

Evrax Oregon Steel Comparison of Benefits 2010
MEDICAL

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:	Kaiser Deductible	Kaiser Traditional Grandfathered - This plan frozen to new entry	OSM Health Plan	High Deductible/HSA Plan
Monthly Employee Cost Share	Employee Only: \$0 Employee + Spouse: \$0 Employee + Child(ren): \$0 Family: \$0	Employee Only: \$42 Employee + Spouse: \$86 Employee + Child(ren): \$86 Family: \$120	Employee Only: \$42 Employee + Spouse: \$86 Employee + Child(ren): \$86 Family: \$120	Employee Only: \$0 Employee + Spouse: \$0 Employee + Child(ren): \$0 Family: \$0
Network	Covered services must be obtained or coordinated through a Kaiser provider. Visit www.kp.org or call 800-813-2000 for information about preferred providers and hospitals.	Covered services must be obtained or coordinated through a Kaiser provider. Visit www.kp.org or call 800-813-2000 for information about preferred providers and hospitals.	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	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
Deductible Based on calendar year	\$250 per individual per year \$750 maximum per family per year	\$0	\$250 per individual per year \$500 maximum per family per year	Deductible Individual Family Plan 1 1,500 3,500 <i>EOSM will contribute to the HSA account:</i> Contribution Individual Family Plan 1 \$750 \$1500
Out of Pocket Maximum	\$2,000 per individual per year \$6,000 maximum per family per year After meeting the deductible	\$1,250 per individual per year \$2,500 maximum per family per year	\$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
Maximum Lifetime Benefits	\$2,000,000	Unlimited	\$3,500,000	\$5,000,000
Dependent Child Eligibility	Age 23 unless a full time student then age 25	Age 23 unless a full time student then age 25	Age 23 unless a full time student then age 25	Age 23 unless a full time student then age 25
Claims Processing/Contact Information	Kaiser Permanente 500 NE Multnomah St. Portland, Oregon 97232 Group #: 1657 Customer Service: 503-813-2000 or 800-813-2000	Kaiser Permanente 500 NE Multnomah St. Portland, Oregon 97232 Group #: 1657 Customer Service: 503-813-2000 or 800-813-2000	Regence Life and Health Insurance Company PO Box 3355 Pittsburgh, PA 15230-3355 Group # 011302 Customer Service: 866-217-5067 www.mybenefitshome.com	Regence Life and Health Insurance Company PO Box 3355 Pittsburgh, PA 15230-3355 Group # 011302 Customer Service: 866-217-5067 www.mybenefitshome.com

Plan Choices:	Kaiser Deductible	Kaiser Traditional	OSM Health Plan	HSA Plan
Alternative Care Providers	Kaiser approved chiropractors \$15 co-pay per visit, maximum 15 visits per year	Kaiser approved chiropractors \$15 co-pay per visit, maximum 15 visits per year	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 (combines) per calendar year
Ambulance	Plan pays 80% not subject to deductible	\$75 co-pay per trip when medically necessary and authorized	Plan pays 80% after deductible	Plan pays 80% after deductible
Chemical Dependency	Outpatient: \$15 co-pay Residential/day treatment plan pays 80% after deductible Inpatient: plan pays 80% after deductible	Outpatient: \$15 co-pay Residential/day \$50 per day up to \$250 per admission Inpatient: same as residential	In-network: \$20 co-pay Out-of-network: Plan pays 70% after deductible In or out of network maximums: No maximums	In-network: Plan pays 80% after deductible Out-of-network: Plan pays 60% after deductible In or out of network maximums: No maximums
Emergency Room	Plan pays 80% after deductible; Coinsurance not waived if admitted	\$100 co-pay Co-pay is waived if admitted to the hospital	In-network: \$100 co-pay then plan pays 80% after deductible. Co-pay waived if admitted to the hospital. Out-of-network: \$100 co-pay then plan pays 70% after deductible	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	Plan pays 80% after deductible	\$50/ day up to \$250 per admission	In-network: Plan pays 80% after deductible Out-of-network: Plan pays 70% after deductible	In-network: Plan pays 80% after deductible Out-of-network: Plan pays 60% after deductible
Hospital Services Outpatient surgery	Plan pays 80% after deductible	\$50 co-pay per visit	In-network: Plan pays 80% after deductible Out-of-network: Plan pays 70% after deductible	In-network: Plan pays 80% after deductible Out-of-network: Plan pays 60% after deductible
Maternity	Plan pays 80% after deductible	<ul style="list-style-type: none"> • Physician visits pre and post natal - \$15 co-pay per visit. • Hospital including routine nursery charges – Plan pays 100% after hospital co-pay • Approved birthing centers – Plan pays 100% after hospital co-pay at Kaiser facilities only. 	In-network: <ul style="list-style-type: none"> • Pre-natal Physician and delivery services - 100% after \$75 co-pay per pregnancy • Hospital including routine nursery charges – 80% after deductible • Approved birthing centers – 80% after deductible Out-of-network: Plan pays 70% of UCR after deductible	In-network: <ul style="list-style-type: none"> • Pre-natal Physician and delivery services - 80% after deductible • Hospital including routine nursery charges – 80% after deductible • Approved birthing centers – 80% after deductible Out-of-network: Plan pays 60% of UCR after deductible

