Benefits Enrollment Guide 2009

Hourly Employee - Grand Eagle Mining, Inc.
Ohio County Coal Company

Welcome to Benefits Enrollment

During the enrollment process, you will make selections for the coming year for medical, dental, vision, optional employee term life insurance, dependent term life insurance and 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. 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.

What You Need to Do to Enroll

You must complete and return the enclosed enrollment form if you want benefits for 2009 by **October 31, 2008**.

If you would like to contribute to a Flexible Spending Account (FSA) in 2009, you need to complete the entire enollment form and submit it by **October 31, 2008**. The IRS requires participants to make an election each year. **When considering your FSA contribution for the 2009 year, please take into account the new prescription drug co-payments and new deductibles.**

What You Need to Do if You Are a New Hire

If you are a new employee and you do not return an enrollment form within 31 days of your date of hire, you will have only basic life, basic AD&D and business travel accident coverage and, for full-time employees, disability coverage. The steps you must take during the enrollment period are spelled out under *What You Must Do to Enroll* on page 1.

Questions?

If you have questions concerning your 2009 enrollment, you may contact the Patriot Benefits Call Center by calling 1-800-633-9005.

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What You Must Do to Enroll

To complete the enrollment process, your completed enrollment form must be received in the Benefits Office in St Louis no later than **October 31, 2008** or if you are a new employee, within 31 days of your eligibility date (date of hire).

If You Do Not Enroll

If you do not complete the enrollment process by **October 31, 2008** your current 2008 benefits **will not** carry over to 2009. You will have only basic life, basic AD&D and business travel accident coverage and, for full-time employees, disability coverage, if you do not complete the enrollment process by the deadline.

If you are a new 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, if you do not complete the enrollment process by the deadline.

Your Choices Are Binding for 2009

The choices you make during the enrollment period are binding for 2009. 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 2009, unless you have a qualifying change in family status.

What's Changing In 2009

Your benefit package for 2009, has many changes from the previous year that you will need to be aware of as you prepare to make your elections for the next year.

- There is a new and improved medical plan including hearing aid benefits
- You may have three visits per calendar year for a dietician
- Lifetime maximum for your health insurance is now $2 million
- Caremark is the new Pharmacy Benefits Manager
- There are new copays for retail and mail order medications
- To ensure that you will have your mail order medications available to you, it is best to get new prescriptions for January 2009
- Vision benefits have been enhanced and the company is sharing the cost
- For Health Care Flexible Spending Account (FSA) participants, the IRS requires participating discount stores and supermarkets to implement systems that allow 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
- If you have dependents, they are eligible for company paid life insurance
- Optional life insurance rates have decreased for all age ranges and is now one to five times your annual base pay
- Optional life insurance for your spouse has increased options
- Optional Accidental Death and Dismemberment is now one to five times your annual base pay and has a new vendor
- Business Travel and accident coverage is now 2 1/2 times your base pay.

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.

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.
- 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 is eligible for medical, dental, vision and optional AD&D coverage (see dependent term life insurance for exceptions)

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, there are no contributions for medical and dental benefits. Your contributions for vision and optional AD&D will automatically be deducted in equal installments from each paycheck on a before-tax basis.

Your costs for optional employee term life and dependent term life coverage will be deducted in equal installments from each paycheck on an after-tax basis.

Medical Benefits

The 90/10 Preferred Provider Organization (PPO) medical plan is available for 2009. It is provided through Blue Cross Blue Shield (BCBS) of Illinois.

To check if your provider is in the BCBS network, you can:

- Ask at your physician's office
- After October 1, call BCBS at 1-888-873-2227
- Go online to *www.bcbsil.com*
    - Select Provider Finder on left side of web page
    - Select PPO as the health plan

Coverage Categories

For medical insurance coverage, you can choose any of the following. You must cover yourself to be able to cover a dependent.

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

Cost for Coverage

There will be NO cost to the employee for medical coverage for 2009. 100% of the cost will be paid by the company.

Things to Know

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. If you use emergency services and it is not a true emergency, a $100 penalty will be charged.

All hospitalization and certain other types of care must be approved under a Medical Services Advisory program. The penalty for not obtaining a precertification is $150.

