

**Evraz Claymont Steel Comparison of Benefits 2010**  
**MEDICAL - Claymont**

This summary is an overview only. The terms and conditions of the benefits described in this guide are determined solely by Health Plan Summary Plan Descriptions.

Plan Choices:	PPO Plan	HSA/High Deductible Plan															
<b>Monthly Employee Cost Share</b>	Employee Only: \$52 Employee + Spouse: \$108 Employee + Child(ren): \$108 Family: \$160	Employee Only: \$0 Employee + Spouse: \$0 Employee + Child(ren): \$0 Family: \$0															
<b>Network</b>	Blue Cross and Blue Shield Networks (out of network services covered at a lesser rate)  Visit <a href="http://www.mybenefitshome.com">www.mybenefitshome.com</a> or call 800-810 BLUE for information about preferred providers and hospitals	Blue Cross and Blue Shield Networks (out of network services covered at a lesser rate)  Visit <a href="http://www.mybenefitshome.com">www.mybenefitshome.com</a> or call 800-810 BLUE for information about preferred providers and hospitals															
<b>Deductible</b> Based on calendar year	\$250 per individual per year \$500 maximum per family per year	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Deductible</td> <td style="width: 33%;">Individual</td> <td style="width: 33%;">Family</td> </tr> <tr> <td></td> <td style="text-align: center;">\$1,500</td> <td style="text-align: center;">\$3,500</td> </tr> <tr> <td colspan="3"><i>EVRAZ will contribute to HSA account:</i></td> </tr> <tr> <td>Contribution</td> <td>Individual</td> <td>Family</td> </tr> <tr> <td></td> <td style="text-align: center;">\$750</td> <td style="text-align: center;">\$1500</td> </tr> </table>	Deductible	Individual	Family		\$1,500	\$3,500	<i>EVRAZ will contribute to HSA account:</i>			Contribution	Individual	Family		\$750	\$1500
Deductible	Individual	Family															
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Contribution	Individual	Family															
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<b>Out of Pocket Maximum</b>	\$1,500 per individual per year \$3,000 maximum per family per year	In Network, in addition to deductible: \$1,500 per individual per year \$3,000 per family per year  Out of Network, in addition to deductible: \$3,000 per individual per year \$6,000 per family per year															
<b>Maximum Lifetime Benefits</b>	\$3,500,000	\$5,000,000															
<b>Dependent Child Eligibility</b>	Age 19 unless a full time student then age 25	Age 19 unless a full time student then age 25															
<b>Claims Processing/Contact Information</b>	Regence Life and Health Insurance Company PO Box 3355 Pittsburgh, PA 15230-3355  Group # 011302  Customer Service: 866-217-5067 <a href="http://www.mybenefitshome.com">www.mybenefitshome.com</a>	Regence Life and Health Insurance Company PO Box 3355 Pittsburgh, PA 15230-3355  Group # 011302  Customer Service: 866-217-5067 <a href="http://www.mybenefitshome.com">www.mybenefitshome.com</a>															

Plan Choices:	PPO Plan	HSA/High Deductible Plan
<b>Alternative Care Providers</b>	Any licensed Naturopath, Chiropractor or Acupuncturist.  \$10 co-pay per visit, maximum 15 visits (combined) per calendar year.  Subject to Usual and Customary fees	Plan pays 80% after deductible  Maximum 15 visits (combined) per calendar year
<b>Ambulance</b>	Plan pays 80% after deductible	Plan pays 80% after deductible
<b>Chemical Dependency</b>	<b>In-network:</b> \$20 co-pay  <b>Out-of-network:</b> Plan pays 70% after deductible  In or out of network maximums: No maximums	<b>In-network:</b> Plan pays 80% after deductible  <b>Out-of-network:</b> Plan pays 60% after deductible  In or out of network maximums: No maximums
<b>Emergency Room</b>	<b>In-network:</b> \$100 co-pay then plan pays 80% after deductible.  Co-pay waived if admitted to the hospital.  <b>Out-of-network:</b> \$100 co-pay then plan pays 70% after deductible	Plan pays 80% after deductible
<b>Hospital Services</b> Inpatient includes: <ul style="list-style-type: none"> <li>• Hospital room and board (semi-private)</li> <li>• Physician services including surgery</li> <li>• Intensive Care</li> <li>• Anesthesia</li> <li>• Lab, X-ray and other services</li> <li>• Pre-admission testing</li> <li>• Maternity – includes routine nursery charges</li> </ul> Approved birthing centers	<b>In-network:</b> Plan pays 80% after deductible  <b>Out-of-network:</b> Plan pays 70% after deductible	<b>In-network:</b> Plan pays 80% after deductible  <b>Out-of-network:</b> Plan pays 60% after deductible
<b>Hospital Services</b>  Outpatient surgery	<b>In-network:</b> Plan pays 80% after deductible  <b>Out-of-network:</b> Plan pays 70% after deductible	<b>In-network:</b> Plan pays 80% after deductible  <b>Out-of-network:</b> Plan pays 60% after deductible
<b>Maternity</b>	<b>In-network:</b> <ul style="list-style-type: none"> <li>• Pre-natal Physician and delivery services – 100% after \$75 co-pay per pregnancy</li> <li>• Hospital including routine nursery charges – 80% after deductible</li> <li>• Approved birthing centers – 80% after deductible</li> </ul> <b>Out-of-network:</b> Plan pays 70% of UCR after deductible	<b>In-network:</b> <ul style="list-style-type: none"> <li>• Pre-natal Physician and delivery services – 80% after deductible</li> <li>• Hospital including routine nursery charges – 80% after deductible</li> <li>• Approved birthing centers – 80% after deductible</li> </ul> <b>Out-of-network:</b> Plan pays 60% of UCR after deductible

