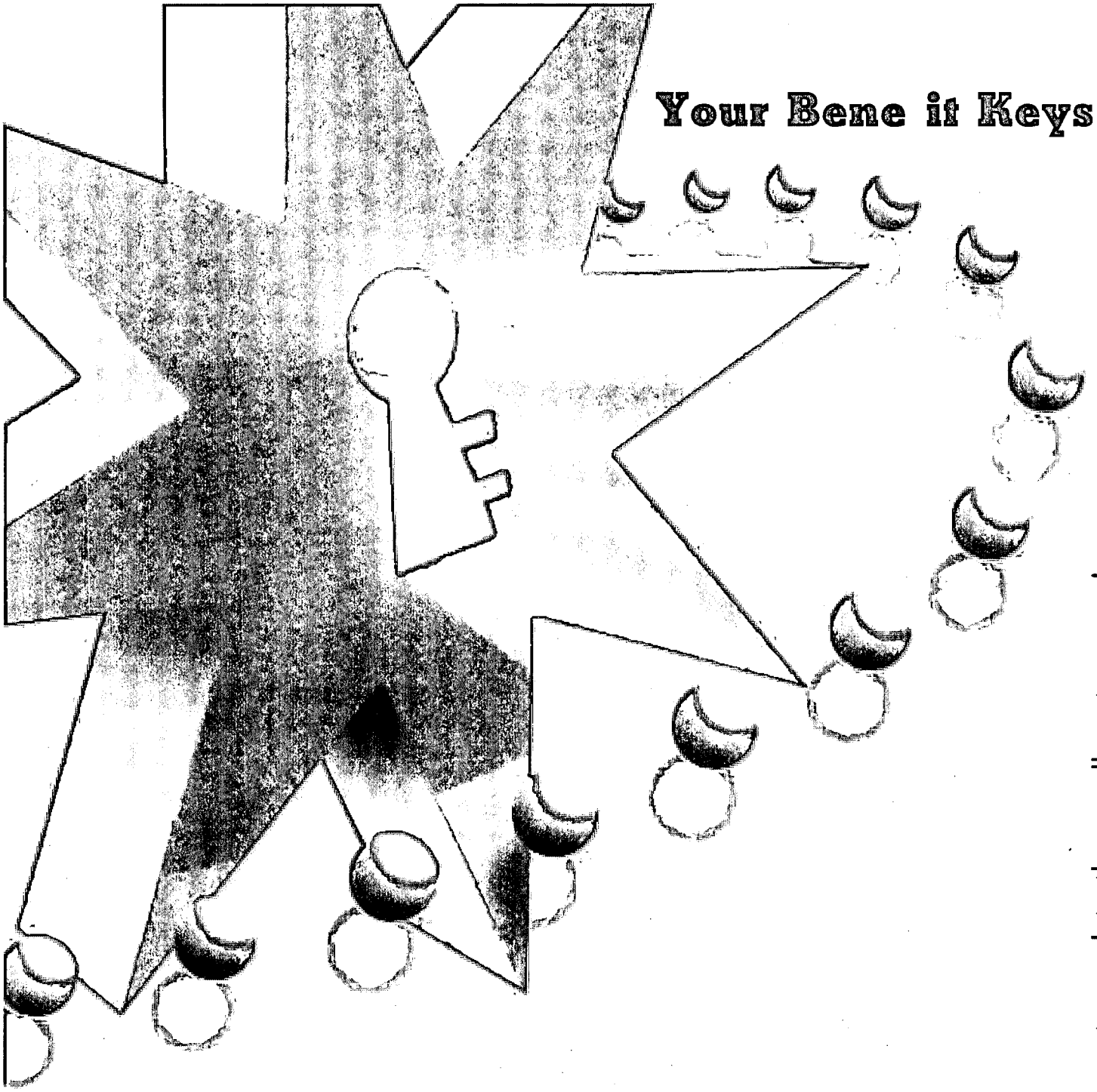
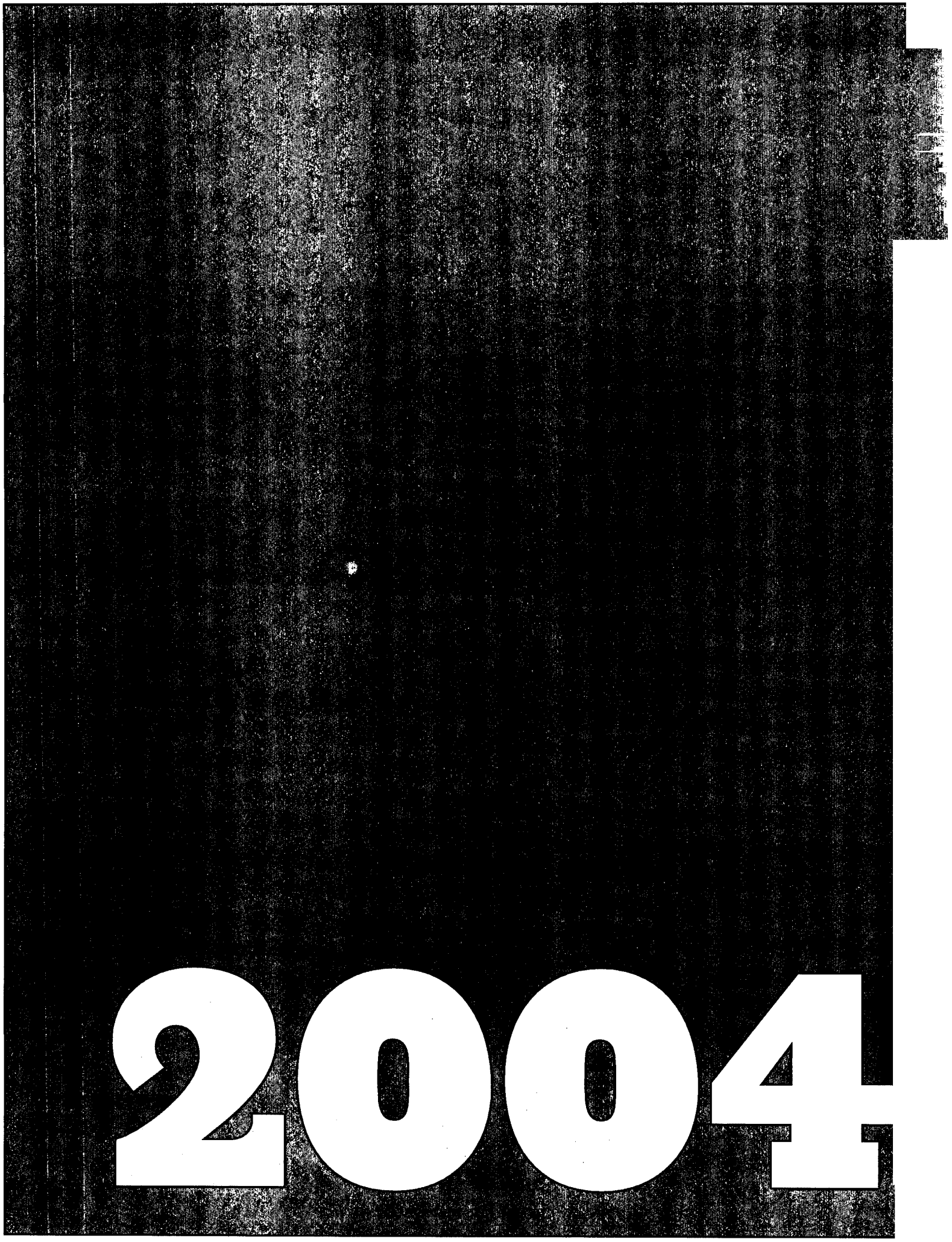