Your Medical Plan Features

Feature	Coverage
Deductible	$100 for individual; $200 for family
Co-insurance	The company pays 90% if you use a network provider The company pays 70% if you use a non-network provider
Maximum Out-of-Pocket (includes deductible)	$500 for individual, $1000 for family
Coverage Begins	Date of Hire
Inpatient Hospital	The company pays 90% if you use a network provider The company pays 70% if you use a non-network provider after the deductible has been met
Outpatient Services	
Doctor's Office Visits and Services	
Emergency Room	The same as above but has a $100 penalty if used for non-medical emergencies
Wellness	100% covered up to $500 maximum per calendar year Not subject to deductible if in-network for non-network you are covered at 80% after deductible
Chiropractic Care	30 visit per calendar year $1200 maximum per calendar year
Hospital Precertification Penalty	$150
Mental Health and Chemical Dependency	Inpatient - up to 30 days/admission 90 days/lifetime Outpatient - $3000 maximum
Home Health Care	60 days per calendar year
Hospice	120 days/lifetime
Private Duty Nursing	$10,000 per calendar year
Hearing Care	1 hearing aid per ear every 2 years if use AHB network
Wigs and Hairpieces	If needed as result of radiation or chemotherapy
Infertility Coverage	Diagnostic coverage only
Physical Therapy	No limit
Occupational Therapy	No limit
Speech Therapy	No limit
Dietician	3 visits/calendar year
Lifetime Maximum	$2 million

Hearing Aid Benefit

A new hearing benefit is available for employees and spouses. American Hearing Benefit (AHB) is the company Patriot uses for hearing aid services. To locate an in-network provider, you may call AHB at 1-866-925-1287 or visit the web site at www.americanhearingbenefits.com. A representative of AHB will assist you in identifying the nearest participating provider in your area. It is important to tell the representative that you are an employee of Patriot Coal. Members who currently have a hearing aid provider may call AHB to determine if their provider is in-network. If the provider is not in-network, AHB will encourage and assist that provider in joining the network. Claims for Patriot members receiving services from AHB will be covered in-network, minus your deductible and coinsurance as applicable. If you use an out-of-network provider, you will be responsible for payment of the hearing claims.

Prescription Drug Benefits

Your new pharmacy benefit manager is Caremark. You will be receiving information and a mail order envelope through the mail from them. Listed below are the copays associated with your prescription benefits. Your co-payments do not count toward the annual health insurance deductible or the out-of-pocket maximum. You will receive new ID cards prior to January 1.

	Network	Non-Network
	No prescription deductible or out-of-pocket maximum	
Retail Generic Drugs (30-day supply)	$5 copay	
Retail Preferred Brand-Name Drugs (30-day supply)	$10 copay	
Retail Non-Preferred Brand-Name Drugs (30-day supply)	$25 copay	
Mail Service Pharmacy Generic Drugs (up to a 90-day supply)	$15 copay	
Mail Service Pharmacy Preferred Brand Name Drugs (up to a 90-day supply)	$25 copay	
Mail Service Pharmacy Non-Preferred Brand-Name Drugs (up to a 90-day supply)	$62.50 copay	

If your prescriptions are filled at a participating pharmacy, you will receive discounts, and the pharmacy will file your claims for you. If you use a non-participating pharmacy, you receive the same level of benefits, but you must file a claim for reimbursement with Caremark.

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

If you require a specialty drug, you will be contacted by Caremark's specialty drug unit to assist with filling your prescription.

Coordination of Benefits

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 Patriot coverage will always be primary for you as an employee, but Patriot 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, 2009, 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 medical coverage.	You can drop coverage at any annual enrollment period. If you drop coverage mid year, you must show proof of other coverage and have a qualifying event.
You elect No Coverage.	You can continue with No Coverage or enroll in the medical plan during an annual enrollment period.
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 Patriot.	You can drop Patriot coverage within 31 days of the date your other coverage starts. If you drop coverage, you must show proof of other coverage and have a qualifying event.
You gain a new dependent through marriage, birth or adoption.	You can change from No Coverage to the Patriot medical plan, or add the new dependent to your current Patriot coverage, within 31 days of the qualifying event.
You have coverage from another source and lose it during the plan year for certain reasons.	

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 the medical plan. 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 select another option if you complete a new enrollment form within 31 days.
- You may decide not to elect medical benefits under a company plan because you and/or your dependents have other coverage, such as through your spouse's employer. In this situation, you may enroll in the medical plan and/or add dependents to your coverage—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 medical coverage 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.

