For Wage Employees
of Ispat Inland Inc.

Program of
Insurance Benefits III
(PIB III)

Summary Plan Description

Effective Pursuant to the Agreement
Dated August 1, 1999

ISPAT INLAND INC.

This Summary Plan Description contains two parts which, together, provide a comprehensive description of the Program of Insurance Benefits III.

Part A:
The User Friendly Guide
is a "user friendly" version
of PIB III
in an easy to understand
format.
(Pages A1 through A44)

Part B:
The Agreement
(The Plan)
is the negotiated
PIB III Agreement
in the traditional format.
(Pages B1 through B66)

Section C:
Index
is an index of terms in Parts A and B.
(Pages C1 through C5)

Who To Call For Benefit Information

MEDICAL BENEFITS AND NETWORKS

For eligibility questions for Medical and Vision benefits claims, or for Ispat Inland/USWA Health Care Network Provider information, call **Harrington Benefit Services**, *the claims administrator*, at **1-800-654-6208.**

Or to check on the status of a medical or vision claim through Automated Voice Response (AVR), call **1-877-256-3731.**

To get Pre-Authorization of a hospital inpatient stay, call *the pre-admission review administrator* at **1-800-499-1688**.

To locate a Network doctor or hospital in the Chicago area and other CCN Network contracted areas nationwide, call **CCN** at **1-888-685-7774**.

Select Option 2

To locate a Network doctor or hospital in Beech Street Network contracted areas, call **Beech Street** at**1-800-227-7464.**

Select Option 2

PRESCRIPTION DRUG BENEFITS

For Prescription Drug Program information, or to request pharmacy cards or Prescription Drug Claim forms or Mail Service forms and envelopes, call **PCS Health Systems**, *the prescription drug benefit manager*, at **1-800-925-5795**.

MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE BENEFITS

For Mental Health and Alcohol/Substance Abuse information and referrals, call **ValueOptions**, *the network manager*, at **1-800-332-2214**.

DENTAL BENEFITS

For Dental benefits/claims questions or for Dental Provider information,
call **First Commonwealth**, *the dental claims administrator*, at **1-800-788-3384**.

Ispat Inland Inc.

Program of Insurance Benefits III
(PIB III)

Basic Life Insurance
Sickness and Accident Benefits
Health Care Benefits
Prescription Drug Benefits
Mental Health and Alcohol/Substance Abuse
Dental Benefits
Vision Benefits
Claiming Benefits
Questions and Answers

Part A: The User Friendly Guide

The Plan ("Agreement") is specifically incorporated herein by reference. Every effort has been made to ensure the accuracy of this guide. However, if there is any contradiction between this guide and the Plan ("Agreement") the Plan ("Agreement") prevails.

PROGRAM OF INSURANCE BENEFITS III (PIB III)
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Chapter 1
Eligibility, Enrollment and Cost

A. Who is Eligible - Employees

You are eligible for coverage under the Program if you are [1] a full-time employee of the Company (see Section 10.1 of the Agreement for eligibility for part-time employees), [2] a member of one of the included Bargaining Units and [3] have completed 60 calendar days of employment from the date of last hiring with the Company.

(See Section 10 of the Agreement if you are a new hire, summer hire, or returning from a layoff or disability to determine when your eligibility begins.)

B. Who is Eligible - Dependents

Under some of the plans (i.e., the health care, dental and vision plans), you may choose to cover your dependents if you are a full-time employee. This also includes coverage under any available health maintenance organizations (HMOs) (see Sections 9.5 - 9.8 of the Agreement for more information on HMOs).

Under the other plans (i.e., the basic life insurance and sickness and accident plans) your dependents are not eligible to participate.

If your spouse can enroll in his or her employer's active or retiree health care plan, they should do so in order to avoid severe financial penalties in case of an illness or injury. The Program will only pay benefits as a secondary payer (see Section 8.0(b) of the Agreement for more information on primary and secondary coverage). If premiums are required by your spouse's employer, the Company may provide reimbursement for a portion of these premiums. In order to receive this reimbursement, you have to complete the proper forms which are available from the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover).