Your Bene it Keys

Everyone must complete the enrollment process!

Enrollment Guide

2004


2004

Enrollment Guide

WELCOME TO YOUR BENEFITS ENROLLMENT GUIDE FOR 2004. DURING THE ENROLLMENT PROCESS, YOU WILL MAKE SELECTIONS FOR THE COMING YEAR FOR MEDICAL, DENTAL, VISION, SUPPLEMENTAL EMPLOYEE TERM LIFE INSURANCE, DEPENDENT TERM LIFE INSURANCE AND OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) COVERAGE, LONG TERM CARE AS WELL AS TAX-FREE REIMBURSEMENT ACCOUNTS.

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

THIS FALL, EVERYONE MUST COMPLETE THE ENROLLMENT PROCESS BY DECEMBER 3, 2003. FOR NEW HIRES, YOU MUST RETURN A PAPER ENROLLMENT FORM WITHIN 31 DAYS OF YOUR ELIGIBILITY DATE.

YOUR ENROLLMENT GUIDE IS YOUR KEY TO UNLOCKING INFORMATION ABOUT YOUR BENEFITS AND CHANGES TO THE PLANS FOR 2004. IT'S FILLED WITH CHARTS TO MAKE IT EASY FOR YOU TO DETERMINE THE BENEFIT PROGRAM THAT'S RIGHT FOR YOU.

Enrollment Guide

Contents

What You Must Do to Enroll

It's important that you complete the enrollment process during the enrollment period. If you have access to the Peabody intranet, you must complete the online enrollment process by December 3, 2003. Your enrollment packet includes instructions for online enrollment. For employees who do not have online access, a completed enrollment form must be returned to the Peabody Benefits Office in St. Louis no later than December 3, 2003, or if you are a new employee, within 31 days of your eligibility date.

