Benefits Enrollment Guide 2008

Appalachia Region –Salaried Employees

Welcome to Benefits Enrollment

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

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

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

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

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 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, you will not be eligible to receive the cash payment that comes with the No Coverage election for medical.

The steps you must take during the enrollment period are spelled out under *What You Must Do to Enroll* on page 1.

If you have questions concerning your 2008 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 Patriot Benefits Ofice in St. Louis no later than **November 26, 2007** or your benefits will default to your 2007 coverage, or if you are a new employee, within 31 days of your eligibility date (your date of hire).

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 all coverages the same for 2008.	↘ Do nothing! Your 2007 benefits (except for FSA) will carry over to 2008. ↘ If you would like to contribute to a Flexible Spending Account (FSA) in 2008, you are required to complete the enrollment process. The IRS requires participants to make an election each year.
You want to change your medical coverage to another option.	↘ Complete the enrollment form indicating your election for 2008. You may choose any available option.
You want to elect the No Coverage medical option and you are a newly hired employee.	↘ You must complete the enrollment form, 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 form. Medical benefits may be limited for pre-existing conditions. Dental benefits may also be limited.
You want to cancel dental coverage for 2008.	↘ Complete the enrollment form. If you cancel dental coverage, your benefits will be limited if you decide to re-enroll at the next enrollment period.

Your Situation	What You Need To Do
You want to cancel optional vision coverage or enroll for optional vision coverage for the first time.	➘ Complete the enrollment form. 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 form. 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 form indicating your election for 2008.
You want to participate in one or both flexible spending accounts for 2008.	➘ Complete the enrollment form indicating the amount you want to deposit for 2008.

If You Do Not Enroll

➘ If you do not complete the enrollment process by **November 26, 2007** your current 2007 benefits (except for Flexible Spending Account) will carry over to 2008.

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, you will not be eligible to receive the cash payment that comes with the No Coverage election for medical.

Your Choices Are Binding for 2008

The choices you make during the enrollment period are binding for 2008. You will not have another opportunity to enroll, cancel or change your options or your dependent coverage choices until the next annual enrollment in the fall of 2008 (with changes effective January 1, 2009), unless you have a qualifying change in family status.

What's Changing In 2008

For the most part, your benefit package for 2008 will look very similar. There are, however, a few changes that you will need to be aware of as you prepare to make your benefit elections for the next year:

- New Prescription Solutions pharmacy network now includes the Walgreens and CVS pharmacy chains.
- For Health Care Flexible Spending Account (FSA) participants, the IRS requires participating discount stores and supermarkets to implement a system that allows the BeneFLEX VISA Card to identify FSA-eligible items at the checkout. For more information, refer to the FSA section in this enrollment guide or the enclosed BeneFLEX brochure.

Eligibility and Enrollment

If you are a full-time 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.
- For medical, dental, vision, and optional AD&D coverage (but not dependent term life insurance), your disabled child, regardless of age, provided he or she is permanently incapable of self-support due to a mental or physical disability before the limiting age.

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

Paying for Coverage

If you elect coverage, your contributions for medical, dental, vision and optional AD&D will automatically be deducted in equal installments from each paycheck on a before-tax basis.

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

Medical Benefits

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

Consumer Choice Option	↘ High deductible plan paired with a company-provided account to help pay the deductible. ↘ Option to save money for health expenses during retirement. ↘ Your share of typical network expenses is 20%. ↘ Prescription drug benefits through Prescription Solutions (no deductible). ↘ Same PPO network as Option 250 through BlueCross BlueShield.
Option 250	↘ $250 annual deductible per person for network expenses. ↘ Your share of typical network expenses is 20%. ↘ Prescription drug benefits through Prescription Solutions (no deductible). ↘ PPO coverage through BlueCross BlueShield network.
Option 1000	↘ No cost for coverage (for full-time employees only). ↘ $1,000 annual deductible per person for network expenses. ↘ Your share of typical network expenses is 30%. ↘ Prescription drug benefits paid through BlueCross BlueShield of Illinois (subject to deductible). ↘ Same PPO coverage as other Option choices through BlueCross BlueShield network.
No Coverage	↘ You receive a $600 cash payment each year ($300 for part-time employees).

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

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.

Cost for Coverage

The cost for coverage depends on how many dependents you choose to cover under the plan. The table below shows the 2008 monthly contributions for each dependent coverage level for full-time and part-time employees.

The majority of the cost continues to be paid by the company. Active employees will share in any cost increases in subsequent years.

Before-Tax Monthly Contributions for Medical Plan Options			
	Yourself Only	Yourself Plus One Dependent	Yourself Plus Two or More Dependents
Consumer Choice Option			
Full-Time Employees	$39.60	$158.12	$277.02
Part-Time Employees	$59.40	$237.18	$415.52
Option 250			
Full-Time Employees	$41.62	$166.16	$291.08
Part-Time Employees	$62.42	$249.22	$436.60
Option 1000			
Full-Time Employees	$0	$0	$0
Part-Time Employees	$0	$42.98	$151.54
No Coverage			
Full-Time Employees	➘ You receive a $600 annual cash payment at the beginning of each year. ➘ You must have group health coverage from another source to elect this option.		
Part-Time Employees	➘ You receive a $300 annual cash payment at the beginning of each year. ➘ You must have group health coverage from another source to elect this option.		

How You Receive the Cash Payment

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

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

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

Comparing Your Options

The table below compares the features of the three medical options available.