Plan Choices:	PPO Plan	HSA/High Deductible Plan
<b>Mental Health</b> <ul style="list-style-type: none"> <li>• Outpatient</li> <li>• Residential/day treatment</li> <li>• Inpatient</li> </ul>	<p><b>In-network:</b> \$20 co-pay</p> <p><b>Out-of-network:</b> Plan pays 70% after deductible</p> <p>In or out of network maximums: No maximums</p>	<p><b>In-network:</b> Plan pays 80% after deductible</p> <p><b>Out-of-network:</b> Plan pays 60% after deductible</p> <p>In or out of network maximums: No maximums</p>
<b>Office Visits</b>	<p>Primary care physician recommended but not required.</p> <p><b>In-network:</b> (not subject to deductible)</p> <ul style="list-style-type: none"> <li>• Primary care physician \$10 co-pay per visit</li> <li>• Specialist: \$20 co-pay per visit</li> </ul> <p><b>Out-of Network:</b> Plan pays 70% after deductible</p>	<p>Primary care physician recommended but no required</p> <p><b>In network:</b> Plan pays 80% after deductible</p> <p><b>Out of network:</b> Plan pays 60% after deductible</p>
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>• Routine physical exams</li> <li>• Well-woman exams</li> <li>• Well-baby and child exams and immunizations</li> </ul>	<p><b>In-network:</b> (not subject to deductible) <i>Includes x-rays and labs in co-pay</i></p> <ul style="list-style-type: none"> <li>• Children under age 2; 8 exams and required immunizations at \$10 co-pay per visit</li> <li>• Children ages 2 through 6; annual exam and required shots at \$10 co-pay per visit</li> <li>• Children over age 7 and adults; up to \$500 benefit per year for \$10 co-pay per visit.</li> </ul> <p><b>Out-of-network:</b> Plan pays 70% after deductible</p>	<p><b>In network:</b> (not subject to deductible) Benefits paid at 100% subject to a \$500 maximum, includes:</p> <ul style="list-style-type: none"> <li>• X-rays and labs</li> <li>• Adult Routine Physical Exams</li> <li>• Pediatric Immunizations</li> <li>• Pediatric Routine Physical Exams</li> <li>• Routine Annual Gyn Exam and Pap Test</li> </ul> <p><b>Out of network:</b> Plan pays 60% after deductible (Adult and Pediatric routine exams not covered)</p>
<b>Physician Services</b>	<p><b>In-network:</b> Plan pays 80% after deductible</p> <p><b>Out-of Network:</b> Plan pays 70% after deductible</p>	<p><b>In-network:</b> Plan pays 80% after deductible</p> <p><b>Out-of Network:</b> Plan pays 60% after deductible</p>
<b>Rehabilitation/Therapy (Specialty Care)</b> <ul style="list-style-type: none"> <li>• Physical therapy</li> <li>• Speech therapy</li> <li>• Hearing therapy</li> <li>• Occupational therapy</li> </ul>	<p><b>In-network:</b> Plan pays 80% after deductible</p> <p><b>Out-of-network:</b> Plan pays 70% after deductible</p> <p>Limited to 30 visits/benefit period combined in and out-of network</p>	<p><b>In-network:</b> Plan pays 80% after deductible</p> <p><b>Out-of-network:</b> Plan pays 60% after deductible</p> <p>Limited to 30 visits/benefit period combined in and out-of network</p>