WHAT YOU NEED TO DO NOW

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

YOUR SITUATION	WHAT YOU NEED TO DO
You want to keep medical, dental, vision and all other coverage the same for 2004.	You must complete the enrollment process. If you do not, your current medical, dental, vision, supplemental life insurance, and optional AD&D will end on December 31, 2003, and you will forfeit the cash payment for the No Coverage medical option. You also will not be enrolled for the reimbursement accounts.
You want to change your medical coverage to another option.	Complete the enrollment process. If you elect Option 1000, your choice in subsequent years will be limited to the Option 500 plan unless you have a qualifying change in family status.
You want to elect the No Coverage medical option.	You must complete the enrollment process, including providing details on other coverage and completing a "Medical Waiver Statement." (If you do not, you will forfeit the cash payment.) If you decide to enroll in future years, your choice will be limited to Option 1000 unless you have a qualifying change in family status.
You want to enroll for medical or dental coverage for the first time, cancel medical coverage or add or drop a dependent from your coverage.	Complete the enrollment process. Medical benefits may be limited for pre-existing conditions. Dental benefits may also be limited.
You want to cancel dental coverage for 2004.	Complete the enrollment process. If you cancel dental coverage, your benefits will be limited if you decide to re-enroll at the next enrollment period.
You want to cancel optional vision coverage or enroll for optional vision coverage for the first time.	Complete the enrollment process. If you cancel your vision coverage, you will have to wait two years to re-enroll.
You want to change your supplemental life insurance.	Complete the enrollment process. You will be required to furnish evidence of insurability (proof of good health) to enroll or increase your supplemental life insurance.
You want to change your optional AD&D coverage level, or enroll for dependent term life coverage.	Complete the enrollment process indicating your election for 2004.
You want to participate in one or both reimbursement accounts for 2004.	Complete the enrollment process indicating the amount you want to deposit for 2004.

Enrollment Guide

IF YOU DO NOT ENROLL

Everyone must complete the enrollment process by December 3, 2003. **If you do not complete the enrollment process by the deadline, you will receive only basic life, accidental death and dismemberment, business travel accident and, for full-time employees, disability coverage.**

This means that effective January 1, 2004, all of your other current coverages will end and you will be enrolled for:

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

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

YOUR CHOICES ARE BINDING FOR 2004

The choices you make during the enrollment period are binding for 2004. 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 2004 (with changes effective January 1, 2005), unless you have a qualifying change in family status.

ANY QUESTIONS?

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

If you have questions concerning your 2004 enrollment, you may contact the Peabody Benefits Call Center by calling 1-800-633-9005 or sending an e-mail to **benefits@peabodyenergy.com**.

What's Changing in 2004

For 2004, there will be no changes to the benefit plan choices that are available to you. However, there are some provisions that will be changing within some of these plans. The changes are summarized below:

1. There will be a new provider for your prescription drug benefit effective February 1, 2004. For the Option 250 and Option 500 medical plan choices, Prescription Solutions will administer your pharmacy benefits and administer the network of participating retail pharmacies. There will be no change to the coinsurance level, but Prescription Solutions will provide some new programs and features. See page 12 for details.

2. Effective January 1, 2004, the maximum coverage amount for basic term life will be $500,000, and the maximum for supplemental term life will also be $500,000. Those employees with more than $500,000 in coverage under either policy on December 31, 2003 may continue that coverage subject to the current $1 million maximum for each policy. See page 24 for more information.

3. Effective January 1, 2004, if supplemental term life coverage is not elected within the initial 31-day enrollment period following your date of hire, you will have to show proof of good health before you can enroll or increase your coverage during a later enrollment period or as the result of a change in family status. See pages 24 and 25 for details.

4. A new IRS ruling allows you to claim reimbursement for eligible over-the-counter medications through your health care reimbursement account. This change means you can get a tax break on common non-prescription medicines that are used to treat a medical condition, such as antacids, allergy medicine, pain relievers and cold medicine. Also, direct deposit of your reimbursements for both the health care and dependent day care reimbursement accounts is available. See page 33 for more information.

5. For Option 1000, just as in 2003, a monthly contribution for full-time employees will not be required. However, the $300 cash payment will no longer be issued. An annual cash payment option will continue to be offered for both full-time and part-time employees electing No Coverage.

6. If you elect Option 250, Option 500 or Option 1000, a new disease management program will be introduced early in 2004. This program is designed to support those employees and covered family members who have certain chronic health conditions. See page 9 for details.

Eligibility and Enrollment

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

DEPENDENT ELIGIBILITY

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

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

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

PAYING FOR COVERAGE

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

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

Your Medical Keys

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

Option 250

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

Option 500

- Lower monthly cost for coverage.
- $500 annual deductible per person for network expenses.
- Your share of typical network expenses is 25%.
- Prescription drug benefits through Prescription Solutions (no deductible).
- Same PPO coverage as Option 250 through BlueCross BlueShield network.

Option 1000

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

No Coverage

- You receive a $600 cash payment each year ($300 for part-time employees).

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

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

COVERAGE CATEGORIES

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

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

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

Enrollment Guide

COST FOR COVERAGE

The cost for coverage depends on how many dependents you choose to cover under the plan. The table below shows the 2004 monthly contributions for each dependent coverage level for full-time and part-time employees. The cost of coverage for the HMO plans (if available) is shown on your enrollment form.