	Consumer Choice Option		Option 250		Option 1000	
Feature	Network*	Non-Network	Network*	Non-Network	Network*	Non-Network
Preventive Care	The plan pays 100% up to $500 per calendar year (no deductible)	The plan pays 60%	The plan pays 100% up to $500 per calendar year (no deductible)	The plan pays 60%	The plan pays 70% up to $500 per calendar year (no deductible)	The plan pays 50%
Primary Deductible	You pay: $250 yourself $500 yourself +1 $750 yourself + 2	You pay: $500 yourself $1,000 yourself +1 $1,500 yourself + 2	You pay: $250 per person	You pay: $500 per person	You pay: $1,000 per person	You pay: $2,000 per person
Employee Choice Account	The company provides $750 yourself $1,500 yourself +1 $2,250 yourself + 2		N/A	N/A	N/A	N/A
Secondary Deductible	You pay: $350 yourself $700 yourself +1 $1,050 yourself + 2	You pay: $700 yourself $1,400 yourself +1 $2,100 yourself + 2	N/A	N/A	N/A	N/A
Inpatient Hospital and Emergency Room and Other Medical Expenses**	The plan pays 80%	The plan pays 60%	The plan pays 80%	The plan pays 60%	The plan pays 70%	The plan pays 50%
Copayment Maximum (the most you pay each year for your percentage share of covered charges)	$1,100 yourself $1,350 yourself+1 $1,600 yourself+2 Excludes primary deductible, Employee Choice Account and secondary deductible	$2,200 yourself $2,700 yourself+1 $3,200 yourself+2	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum (the most you pay out of your pocket each year for your deductibles and your share of covered expenses)	$1,700 yourself $2,550 yourself+1 $3,400 yourself+2 Includes primary and secondary deductibles and copayment maximum	$3,400 yourself $5,100 yourself+1 $6,800 yourself+2	$1,700 per person $3,400 per family Includes deductible	$3,400 per person $6,800 per family	$4,500 per person $9,000 per family includes deductible	$9,000 per person $18,000 per family
Lifetime Maximum Benefit	$1 million Indexed annually for inflation (In 2008, limit is $2.5 million)		$1 million Indexed annually for inflation (In 2008, limit is $2.5 million)		$1 million Indexed annually for inflation (In 2008, limit is $2.5 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 Patriot Benefits Call Center at 1-800-633-9005 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.

Perscription Drug Benefits

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

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

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

(2) If you receive a maintenance drug from a retail pharmacy instead of using the Prescription Solutions Mail Service pharmacy, you will pay a $10 surcharge in addition to your regular percentage 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 copayment plus the difference in cost.

(4) Minimum and maximum copays will be indexed for annual Patriot prescription drug inflation.

Consumer Choice Option

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

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

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

1. You have reduced monthly contributions compared to Option 250.

2. You have the option to "save" or "spend" the company-provided credit in your Employee Choice Account each year. You "save" by choosing to use your own money to pay for expenses that would have been paid from the Employee Choice Account. (You also can "save" part of the credit and "spend" part.)

3. You have the opportunity to accumulate funds—tax-free—in your Retiree Choice Account to pay for health care expenses in your retirement. You also pay no taxes on the credit placed in your Employee Choice Account.

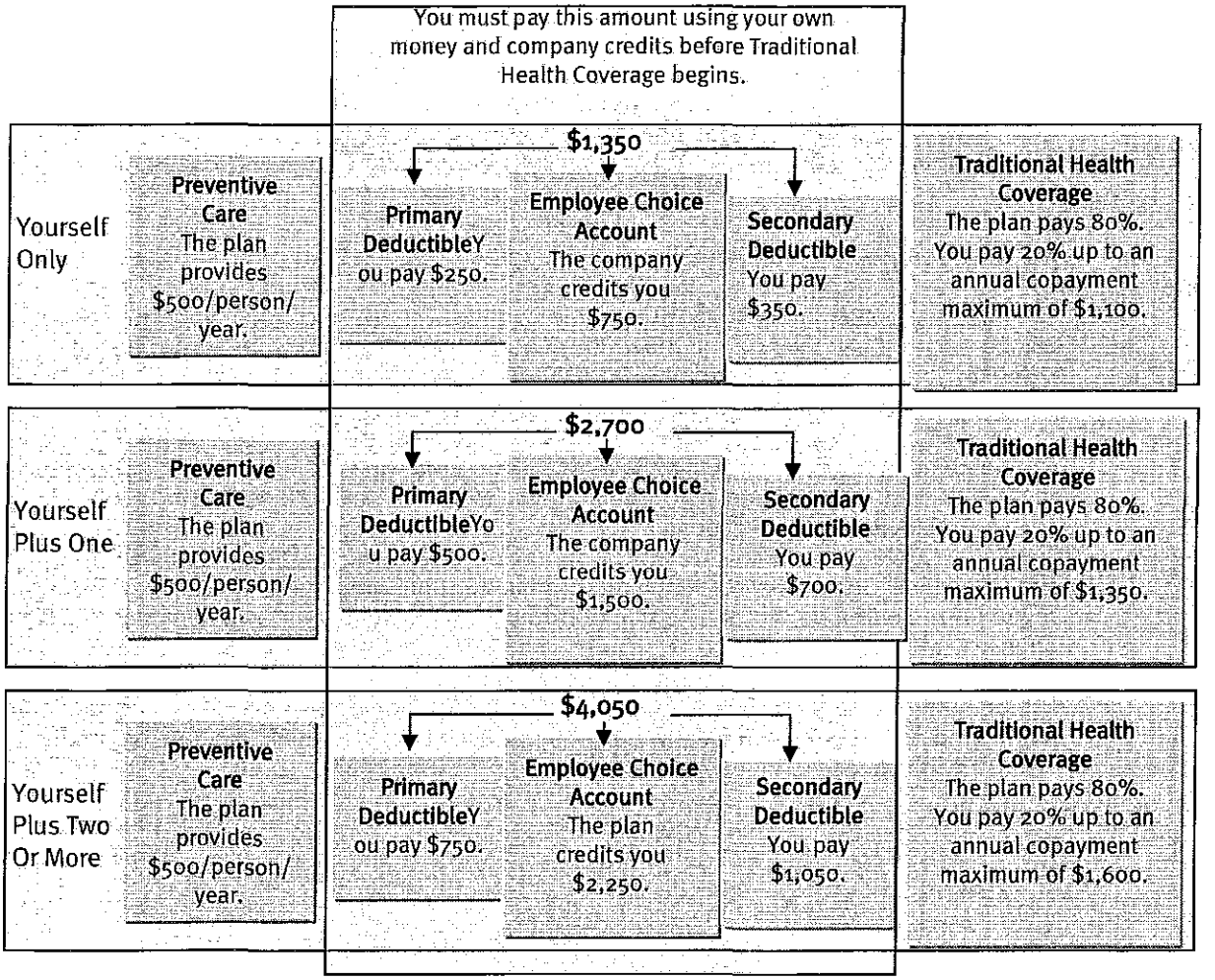
4. The Consumer Choice Option supplements your current retiree medical plan, which allows you to earn a one-time company credit toward the purchase of your own health care policy when you retire.