If Medicare coverage is available for you or your dependents because of kidney dialysis or a kidney transplant, the Program will only pay benefits as a secondary payer, but will reimburse you for Medicare premiums you are required to pay. Contact the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) for more information.

Your eligible dependents include:

- your spouse (i.e., the person you are legally married to)
- your unmarried children under age 19, including:
  - natural children;
  - step children living with you;
  - legally adopted children (including a child living with you during the period of probation);
  - children living with you for whom you are the sole support, provided you are related by blood or marriage; and
  - children living in your house and being supported solely by you as their legal guardian.
- a newborn baby of your covered female dependent other than your spouse (i.e., your grandchild). This newborn grandchild is automatically covered for hospital benefits until he or she is 15 days old. Then the baby is no longer covered under the Program, unless it meets the definition of an eligible dependent as stated above;
- your unmarried child between 19 and 25 years old who:
  - qualified as an eligible dependent before turning age 19; and
  - is enrolled as an active, full-time student (see Sections 9.32 - 9.35 of the Agreement for more information); and
  - is not working on a full-time basis; and
  - is not covered under any other employer group plan.

- your unmarried disabled (physically or mentally) child who:
  - became handicapped before turning age 19; and
  - is unable to be self-supporting; and
  - is financially dependent on you for support and maintenance (see Section 9.36 of the Agreement for more information).

You must file for disabled dependent status within 90 days after your child turns 20.

There are also some rules which affect a dependent's eligibility:

- a dependent who is a member of the military is not eligible under the Program during any period of active duty; and
- a dependent child of parents who are covered by their employer's health plan is assigned to the parent whose birthday falls first in the year for primary coverage, unless the parents are divorced and there is a court decree assigning responsibility for primary coverage to the other parent (see Section 8.0(c) of the Agreement for more information on primary and secondary coverage).
- a dependent does not include any person who is already covered under a Company health care plan (see Section 8.3 of the Agreement for more information).

C. How Am I Enrolled

You are automatically enrolled in PIB III. If your dependents were enrolled under the former Program and are still eligible for coverage, they are also automatically enrolled.

To enroll your new dependents, you must submit proof to the claims administrator that they are actually your dependents. "Proof" includes such items as birth certificates, marriage certificates, etc.

If both you and your spouse are covered as employees or retirees under Ispat Inland's health care plans, you are both enrolled for single coverage.

If both you and your spouse are active employees of Ispat Inland Flat Products Company and/or Ispat Inland Bar Company, you may choose to enroll your dependent children under either parent's health care plan, but not both.

If you have a change in dependents, you should notify the claims administrator within 30 days. You will need to submit proof of the change (e.g., birth or marriage certificate, divorce decree). Your new coverage is effective on the date the change occurred (see Section 8.5 of the Agreement for more information).

D. Program Cost

The Company pays the entire cost of the Program for you and your eligible dependents.

HMO participation may require a monthly contribution (see Section 9.6 of the Agreement for more information).

E. When Coverage Begins

Coverage under the Program begins on the date you complete 60 calendar days of employment with the Company. If you return to work after an extended absence, you may be required to complete an additional 60 calendar days (see Section 9.28 of the Agreement for more information).

F. Circumstances That May Affect Your Benefits

1. When Coverage Ends

Coverage for you under the Program stops on the earliest of the following:

- your termination of employment (see Sections 9.17 - 9.18 of the Agreement for more information);
- your retirement (see Sections 9.24 - 9.26 for more information);
- your death;
- your loss of eligibility under the Program (i.e., after extended layoff);
- termination of the Program.

You may continue your medical, dental and vision coverage through COBRA continuation (see Section 10.2 of the Agreement for more information).

2. When Dependent Coverage Ends

For those plans in which dependent coverage is available, coverage for your dependents ends on the earliest of the following:

- the date your coverage terminates, except that dependent coverage continues until the end of the third month following your death;
- your dependent spouse and/or children no longer meet the definition of eligibility (see Section 8.1 of the Agreement for more information);
- you elect to have a dependent removed from coverage;
- you transfer to part-time status. Your coverage will continue, but your dependents' coverage will end; or
- termination of the Program.