Active employees will share in any cost increases or decreases in subsequent years. For more on your costs after retirement, refer to the *Retiree Medical* section starting on page 37.

The table below shows the employee share of monthly medical costs for the various plan options. The majority of the cost continues to be paid by Peabody.

Before-Tax Monthly Contributions for Medical Plan Options

	YOURSELF ONLY	YOURSELF PLUS ONE DEPENDENT	YOURSELF PLUS TWO OR MORE DEPENDENTS
OPTION 250			
FULL-TIME EMPLOYEES	$32.06	$128.00	$224.24
PART-TIME EMPLOYEES	$64.12	$256.00	$448.48
OPTION 500			
FULL-TIME EMPLOYEES	$8.44	$64.46	$120.68
PART-TIME EMPLOYEES	$19.66	$170.96	$322.72
OPTION 1000			
FULL-TIME EMPLOYEES		No cost to you	
PART-TIME EMPLOYEES	$0.00	$61.10	$161.42
NO COVERAGE			
FULL-TIME EMPLOYEES	You receive a $600 annual cash payment at the beginning of each year. You must have group health coverage from another source to elect this option.		
PART-TIME EMPLOYEES	You receive a $300 annual cash payment at the beginning of each year. You must have group health coverage from another source to elect this option.		

HOW YOU RECEIVE THE CASH PAYMENT

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

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

- If you leave the company or retire during the year, you will have to repay a portion of the cash payment, based on when your employment ends. The repayment amount will be deducted from your last paycheck.
- If you elect No Coverage during the year (because you are decreasing your coverage due to a qualifying change in family status), you will receive a prorated amount of the cash payment based on when you elect the lower option.
- If you change your coverage from No Coverage to Option 250, Option 500 or Option 1000 (due to a qualifying change in family status), you will have to repay a prorated amount of the cash payment, based on when you upgrade to the higher coverage.

NEW DISEASE MANAGEMENT PROGRAM

If you elect Option 250, Option 500 or Option 1000, a new disease management program will be introduced in early 2004. This program will be designed to identify and support those employees and covered family members who have certain chronic health conditions, for example, diabetes.

The program will provide at-risk patients with additional tools and support that can help maintain and improve their health over the long term. In addition, because chronic conditions account for a large portion of our plan's cost, managing these chronic conditions successfully can help avoid unnecessary hospital stays, emergency care and other medical intervention. Better health, combined with lower treatment cost, is good news for all of us.

More information on this new program will be communicated soon.

Comparing Your Options

The table below compares the features of the three Option choices. For St. Louis-area employees, you will receive more information about additional HMO options during the enrollment period.

	OPTION 250		OPTION 500		OPTION 1000	
	NETWORK AND OUT-OF-AREA★	NON-NETWORK	NETWORK AND OUT-OF-AREA★	NON-NETWORK	NETWORK AND OUT-OF-AREA★	NON-NETWORK
DEDUCTIBLES AND COPAYMENTS YOU PAY						
Annual Deductible	$250	$400	$500	$800	$1,000	$1,500
Hospital Copayment (per admission)	$0	$0	$100	$200	$200	$300
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE AND COPAYMENTS						
Inpatient Hospital and Emergency Room★★	80%	60%	75%	55%	70%	50%
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE						
Wellness Benefits (including well-child care, routine physicals and screenings)	100% up to $250 per calendar year (no deductible)	60%	100% up to $250 per calendar year (no deductible)	55%	70% up to $250 per calendar year (no deductible)	50%
Most Other Medical Expenses★★	80%	60%	75%	55%	70%	50%
ANNUAL OUT-OF-POCKET MAXIMUMS YOU PAY (includes deductible, hospital copayment and coinsurance—will be indexed annually for Peabody medical inflation)						
Individual Out-of-Pocket Maximum	$1,700	$2,250	$2,800	$4,500	$4,500	$6,800
Family Out-of-Pocket Maximum	$3,400	$4,500	$5,600	$9,000	$9,000	$13,600
LIFETIME MAXIMUM BENEFIT						
	$1 million indexed annually for inflation (in 2004, limit is $2.1 million)		$1 million indexed annually for inflation (in 2004, limit is $2.1 million)		$1 million indexed annually for inflation (in 2004, limit is $2.1 million)	

If emergency services meet the requirements of "urgent or emergency care" as defined by the plan, then the covered charges are treated as if they were from a network provider, whether you go to a network or non-network provider. All hospitalization and certain other types of care must be approved under a Medical Services Advisory program. Benefits may be reduced if you don't comply.

