

2010
EVRAZ Rocky Mountain Steel
Comparison of Benefits
MEDICAL

This summary is an overview only. The terms and conditions of the benefits described in this guide are determined solely by the plan design documents.

Plan Choices:	RMSM Health Plan	High Deductible/HSA Plan (Management Employees Only)
Network	Blue Cross and Blue Shield Networks (out of network services covered at a lesser rate) Visit www.mybenefitshome.com or call 800-810 BLUE for information about preferred providers and hospitals.	
Company HSA Contributions	Not applicable	Employee Only \$750 per year Family \$1500 per year
Deductible Based on calendar year	<i>In network:</i> \$250 per individual per year \$500 maximum per family per year <i>Out of network</i> \$300 per individual per year \$600 maximum per family per year	\$1500 per individual per year \$3000 maximum per family per year
Out of Pocket Maximum Based on calendar year after meeting deductible	<i>In network:</i> \$1,500 per individual per year \$3,000 per family per year <i>Out of network</i> \$2,000 per individual per year \$4,000 per family per year	<i>In network: in addition to deductible:</i> \$1,500 per individual per year \$3,000 per family per year <i>Out of network: in addition to deductible:</i> \$3,000 per individual per year \$6,000 per family per year
Maximum Lifetime Benefits	\$3,500,000 \$1,000,000 human organ and tissue transplants	\$5,000,000 \$1,000,000 human organ and tissue transplants
Dependent Child Eligibility	Age 19 unless a full time student then age 25	
Claims Processing/Contact Information	Regence Life and Health Insurance Company PO Box 3355 Pittsburgh, PA 15230-3355 Group # 011302 Customer Service: 866-217-5067 www.mybenefitshome.com	
Alternative Care Providers	<i>In network:</i> Any licensed Naturopath, Chiropractor or Acupuncturist Plan pays 100% after \$15 copay <i>Out of network:</i> Plan pays 70% after deductible Maximum 12 visits (combined) per calendar year	Any licensed Naturopath, Chiropractor or Acupuncturist Plan pays 80% after deductible Maximum 15 visits (combined) per calendar year.
Ambulance	Plan pays 100%	Plan pays 80% after deductible

Chemical Dependency	<i>In-network:</i> <ul style="list-style-type: none"> • Outpatient: 100% after \$15 co-pay • Inpatient: Plan pays 90% <i>Out-of-network:</i> Plan pays 70% after deductible	<i>In-network:</i> Plan pays 80% after deductible <i>Out-of-network:</i> Plan pays 60% after deductible
Emergency Room	<i>In-network or Out of network:</i> 100% of allowable expense after \$100 co-pay per visit (co-pay waived if admitted) <i>No deductible applied</i>	Plan pays 80% after deductible
Hospital Services Inpatient includes: <ul style="list-style-type: none"> • Hospital room and board (semi-private) • Physician services including surgery • Intensive Care • Anesthesia • Lab, X-ray and other services • Pre-admission testing • Maternity – includes routine nursery charges Approved birthing centers	<i>In-network:</i> Plan pays 80% <i>Out-of-network:</i> Plan pays 70% after deductible	<i>In-network:</i> Plan pays 80% after deductible <i>Out-of-network:</i> Plan pays 60% after deductible
Hospital Services Outpatient surgery	<i>In-network:</i> Plan pays 80% <i>Out-of-network:</i> Plan pays 70% after deductible	<i>In-network:</i> Plan pays 80% after deductible <i>Out-of-network:</i> Plan pays 60% after deductible
Maternity <ul style="list-style-type: none"> • Pre-natal Physician and delivery service • Hospital including routine nursery charges • Approved birthing centers 	<i>In-network:</i> Plan pays 80% <i>Out-of-network:</i> Plan pays 70% of UCR after deductible	<i>In-network:</i> 80% after deductible <i>Out-of-network:</i> Plan pays 60% of UCR after deductible
Office Visits	Primary care physician recommended but not required. <i>In-network: (not subject to deductible)</i> <ul style="list-style-type: none"> • Primary care physician \$15 co-pay per visit <i>Out-of Network:</i> Plan pays 70% after deductible	Primary care physician recommended but not required <i>In network:</i> Plan pays 80% after deductible <i>Out of network:</i> Plan pays 60% after deductible
Mental Health <ul style="list-style-type: none"> • Outpatient • Residential/day treatment • Inpatient 	<i>In-network:</i> <ul style="list-style-type: none"> • Outpatient: 100% after \$15 co-pay • Inpatient: Plan pays 90% <i>Out-of-network:</i> Plan pays 70% after deductible	<i>In-network:</i> Plan pays 80% after deductible <i>Out-of-network:</i> Plan pays 60% after deductible
Physician Services	<i>In-network:</i> Plan pays 100% after co-pay <ul style="list-style-type: none"> • \$15 co-pay per date of service per provider <i>Out-of Network:</i> Plan pays 70% after deductible	Primary care physician recommended but not required. <i>In-network:</i> Plan pays 80% after deductible <i>Out-of-network:</i> Plan pays 60% after deductible