Your dependents may continue medical, dental and vision coverage through COBRA continuation (see Section 10.2 of the Agreement for more information).

If you or one of your dependents is totally disabled when coverage ends, additional benefits may be available (see Section 3.68 of the Agreement for additional information).

3. PIB III Benefits While Outside The United States or Puerto Rico

If you are hospitalized or treated by a doctor while traveling outside the United States or Puerto Rico, you will probably be required to pay in advance for all services. To receive reimbursement for these expenses you must have itemized receipts detailing the dates, types of service performed and the charges incurred.

You must submit these receipts to the claims administrator for reimbursement (see Section 8.10 of the Agreement for more information).

Medicare does not cover hospitalization or treatment by a doctor while traveling outside the United States. If you are Medicare eligible and have such expenses, coverage will be provided under PIB III as if you were not eligible for Medicare.

If you retire and choose to live outside the United States (with the exception of Puerto Rico), medical coverage for you and your dependents under the retiree plan will end on the date you move outside the United States.

4. If You Go On An Approved Leave of Absence

(a) Approved Leave Of Absence

If you take an approved leave of absence, that is not considered a Family or Medical leave, your coverage (except under the basic life insurance and sickness and accident plans) will end on the last day of the month in which you worked. You may continue your coverage for an additional 3 months if you make the required monthly premium payments to the claims administrator. Thereafter, your coverage will end unless you elect to continue your medical, dental and vision coverage under COBRA continuation (see Section 10.2 of the Agreement for more details).

Basic life insurance coverage continues during a leave of absence for up to 6 months.

Sickness and accident coverage ends on the day you go on leave.

(b) Family or Medical Leave

If you take a Family or Medical leave you will be considered to be in layoff status for benefit purposes (see Section 9.12 of the Agreement for more information).

5. If You Are Laid Off

If you are laid off, your coverage under the

- Sickness and accident plan will end on the day you are laid off;
- Medical, dental, vision, and basic life insurance plans will continue for a period of time based on your length of service as outlined below:

Years of Service on the Day Your Layoff Begins	Coverage Continues
• Less than 2	• To the last day of the month (6 months for life insurance)
• 2 to 10	• For 6 months
• 10 to 20	
• For 12 months	
• 20 or more	
• For 12 months or more	

(See Section 9.12 of the Agreement for more details and special rules for Local 5000 Fleet employees.)

You may also continue your medical, dental and vision coverage under COBRA (see Section 10.2 of the Agreement for more details).

6. If You Become Disabled

(a) Nonoccupational Disability

If you become disabled due to a nonoccupational disability, medical, dental, vision, and basic life insurance coverage will continue for as long as you remain disabled for up to 6 months, if you have less than 2 years of service, or for up to 1 year (or more) if you have 2 or more years of service.

For those individuals with less than 2 years of service who continue to be disabled beyond six months, basic life insurance coverage will continue for up to an additional six months (see Section

9.10 of the Agreement for more information).

Sickness and Accident benefits will continue in accordance with the schedule in Section 2.2 of the Agreement.

After this time, your coverage will end. You may, however, have the option of continuing your medical, dental and vision coverage under COBRA continuation (see Section 10.2 of the Agreement for more details).

(b) Occupational Disability

If you are unable to work because of an occupational disability, medical, dental, vision, and basic life insurance will continue for as long as you remain disabled, but not beyond one month following the end of the month for which statutory compensation payments (e.g. worker's compensation) end.

Sickness and accident benefits will continue in accordance with the schedule in Section 2.2 of the Agreement.

After this time, your coverage will end. You may, however, have the option of continuing your medical, dental and vision coverage under COBRA continuation (see Section 10.2 of the Agreement for more details).

7. If You Are Suspended

If you are unable to work because of a suspension, you are entitled to the same benefits as if you were laid off. Additionally, benefits under the sickness and accident plan will continue for the period of suspension if it is not converted into a discharge.

G. COBRA Continuation

You and your family may continue your medical, dental and vision coverage at group rates in certain instances where coverage would otherwise end. This is called COBRA continuation coverage. You must pay the full cost of this coverage (see Section 10.2 of the Agreement for more details).