Plan Choices:	Kaiser Deductible	Kaiser Traditional	OSM Health Plan	HSA Plan
Mental Health <ul style="list-style-type: none"> Outpatient Residential/day treatment Inpatient 	<ul style="list-style-type: none"> Outpatient: \$15 co-pay Residential: plan pays 80% after deductible Inpatient: plan pays 80% after deductible 	<ul style="list-style-type: none"> Outpatient: \$15 co-pay Residential: \$50 per day up to \$250 per Inpatient \$50 per day up to \$250 per admission 	In-network: \$20 co-pay Out-of-network: Plan pays 70% after deductible In or out of network maximums: No maximums	In-network: Plan pays 80% after deductible Out-of-network: Plan pays 60% after deductible In or out of network maximums: No maximums
Office Visits	\$15 co-pay General \$25 co-pay Specialty \$0 co-pay Preventive (see below)	\$15 co-pay General \$15 co-pay Specialty \$15 co-pay Preventive (see below)	Primary care physician recommended but not required. In-network: (not subject to deductible) <ul style="list-style-type: none"> Primary care physician \$10 co-pay per visit Specialist: \$20 co-pay per visit Out-of Network: Plan pays 70% after deductible	Primary care physician recommended but no required In network: Plan pays 80% after deductible Out of network: Plan pays 60% after deductible
Preventive Care <ul style="list-style-type: none"> Routine physical exams Well-woman exams Well-baby and child exams and immunizations 	\$0 co-pay per visit \$10 co-pay per visit for labs \$10 co-pay per visit for x-rays No charge for immunizations	\$15 co-pay per visit \$0 co-pay for labs & x-rays No charge for immunizations	In-network: (not subject to deductible) <i>Includes x-rays and labs in co-pay</i> <ul style="list-style-type: none"> Children under age 2; 8 exams and required immunizations at \$10 co-pay per visit Children ages 2 through 6; annual exam and required shots at \$10 co-pay per visit Children over age 7 and adults; up to \$500 benefit per year for \$10 co-pay per visit. Out-of-network: Plan pays 70% after deductible	In network: (not subject to deductible, each benefits paid at 100% subject to a \$500 maximum, includes x-rays and labs Adult Routine Physical Exams Pediatric Immunizations Pediatric Routine Physical Exams Routine Annual Gyn Exam and Pap Test Out of network: Plan pays 60% after deductible (Adult and Pediatric routine exams not covered)
Physician Services	\$15 co-pay per visit	\$15 co-pay per visit	In-network: Plan pays 80% after deductible Out-of Network: Plan pays 70% after deductible	In-network: Plan pays 80% after deductible Out-of Network: Plan pays 60% after deductible
Rehabilitation/Therapy (Specialty Care) <ul style="list-style-type: none"> Physical therapy Speech therapy Hearing therapy Occupational therapy 	\$25 co-pay per visit after deductible	\$15 co-pay per visit	In-network: Plan pays 80% after deductible Out-of-network: Plan pays 70% after deductible Limited to 30 visits/benefit period combined in and out-of network	In-network: Plan pays 80% after deductible Out-of-network: Plan pays 60% after deductible Limited to 30 visits/benefit period combined in and out-of network

