain other types of care must be approved by Blue Care Connection (BCC) program of BlueCross BlueShield of Illinois. BCC group will precertify (authorize in advance as being medically necessary) certain types of care and make sure that it is medically necessary.

If you use a network provider, the provider should call precertification for you; however, it's your responsibility to precertify by calling BCC at 1-800-325-4705 before receiving care. If you use a non-network provider, they are not required to call for precertification and it continues to be your responsibility to call BCC for precertification.

Remember, if you don't call first, you must pay an additional $250 penalty for each procedure that is not precertified. This precertification penalty is in addition to your annual deductible, percentage share of hospital expenses and out-of-pocket maximum.

If You Have an Emergency

If you have an emergency, you should seek medical help immediately – within the network or from a non-network provider. In either case, if you are admitted to a hospital, you or someone on your behalf must call BCC within two working days of your admission. If the emergency visit meets the requirements of "urgent or emergency care" as defined by the plan, then the covered charges are treated as if they were from a network provider, whether you go to a network or non-network provider.

If You Need Care Your Network Doctor Can't Provide

If there is no network doctor who provides a certain type of service, you may be able to go to a non-network provider and have your covered expenses paid at network levels. To be eligible for this, you must call BlueCross BlueShield of Illinois at 1-888-873-2227.

Traveling in the United States

If you need emergency medical attention, go immediately to the nearest medical facility. Then follow standard emergency procedures (see the above section on *If You Have an Emergency*). If you are traveling and you need non-emergency medical attention, call BlueCross BlueShield of Illinois at 1-888-873-2227. The BlueCross BlueShield representatives will direct you to a network provider in the area if one is available. If you do not use a network provider when one is available, any covered expenses you have will be paid at non-network levels.

Medical Plan Summary

Medical Plan Summary		
	Network	Non-Network
Annual Deductible	None	$300 individual/$600 family
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE		
Wellness	100% up to $500/individual	60% up to $500/individual
Hospital Services	80%	60%
Emergency Medical Care	80%	80%
Outpatient Surgery	80%	60%
Ambulance	100%	100%
Physician Visits	80%	60%
Mental Health Inpatient	80% Limited to 30 days/calendar year Limited to 60 days lifetime maximum	60%
Outpatient	80% Limited to 50 visits/calendar year	60%
Substance Abuse (Copayment does not apply to out-of-pocket maximum) Limited to a maximum of $10,000 per calendar year combined. Limited to a lifetime maximum of $25,000 combined. Inpatient	50% Limited to 30 days/calendar year	50%
Outpatient	50% Limited to 30 days/calendar year	50%
Hospice Care	80%	60%
Coordinated Home Care	100%	60% Limited to 30 visits/calendar year
Skilled Nursing	80% Limited to 60 days/calendar year	60%
Chiropractic Care	80% Limited to 12 visits/calendar yr.	60%
Speech Therapy	80% Limited to 20 visits/calendar year	60%
Physical & Occupational Therapy	80% Limited to 60 combined visits/calendar year	60%
Organ transplants	80% Limited to $1,000,000 individual/lifetime maximum	60%
ANNUAL OUT-OF-POCKET MAXIMUMS YOU PAY (Includes deductible and copayment)		
Out-of-Pocket Maximum	$1,000/individual $2,000/family	$2,000/individual $4,000/family
LIFETIME MAXIMUM BENEFIT	$2,000,000	

Participating physicians agree to accept a special rate. Coverage for other providers is limited to usual, reasonable, and customary (UCR) expenses. All hospitalization and certain other types of care must be approved by the Blue Care Connection (BCC) at the number shown on your medical plan ID card.

Coverage for Disabled Employees

Disabled employees will remain eligible for group health coverage for a maximum period of 30 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).
- If you are receiving long-term disability (LTD) benefits, your medical coverage will continued for a maximum period of 24 months.
- Coverage will end prior to the 30-month maximum if you are no longer receiving LTD benefits.
- COBRA will not be available at the end of the 30-month period.

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 lymph edemas.

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

Personal Health Resource Program

The Personal Health Resource is available to help individuals with chronic conditions better manage their health. The current programs that are available to eligible members include the following: diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease, musculoskeletal chronic pain and oncology.

The Personal Health Resource program is provided by Matria, our partner in helping you improve your health. Because the company believes in the health of its employees and their dependents, Patriot is offering this confidential program at no cost.