H. When You Reach Age 65 While Actively Employed

When you reach age 65 while actively employed, you will continue to be covered under the Program. You and any covered dependents will continue to receive full benefits under PIB III until you retire.

If you enroll in Medicare while you are an active employee and are still covered by PIB III, Medicare will be considered a secondary payer of benefits. Medicare may supplement the payments you receive from PIB III. If PIB III pays more than Medicare would have paid, you will not receive any additional reimbursement from Medicare.

If your spouse reaches age 65 and enrolls in Medicare while you are actively employed, your spouse will also continue to have primary coverage under PIB III.

I. When You Retire

Employees who retire from the Company with 10 or more years of service under the Company's pension plan on other than a deferred vested pension, will be eligible for medical coverage under the retiree plan (Program of Insurance Benefits for Eligible Pensioners and Surviving Spouses effective January 1, 1994). The monthly premiums will be deducted from your pension check. Your basic life insurance will continue until you reach age 62. At age 62, your basic life coverage will be reduced to $7,500. All other coverage under PIB III ends on your retirement date. For more information on retiree benefits, contact the pension administrator or the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover).

Chapter 2
Basic Life Insurance Benefit Plan

A. How The Basic Life Insurance Plan Works

This chapter describes the benefits available to you and your family under the basic life insurance plan. The basic life insurance plan helps you make financial provisions for your family in the case of your death.

In addition, the Company sponsors an optional life insurance plan and an accidental death and dismemberment plan (AD&D Plan). These plans allow you to purchase additional insurance coverage (refer to the Ispat Inland Inc. Optional Life Insurance Plan and the Ispat Inland Inc. Accidental Death & Dismemberment Plan for further details).

(See Section 1 of the Agreement for complete details of your coverage under the basic life insurance plan.)

If you die from any cause, the basic life insurance plan will pay a benefit to anyone you select. The amount is determined as follows:

Classification	Coverage
• Full-time* bargaining-unit employee	$25,000
• Pension Plan Retiree	$25,000 to age 62 $ 7,500 at and after age 62
• Retiree with a Deferred Vested Pension	$0 (you may convert to an individual policy. See Sections 1.5, 9.20 and 9.23 of the Agreement for more details).
• Total disability for more than 6 months but not retired	$25,000

* See Section 9.1 of the Agreement for information about part-time employees.

B. Beneficiary Designations

Your beneficiary is the person (or persons) you name to receive your benefit in the event of your death.

Your beneficiary may be anyone you choose unless you have a court order which says you must name a specific beneficiary (for example, a former spouse).

You also have the right to make an absolute assignment of your life insurance subject to certain restrictions. In an absolute assignment, you give away the ownership of your policy to another person. It is called absolute because once you have done it, you cannot change your mind. Neither the Company, the Plan Administrator nor the insurance company assume any responsibility for an assignment. It is recommended that you check with a lawyer if you are considering assignment. Contact your Employee Benefits Office for more details.

You have the option of changing your beneficiary or beneficiaries at any time by completing a Change of Beneficiary Form. This change will be effective on the date your Employee Benefits Office receives your properly completed form. Please be sure to keep this designation up to date.

If your designated beneficiary is not alive (or if you did not designate a beneficiary), your basic life insurance plan benefits will be paid to the first of the following who is living:

- your spouse,

- your children (in equal shares),
- your parents (in equal shares),
- your brothers and sisters (in equal shares).

If none of your relatives listed above are alive when you die, your basic life insurance benefits will be paid to your estate.

C. How Benefits Will Be Paid

Basic life insurance plan benefits will be paid in one check, unless you have selected an alternative method of payment (i.e., installments). If you select an alternative payment method, your beneficiary cannot change your selection. If you do not select an alternative payment method, your beneficiary has the option to do so after your death.

D. Conversion Privileges

If your coverage under the plan would otherwise end or be reduced because of a layoff, leave of absence, disability, termination of employment, or retirement, you may have the right to convert to an individual policy (see Sections 9.20 - 9.23 of the Agreement for more information).