5. The amount of your deductibles, Employee Choice Account and certain plan maximums vary based on the coverage level you choose (yourself only, yourself plus one dependent, or yourself plus two or more dependents).

Highlights of the Consumer Choice Option

The diagram below summarizes how the Consumer Choice Option works:

Consumer Choice Option Coverage Levels



Amounts listed are for network services. (See page 8 for non-network amounts).

How the Consumer Choice Option Works

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

Preventive Care: The Consumer Choice Option pays 100% of the cost of preventive care services (which include well-child care, routine physical exams, and related tests and screenings), up to $500 per covered person per calendar year, with no deductible, if you receive them from a BlueCross BlueShield of Illinois network provider. This works the same as Option 250.

Primary Deductible: You must pay a primary deductible before your Employee Choice Account (credited by the company) is available to you. The amount of your primary deductible depends on how many people you are covering, and whether you are using network or non-network providers (see chart on page 8). The primary deductible can be met with a combination of expenses from any or all family members. This is different from Option 250, which requires a separate deductible for each covered person.

Employee Choice Account: After you have met your primary deductible, you gain access to your Employee Choice Account. This account gives you the opportunity to choose how and when the dollars in your account are spent to pay for eligible medical expenses. The amount of credit the company provides each year varies based on how many dependents you are covering (see chart on page 8). The Employee Choice Account gives you the option to save money for the future if you do not need or want to use the money now ("save"). You also have the option to pay for medical needs now ("spend"). Here's a brief summary of how these two paths—"save" vs. "spend" differ.

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

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

Secondary Deductible: After you meet your primary deductible and "spend" the money in your Employee Choice Account (or "save" by choosing to use your own money for medical expenses that would have been paid from your Employee Choice Account), you are responsible for paying any additional health care expenses you have until you meet the secondary deductible. It may be helpful to think of the primary deductible, the Employee Choice Account credit and the secondary deductible as one large deductible, as shown in the chart on page 11.

Traditional Health Coverage: After you've met the secondary deductible, the plan will provide coverage for any further expenses, just like a traditional health plan. The plan will pay for 80% of the cost of eligible services received from a network provider. You pay the other 20%, up to an annual "copayment maximum." The annual maximum you pay for your share of expenses depends on how many people you are covering, and whether you are using network or non-network providers (see chart on page 8). The primary deductible, secondary deductible, and amounts paid out of the Employee Choice Account do not count toward the copayment maximum.

How to "Save"

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

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

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

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

Investing in a Retiree Choice Account

If you carry over the maximum toward next year's secondary deductible, the remaining amount in your Employee Choice Account will transfer to your Retiree Choice Account. You can use money from your Retiree Choice Account to reimburse yourself for medical expenses you incur during your retirement. Interest will be credited to your Retiree Choice Account based on the rate of interest earned by one-year U.S. Treasury bills. (This rate is subject to change based on business conditions.) See more details about the Retiree Choice Account on page 22.

