2007 Medical Coverage News for Retired Employees

THIS NEWSLETTER OUTLINES MEDICAL COVERAGES AND 2007 CONTRIBUTIONS FOR RETIRED EMPLOYEES. AN ENROLLMENT FORM IS ALSO INCLUDED. **PLEASE RETURN THIS ENROLLMENT FORM BY NOVEMBER 28, 2006 TO CHANGE YOUR CURRENT COVERAGE OPTION. OTHERWISE, YOUR CURRENT MEDICAL PLAN OPTION WILL CONTINUE FOR 2007 AT THE RATE INDICATED ON THE ENROLLMENT FORM.**

WHAT'S CHANGING IN 2007

For 2007, there will be no changes to the benefit plan choices that are available to you.

KEY MEDICAL HIGHLIGHTS

Once again for 2007, you have a choice of three Company Group Medical Plan options, or you can waive coverage. These plan options are not changing for 2007. As a reminder, here are the key differences among the options:

Option 250

- Highest monthly cost and highest benefits of the three options.
- $250 annual deductible per person for network expenses.
- Your share of typical network expenses is 20%.
- Prescription drug benefits through separate program (no deductible).

Option 500

- Lower monthly cost for coverage than Option 250.
- $500 annual deductible per person for network expenses.
- Your share of typical network expenses is 25%.
- Prescription drug benefits through separate program (no deductible).

Option 1000

- Lowest monthly cost for coverage of the three options.
- $1,000 annual deductible per person for network expenses.
- Your share of typical network expenses is 30%.
- Prescription drug benefits through BlueCross BlueShield of Illinois (subject to deductible).

REMINDER: HOW THE PLANS WORK WITH MEDICARE

For retirees who are eligible for Medicare, Medicare is the primary plan and the company plan is secondary under any of these options. This also applies to any covered dependents who are Medicare-eligible. The company plan's benefits are reduced by the amount of Medicare's benefits for the same claim. The plan will not pay any benefit unless the Medicare eligible retiree and dependent(s) are enrolled in Part A and Part B of Medicare. You *must contact Peabody immediately when you or your spouse or dependents become eligible for Medicare.* You may call the Peabody Benefits Call Center at I–800-633-9005 or send an e-mail to benefits@peabodyenergy.com.

HOW TO RENEW YOUR COVERAGE FOR 2007

You will need to complete and return this enrollment form to the Peabody Benefits Department in St. Louis by **November 28, 2006**. If you fail to return the enrollment form, your medical plan option will default to your 2006 election and you will not be able to change your election except for certain circumstances as outlined below. The rates shown on the enclosed enrollment form will apply starting January 1, 2007.

CHANGING YOUR MEDICAL COVERAGE

The choices you make during the annual enrollment period are effective January l, 2007, and are binding throughout the calendar year. Except in certain cases, you will not be able to enroll or change your options or your dependent coverage choices until the next annual enrollment period.

If you are enrolled for one of the medical Options, you can only increase your coverage by one level during the annual enrollment period. For example, you can switch from Option 1000 to Option 500, or from Option 500 to Option 250. You cannot increase **two** coverage levels - from Option 1000 to Option 250. The options available to you depend on your situation, as shown in the summary below.

YOUR SITUATION	YOUR OPTIONS
You are now enrolled in Option 250	You can decrease or drop coverage during this annual enrollment period. If you drop coverage for yourself or your eligible dependents, you cannot re-enroll in the future unless you lose coverage from another plan.
You are now enrolled in Option 500 or Option 1000	You can decrease or drop coverage, or upgrade your coverage one level during this annual enrollment period. If you drop coverage for yourself or your eligible dependents, you cannot re-enroll in the future unless you lose coverage from another plan.
You gain coverage under another plan because of marriage or a change in your spouse's job	You can drop or decrease Peabody coverage within 31 days of the date your other coverage starts. If you drop coverage for yourself or your eligible dependents, you cannot re-enroll in the future unless you lose coverage from another plan.
You or your eligible dependents have coverage from another source and lose it for certain reasons	You can enroll for any Peabody medical option, add eligible dependents or upgrade your coverage, within 31 days of the loss of coverage.
You drop coverage for yourself or eligible dependents	You cannot re-enroll in the future unless you lose coverage from another plan.

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 states 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.

COMPARING YOUR MEDICAL PLAN OPTIONS

The table below compares the features of the medical plan options in more detail. You may also waive coverage. See the following page for details on prescription drug coverage.