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

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

	OPTION 250		OPTION 500		OPTION 1000	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
PRESCRIPTION DRUG BENEFITS (AMOUNT THE PLAN PAYS)	**PAID THROUGH SEPARATE PRESCRIPTION DRUG PROGRAM** (no deductible or out-of-pocket maximum)		**PAID THROUGH SEPARATE PRESCRIPTION DRUG PROGRAM** (no deductible or out-of-pocket maximum)		**PAID THROUGH BLUECROSS BLUESHIELD OF ILLINOIS[1]** (annual deductible and out-of-pocket maximum apply)	
Retail Generic Drugs (30-day supply)[4]	85%[2] $10 minimum copay	70%[2] $10 minimum copay	75%[2] $10 minimum copay	60%[2] $10 minimum copay	70% after deductible	
Retail Preferred Brand-Name Drugs (30-day supply)[4]	70%[2][3] $20 minimum copay – $75 maximum	60%[2][3] $20 minimum copay – $100 maximum	60%[2][3] $20 minimum copay – $100 maximum	50%[2][3] $20 minimum copay – $125 maximum	70% after deductible	
Retail Non-Preferred Brand-Name Drugs[4] (30-day supply)	50%[2][3] $40 minimum copay – $150 maximum	40%[2][3] $40 minimum copay – $200 maximum	40%[2][3] $40 minimum copay – $200 maximum	30%[2][3] $40 minimum copay – $250 maximum	70% after deductible	
Mail Service Pharmacy Generic Drugs[4] (up to a 90-day supply)	85% $10 minimum copay	N/A	75% $10 minimum copay	N/A	N/A	
Mail Service Pharmacy Preferred Brand-Name Drugs[4] (up to a 90-day supply)	70%[3] $50 minimum copay – $200 maximum	N/A	60%[3] $50 minimum copay – $250 maximum	N/A	N/A	
Mail Service Pharmacy Non-Preferred Brand-Name Drugs[4] (up to a 90-day supply)	50%[3] $100 minimum copay – $400 maximum	N/A	40%[3] $100 minimum copay – $500 maximum	N/A	N/A	

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

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

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

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

NEW PRESCRIPTION DRUG ADMINISTRATOR

Effective February 1, 2004, prescription drug benefits under Option 250 and Option 500 will be administered by Prescription Solutions, replacing Medco Health Services. Although your coinsurance amount (shown on the previous page) will not change with the new vendor, there will be changes in the administration of the plan. Among these changes will be the full implementation of the preferred and non-preferred brand-name drug copays.

Most of the other plan changes are noted below. Full details of the new program will be provided in a mailing you will receive later this year. This mailing will include an overview of how the new administration works, a list of major participating pharmacies, the plan's preferred brand-name drug list (formulary), and information about the mail service program.

In the meantime, here is a brief summary of how the change to Prescription Solutions may affect you:

- **New pharmacy network:** The network is changing and you will be receiving detailed information soon on which pharmacies are in the network and how to contact Prescription Solutions.
- **Generic requirement:** Under Prescription Solutions, the plan will continue to require 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 coinsurance plus the difference in cost (see the table on page 11).
- **Preferred drug list (formulary):** Drugs on the plan's preferred drug list (also called a formulary) 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" coinsurance.

  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 coinsurance. A copy of the preferred drug list will be included in your mailing, but you should check **www.rxsolutions.com** regularly for updates.

- **Prior authorization and step therapy:** The program will continue to require prior authorization for certain medications. A list of these drugs will be provided in the mailing you will receive later this year. If you are prescribed one of these medications, Prescription Solutions will verify your medical condition with your doctor to ensure that the medication is appropriate.

  In some cases, you may be required to follow a "step therapy program." This approach may require you to try more traditional and proven medications first, before trying the newest, more costly medications. Or, continued medications beyond a certain period may require review and approval by the plan.

  All of these provisions are designed to ensure that you receive an appropriate drug therapy for your condition. Prior authorization and step therapy typically apply to only a small number of medications.

- **Injectable drugs:** These medications are also known as specialty drugs. If your condition requires regular use of injectable medications—either self-injected or by a caregiver or doctor—the Prescription Solutions Specialty Pharmacy will dispense your injectable prescriptions and provide additional support.

  The Specialty Pharmacy will deliver your medications and necessary supplies to your home or physician's office, with an option for express mail delivery at no additional cost. Features include a Patient Care Coordinator who will help you manage your supplies so that you don't run out of medication. You will also have access to educational materials and Clinical Pharmacists who specialize in injectable medications.

IF YOU ENROLL YOURSELF AND YOUR DEPENDENTS UNDER TWO PLANS

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

Enrollment Guide

CHANGING YOUR MEDICAL COVERAGE

The choices you make during the annual enrollment period are effective January 1, 2004, 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 Option 250.	You can decrease or drop coverage, or switch to an HMO, at any annual enrollment period. If you drop coverage, you must show proof of other coverage.
You elect Option 500, Option 1000, or No Coverage.	You can decrease or drop coverage, upgrade your coverage one level, or switch to an HMO during any annual enrollment period. If you drop coverage, you must show proof of other coverage.
You elect HMO coverage (if available).	You can switch to any Option choice or drop coverage at any annual enrollment period. If you drop coverage, you must show proof of other coverage.
You obtain coverage under another plan due to marriage or a change in your spouse's job, or because your spouse's employer offers annual enrollment at a different time of year than Peabody.	You can drop or decrease Peabody coverage within 31 days of the date your other coverage starts. If you drop coverage, you must show proof of other coverage.
You gain a new dependent through marriage, birth or adoption.	You can change from No Coverage to any Peabody medical option, or add the new dependent to your current Peabody coverage, within 31 days of the qualifying event.
You have coverage from another source and lose it during the plan year for certain reasons.	You can enroll for any Peabody medical option, or upgrade your coverage, within 31 days of the loss of coverage. (You may not change to an HMO option in this case, unless you had previously elected No Coverage.)