Building Up Your Employee Choice Account

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

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

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

Spending Before-Tax or After-Tax

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

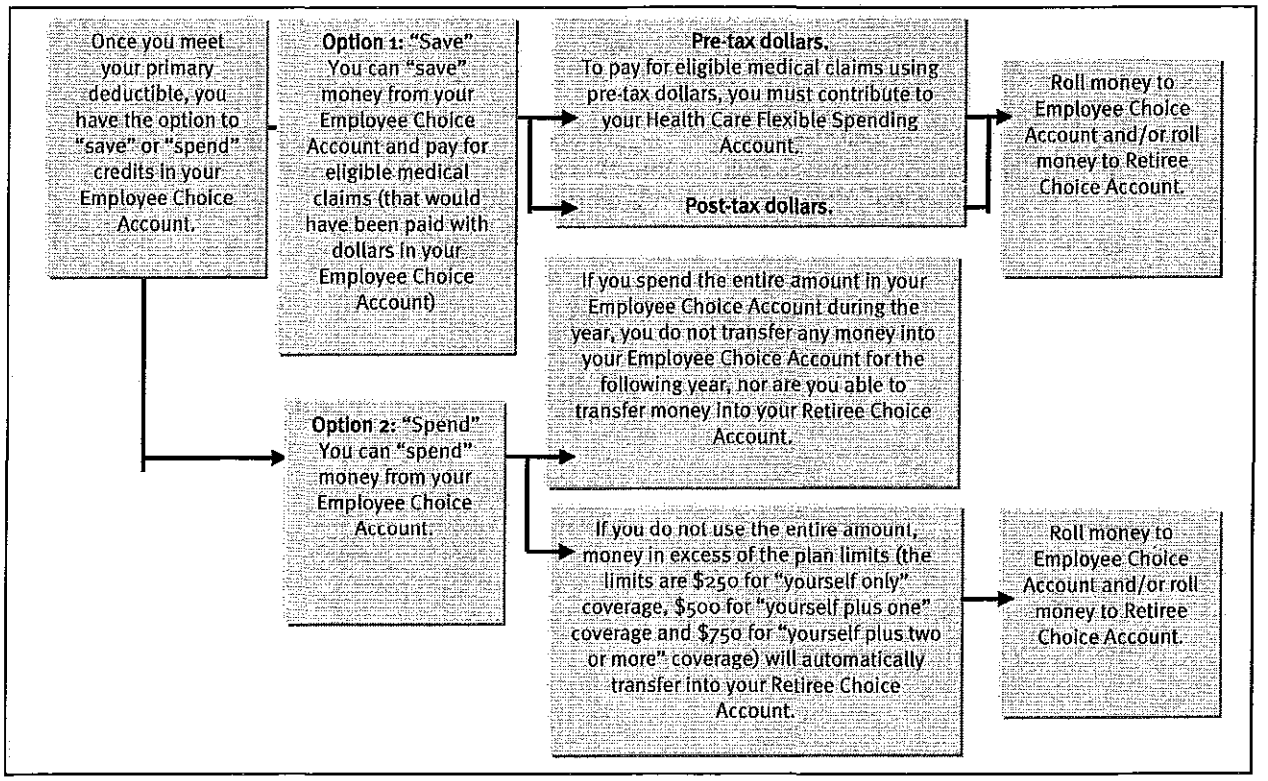
- **Spending before-tax dollars** means you can pay for eligible expenses using tax-free money. To do this, you must elect to contribute to a health care flexible spending account. If you use a health care flexible spending account along with the Employee Choice Account, there are several plan rules you'll need to understand. These are explained in more detail on page 19.

- **Spending after-tax dollars** simply means using your own cash. This may make sense if you have the cash flow to cover typical health expenses. In exchange, you have the opportunity to save the company-provided account for your retirement health care needs.

Is the Consumer Choice Option Right For You?

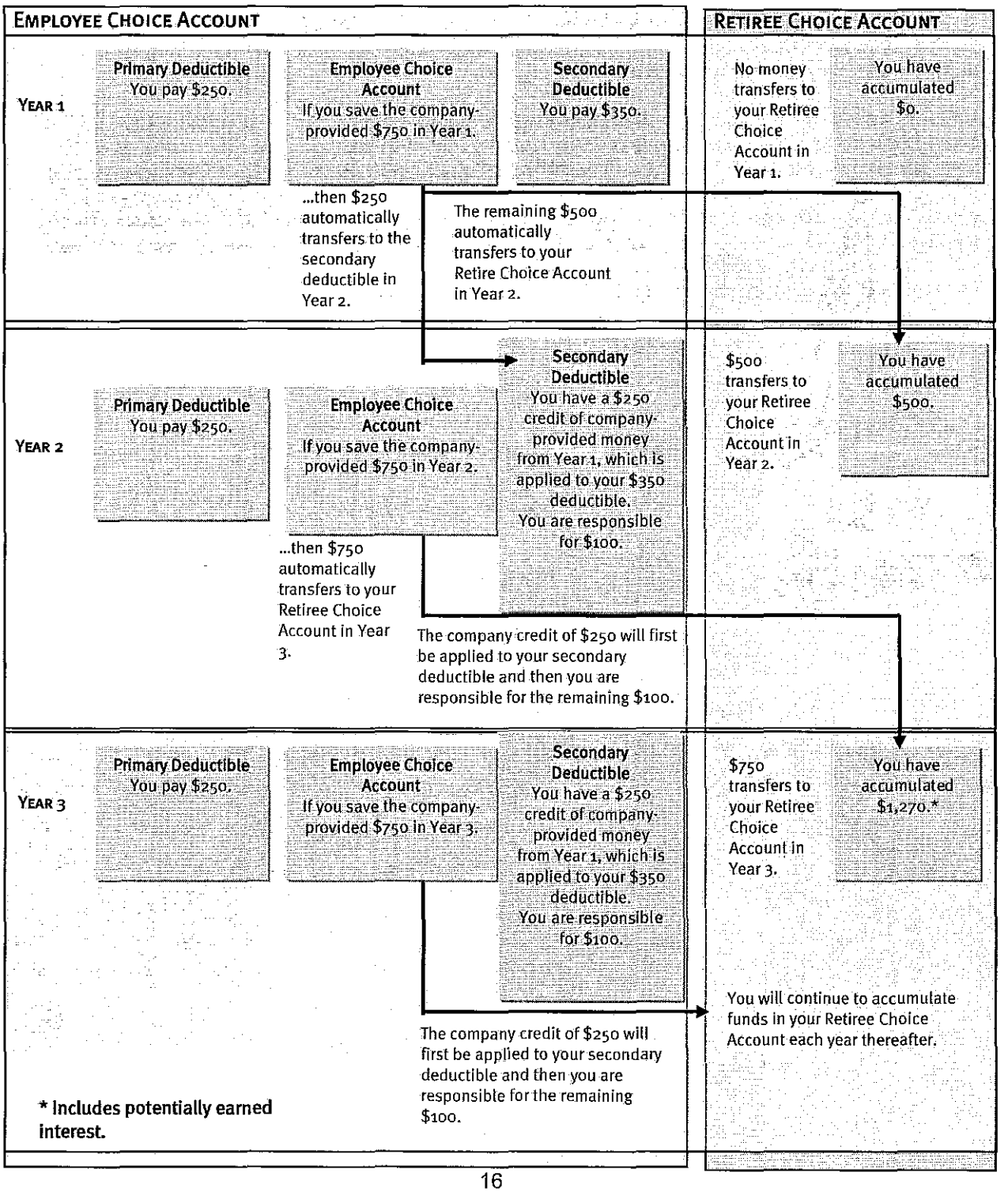
You need to know if this is the right plan for your personal situation. The following decision tree examples may give you some ideas of how the plan works. This is just a sample—you should base your decision on your own situation.