<p>Preventive Care</p> <ul style="list-style-type: none"> • Routine physical exams • Well-woman exams • Well-baby and child exams and immunizations 	<p><i>In-network:</i> Plan pays 100% after \$15 co-pay including mammograms.</p> <p><i>Out-of-network:</i> Plan pays 70% after deductible</p>	<p><i>In-network:</i> (not subject to deductible, each benefit paid at 100% subject to a \$500 Maximum; Includes x-rays and labs)</p> <ul style="list-style-type: none"> • Adult Routine Physical Exam • Pediatric Immunizations • Pediatric Routine Physical Exam • Routine Annual Gyn Exam and Pap Test <p><i>Out-of-network:</i> Plan pays 60% after deductible* (Adult and Pediatric routine exams not covered)</p>
<p>Rehabilitation/Therapy</p> <ul style="list-style-type: none"> • Physical therapy • Speech therapy • Hearing therapy • Occupational therapy 	<p><i>In-network:</i> Plan pays 100% after \$15 co-pay</p> <p><i>Out-of-network:</i> Plan pays 70% after deductible</p> <p>Physical and Occupational Therapy limited to 60 visits/calendar year combined in and out-of network</p> <p>Speech & Language Therapy limited to 20 visits per calendar year combined in and out of network</p>	<p><i>In-network:</i> Plan pays 80% after deductible</p> <p><i>Out-of-network:</i> Plan pays 60% after deductible</p> <p>Limited to 30 visits/benefit period combined in and out-of network</p>
<p>Diagnostic Services (Lab, X-ray)</p>	<p><i>In-network:</i> Plan pays 80%</p> <p><i>Out-of-network:</i> Plan pays 70% after deductible</p>	<p><i>In network:</i> Plan pays 80% after deductible</p> <p><i>Out of network:</i> Plan pays 60% after deductible</p>

All payments under the RMSM plan are subject to *Usual, Customary and Reasonable (UCR)* rates. This is the fee that is typically charged by a similar provider for a particular service in your geographic area.

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PRESCRIPTION**

Plan Choices:	RMSM Health Plan	HSA Plan (Management Employees Only)
Network	Express Scripts www.express-scripts.com	Merck/Medco
Deductible	\$0	\$1500 per individual per year \$3000 maximum per family per year The above deductibles are integrated with medical
Prescription Drugs	<p>Retail:</p> <ul style="list-style-type: none"> • \$10 co-pay generic formulary • \$20 co-pay brand name formulary • \$40 non-formulary <p>Mail Order: 90-day supply through Express Scripts</p> <ul style="list-style-type: none"> • \$20 co-pay generic formulary • \$40 co-pay for brand formulary • \$80 for non-formulary 	<p>In-network: Plan pays 80% after deductible; 31 day supply.</p> <p>Out-of-network: Not Covered</p> <p>Mail Order: Covered the same as in-network, 90-day supply</p>
Claims Processing/Contact Info	<p>Express Scripts PO Box 66773 St. Louis, MO 63166</p> <p>Group # P22</p> <p>Customer Service 800-468-9744 www.express-scripts.com</p>	<p>Merck/Medco More information will be provided upon enrollment.</p>

For a list of Formulary Prescription Drugs please contact Customer Service at Express Scripts or Merck/Medco.

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VISION (Included with Medical)

Plan:	VSP
Network	Vision Service Plan (VSP) 800-877-7195 www.vsp.com
Vision Benefits	<ul style="list-style-type: none"> • Exams: \$10 copay; maximum one per 12 months. • Eyeglasses: \$20 copay; maximum one per 24 months • Frame of your choice covered up to \$120. Plus, 20% off any out-of-pocket costs. • Contacts: \$125 allowance towards the cost of your lenses and fitting and evaluation exams, one per 24 months <p>Co-pay amounts apply to in-network providers only, contact VSP for more information about out of network benefits.</p>
Claims Processing/Contact Info	Vision Service Plan (VSP) PO Box 997105 Sacramento, CA 95899 Group # 12228650 Customer Service: 800-877-7195 www.vsp.com

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DENTAL

This summary is an overview only. The terms and conditions of the benefits described in this guide are determined solely by the Plan Description provided for the ODS Dental Plan.

Plan:	ODS Dental
Network	ODS Dental– information available regarding participating dentists from ODS customer service or www.odshp.com For in network pricing please use a PPO network provider.
Calendar Year Deductible	<i>In network:</i> \$25 per individual per year \$75 maximum per family per year <i>Out of network:</i> \$50 per individual per year \$150 maximum per family per year
Calendar Year Maximum	\$1,500 per person
Claims Processing/Contact Information	ODS Dental Group #: 10000166 Customer Service: 800-452-1058
Preventive and Diagnostic Includes exams (2 in a twelve month period), cleaning, X-rays , fluoride treatments, etc.	<i>In network:</i> Plan pays 100% Allowable fee*. No deductible for preventative services. <i>Out of network:</i> Plan pays 90%
Basic Restorative Services Includes fillings, extractions, anesthetics, etc.	<i>In-network:</i> Plan pays 70% of allowable fee <i>Out-of-network:</i> Plan pays 50 % of allowable fee
Periodontics and Endodontics	<i>In-network:</i> Plan pays 70% of allowable fee <i>Out-of-network:</i> Plan pays 50 % of allowable fee
Oral Surgery	<i>In-network:</i> Plan pays 70% of allowable fee <i>Out-of-network:</i> Plan pays 50 % of allowable fee
Major Restorative Care Includes crowns, dentures, bridge, in-lays, implants, etc.	<i>In-network:</i> Plan pays 60% of allowable fee <i>Out-of-network:</i> Plan pays 40 % of allowable fee
Orthodontia for Children under 19 Includes consultation, X-rays, braces, etc.	Plan pays 50% up to \$1,500 lifetime maximum per person.

*Allowable fee for a PPO dentist is the fee schedule which the dentist has agreed to charge. Allowable fee for a Premier Dentist is the filed and approved fee. Allowable fee for a non-participating dentist is the average fee for the service performed in that site.