More details about the rules that apply to changing your coverage are below.

During the Annual Enrollment Period

- If you decline coverage now for you and/or your dependents, you may enroll during the next annual enrollment period, but your choice of plans will be limited to Option 1000.
- If you enroll for one of the Option choices, you can only increase your coverage by one level in the following year. For example, you can switch from Option 1000 to Option 500, or from Option 500 to Option 250. You cannot increase **two** coverage levels—from Option 1000 to Option 250.
- You may change to or from an HMO (if available) during any annual enrollment period. If you are moving from an HMO, you can choose any Option choice.

Special Situations (Changes in Family Status)

- If you have a change in status as a result of marriage, birth, adoption or placement for adoption, you may add the new dependent to your current coverage option. Or, if you previously elected No Coverage, you may enroll yourself, your spouse and any new dependent child in any one of the Option choices (or an HMO alternative, if available). Provided you enroll within 31 days of the event, coverage will begin on the date the person becomes your dependent.

- You may cancel coverage or drop a dependent if you need to because of a divorce, death, or because a dependent is no longer eligible. You must complete a new enrollment form within 31 days of the event.

- If you become covered under another medical plan due to marriage or a change in your spouse's employment, or because your spouse's employer offers annual enrollment at a different time of year than our company, you may cancel coverage or decrease to a lower option if you complete a new enrollment form within 31 days.

- You may decide not to elect medical benefits under a company plan or select a lower plan option because you and/or your dependents have other coverage, such as through your spouse's employer. In this situation, you may enroll in any available option and/or add dependents to your coverage—or upgrade your coverage one level—if (1) the other coverage ends because you or your dependent is no longer eligible for such other coverage; (2) an employer makes a significant change to the cost or benefits of the other coverage; or (3) the other coverage ends because it was provided under a COBRA continuation provision and the right to coverage has been exhausted. You must complete a new enrollment form within 31 days after the other coverage ends. You may be required to provide evidence of loss of coverage.

PRE-EXISTING CONDITIONS LIMITATION

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

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

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

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

IMPORTANT INFORMATION ABOUT MEDICAL COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

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

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

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

Your Dental Keys

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

COVERAGE CATEGORIES

For dental, you can select coverage for:

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

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

Before-Tax Monthly Contributions for Dental Coverage

	YOURSELF ONLY	YOURSELF PLUS ONE DEPENDENT	YOURSELF PLUS TWO OR MORE DEPENDENTS
FULL-TIME EMPLOYEES	$2.34	$9.34	$16.34
PART-TIME EMPLOYEES	$4.68	$18.68	$32.68

You will share in any cost increases or decreases in subsequent years.

Dental Benefits Summary

	PREVENTIVE	BASIC	MAJOR	ORTHODONTIA
Deductible	$0	$50 (lifetime)	$50 (per calendar year)	$100 (lifetime)
Amount the plan pays	100%★	80%★	60%★	60%★
Maximum benefits	$750 (per calendar year)			$1,000 (lifetime)

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

DELTA DENTAL PARTICIPATING DENTISTS

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

NON-PARTICIPATING DENTISTS

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

Example

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

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

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

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

CHANGING YOUR DENTAL COVERAGE

The choices you make during the annual enrollment period are effective January 1, 2004, and are binding throughout the calendar year. Except in certain cases, you will not be able to enroll, cancel or change your dependent coverage choices until the next annual enrollment period.

The following rules apply to changing your coverage:

During the Annual Enrollment Period

- If you decline coverage now for you and/or your dependents, you may enroll during the next annual enrollment period (for 2005), but your coverage will be limited to preventive care benefits only during the first 12 months of your coverage. This also applies if you did not elect dental coverage for 2003 and now wish to enroll for 2004.

Special Situations (Changes in Family Status)

- If you gain a new dependent through marriage, birth, adoption or placement for adoption, you may add that dependent as long as you do so within 31 days of the date the person becomes your dependent. If you enroll during this 31-day period, coverage will begin on the day you gain the new dependent.

- You may cancel coverage or drop a dependent if you need to because of a divorce, death, or because a dependent is no longer eligible. You must complete a new enrollment form within 31 days of the event.

- If you decide not to enroll in the plan because you and/or your dependents have coverage under your spouse's plan, and then you lose that coverage as the result of a divorce, death or a change in your spouse's employment, you may enroll in the plan at that time. To do so, you must complete an enrollment form within 31 days of the date the other coverage ends.