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



Consumer Choice Option—How the Money Transfers Year After Year

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



How to "Spend"

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

Once you meet your annual primary deductible, you can use money from your Employee Choice Account to pay for eligible medical expenses covered under the medical plan. If you use the entire amount in your Employee Choice Account during the year, you then pay for your additional medical expenses by meeting a secondary deductible. After that, traditional health coverage steps in, and you pay only your copayment (20% of charges for network services) until you reach your annual copayment maximum (see chart on page 8).

Under this scenario, you may use all of your annual Employee Choice Account credit. When you enroll again for 2009, you will receive another credit to replenish your account. But you could also have some money leftover. If so, you may still "save" a portion for the next year as described under "How to Save" on the previous page. With the Employee Choice Account each year, keep in mind you can only roll over or "save" up to $250 if you cover yourself only, up to $500 if you cover yourself plus one dependent or up to $750 if you cover yourself plus two or more dependents. Any amounts in excess of these limits will automatically be transferred to a Retiree Choice Account to reimburse you for medical expenses during retirement (see details on page 22).

Consumer Choice Option vs. Option 250: How The Approaches Compare

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

	CONSUMER CHOICE OPTION	OPTION 250
Focus	The company provides a fixed amount each year, which you can choose to spend or save. This focuses attention on the full cost of health care coverage. It encourages you to seek preventive care and play an active role in managing your spending and/or savings.	After you meet an annual deductible, you pay a share of the cost. This focuses more on the portion of the expense you must pay. This plan also encourages you to seek preventive care.
Philosophy	This option lets you treat plan benefits like they are your own money. Unused amounts in your Employee Choice Account (ECA) can be rolled over to the next year's plan, up to certain limits. Beyond these limits, the extra amount can be shifted to a Retiree Choice Account for use during retirement. In combination with the retiree medical plan, your savings can help provide financial security during retirement.	Many people regret paying for "insurance" they never use. With traditional coverage, if you do not use the plan, you receive no benefit—you cannot build up cash value over time.
Health Care for Retirement	In combination with the retiree medical plan, your savings can help provide more financial security during retirement. You can use up to $5,000 per calendar year to pay for deductibles and co-payments. You can also use it to purchase an individual health insurance policy.	You still have access to the retiree medical plan, but that only covers purchase of a policy, not out-of-pocket expenses for health care.
Deductibles	Although the plan has a high deductible before traditional health coverage steps in, you have a company-provided ECA to cover a portion of that deductible (if you choose to spend it). The deductible can be met with a combination of expenses from any or all family members.	The annual deductible is more modest, but it is completely your responsibility. What's more, each covered person meets an individual deductible before the plan pays a percentage of covered charges.
Copayment (Your percentage share of covered expenses)	If you spend your ECA for current health expenses, you will have 100% coverage for eligible charges while you are spending your ECA credit. After your credit is used up and you have met the secondary deductible, the plan pays a percentage of covered charges, the same as Option 250.	Until you reach your out-of-pocket maximum, Option 250 will never pay 100% of any expense (except preventive care). You will always have to pay a portion of the covered charge.
Out-of-Pocket Expenses	Traditional health coverage begins after you meet the full deductible (primary + ECA + secondary deductible). After the deductible, both plans pay 80% of covered network expenses while you pay 20%. Your 20% share is capped at a certain level, depending on how many people you are covering. This copayment maximum can be met with a combination of expenses from any or all family members. Both plans protect you from runaway health costs with an annual out-of-pocket maximum. See chart on page 8.	Option 250 coverage begins after you meet an annual deductible per person. After the deductible, both plans pay 80% of covered network expenses while you pay 20%. Both plans protect you from runaway health costs with an annual out-of-pocket maximum. See chart on page 8.
Cash Flow	If you choose to "save" your ECA and later have a large health care expense, such as for the birth of a baby or as the result of a serious accident, you may have to pay the full deductible (primary + ECA + secondary deductible) all at once before the traditional coverage steps in. However, if unexpected expenses arise, you always have the option of changing your mind and spending your ECA instead of saving it. When you are spending your ECA, you have 100% coverage for eligible charges covered by your ECA credit.	Under Option 250, if you have a large health care expense, such as for the birth of a baby or as the result of a serious accident, you will also have to pay the full deductible for each person before the traditional coverage steps in for that person. However, the smaller deductible required may make it easier to manage for your family's budget.