Plan Choices:	Kaiser Deductible	OSM Health Plan	OSM Health Plan	HSA Plan
Urgent Care	\$35 co-pay at Kaiser facilities	\$35 co-pay at Kaiser facilities	In-network: \$20 co-pay then plan pays 100% for office visit. Out-of-network: \$100 co-pay then plan pays 70% after deductible.	In-network: Plan pays 80% after deductible Out-of Network: Plan pays 60% after deductible
Prescription Drugs	Covered by Kaiser 800-813-2000 www.kp.org No deductible Retail: <ul style="list-style-type: none"> \$10 co-pay for 30 day supply generic formulary \$20 co-pay 30 day supply brand name formulary Non-formulary not covered Mail order: (Maintenance Rx) <ul style="list-style-type: none"> \$20 for 90-day supply generic formulary \$40 co-pay 90 day supply brand name formulary 	Covered by Kaiser 800-813-2000 www.kp.org No deductible Retail: <ul style="list-style-type: none"> \$10 co-pay for 30 day supply generic formulary \$20 co-pay 30 day supply brand name formulary Non-formulary not covered Mail order: (Maintenance Rx) <ul style="list-style-type: none"> \$20 for 90-day supply generic formulary \$40 co-pay 90 day supply brand name formulary 	Covered by Express Scripts 800-468-9744 www.Express-scripts.com \$25 deductible per individual per year Retail: <ul style="list-style-type: none"> \$10 co-pay for 30 day supply generic formulary \$20 co-pay or 20% whichever is greater up to \$50 maximum for 30 day supply brand name formulary \$40 or 40% whichever is greater up to \$100 maximum for 30 day supply non-formulary Mail order: (90 day supply) <ul style="list-style-type: none"> \$20 for 90-day supply generic formulary \$40 co-pay 90 day supply brand name formulary \$80 for non-formulary 	Covered by Merck/Medco Medical deductible applies to Rx In Network: Plan pays 80% after deductible; 30 day supply Out of Network: Not Covered Mail Order: Covered the same as in network, 90 day supply
Vision Benefits	Covered by Kaiser 800-813-2000 www.kp.org Exams: \$15 co-pay, maximum one per 12 months Eyeglasses and contact lenses: Plan pays \$150 towards one prescription of lenses, frames and/or contact lenses every 24 months.	Covered by Kaiser 800-813-2000 www.kp.org Exams: \$15 co-pay, maximum one per 12 months Eyeglasses and contact lenses: Plan pays \$150 towards one prescription of lenses, frames and/or contact lenses every 24 months.	Covered by VSP 800-877-7195 www.vsp.com Exams: \$10 co-pay: maximum one per 12 months Eyeglasses: single vision lenses \$20 co-pay and frame of your choice covered up to \$120 Plus 20% off any out-of pocket costs; one pair per 24 months Contact lenses \$105 allowance towards the cost of your lenses and fitting and evaluation exams, one per 24 months.	Covered by VSP 800-877-7195 www.vsp.com Exams: \$10 co-pay: maximum one per 12 months Eyeglasses: single vision lenses \$20 co-pay and frame of your choice covered up to \$120 Plus 20% off any out-of pocket costs; one pair per 24 months Contact lenses \$105 allowance towards the cost of your lenses and fitting and evaluation exams, one per 24 months.

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

Plan Choices:	ODS Dental	Kaiser Dental
Network	<p>ODS – information available regarding participating dentists from ODS customer service or www.odskompanies.com</p> <p>You may use any licensed dentist outside of the network. The services may be covered at a different rate.</p>	Covered services must be obtained from a Kaiser Dental Provider.
Calendar Year Deductible	\$50 per individual per year \$150 maximum per family per year	\$0
Calendar Year Maximum	\$2,000 per person	\$2,000 per person
Claims Processing/Contact Information	<p>ODS Dental Service 601 SW 2nd Ave Portland, OR 97204</p> <p>Group #: 10000166</p> <p>Customer Service: 503-243-4494 or 800-452-1058</p>	<p>Kaiser Permanente 500 NE Multnomah St. Portland, Oregon 97232</p> <p>Group #: 1657</p> <p>Customer Service: 503-813-2000 or 800-813-2000</p>
Preventive and Diagnostic Includes exams, cleaning, X-rays, fluoride treatments, etc.	Plan pays 100% of the Usual, Customary and Reasonable. No deductible for preventative services.	\$5 co-pay per visit, then plan pays 100% \$25 co-pay for Emergency/Urgent Services
Basic Restorative Services Includes fillings, extractions, anesthetics, implants, etc.	In-network: Plan pays 90% of UCR Out-of-network: Plan pays 85 % of UCR	\$5 co-pay per visit then plan pays 100%
Periodontics and Endodontics	In-network: Plan pays 90% of UCR Out-of-network: Plan pays 85 % of UCR	\$5 co-pay per visit then plan pays 80%
Oral Surgery	In-network: Plan pays 90% of UCR Out-of-network: Plan pays 85 % of UCR	\$5 co-pay per visit then plan pays 100%
Major Restorative Care Includes crowns, dentures, bridge, in-lays, etc.	In-network: Plan pays 60% of UCR Out-of-network: Plan pays 50 % of UCR	\$5 co-pay per visit then plan pays 50%
Orthodontia for Adults and Children Includes consultation, X-rays, braces, etc.	Plan pays 50% up to \$2,000 lifetime maximum per person.	Plan pays 50% up to \$3,000 lifetime maximum per person.