	OPTION 250		OPTION 500		OPTION 1000	
	NETWORK	NON-NETWORK*	NETWORK	NON-NETWORK*	NETWORK AND OUT-	NON-NETWORK*
DEDUCTIBLES/COPAYMENTS YOU PAY						
Annual Deductible	$250	$500	$500	$1,000	$1,000	$2,000
Emergency Room Co-payment (if not true emergency)	$50	$50	$50	$50	$50	$50
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE AND COPAYMENTS						
Inpatient Hospital and Emergency Room **	80%	60%	75%	55%	70%	50%
BENEFITS THE PLAN PAYS AFTER ANNUAL DEDUCTIBLE						
Wellness Benefits (including well-child care, routine physicals and screenings)	100% up to $500 per calendar year (no deductible)	60%	100% up to $500 per calendar year (no deductible)	55%	70% up to $500 per calendar year (no deductible)	50%
Most Other Medical Expenses**	80%	60%	75%	55%	70%	50%
ANNUAL OUT-OF-POCKET MAXIMUMS YOU PAY (includes deductible, hospital co-payment and coinsurance – will be indexed annually for Peabody medical inflation)						
Individual Out-of-Pocket Maximum	$1,700	$3,400	$2,800	$5,600	$4,500	$9,000
Family Out-of-Pocket Maximum	$3,400	$6,800	$5,600	$11,200	$9,000	$18,000
LIFETIME MAXIMUM BENEFIT	$1 million Indexed annually for inflation (In 2007, limit is $2.4 million)					

* If you and your covered dependent's claims are processed by AAG, the non-network provisions of the plan do not apply.

* * 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.

PRESCRIPTIONS – Option 250 and Option 500

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

- **Generic requirement:** The plan requires the use of generic drugs whenever a generic form is available. This means if your doctor or you select a brand-name drug when a generic is available, you will pay the generic coinsurance plus the difference in cost.
- **Preferred drug list:** Drugs on the plan's preferred drug list are preferred by the plan generally due to their effectiveness and/or cost. When a generic drug is not available, you are encouraged to choose a brand-name drug from this list. Brand-name drugs not on this list are considered less cost effective and will require a higher "non-preferred" coinsurance. If you or your doctor chooses a brand-name drug that's not on the plan's preferred drug list ("non-preferred"), you will pay a higher coinsurance.
- **Prior authorization and step therapy:** The program requires prior authorization for certain medications. If you are prescribed one of these medications, Prescription Solutions will verify your medical condition of your doctor to ensure that the medication is appropriate.

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

PRESCRIPTION DRUG SUMMARY

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

1. If your prescriptions are filled at a participating BlueScript pharmacy, you will receive discounts, and the pharmacy will file your claims for you. After you meet your annual deductible, BlueCross BlueShield of Illinois will reimburse 70% of the

cost of each prescription for the rest of the calendar year (or 100% after you have met the annual out-of-pocket maximum). If you use a non-participating provider, you receive the same level of benefits, but you must file a claim for reimbursement with BlueCross BlueShield of Illinois.

2. If you receive a maintenance brand name drug from a retail pharmacy instead of using the Prescription Solutions Mail Service pharmacy, you will pay a $10 surcharge in addition to your regular coinsurance/copayment share of the cost.
3. If you or your doctor requests a brand-name drug when a generic equivalent is available, you will pay the generic coinsurance plus the difference in cost.
4. Minimum and maximum copays will be indexed for annual Peabody prescription drug inflation.

YOUR MONTHLY COST FOR COVERAGE

The monthly contributions for coverage under the three plans for 2007 are indicated on the enclosed enrollment form. If your pension check is insufficient to cover your 2007 contributions, you must make direct payments to the plan by the first of each month.

YOUR COVERAGE FOR 2007

THE ENCLOSED ENROLLMENT FORM MUST BE RECEIVED IN THE BENEFITS OFFICE
NO LATER THAN **NOVEMBER 28, 2006**
PLEASE MAIL FORMS TO:

Peabody Investments Corp.
Attn: Benefits
701 Market St.
St. Louis, MO 63101-1826

IF YOU DO NOT RETURN A NEW ENROLLMENT FORM BY NOVEMBER 28, 2006,
YOUR COVERAGE WILL REMAIN THE SAME AS YOUR 2006 ELECTION.

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.