The primary goal of the Personal Health Resource is to improve the overall health of those who have been diagnosed with chronic conditions along with providing assistance in managing the condition. Selected participants will have access to Nurse Connections^{SM}, the 24-hour toll-free support line, which will allow one-on-one contact with an experienced, registered nurse for questions regarding your condition, symptoms, medications, or other health information. Participants can also conveniently access additional educational information at the Matria web site, http://www.ecorsolutions.com. In addition, complimentary educational materials will be mailed periodically.

Prescription Drug Benefits

Your prescription drug benefits are administered by Prescription Solutions. Here is a brief summary of how your prescription plan will be administered.

- GENERIC REQUIREMENT: The plan requires the use of generic drugs whenever a generic form is available. This means if your doctor or you select a brand-name drug when a generic is available, you will pay the generic co-payment plus the difference in cost.
- PREFERRED DRUG LIST: Drugs on the plan's preferred drug list are preferred by the plan generally due to their effectiveness and/or cost. When a generic drug is not available, you are encouraged to choose a brand-name drug from this list. Brand-name drugs not on this list are considered less cost effective and will require a higher "non-preferred" co-payment.

  If you or your doctor chooses a brand-name drug that's not on the plan's preferred drug list ("non-preferred"), you will pay a higher co-payment.

Prescription Copayment Summary

PRESCRIPTION Plan Summary		
	Employee Copayment	
	Retail (30 day supply)	**Mail Service (up to a 90 day supply**
Generic Drugs	$10	$20
Preferred Brand-Name Drugs	$20	$40
Retail Non-Preferred Brand Name Drugs	$30	$60

Note: Your copayment will never exceed the cost of the medication.

Dental Benefits

The company provides coverage under a dental plan administered by Delta Dental of Missouri. This coverage is provided at no cost to you. 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

The company currently provides this coverage to you at no cost.

Coverage Categories

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 coverage for yourself.

Dental Plan Summary

DENTAL PLAN SUMMARY				
	PREVENTIVE*	**BASIC***	**MAJOR***	**ORTHODONTIA***
Annual Deductible	$0	$50 individual/$150 family per year		$0
Amount the plan pays	100%	80%	60%	60%
Maximum	$1,000 per person/per year annual combined			$1,000 lifetime

* Coverage limited to allowable fees charged by the majority of Delta Dental participating dentists. Orthodontia coverage is limited to individuals up to age 21.

Delta Dental of Missouri 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 co-payment 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.

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, 2008, 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:

- If you gain a new dependent through marriage, birth, adoption or placement for adoption, you may add the new 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.

The plan will not cover treatment already in progress on the date your coverage begins.

Vision Plan

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).

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 Plan Summary

Vision Care Benefits Summary			
Service	Plan pays after Co-payment		Frequency Covered
	Network (VSP Providers)	Non-network (maximum reimbursement)	
Eye examination	100%[1]	$38[1]	Every 12 months
Materials			
Eyeglass lenses, one pair			Every 24 months
Single-vision	100%[2]	$31[2]	
Bifocal		$51[2]	
Trifocal		$64[2]	
Frames	$120	$45	
Elective contact lenses, one pair (instead of eyeglasses)	Up to $105	Up to $105	

(1)You pay a $10 co-payment
(2)You pay a $15 co-payment

The following table outlines your cost for vision coverage. The company does not contribute toward the cost of the optional vision care coverage.

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

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 do not have an ID card and 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 1-800-877-7195 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 (Patriot Coal Corporation). 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 co-payment for each examination and a $15 co-payment for eyeglass lenses and frames (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, plus the eye examination co-payment.

Non-Network Care

You may obtain vision services from any licensed vision provider, although using non-network providers will greatly affect your out-of-pocket expenses and the claims procedure.

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 co-payments), 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 co-payment 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 2008 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 2007 enrollment period, you may not enroll for coverage in 2008. (Your next opportunity to enroll will be in the fall of 2008, with coverage effective January 1, 2009). 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 2008. 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.

Basic and Supplemental Life Insurance Benefits

The company provides a “basic” employee term life insurance equal to one and one-half times your annual base salary (maximum $500,000) at no cost to you. In addition to your basic term life insurance benefit, you have the option to purchase supplemental employee term life insurance coverage equal to one, two, three, four or five times your annual base salary, up to a maximum of $500,000. For purposes of life insurance your base annual salary is calculated by multiplying your base hourly rate by 2080 hours. UNUM is the basic and supplement life insurance provider.