Chapter 3
Sickness and Accident Benefit Plan

A. How The Sickness And Accident Plan Works

The sickness and accident plan provides you with a continuing weekly income if an injury, illness, or a maternity condition prevents you from working.

Weekly income benefits are payable to you during a period of disability for up to 104 weeks, depending on your length of service with the Company, and other circumstances. You must remain under the care of an authorized provider. (See Section 2.0 of the Agreement for more information.)

In order for you to be eligible for benefits and to begin receiving them in a timely manner, the Company must receive written notice of your claim within 21 days after your disability begins. If it is impossible for you to notify the Company within this time, the Company may waive this requirement as long as you can show reasonable justification for why you could not do so (see Section 2 of the Agreement for additional information).

B. When You Receive Benefits

Your sickness and accident benefits will be payable from:
- the first day you are unable to work due to an accident;
- the first day of hospital confinement;
- the eighth day of a disability due to an illness or maternity condition except if hospitalized;
- the seventh day if you have outpatient pre-admission testing within 5 days of your hospital confinement; or
- the first day following an outpatient surgery.

You will also receive sickness and accident benefits during certain other absences from work due to medical reasons. Specifically, if you are disabled because you donated a vital human organ or tissue to another person in a transplant operation, you will be considered on a disability due to illness. Your disability will be considered to have started when you went into the hospital.

C. Duration of Benefits

Years of Continuous Service	Weeks of
<u>When Absence Begins</u>	<u>Benefits</u>
Less than 6 months	*
6 months but less than 2 yrs.	26
2 yrs. but less than 20 yrs.	52
20 yrs. or more	52+

* Benefits are payable for up to one week for each full week of continuous service

The 100% benefit begins the third week of disability - 15th day, (see Section 2.2 of the Agreement for complete details).

If both of the following apply to you, you will be eligible for an additional 52 weeks of sickness and accident benefits for each continuous disability:
- you have 20 or more years of continuous service as of your last day worked; and
- you are not permanently disabled and your doctor certifies that you will be able to return to work.

If you have more than one disability from the same or related causes, and these disabilities are separated by less than 2 weeks of continuous active work with the Company, all of these disabilities combined will be considered one period. If it is clear that these disabilities are from unrelated causes, they will be considered different disability periods for purposes of determining the maximum benefit

payable (see Section 2.3 of the Agreement for more details).

D. Amount Of Sickness And Accident Benefit Payable

The amount of weekly benefits you are eligible for under the sickness and accident plan is determined by your insurance classification.

Below is a schedule which shows the weekly sickness and accident benefit payable:

Insurance	Weekly Benefit		
Classification*	At 100%	At 60%	
1- 4	$472	$283.20	
5-10	$498	$298.80	(includes all Fleet Local 5000 employees)
11-16	$524	$314.40	
17-23	$550	$330.00	
24-29	$576	$345.60	
30 +	$602	$361.20	

*Based on Job Class in effect August 1, 1999

Your weekly benefit will be reduced by amounts received from worker's compensation or any other occupational disease law. If, however, you continue to be eligible for benefits beyond 6 consecutive weeks, your weekly benefit from the sickness and accident plan will not be reduced by more than 75% of the worker's compensation amount for weeks 7-26 and 85% for weeks beyond 26.

Example:
Let's suppose you become disabled. If your insurance classification is 15 you would be entitled to $524 per week. However, let's suppose you are also entitled to benefits from worker's compensation of $400 a week. For the first 2 weeks of your disability, you would receive only the $400 from worker's compensation since your sickness and accident benefit is at 60% or $314.40. After this 2 week period, you would be entitled to an additional amount which is calculated as follows:

• Scheduled benefit	$ 524
• worker's compensation benefit	$ 400
• sickness and accident benefit	$ 124

Therefore, after your second week, you would receive $524 in weekly benefits:
($400 + $124)

After 6 weeks, your scheduled benefit of $524 would be reduced by 75% of $400, or $300 for a sickness and accident benefit of $224 or a total benefit of $624 ($400 + $224).