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

Your Vision Keys

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

COVERAGE CATEGORIES

For vision, you can select coverage for:

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

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

Vision Care Benefits Summary

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

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

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

Before-Tax Monthly Contributions for Optional Vision Care Coverage

	YOURSELF ONLY	YOURSELF PLUS ONE DEPENDENT	YOURSELF PLUS TWO OR MORE DEPENDENTS
Employee Cost*	$6.74	$9.78	$17.54

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

NETWORK CARE

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

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

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

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

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

NON-NETWORK CARE

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

CHANGING YOUR VISION CARE COVERAGE

You may elect or continue vision coverage for 2004 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 2003 enrollment period, you may not enroll for coverage in 2004. (Your next opportunity to enroll will be in the fall of 2004, with coverage effective January 1, 2005.)

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 2004. You may add or drop dependents from your coverage during the year if you have a change in family status that justifies a change. In addition, you may change your election during the next annual enrollment period.

Your Employee Term Life Insurance Keys

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

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

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

Effective January 1, 2004, the basic and supplemental employee term life insurance maximum is $500,000 for each policy. However, those employees with more than $500,000 in coverage under either policy on December 31, 2003 may continue that coverage subject to the $1 million maximum for each policy.

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

HOW YOUR BASIC AND SUPPLEMENTAL COVERAGE WORKS

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

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

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

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

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

YOUR SUPPLEMENTAL EMPLOYEE TERM LIFE INSURANCE

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

Supplemental Employee Term Life Insurance Coverage Amounts

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

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

Changing Your Coverage

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

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

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.

Effective January 1, 2004, if supplemental life insurance coverage is not elected within the initial 31-day enrollment period and you later want to enroll, or if you later wish to increase your coverage during an enrollment period or following a change in family status, you will have to show proof of insurability.

The Evidence of Insurability form required by the insurance company is included in your enrollment packet. 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.

You may drop or decrease coverage during any enrollment period.

Tobacco Versus Non-Tobacco Rates

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

How to Make the Right Choice

Your premium rates will depend on your age (as of January 1, 2004), your coverage amount and whether or not you use tobacco. For more information about your life coverage options, including information about coverage for retired and disabled employees, refer to your summary plan description booklet.

Your Dependent Term Life Insurance Keys

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

These are your choices for covering your spouse:

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

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

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

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

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

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

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

After-Tax Monthly Contributions for Dependent Term Life

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

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

CHANGING YOUR COVERAGE

You may choose dependent life insurance or change the amount of your spouse's coverage during the annual enrollment period. The choices you make during this enrollment period are effective January 1, 2004. 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 your spouse first becomes eligible, and then you decide to enroll him/her later, coverage for your spouse will be limited to the $10,000 option. During the following annual enrollment, you may choose to increase the spouse coverage amount to $20,000 without having to provide evidence of insurability.

Your Basic Accidental Death & Dismemberment Keys

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

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

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

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

Your Optional Accidental Death & Dismemberment Keys

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

OPTIONAL AD&D COVERAGE AMOUNT

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

FAMILY COVERAGE OPTION

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

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

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

COVERAGE AMOUNT AFTER AGE 70

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

CHANGING YOUR COVERAGE

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

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

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

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

Your Disability Keys

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

SHORT-TERM DISABILITY (STD) BENEFITS

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

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

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

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

Enrollment Guide

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

VPA will:

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

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

Your Reimbursement Accounts Keys

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

You can opt to have your reimbursement checks from either account deposited directly to your bank account. Otherwise, checks will be mailed directly to your home. Direct deposit forms are available by calling Tri-Star Benefit Systems, Inc. at 1-800-727-0182 (in St. Louis 314-576-4022) or visit **www.tri-starsystems.com**.

HEALTH CARE REIMBURSEMENT ACCOUNT

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

You may set aside any amount from $120 to $4,800 a year. This money is deducted from your pay—before it is taxed—in equal installments for each pay period throughout the year and placed in your health care reimbursement account.

Over-The-Counter (OTC) Drugs

Recently the IRS clarified that OTC drugs are eligible for reimbursement through your flexible spending account. The health care reimbursement account plan will consider eligible OTC expenses purchased on and after January 1, 2004. To be eligible for reimbursement, a drug must be used for "medical care" which means the drug or service is needed to treat a medical condition.

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

Covered medicines include items such as:

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

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

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

If you're not sure if an item qualifies or what proof you need to provide, call Tri-Star Systems, Inc. at 1-800-727-0182 or 314-576-4022.