How Your Basic and Supplemental Coverage Works

All eligible employees receive a basic term life insurance benefit equal to one and one-half times annual base 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 base 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.

The basic and supplemental employee term life insurance maximum is $500,000 for each policy.

Supplemental Employee Term Life Insurance Plan

Supplemental employee term life insurance options are multiples of your annual base salary rounded to the next $100. For example, if your annual base salary is $40,000 and you choose two times, your supplemental employee term life insurance benefit is $80,000 and your basic term life insurance benefit is $60,000 (for a total coverage amount of $140,000).

Changing Your Coverage

You may enroll for supplemental employee life coverage during this annual enrollment period, subject to evidence of insurability (proof of good health) requirements described in the next section. You may drop or decrease coverage during any future enrollment period.

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.

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 following your date of hire 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 requested from your local Human Resources representative. 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 on 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, 2008), your coverage amount and whether or not you use tobacco products. The rates for the supplemental term life insurance can be found on your enrollment form.

Dependent Life Insurance Plan

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.
- You may choose any amount of coverage for your spouse from $10,000 to $60,000, in multiples of $10,000. If you choose coverage for your spouse in excess of $50,000, evidence of insurability will be required.

Your spouse's premium rates will depend on your spouse's age (as of January 1, 2008) and the amount of coverage. In addition, rates for dependent term life insurance for your spouse vary depending whether or not your spouse smokes or uses other tobacco products. Any time your spouse has gone at least 12 consecutive months without smoking or using other tobacco products, your spouse is eligible for the lower "Non-Tobacco" rates. If your spouse uses tobacco now and you elect the "Tobacco" rates but your spouse later stops using tobacco, you can change to the "Non-Tobacco" rates after your spouse has been tobacco-free for 12 months. The rates for the spouse dependent term life insurance are the same as rates for the employee supplemental coverage can be found on your enrollment form.

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 at a cost of $0.35 per month.
- Child coverage in the amount of $10,000 per child at a cost of $0.70 per month.

The cost of each level 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.

Changing Your Coverage

You may choose dependent life insurance during this annual enrollment period. The choices you make during this enrollment period are effective January 1, 2008. 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 spouse within 31 days of when he/she first becomes eligible, and then you decide to enroll him/her later, coverage for your spouse will be limited to $10,000. During the following annual enrollment, you may choose to increase the spouse coverage amount to $20,000, the following year $30,000 and so forth. The same rule applies if you do not enroll your child(ren) within 31 days of eligibility and then you decide to enroll for child coverage at a later date. The coverage will be limited to $5,000. During the following annual enrollment, you may choose to increase the child(ren) coverage amount to $10,000.

Basic Accidental Death and Dismemberment Benefits

The company provides all eligible employees with basic accidental death and dismemberment (AD&D) insurance benefits equal to one and one-half times your annual base 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 a result of an accident. Zurich American Insurance Company is the provider for the basic accidental death and dismemberment coverage.

The company also provides a business travel accident insurance benefit equal to five times your annual base salary ($150,000 minimum; $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 when you enroll for benefits.

Optional Accidental Death and Dismemberment Plan

You may purchase optional accidental death and dismemberment (AD&D) insurance 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. Zurich American Insurance Company is the provider for the optional accidental death and dismemberment coverage.

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 base 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.

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 COVERAGE EQUALS THIS PERCENTAGE OF YOUR COVERAGE
Spouse and dependent children	55% spouse, 15% each child*
Spouse, no children	60% spouse
Dependent children, no spouse	25% each child*

**The maximum benefit for each child is $150,000.*

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.

Disability Benefits

The company provides short-term and long-term disability coverage under the Disability Plan to all full-time employees. The company has contracted with Liberty Mutual to administer disability benefits. Because you do not have to make an election for disability benefits, this coverage 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

Although you are immediately eligible for short-term disability coverage, the plan will not pay benefits until you have been absent due to an illness or injury for at least seven days. After you have been absent from work due to an illness or injury for seven consecutive days or longer, the plan will pay 60% of your daily base pay thereafter, up to a total of 180 consecutive calendar days for an approved absence.

The company currently pays 100% of the cost for this coverage.

If You Become Disabled

Liberty Mutual is the administrator of the disability plan. Liberty Mutual 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.