After you have been receiving a sickness and accident benefit for 26 weeks of continuous disability, this benefit may be reduced. Your weekly benefit will be reduced by any income (converted to a weekly amount) you are entitled to receive for the same period from Social Security (disability or non-disability). This offset happens whether or not you apply for these benefits and as long as you are entitled to them. Thus, you should be sure to apply for these benefits. For assistance, contact your local Employee Benefits Office.

There is one exception. If you are eligible for sickness and accident benefits for 26 weeks, you may send written proof to your local Benefits Office that you have applied for Social Security benefits within the first 15 weeks of your disability. If, after 26 weeks, you do not begin receiving these Social Security disability benefits, you may be entitled to your full benefit under the sickness and accident plan. These unreduced payments will continue until the earlier of the date your Social Security disability benefits begin or the date 34 weeks of sickness and accident benefits have been paid, provided you agree to repay any overpayments

of sickness and accident benefits resulting from the receipt of Social Security benefits.

You may be entitled to receive sickness and accident benefits during a period of suspension if your suspension does not result in a discharge (see Section 2.8 of the Agreement for more information).

E. What Is Not Covered

Benefits are not payable for illnesses or injuries resulting from employment outside of the Company, including self-employment (see Section 2.5 of the Agreement for more details).

F. Right to Recovery

Individuals receiving benefits under provisions of the program are required to subrogate their rights to payment of any reimbursements received as a result of an action against a third party.

Any individual receiving benefits under the Plan agrees that his or her rights to any recovery or payment personally or for the account of such individual (including any covered dependent) arising out of any legal action of settlement (other than claims against the employee's or dependent's personal coverage for which he/she pays premiums) thereof (including any settlement prior to the institution of legal action) are subrogated to the rights of the Plan as provided hereunder. By filing a claim, he/she acknowledges and agrees (for themselves and any covered dependents) that the right to subrogation of the Plan is the right to be fully reimbursed for all payments paid by or on behalf of the Plan, from the first dollar paid by any source or sources of any recovery (whether deemed for personal injury or reimbursement of medical payments for any other reason) up to and including the full extent of payments made or benefits provided by or on behalf of the Plan, irrespective of whether any covered dependent has recovered for all or any part of his or her claim for personal injury or other damages and expenses arising therefrom or related thereto. He/she has the responsibility of (i) notifying the Plan promptly upon making claim against any party for any personal injuries, damages or expenses related in any way to the subrogation rights provided hereunder or receiving any settlement, court decision or payment related to such claim and (ii) cooperating with the Plan (including (a) promptly providing any information reasonable requested related to any such claim and (b) assisting the Plan in perfecting its subrogation rights). Any failure to promptly notify and cooperate with the Plan with respect to its subrogation rights hereunder shall make the participant subject to appropriate disciplinary action, including discharge.

Chapter 4
Health Care Benefit Plan

A. How The Health Care Plan Works

The health care plan provides financial assistance when you or your family become sick or injured. You may also have the option of choosing a Health Maintenance Organization (HMO) if one exists in your area. (See Section 9.5 - 9.8 of the Agreement for more HMO information.)

The benefits you receive from the health care plan depend on whether you use the plan properly:

- Medical benefits are subject to the limitations of the health care plan.
- Some medical expenses are not covered.
- You will have greater out-of-pocket costs if you use an out-of-network provider in a location where networks exist.
- Expenses covered by other benefit plans such as worker's compensation are not covered under the health care plan.
- Services and supplies are covered only if they are medically necessary.
- Experimental procedures and treatments are not covered under the health care plan.

PIB III generally provides 80% coverage for physician services or 90% for hospital services of allowed charges after you meet a deductible of $150 per person or $250 per family. You pay the remaining 20%, or 10% of hospital services, until you have satisfied the annual co-payment maximum. The annual co-payment maximum is $600. If you use an out-of-network provider in a location where networks exist, your family deductible is $300, the annual co-payment maximum is $750, and your hospital co-payment percentage is 30%. (See Section 3.2 (b) of the Agreement for more deductible and co-pay information.)

Once you have met the annual co-payment maximum, the health care plan will cover 100% of allowed charges.