2007 Retiree Enrollment Form

Filling Out Your Form: If you are already retired and are receiving retiree medical benefits, complete and return this form by November 28, 2006. If you are enrolling as a retiree for the first time, you must turn in a completed enrollment form with your retirement application. If you are currently enrolled in the medical plan as an active employee and you do not turn in a completed form with your retirement application, your coverage will end as of your pension commencement date. Note: If you need to request a change to your coverage, please make a photocopy of your completed form for your records. **If you are requesting a change, be sure to complete the entire form.**

I . RETIREE INFORMATION Please complete all information requested

Name: _____
Last First MI Date of Birth

Address: _____
Street Apt # City State Zip

Social Security No.: _____ Home Phone No.: _____

Medicare Identification Number: _____ Medicare Effective Date: _____

2. YOUR MEDICAL COVERAGE CHOICES Please indicate your choice of medical plan and select the coverage level you wish to enroll for by checking the appropriate box. Then circle the corresponding price, which varies depending on the plan you choose, your Medicare status and that of your spouse. This will be your monthly cost for medical coverage.

OPTION 250	Monthly Cost
RETIREE ONLY	
❑ Not Medicare Eligible	$52.11
❑ Medicare Eligible	$13.25
RETIREE PLUS 1 DEPENDENT	
❑ Both Not Medicare Eligible	$208.42
❑ Both Medicare Eligible	$53.00
❑ Retiree Medicare Eligible/Dependent Not Medicare Eligible	$169.56
❑ Retiree Not Medicare Eligible/Dependent Medicare Eligible	$91.86
RETIREE PLUS 2 OR MORE DEPENDENTS	

❑ All Not Medicare Eligible	$294.84
❑ Retiree and Spouse Medicare Eligible/Dependent Child	$105.87
❑ Retiree Medicare Eligible/Spouse Not Medicare Eligible and Dependent Child	$239.21
❑ Spouse Medicare Eligible/Retiree Not Medicare Eligible and Dependent Child	$161.50

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OPTION 500	Monthly Cost
RETIREE ONLY	
❑ Not Medicare Eligible	$27.92
❑ Medicare Eligible	$7.58
RETIREE PLUS 1 DEPENDENT	
❑ Both Not Medicare Eligible	$144.24
❑ Both Medicare Eligible	$39.18
❑ Retiree Medicare Eligible/Dependent Not Medicare Eligible	$133.37
❑ Retiree Not Medicare Eligible/Dependent Medicare Eligible	$59.52
RETIREE PLUS 2 OR MORE DEPENDENTS	
❑ All Not Medicare Eligible	$208.55
❑ Retiree and Spouse Medicare Eligible/Dependent Child	$81.21
❑ Retiree Medicare Eligible/Spouse Not Medicare Eligible and Dependent Child	$186.54
❑ Spouse Medicare Eligible/Retiree Not Medicare Eligible and Dependent Child	$112.69

OPTION 1000	Monthly Cost
RETIREE ONLY	
❑ Not Medicare Eligible	$12.94
❑ Medicare Eligible	$3.03
RETIREE PLUS 1 DEPENDENT	
❑ Both Not Medicare Eligible	$99.23
❑ Both Medicare Eligible	$23.20
❑ Retiree Medicare Eligible/Dependent Not Medicare Eligible	$96.06
❑ Retiree Not Medicare Eligible/Dependent Medicare Eligible	$33.11
RETIREE PLUS 2 OR MORE DEPENDENTS	
❑ All Not Medicare Eligible	$146.93
❑ Retiree and Spouse Medicare Eligible/Dependent Child	$50.02
❑ Retiree Medicare Eligible/Spouse Not Medicare Eligible and Dependent Child	$133.32
❑ Spouse Medicare Eligible/Retiree Not Medicare Eligible and Dependent Child	$70.37

❑ **NO COVERAGE**

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2007 Enrollment Form

3. DEPENDENT INFORMATION FOR MEDICAL COVERAGE Please fill in all requested information for each dependent.

Name	Date of Birth	Social Security Number	Relationship to You

4. OTHER COVERAGE Please indicate whether you or any covered dependents have other medical coverage. List all covered dependents who may be eligible for Medicare Part A and Part B. In addition, please indicate the Medicare effective date and the Medicare Identification Number for each individual.

Medicare Eligible Individual	Medicare Effective Date	Medicare Card Identification Number

Please list all dependents who may be covered under any other group medical plan.

Dependent	Other Insurance Effective Date	Other Insurance Name and Address

5. SIGNATURE Please read, sign and date.

I authorize the company to deduct my contribution for medical coverage from my monthly pension check. I understand that if my pension check is insufficient to cover the election I have made above, I must make direct payments to the plan by the first day of each month to maintain coverage. I also understand that the company may amend or discontinue my medical and/or life coverage at any time in the future and that contributions are subject to change periodically.

Signature Date

2007 Enrollment Form