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, chronic obstructive pulmonary disease, asthma, musculoskeletal pain, cancer and coronary artery disease.** You may be contacted if you or a family member has one of the listed chronic conditions.

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 a 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. In addition, complimentary educational materials will be mailed periodically.

Dental Benefits

During annual enrollment you choose the dental coverage you need for your family. You may select the company dental plan through Delta Dental of Missouri, or you may choose No Coverage. Your dental coverage choice is completely separate from your medical election. There is NO cost to your for dental coverage.

Coverage Categories

For dental, you can select coverage for:

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

Dental Benefits Summary				
	Preventive	Basic	Major	Orthodontia
Deductible	$0	$50 per individual per calendar year		$0 (up to age 21)
Amount the Plan Pays	100%*	80%*	60%*	60%*
Maximum Benefits	$1,200 annual combined per person per calendar year			$1,900 (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 of Missouri, 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 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

	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.deltadentalmo.com***.

Changing Your Dental Coverage

The choices you make during the annual enrollment period are effective January 1, 2009, 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.

If you decline coverage now for you and/or your dependents, you may enroll during the next annual enrollment period with coverage effective January 1, 2010 but your benefits will be limited to preventive care services only during the first twelve months of coverage.

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.

Vision Benefits

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). An enhanced Basic Plan is being offered for 2009. In addition, a Plus Plan is offered to provide 100% coverage for the higher cost lenses, e.g. progressive lenses, polycarbonate lenses, scratch resistant and anti-reflection. Patriot is cost sharing the premiums with you for this benefit. There are no ID cards for this benefit.

Coverage Categories

For vision, you can select coverage for:

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

Vision Care Benefits Summary			
Service	Frequency	Network benefit (VSP Providers)	Non-network benefit (Maximum Reimbursement)
Eye examination	12 months $10 copay	100%	$38
Eyeglass Lenses Single-Vision Bifocal Trifocal	12 months	100% 100% 100%	$31 $51 $64
Frames	24 months $15 copay	Up to $120	$45
Contact Lenses (instead of eyeglasses)	12 months	Up to $125	$105

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
Basic Plan	$4	$6	$10
Plus Plan	$6	$9	$14

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 are not required to complete any up-front paperwork or obtain a benefit form. No ID card is required for coverage.

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 (Patriot Coal Corporation). You will 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 and/or a $15 materials copayment if you purchase frames or lenses. 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 greatly affect the amount of benefits you receive 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 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) If you choose special lenses and use a non-network provider but you didn't choose the Plus Plan, you will only receive an average savings of 30%.

Changing Your Vision Care Coverage

You may elect or continue vision coverage for 2009 if:

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

You may 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 2009. 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.

Employee Term Life Insurance Benefits

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 and one half times your annual base pay 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 Optional employee term life insurance coverage equal to one to five times your annual base pay.

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 Optional Coverage Works

All eligible employees receive a basic term life insurance benefit equal to one and one half times your annual base pay. 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 opportunity to purchase optional employee term life insurance coverage.

For purposes of both the basic employee term life insurance plan and the optional employee term life insurance plan, the coverage amount will be based on your current annual base Pay rounded to the next $1000. The coverage amount(s) will automatically be adjusted for Pay fluctuations.

If you die, the amount of your term life insurance coverage will be paid to the beneficiary you designate**. Please make sure you complete your beneficiary information on the back of your enrollment form**.

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

Optional Employee Term Life Insurance

As you can see from the following chart, optional employee term life insurance options are multiples of your annual base pay rounded to the next $1000. For example, if your annual base pay is $40,120 and you choose Option 2 (two times annual base pay), your optional employee term life insurance benefit is $62,000, and your basic term life insurance benefit is $82,000 (for a total coverage amount of $144,000).

Option 1	One times annual base pay
Option 2	Two times annual base pay
Option 3	Three times annual base pay
Option 4	Four times annual base pay
Option 5	Five Times annual base pay

Basic and optional employee term life insurance maximum is $500,000 for each policy.