Prescription Drug Benefits

When you choose coverage under the Consumer Choice Option, prescription drugs are covered, but they are treated a little differently than other eligible health care expenses. Prescriptions are covered exactly the same way as under Option 250. For covered drugs, the plan pays a certain percentage, and you pay a certain percentage, subject to a minimum and maximum copayment, as shown in the chart on page 9. You do not pay a deductible for prescription drugs.

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

Eligible Expenses for the Employee Choice Account

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

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

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

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

The Consumer Choice Option and the Health Care Flexible Spending Account

These special accounts let you pay yourself back with tax-free money for many out-of-pocket health care expenses. To receive reimbursement, you must submit a claim to BeneFLEX HR Resources, Inc. (BeneFLEX), as shown in the box on page 21. In some ways, the health care flexible spending account may seem similar to the Employee Choice Account: both provide money to reimburse you for eligible health care expenses during the year. But there are some important differences:

- The money in your Employee Choice Account comes from the company. The money in the health care flexible spending account (if you choose to use it) is provided by you, through before-tax payroll deductions from your pay.
- If you don't spend all the money in your health care flexible spending account on eligible expenses you have incurred during the year, under IRS rules you must forfeit any amounts that are leftover. If you have money left in the Employee Choice Account, on the other hand, you can roll it over into an Employee Choice Account for the next year, up to the plan limits—and any amounts over those limits can be transferred into your Retiree Choice Account.

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

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

Timing Your Claims if You Participate in the HC FSA

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

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

Filing a Claim for the Employee Choice Account

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

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

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

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

MORE ABOUT BENEFLEX AND CLAIM FORMS

If you have any questions about filing claims for the Employee Choice Account, you may call BeneFLEX HR Resources, Inc. (BeneFLEX) at 1-800-631-3539 and ask to speak with a claims representative. Identify yourself as a Patriot Coal Corporation employee, state the assistance you need, and your call will be forwarded to the appropriate representative.

All claim forms, including direct deposit forms, may be printed from the BeneFLEX website at *www.beneflexhr.net*. As this web site you will also find directions on how to submit claims on-line.

All forms require your signature and date as indicated on the bottom of the form. Receipts substantiating your claim must be attached to the claim form.

To submit completed forms to BeneFLEX, you can mail to:

BeneFLEX HR Resources, Inc.
3660 S. Geyer Road, Suite 340
St. Louis, MO 63127

Claim forms may be faxed to 314-909-6983.

Retiree Choice Account

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

Who Is Eligible for the Retiree Choice Account

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

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

How the Retiree Choice Account Works

As explained in the *Consumer Choice Option* section beginning on page 10, if you are enrolled in the Consumer Choice Option for medical coverage, that option includes a company-provided Employee Choice Account you can use to pay for eligible expenses. If you don't use the entire amount in your Employee Choice Account by the end of the year, you can roll what remains—up to certain limits—into your Employee Choice Account for the following year.

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

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

Earning Interest on Your Retiree Choice Account

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

Eligible Expenses for the Retiree Choice Account

Like the retiree medical plan, you can use the Retiree Choice Account to purchase your own health care policy when you retire. This can be another employer's group health plan, an individual policy, or the Patriot Coal Corporation's Catastrophic Medical Plan or Medicare.

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

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

If You Leave The Company Before Retirement

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

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

Years of Service	Percentage of Retiree Choice Account You Are Eligible For
Less than 1 year	0%
1 year	20%
2 years	40%
3 years	60 %
4 years	80%
5 or more years	100%

Additional Details of the Employee Choice Account and Retiree Choice Account

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

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

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

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

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

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

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

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

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

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

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

If you terminate employment with the company (for any reason): If you choose to continue coverage under the provisions of the law known as COBRA, the plan continues as usual. After COBRA coverage ends, or if you don't elect COBRA continuation, any remaining balance in your Employee Choice Account is forfeited (except for reimbursements you receive for claims filed before the end of the filing time limit). If you have a balance in the Retiree Choice Account, your right to money in that account is subject to the Retiree Choice Account's rules based on years of service (see page 23).

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

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

If you die while an active employee: If your surviving covered dependents choose to continue coverage under COBRA, the plan continues as usual. After COBRA coverage ends, or if your dependents don't elect COBRA continuation, any remaining balance in your Employee Choice Account is transferred to your Retiree Choice Account. Your surviving dependents may use your Retiree Choice Account immediately, subject to the account's rules based on your years of service (see page 23).

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

When you retire: When you retire, the remaining amount in your Employee Choice Account transfers to your Retiree Choice Account. Your Retiree Choice Account becomes available to you, subject to that account's rules based on years of service (see page 23). The Retiree Choice Account is completely separate from the retiree medical program (which requires you to be at least age 55 and have 5 years of service).

If you die after you retire: The Retiree Choice Account is immediately available for use by your surviving dependents for eligible expenses, subject to the account's rules based on your years of service (see page 23). If you have no dependents, the Retiree Choice Account is forfeited after all claims have been received within the time limits for filing them.

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

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

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

Keeping It All Straight

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

The table shows only key highlights of each of these accounts. Each has important rules and limits that you need to understand.