Listed below are the steps that will be used in the management of your disability claims. If you are absent from work due to an illness or injury for seven consecutive calendar days or longer, you must contact Liberty Mutual on the eighth day at 1-866-502-8837 or *www.mylibertyclaim.com* to file an STD claim. Liberty Mutual 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. Liberty Mutual will manage your claim for STD. If you have a recurrence of a prior disability, you must call Liberty Mutual immediately.

Liberty Mutual will:

- Ask you about your condition and medical treatment.
- Ask you to have your physician provide relevant medical information to Liberty Mutual.
- Review the medical information provided by your doctor.
- Consult with your supervisor about the job requirements.
- Approve your absence, if appropriate.
- Notify you 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 Liberty Mutual, you can call 1-866-502-8837 or go to *www.mylibertyclaimstatus.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 Liberty Mutual claims representative.

Long-Term Disability (LTD) Benefits

If your approved disability continues after 180 consecutive calendar 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 for a maximum of 24 months.

The plan will not pay LTD benefits for a disability that begins during the first twelve months of coverage if it is related to a pre-existing condition. A condition will be considered pre-existing if you received any treatment, consultation or prescription drugs for the condition during the twelve months immediately before the effective date or your coverage.

Family and Medical Leave

The Family and Medical Leave (FML) is administered by Liberty Mutual.

If you have an absence that you feel qualifies for FML, you can contact Liberty Mutual at 866-502-8837. If you have an absence due to your own serious medical condition, Liberty Mutual will automatically review your leave for possible FML.

Along with answers to a series of questions, you will be asked to provide medical certification for leaves other than your own serious health condition.

Employee Assistance Program (EAP)

The company is pleased to provide an Employee Assistance Program as part of your benefit package. The Employee Assistance Program (EAP) is available to you and your dependents at no cost to you. Your EAP is administered by Deaconess CONCERN.

Services provided by the EAP are:

- Counseling
  - Family.
  - Parenting.
  - Relationship.
  - Alcohol and substance abuse.
  - Loss and grief.
  - Stress management.
  - Job related issues.
- Wellness and lifestyle consultation.
- Legal consultation, resources and referrals.
- College planning information and referrals.

All the services offered under the program are entirely confidential and free of charge. You may contact Deaconess CONCERN at 800-874-7104 for more information about the services.

Flexible Spending Accounts

You have two flexible spending accounts that allow you to pay for many common expenses using untaxed money deducted from your paycheck: the health care flexible spending account (HC FSA) and the dependent care flexible spending account (DC FSA). 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.

The flexible spending accounts are administered by BeneFLEX HR Resources, Inc. (BeneFLEX). You can visit their website at *www.beneflexhr.net*. Click on FSA Section 125 to obtain forms and find information about filing claims, account balances, eligible expenses and more. For questions, you may also contact BeneFLEX via phone at 314-909-6979 or 800-631-3539. Be sure to identify yourself as a Patriot Coal Corporation employee.

If you elect to participate in the HC FSA, you will automatically receive the BeneFLEX VISA Card. See more information below regarding this card.

Health Care Flexible Spending Account (HC FSA)

The tax-free HC FSA 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 save taxes on your deductibles and other out-of-pocket expenses by using the HC FSA. You may also 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 or check the IRS web site.

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 from the first four pay checks each month and placed in your HC FSA.

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.

BeneFLEX Card

The BeneFLEX VISA Card (Card) works like a "debit" card since the cost of your qualified products or services are deducted automatically from your HC FSA account. Use the card at any eligible medically coded business that accepts VISA. In most situations, using the card will eliminate out-of-pocket cash outlay, claim forms and the need to wait for your reimbursement.

Here's some information you need to know about the BeneFLEX Card:

- If you are enrolling in the HC FSA for the first time, you will receive two BeneFLEX VISA Cards in January 2008.
- The Card will only work at businesses that have a specific "merchant code" for health care products or services – such as your physician's office or a pharmacy. If you are asked to select Credit or Debit, select Credit.
- Effective January 1, 2008, new IRS rules allow you to use your Card in participating discount stores and supermarkets that have the Inventory Information Approval System (IIAS) that can identify FSA-eligible items at the checkout. This means you can use your Card at participating stores that offer this feature for the total FSA-eligible amount and NO receipts are needed to verify the eligibility of the purchase. You still need to save all your receipts because it is an IRS governed plan. Visit the BeneFLEX web site and click on the IIAS icon to access a list of participating merchants that have this feature.
- If you use your Card on or after January 1, 2008 in a discount store or supermarket that is not participating – even if you purchased FSA-eligible items in the store prior to January 1, 2008 – your Card may decline. Remember anytime you do not use your Card you can turn in a manual claim for reimbursement.
- **You are still responsible for keeping all your receipts**. The IRS requires every claim to be substantiated. BeneFLEX will notify you if you are required to submit a receipt.
- Keep your Card for next year. If you elect to participate in the HC FSA again in 2009, your Card will be "reloaded" with your new annual election. Otherwise, you will need to pay $10 for a replacement card in 2009.