Changing Your Coverage

You may enroll or change your optional 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 optional employee term life insurance coverage is if you have a change in family status that justifies a change. You must submit the appropriate change forms within 31 days of the event. At that time, you can decrease your coverage to any level or increase your optional 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

For 2009 open enrollment, you may elect the amount of insurance that you choose regardless of what you elected in 2008 as long as long as the amount of your election does not exceed $300,000. If you have provided evidence of insurability in 2008 to your employer's previous life insurance carrier, you will not be required to complete another evidence of insurability requirement.

If you elect optional 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 of good health will be required for any coverage requested in excess of $300,000.

If optional 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 may be obtained through the Benefits Department. 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.

How to Make the Right Choice

Your premium rates will depend on your age (as of January 1, 2009), and your coverage amount. The rates are:

AGE	**RATE**
< 25 – 29	.00006
30 – 34	.00006
35 – 39	.00009
40 – 44	.00015
45 – 49	.00025
50 – 54	.00042
55 – 59	.00067
60 – 64	.00102
65 – 69	.00162
> 69	.00258

Dependent Term Life Insurance Benefits

The company provides a “basic” term life insurance benefit for your dependents in the amount of $5,000 for a spouse and $2,000 for an eligible dependent child at no cost to you. The IRS requires that the employer cost of your basic dependent term life insurance coverage in excess of $2,000 be considered taxable income to you. This benefit helps provide you with protection against financial difficulties in the event of a loved one’s death. You do not need to make an election for this basic coverage.

In addition to this coverage, you may also purchase optional term life insurance for your spouse and/or your eligible dependent children. You may elect coverage for your dependents without electing optional life for yourself.

These are your choices for covering your spouse:

- No spouse coverage.
- Spouse coverage in the amount of $10,000 - $250,000 in increments of $10,000
- Amounts over $50,000 require evidence of insurability
- Spouse coverage cannot exceed employee basic and optional coverage combined

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.

Changing Your Coverage

You may choose dependent life insurance or change the amount of your dependent's coverage during the annual enrollment period. The choices you make during this enrollment period are effective January 1, 2009. However, coverage may be delayed if you are not actively at work due to illness or injury, 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.

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 your annual base pay ($500,000 maximum). 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.

Business Travel and Accident Insurance

The company will provide a business travel accident insurance benefit equal to two and one-half times your annual base pay through Hartford. You are eligible for this benefit if you are traveling on company business. This does not include your regular commute to work, driving during work, a leave of absence or vacation. You would receive all or a portion of your benefit if you suffer a covered loss within 365 days of an accident such as dismemberment, loss of sight, hearing or speech, paralysis etc. This coverage is in addition to AD&D.

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.

Optional Accidental Death and Dismemberment Benefits

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 one to five times your base pay ($500,000 maximum). 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, 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 that may result from these injuries.

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, 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. 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 a child.

In either case, your new coverage will become effective on the date of the event, provided you return your completed enrollment form within 31 days of the event..

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 salaried employees. Part-time employees are not eligible for disability benefits. The company has contracted with Liberty Mutual to administer disability benefits. Because you do not have to make an election for disability benefits, these will not appear as an option when you enroll for benefits. Your disability 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.

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.

Long-Term Disability (LTD) Benefits

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

Liberty Mutual, 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 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 and later for LTD, if necessary. 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 the same toll-free number (1-866-502-8837) or go to ***www.mylibertyclaim*****status.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.

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 is as follows: 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 that began 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.

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.

Services provided by the EAP are:

- Counseling (up to 5 sessions per issue)
  - 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.

The EAP for your state is listed below:

Kentucky: Deaconess CONCERN (800) 874-7104
St. Louis: BJC Employee Assistance Program (314) 729-4030
West Virginia: REACH Employee Assistance Program (800) 788-7322

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

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.

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 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 and 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:

- You will receive your BeneFLEX VISA Cards before January 2009.
- 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.
- 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.

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

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. This is an IRS rule. Therefore, you should put aside money only for those expenses that you feel certain you will have in 2009.
- 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 DC FSA 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 DC FSA cannot exceed the amount you currently have deposited. HC FSA 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 2009 is March 31, 2010.
- 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 benefits, including your short-term disability, basic and optional term life insurance and basic and optional AD&D, are not affected by the flexible spending accounts. These benefits are based on your total, unreduced pay.
- You cannot fund your monthly vision plan contributions through a HC FSA. These contributions are automatically deducted on a tax-free basis through separate payroll deductions

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Enrollment Guide

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 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.

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

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