Account/Program	How It's Funded	How It Works	Your Best Strategy
Employee Choice Account (ECA)	➘ Annual credit provided by the company. ➘ Portion of the credit can be rolled to next year's ECA and be applied to your secondary deductible the following year.	➘ Part of the Consumer Choice Option. ➘ Available to you after you pay the primary deductible. ➘ To spend the credit for health care, you file a claim for reimbursement to BeneFLEX. ➘ You have to use up your HC FSA if applicable (see below) before you can use the ECA.	➘ You can "spend" for current health care needs. ➘ You can "save" for health care during retirement. ➘ You pay no taxes on the value you receive from these accounts.
Retiree Choice Account (RCA)	➘ Excess savings from the ECA roll over into this account.	➘ Excess savings accumulate here, tax-free, to cover premiums for health care coverage. ➘ You can also use your RCA for deductibles, coinsurance or copayments during retirement, limited to $5,000 a year.	➘ Works well with the retiree medical program, which helps cover premium costs for the purchase of a personal health care policy.
Retiree Medical Plan	➘ A one-time credit provided by the company.	➘ Based on your age and years of service, you earn a one-time credit to help pay premiums associated with a private health insurance policy. ➘ You cannot use this plan to pay out-of-pocket health expenses, such as deductibles, your share of covered charges or charges not covered by insurance.	➘ You can use this benefit in combination with the new RCA account. ➘ You can increase your retiree medical plan benefit the longer you work at the company. ➘ You can use the money towards the purchase of another employer's group plan, a private health policy, COBRA coverage, the Patriot Coal Corporation Catastrophic Medical Plan or Medicare.
Health Care Flexible Spending Account (HC FSA)	➘ You fund this account with before-tax dollars deducted from your pay.	➘ You may defer up to $5,000 a year. ➘ Use the money to pay yourself back for health care expenses not paid by insurance (including deductibles). ➘ You file a claim for reimbursement to BeneFLEX. ➘ You must use the money each year or lose it (IRS rule).	➘ You save money in taxes. ➘ You can use this account for items not covered by health insurance, including over-the-counter medicines. ➘ If you wish to "save" all of your ECA for retirement, you can use the HC FSA instead. ➘ This account must be used first before claiming reimbursement from your ECA.
Dependent Care Flexible Spending Account (DC FSA)	➘ You fund this account with before-tax dollars deducted from your pay.	➘ You may defer up to $5,000 a year (or $2,500 if you're married filing separate taxes). ➘ Use the money to pay for dependent care for children under 13 or dependent adults. ➘ You file a claim for reimbursement to BeneFLEX. ➘ You must use the money each year or lose it (IRS rule).	➘ You save money in taxes. ➘ You cannot use the account for dependent health care expenses.

Medical Coverage During Disablity

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.

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 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. For more information, consult the *Coordination of Benefits* section of your medical summary plan description.

Changing Your Medical Coverage

The choices you make during the annual enrollment period are effective January 1, 2008, and are binding throughout the calendar year. Except in certain cases, you will not be able to enroll, cancel or change your options or your dependent coverage choices until the next annual enrollment period. The options available to you depend on your situation, as shown in the summary below.

Your Situation	Your Options
You elect Consumer Choice Option, Option 250 or Option 1000.	You can decrease or drop coverage at any annual enrollment period. If you drop coverage, you must show proof of other coverage.
You elect No Coverage.	You can continue with No Coverage, or enroll in Option 1000 during any 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 or decrease Patriot 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 Patriot medical option, 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.	You can enroll for any Patriot medical option within 31 days of the loss of coverage.

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

During the Annual Enrollment Period

- If you decline coverage now for you and/or your dependents, you may enroll during the next annual enrollment period, but your choice of plans will be limited to Option 1000.

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

Pre-Existing Conditions Limitation

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

- A pre-existing condition is any physical or mental condition for which medical advice, diagnosis, care or treatment (including prescription drugs) was recommended or received within the six-month period ending on the individual's enrollment date. For this purpose, the term "enrollment date" means, for an employee who enrolls when first eligible, the first day of employment as an eligible employee; in all other cases, enrollment date is the date coverage begins.
- Charges related to a pre-existing condition are not covered during the 12-month period starting on the individual's enrollment date, as defined on the previous page.
- The 12-month period will be reduced by the length of time an individual had "creditable coverage" under a previous plan.
- The limit for pre-existing conditions will not apply to pregnancy. It also does not apply to a child enrolled within 31 days of birth or placement for adoption, in most cases.

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

Important Information About Medical Coverage for Reconstructive Surgery Following Mastectomies

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

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

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

Personal Health Resource Program

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

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

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

Dental Benefits

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	$3.00	$12.00	$21.00
Part-Time Employees	$4.50	$18.00	$31.50

Dental Benefits Summary				
	Preventive	Basic	Major	Orthodontia
Deductible	$0	$50 (lifetime)	$50 (per calendar year)	$100 (lifetime)
Amount the Plan Pays	100%*	80%*	60%*	60%*
Maximum Benefits	$1,000 (per person per calendar year)			$1,000 (lifetime)

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

Delta Dental Participating Dentists

Your dental benefits are administered by Delta Dental 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.deltadental.com**.

Changing Your Dental Coverage

The choices you make during the annual enrollment period are effective January 1, 2008, and are binding throughout the calendar year. Except in certain cases, you will not be able to enroll, cancel or change your dependent coverage choices until the next annual enrollment period.

The following rules apply to changing your coverage:

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 coverage effective January 1, 2009).

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).

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 Single-Vision Bifocal Trifocal	24 months	 100%** 100%** 100%**	 $31** $51** $64**
Frames	24 months	$120	$45
Contact Lenses (instead of eyeglasses)	24 months	Up to$105	Up to$105

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

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

Before-Tax Monthly Contributions for Optional Vision Care Coverage			
	Yourself Only	Yourself Plus One Dependent	Yourself Plus Two or More Dependents
Employee Cost*	$6.62	$9.64	$17.22

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

Network Care

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

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

If you need assistance in locating a VSP participating doctor, you may call VSP at 1-800-VSP-7195 (1-800-877-7195) or go to www.vsp.com on the Internet. When you call, the VSP participating doctor will also need to know your identification number (usually the Social Security number), and the organization that provides your benefits (Patriot Coal Corporation). You'll need to have this information on hand.