For questions, contact BeneFLEX at 314-909-6979 or 800-631-3539. You may also learn more about the BeneFLEX Card at *www.beneflexhr.net* or in the BeneFLEX brochure included with this enrollment guide.

Dependent Care Flexible Spending Account (DC FSA)

You can use the DC FSA to pay the cost of dependent care for children up to age 13 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 DC FSA 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 DC FSA 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 flexible spending 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 year. Therefore, you should put aside money only for those expenses that you feel certain you will have in 2008.
- ↘ 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. Also, you may change your deposits to the dependent care flexible spending account if you must do so due to a change in dependent care providers, a change in your need for dependent care, or a significant increase in your cost for dependent 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 dependent care flexible spending account cannot exceed the amount you currently have deposited. Health care flexible spending 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.

Note: You must complete the enclosed enrollment form for 2008 if you want to participate in the Health Care or Dependent Care Flexible Spending Accounts.

Retiree Medical Benefits

Retiree Medical Program

The retiree medical 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 leaving the company on or after January 1, 2008. The dollar amount will be based on your years of service as defined by the plan with Patriot Coal Corporation and selected subsidiaries and affiliates (Patriot).

Please note that the retiree medical 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 Retiree Medical Program

To be eligible to participate in the retiree medical 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 5 or more years of service as defined by the plan.

How the Retiree Medical Program Works

When you end your employment with the company, your allowance will be based on your age and years of service with Patriot (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	$2,000 x Years of Service, plus
From age 50-54	$4,000 x Years of Service, plus
At age 55 and beyond	$6,000 x Years of Service

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, Patriot Coal Corporation'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 retiree medical 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 the retiree medical allowance towards the purchase of basic Catastrophic Medical coverage through Patriot, as describer below.

Claims for Reimbursement

At this time, the retiree medical program is administered by BeneFLEX HR Resources, Inc. (BeneFLEX), a third-party administrator located in St. Louis, Missouri. For reimbursement of premiums, you will need to send proof of your paid medical premiums to BeneFLEX. 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 retiree medical allowance.

Patriot Catastrophic Medical Insurance

Eligible employees may elect coverage under the Patriot Coal Corporation's Catastrophic Medical Plan.

Who Is Eligible for Catastrophic Coverage

The eligibility rules are different than for the retiree medical 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 5 or more years of service as defined by the plan.
- You must enroll within 31 days from the date you end your employment unless you elect COBRA coverage or are eligible for coverage through another employer as described in the next section.

Important Plan Provisions

If you have coverage through another employer-sponsored group plan at the time you end your employment or obtain other employer-sponsored group coverage after you end your employment, 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 Patriot 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 when you end your employment. You must provide proof of your other coverage at the time of your election. You may contact the Patriot Benefits Call Center at 1-800-633-9005 for an enrollment form.

Only eligible dependents at the time you end your employment can be covered under the Catastrophic Medical Plan; new dependents cannot be added at a later date. If you have a dependent that 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.

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

The Cost of Coverage

An enrollment form for the Catastrophic Medical Plan coverage will be available when you terminate employment and meet the eligibility requirements. 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 2008. These costs are subject to change each year. Once enrolled, you may use any of your retiree medical allowance to offset the cost of Catastrophic Medical Plan coverage.

Catastrophic Medical Plan	Monthly Cost
Retiree Only	
Not Medicare Eligible	$460.53
Medicare Eligible	$103.72
Retiree Plus One Dependent	
Both Not Medicare Eligible	$921.09
Both Medicare Eligible	$207.42
One Medicare Eligible/One Not Medicare Eligible	$564.26
Retiree Plus Two or More Dependents	
All Not Medicare Eligible	$1,175.70
Retiree and Spouse Medicare Eligible	$345.37
One Medicare Eligible/One Not Medicare Eligible	$760.54

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 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 Patriot Coal Corporation's Catastrophic coverage with Medicare and/or Medigap coverage. (Keep in mind that the retiree medical program can also reimburse your premiums for Medicare and Medigap coverage, up to your credited allowance.).