DAY CARE REIMBURSEMENT ACCOUNT

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

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

Special Rules for Both Accounts

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

- You will lose any money that you put into your accounts and do not use by the end of the year. This is an IRS rule. Therefore, you should put aside money only for those expenses that you feel certain you will have in 2004.
- If your family status changes because of a birth, death, marriage, divorce or a spouse losing his or her job, you can enroll, cancel or change your monthly deposit for either account subject to the plan rules explained in your summary plan description. Also, you may change your deposits to the day care reimbursement account if you must do so due to a change in day care providers, a change in your need for dependent day care, or a significant increase in your cost for day care (other than a cost increase imposed by a relative). Otherwise, according to IRS rules, you may change your deposits to either account only during annual enrollment.
- Reimbursement under the day care reimbursement account cannot exceed the amount you currently have deposited. Health care reimbursement account claims will be paid as long as they do not exceed the amount of your annual election.
- The deadline for submitting reimbursement expenses incurred during the current calendar year is March 31 of the following year.
- You cannot transfer amounts between your accounts, nor can you use funds from one account to pay expenses eligible under the other account, or vice versa.
- Expenses you incur before becoming a participant, or after participation ends, are not eligible.
- Your salary-related benefits, including your short-term and long-term disability, basic and supplemental term life insurance and basic and optional AD&D, are not affected by the reimbursement accounts. These benefits are based on your total, unreduced pay.
- You cannot fund your monthly medical, dental or vision plan contributions through a reimbursement account. These contributions are automatically deducted on a tax-free basis through separate payroll deductions.

Your Long Term Care Keys

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

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

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

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

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

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

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

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

Retiree Medical

MEDICAL PREMIUM REIMBURSEMENT (MPR) PROGRAM

The option available for medical coverage after retirement has changed for most employees who retire after January 1, 2003. Under the program, Peabody will provide an allowance toward the purchase of medical coverage. The dollar amount will be based on your years of service as defined by the plan with Peabody Holding Company, Inc. and selected subsidiaries and affiliates (Peabody).

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

For certain employees already close to retirement, a transition benefit under the current retiree medical plan will apply, as described on page 40.

Who Is Eligible for the MPR Program

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

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

How the MPR Program Works

At the time of termination of employment, your allowance will be $1,000 for each year of service with Peabody rounded up to the next full year. For example, if you have 19 years and two months of service with Peabody when you terminate employment, your allowance will be $20,000. You can use the allowance at any time in the future to request reimbursement for any premiums you pay for medical, dental or vision insurance for you and your eligible dependents (as defined by the plan). This insurance coverage can be through another employer's group health plan, an individual policy, COBRA, Peabody's Catastrophic Medical Plan or Medicare.

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

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

Enrollment Guide

Claims for Reimbursement

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

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

PEABODY CATASTROPHIC MEDICAL INSURANCE

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

Who Is Eligible for Catastrophic Coverage

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

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

Important Plan Provisions

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

through another employer-sponsored group plan, you may elect coverage under the Catastrophic Medical Plan upon retirement. You must provide proof of your other coverage at the time of your election. You may contact the Peabody Benefits Call Center at 1-800-633-9005 for an enrollment form.

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

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

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

The Cost of Coverage

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

Listed below is the cost for Catastrophic Medical Plan coverage in 2004. These costs are subject to change each year. Once enrolled, you may use any of your MPR allowance to offset the cost of Catastrophic Medical Plan coverage.

OPTION 1000	MONTHLY COST
RETIREE ONLY	
Not Medicare Eligible	$305.84
Medicare Eligible	$221.03
RETIREE PLUS ONE DEPENDENT	
Both Not Medicare Eligible	$611.70
Both Medicare Eligible	$442.04
Retiree Medicare Eligible/Dependent Not Medicare Eligible	$526.87
Retiree Not Medicare Eligible/Dependent Medicare Eligible	$526.87

continued on next page

RETIREE PLUS TWO OR MORE DEPENDENTS	
All Not Medicare Eligible	$780.78
Retiree and Spouse Medicare Eligible/Dependent Child Not Medicare Eligible	$736.13
Retiree Medicare Eligible/Spouse and Dependent Child Not Medicare Eligible	$758.46
Spouse Medicare Eligible/Retiree and Dependent Child Not Medicare Eligible	$758.46

Making the Right Choice

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

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

TRANSITION PROVISION FOR PEABODY GROUP HEALTH AND LIFE PLAN FOR SALARIED EMPLOYEES

If you were at least 55 years of age and had 10 or more years of service as of December 31, 2002, you will be eligible for retiree medical coverage under the terms of The Peabody Group Health and Life Plan for Salaried Employees provided you retire on or before January 1, 2005.

For purposes of determining eligibility for this coverage, you will be deemed to have "retired" only if you leave employment with Peabody Holding Company, Inc. and its subsidiaries and affiliates and immediately elect to begin receiving pension benefits under The Peabody Holding Company, Inc. Retirement Plan for Salaried Employees. If you leave Peabody before January 1, 2005 and do not elect to receive pension benefits at that time, you will be eligible for the MPR program. However, you will not be eligible for medical coverage as described in the preceding paragraph.

Keep in mind that this coverage is not guaranteed. The company reserves the right to terminate the plan, change required contributions or modify this plan in whole or in part at any time or for any reason, including changes in any and all of the benefits provided.

For those eligible for the transition period, you may elect retiree medical coverage under The Peabody Group Health and Life Plan for Salaried Employees or the MPR program, but not both.

Contact the Peabody Benefits Call Center at 1-800-633-9005 for more information.

Enrollment

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