If you obtain services from a VSP network provider, VSP will pay the provider directly. You pay only a $10 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 greatly reduce 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).

Changing Your Vision Care Coverage

You may elect or continue vision coverage for 2008 if:

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

However, if you dropped your vision coverage during the 2007 enrollment period, you may not enroll for coverage in 2008. (Your next opportunity to enroll will be in the fall of 2008, with coverage effective January 1, 2009). You may also drop your vision coverage during the annual enrollment period. However, if you do, you will have to wait two years before you can re-enroll in this coverage.

Your election is binding for 2008. You may add or drop dependents from your coverage during the year if you have a change in family status that justifies a change. In addition, you may change your election during the next annual enrollment period.

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 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 base salary.

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

How Your Basic and Supplemental Coverage Works

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

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

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

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

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.

Supplemental Employee Term Life Insurance

As you can see from the following chart, supplemental employee term life insurance options are multiples of your annual base salary rounded to the next $100. For example, if your annual base salary is $40,120 and you choose Option 2 (two times annual base salary), your supplemental employee term life insurance benefit is $80,300, and your basic term life insurance benefit is $60,200 (for a total coverage amount of $140,500).

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

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

Changing Your Coverage

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

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

Evidence of Insurability Requirements

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

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

The Evidence of Insurability form required by the insurance company may be obtained through your local HR representative. Complete this form and submit to the insurance company. Your new or higher coverage amount, and the contributions required for the new coverage, will not take effect until the insurance company approves your application. The effective date of coverage will be the approval date designated by the insurance company. Your coverage will also be delayed if you are not actively at work on the date your coverage or an increase in coverage would become effective.

Tobacco Versus Non-Tobacco Rates

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

How to Make the Right Choice

Your premium rates will depend on your age (as of January 1, 2008), your coverage amount and whether or not you use tobacco. For more information about your life coverage options, including information about coverage for retired and disabled employees, refer to your summary plan description booklet.

Dependent Term Life Insurance Benefits

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

These are your choices for covering your spouse:

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

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

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

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

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

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

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

After-Tax Monthly Contributions for Dependent Term Life		
	Coverage Amount	Employee Cost*
Spouse Coverage Amount	$10,000 $20,000	$3.50 $7.00
Child Coverage Amount	$5,000 $10,000	$1.00 $2.00 (regardless of number of children)

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

Changing Your Coverage

You may choose dependent life insurance or change the amount of your spouse's coverage during the annual enrollment period. The choices you make during this enrollment period are effective January 1, 2008. However, coverage may be delayed if you are not actively at work, or your coverage choice requires evidence of insurability (proof of good health).

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

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

Basic Accidental Death and Dismemberment Benefits

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

The company will continue to provide a business travel accident insurance benefit equal to five times your annual base 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.

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 $10,000 to $500,000, in multiples of $10,000. However, you may not choose more than $250,000 if that amount is more than 10 times your annual base salary. The plan pays all or a portion of your benefit amount if you die or sustain certain types of injuries within 365 days of a covered accident. Covered losses include accidental death or paralysis, loss of hands, feet, speech, hearing or sight. There also are several plan features that provide additional benefits to help you and your family recover from the financial losses these injuries may cause. 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, 15% each child*
Spouse, no children	60% spouse
Dependent children, no spouse	25% each child*

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

Coverage Amount After Age 70

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

Changing Your Coverage

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

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

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

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

Disability Benefits

The company provides short-term and long-term disability coverage under the Disability Plan to all full-time 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 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

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 an illness or injury for seven consecutive calendar days or longer, you must contact Liberty Mutual on the eighth day at 1-866-502-8837 or ***www.mylibertyclaim.com*** to file an STD claim. Liberty Mutual will work with you and your doctor to evaluate your claim for benefits. If you do not file a claim, your pay will not continue. Liberty Mutual will manage your claim for STD 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 1-866-502-8837 or go to ***www.mylibertyclaimstatus.com*** 24 hours a day, seven days a week, to obtain the status of your claim. If you call during normal business hours, you can discuss your claim with a Liberty Mutual claims representative.

Pre-Existing Conditions Limit for Disability

For employees hired on or after January 1, 2005, the definition of a pre-existing condition for purposes of disability claims is 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.

Family and Medical Leave

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

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

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

Employee Assistance Program (EAP)

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

Services provided by the EAP are:

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

All the services offered under the program are entirely confidential and free of charge. You may contact REACH at 800-788-7322 for more information about the services.

Flexible Spending Accounts

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

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

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

Health Care Flexible Spending Account

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

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.

If you choose the Consumer Choice Option for your medical coverage, the HC FSA can be used in combination with your Employee Choice Account. Please see pages 19 for details. You will submit claims for both accounts to BeneFLEX.

BeneFLEX Card

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

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

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

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

Dependent Care Flexible Spending Account

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 2008.
- If your family status changes because of a birth, death, marriage, divorce or a spouse losing his or her job, you can enroll, cancel or change your monthly deposit for either account subject to the plan rules explained in your summary plan description. 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 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 disability, basic and supplemental 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 medical, dental or vision plan contributions through a HC FSA. These contributions are automatically deducted on a tax-free basis through separate payroll deductions.
- If you enroll in the Consumer Choice Option medical plan and also participate in a HC FSA, you must submit claims to your HC FSA first. When that account is used up, additional claims may be submitted to your Employee Choice Account. See page 19 for details.

Enrollment Guide

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.

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

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.