What You Must Do To Enroll

If you would like to make a change to your benefit selections or a change to your covered dependent(s) for 2008, you must complete the enrollment process by **November 26, 2007**.

If you do not want to make a change to your benefit selections for 2008 – do nothing! Your 2007 benefits (except for Flexible Spending Account) will carry over to 2008.

If you would like to contribute to a Flexible Spending Account (FSA) in 2008, you must complete the entire enollment form and submit it by **November 26, 2007**. The IRS requires participants to make an election each year.

New Hires

If you are a new employee, you must return the enrollment form within 31 days of your eligibility date or you will have only basic life, basic AD&D and business travel accident coverage, and for full-time employees, disability coverage.

This enrollment guide provides highlights of your benefit plans. This is not a complete detailed description. 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 and the summary plan description booklet, the actual summary plan description (SPD) 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 part at any time. This summary of material modifications is part of your summary plan description and should be kept with your other booklets.

Patriot and Its Affiliates: The use of the words “Patriot,” “the company,” and “our” relate to Patriot Coal Corporation, our subsidiaries and our majority-owned affiliates.

Health Care Flexible Spending Account Worksheet

Use this worksheet to help estimate how much money to contribute to your health care flexible spending account for health expenses not covered by the benefit choices you're making. You may contribute up to $5,000 annually. Remember to plan your contributions carefully. If you contribute more to your account than you can use during the year, you lose the balance. As a first step, it may be helpful to list your expenses for this year. Annual contributions will be withheld in equal installments from your first four paychecks of each month throughout the year.

ESTIMATED ANNUAL EXPENSES (that are not reimbursed by an insurance plan)	ESTIMATED COST	
	Current year	**Next year**
Medical plan deductibles	*$*	*$*
Medical plan co-payments or expenses not covered – up to the out-of-pocket maximum per year	*$*	*$*
Co-payments for prescription drugs	*$*	*$*
Dental deductibles, co-payments or expenses not covered by the plan	*$*	*$*
Eye examinations, contacts and/or glasses not paid in full by the vision plan, or not paid if you choose not to enroll in the vision plan	*$*	*$*
Expenses for mental illness and substance abuse care above the medical plan limits	*$*	*$*
Chiropractic care	*$*	*$*
Hearing care	*$*	*$*
Birth control devices prescribed by a physician	*$*	*$*
Special services or equipment for the mentally or physically disabled	*$*	*$*
Over the counter medications	*$*	*$*
Other	*$*	*$*
TOTAL ANNUAL ESTIMATED OUT-OF-POCKET HEALTH CARE EXPENSES	*$*	*$*
	÷12	***÷12***
ESTIMATED MONTHLY CONTRIBUTION FOR HEALTH CARE EXPENSES =	*$*	*$*

Dependent Care Flexible Spending Account Worksheet

Use this worksheet to help estimate how much money to contribute to your dependent care flexible spending account to cover expenses for the care of your dependents while you work. You may contribute up to $5,000 annually depending on the income and tax filing status of you and your spouse. Remember to plan your contributions carefully. If you contribute more to your account than you can use during the year, you lose the balance. As a first step, it may be helpful to list your expenses for this year. Annual contributions will be withheld in equal installments from your first four paychecks of each month throughout the year.

ESTIMATED ANNUAL EXPENSES	ESTIMATED COST	
	Current year	**Next year**
Dependent care expenses for dependent children under age 13 and living with you	*$*	*$*
Babysitter		
Dependent care center	*$*	*$*
Nursery school (not in first grade and above)	*$*	*$*
Summer dependent care or camp (excluding overnight camp)	*$*	*$*
Expenses for mentally/physically disabled children of any age	*$*	*$*
Expenses for adults who are incapable of caring for themselves, who spend at least eight hours a day in your home and who are totally dependent on you for support	*$*	*$*
TOTAL ANNUAL ESTIMATED OUT-OF-POCKET DEPENDENT CARE EXPENSES	*$*	*$*
	÷12	***÷12***
ESTIMATED MONTHLY CONTRIBUTION FOR DEPENDENT CARE EXPENSES =	*$*	*$*