Plan Choices:	PPO Plan	HSA/High Deductible Plan
<b>Urgent Care</b>	<p><b>In-network:</b> \$20 co-pay then plan pays 100% for office visit.</p> <p><b>Out-of-network:</b> \$100 co-pay then plan pays 70% after deductible.</p>	<p><b>In-network:</b> Plan pays 80% after deductible</p> <p><b>Out-of Network:</b> Plan pays 60% after deductible</p>
<b>Prescription Drugs</b>	<p>Covered by Express Scripts 800-468-9744 www.Express-scripts.com</p> <p>\$25 deductible per individual per year</p> <p><b>Retail:</b></p> <ul style="list-style-type: none"> <li>• \$10 co-pay for 30 day supply generic formulary</li> <li>• \$20 co-pay or 20% whichever is greater up to \$50 maximum for 30 day supply brand name formulary</li> <li>• \$40 or 40% whichever is greater up to \$100 maximum for 30 day supply non-formulary</li> </ul> <p><b>Mail order: (90 day supply)</b></p> <ul style="list-style-type: none"> <li>• \$20 for 90-day supply generic formulary</li> <li>• \$40 co-pay 90 day supply brand name formulary</li> <li>• \$80 for non-formulary</li> </ul>	<p>Covered by Merck/Medco</p> <p>Medical deductible applies to Rx</p> <p><b>In Network:</b> Plan pays 80% after deductible; 30 day supply</p> <p><b>Out of Network:</b> Not Covered</p> <p><b>Mail Order:</b> Covered the same as in network, 90 day supply</p>
<b>Vision Benefits</b>	<p>Covered by VSP 800-877-7195 www.vsp.com</p> <p>Exams: \$10 copay: maximum one per 12 months</p> <p>Eyeglasses: single vision lenses \$25 copay and frame of your choice covered up to \$130 Plus 20% off any out-of-pocket costs; one pair per 12 months</p> <p>Contact lenses \$130 allowance towards the cost of your lenses and fitting and evaluation exams, one per 12 months.</p>	<p>Covered by VSP 800-877-7195 www.vsp.com</p> <p>Exams: \$10 copay: maximum one per 12 months</p> <p>Eyeglasses: single vision lenses \$25 copay and frame of your choice covered up to \$130 Plus 20% off any out-of-pocket costs; one pair per 12 months</p> <p>Contact lenses \$130 allowance towards the cost of your lenses and fitting and evaluation exams, one per 12 months.</p>

## DENTAL - Claymont

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Plan Choices:	ODS Dental
<b>Network</b>	<p>ODS – information available regarding participating dentists from ODS customer service or <a href="http://www.odscompanies.com">www.odscompanies.com</a></p> <p>You may use any licensed dentist outside of the network. The services may be covered at a different rate.</p>
<b>Calendar Year Deductible</b>	<p>\$50 per individual per year \$150 maximum per family per year</p>
<b>Calendar Year Maximum</b>	\$2,000 per person
<b>Claims Processing/Contact Information</b>	<p>ODS Dental Service 601 SW 2<sup>nd</sup> Ave Portland, OR 97204</p> <p>Group #: 10000166</p> <p>Customer Service: 503-243-4494 or 800-452-1058</p>
<p><b>Preventive and Diagnostic</b></p> <p>Includes exams, cleaning, X-rays, fluoride treatments, etc.</p>	Plan pays 100% of the Usual, Customary and Reasonable. No deductible for preventative services.
<p><b>Basic Restorative Services</b></p> <p>Includes fillings, extractions, anesthetics, etc.</p>	<p><b><i>In-network:</i></b> Plan pays 90% of UCR</p> <p><b><i>Out-of-network:</i></b> Plan pays 85 % of UCR</p>
<p><b>Periodontics and Endodontics</b></p>	<p><b><i>In-network:</i></b> Plan pays 90% of UCR</p> <p><b><i>Out-of-network:</i></b> Plan pays 85 % of UCR</p>
<p><b>Oral Surgery</b></p>	<p><b><i>In-network:</i></b> Plan pays 90% of UCR</p> <p><b><i>Out-of-network:</i></b> Plan pays 85 % of UCR</p>
<p><b>Major Restorative Care</b></p> <p>Includes crowns, dentures, bridge, in-lays, implants etc.</p>	<p><b><i>In-network:</i></b> Plan pays 60% of UCR</p> <p><b><i>Out-of-network:</i></b> Plan pays 50 % of UCR</p>
<p><b>Orthodontia for Adults and Children</b></p> <p>Includes consultation, X-rays, braces, etc.</p>	Plan pays 50% up to \$2,000 lifetime maximum per person.