The following types of health care expenses are covered by the health care plan:

- hospitalization;
- confinements in an approved rehabilitative facility, skilled nursing facility or hospice;
- home health care;
- most physicians' charges for services performed in a hospital as an inpatient or an outpatient;
- routine physicals; and
- well baby care.

B. How Your Benefits Can Be Affected

How much of your health care costs are paid by the health care plan depends in part on you. You can minimize your financial responsibilities by being aware of and following the requirements of the health care plan.

1. Managed Care Programs

There are certain programs in the health care plan designated as "managed care programs" that require you to follow certain rules when you seek treatment. If you don't follow these rules, you may incur a financial penalty of $300 when your claims are paid. Managed care programs include:

- pre-admission review (see "Who To Call For Benefit Information" phone numbers on inside front cover) before you go into the hospital (or a birthing center) as an inpatient, and continued stay review while you are hospitalized (see Sections 3.7 and 3.8 of the Agreement);
- mandatory outpatient surgery for certain surgical procedures (see Section 3.15 of the Agreement);
- Friday and Saturday hospital admission restrictions (see Section 3.40(e) of the Agreement); and
- pre-admission testing before an inpatient admission (see Section 3.21 of the Agreement).

2. Allowed Charge

You may be responsible for paying the difference between the provider's (e.g., physician's, podiatrist's) actual charge and the allowed charge. The allowed charge is based on either a local or a national fee schedule of reasonable and customary charges by physicians for the same procedures in the same geographic location.

3. In-Network Providers

The Company has networks of health care providers in Northwest Indiana and the Chicago area and other geographic areas through a nationwide network. These networks of doctors, hospitals and clinics have contracted with the Company or the Company's agent to provide services at or below certain agreed-upon rates. If you use an in-network provider you are not responsible for paying any amount above the allowed charge. Contact the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) to determine whether or not your provider is an in-network provider.

4. Catastrophic Case Management

For certain types of illnesses and injuries, it is important to have the patient's treatment plan carefully managed. Examples of conditions for which case management is available are: AIDS, multiple sclerosis, neonatal high risk infants, severe burns and spinal cord injury.

If the patient's condition is suitable for catastrophic case management, the pre-admission review administrator will generally advise you, or you can request it by contacting the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) (see Section 3.22 of the Agreement for more details).

5. Plan Maximums

Certain types of health care expenses are subject to maximum limits each year by the health care plan. There are dollar limits, day limits and frequency limits on certain benefits. All maximums are accumulated by individual, not by family.

The health care plan's maximums are noted below:

- $1,250,000 lifetime maximum medical benefit, except that benefits for out-of-network providers are limited to $500,000.
- 365 days in the hospital per admission if you have less than 10 years of service (see Section 3.10 of the Agreement)
- 730 days in the hospital per admission if you have 10 or more years of service (see Section 3.10 of the Agreement)
- $150 per day maximum benefit for inpatient hospice charges
- $500 per year maximum benefit for recurrent or related operations performed in an office or outpatient setting
- 240 hours per year maximum for services of a private-duty licensed practical nurse (LPN). Services in excess of 240 hours are payable at 50%
- Replacement of artificial limbs or other prosthetic appliances (after 5 years of installation)
- $1,000 per ear in a five-year period maximum benefit for hearing aids and related examinations. Replacement hearing aid(s) if at least 5 years have passed and previous hearing aids are unserviceable.
- Approved Skilled Nursing Facility
  - 365 days per admission maximum benefit (see Section 3.23 of the Agreement for details)
  - 2 physician's visits in a seven-day period but the physician cannot be employed by the facility (see Section 3.54 of the Agreement)

- Home Health Care Agency
  - 100 visits per calendar year
  - 10 physician's visits per year

Any individual who meets their lifetime maximum who has had an organ transplant procedure on or after August 1, 1999, will have their lifetime maximum increased by the amount of benefits paid for the transplant procedure.

C. What Is Covered Under The Health Care Plan

1. Physicians' Services Under The Health Care Plan

Charges for licensed physicians' services performed in the hospital when you are an inpatient or an outpatient, medical and surgical consultations, and office visits are covered under the health care plan. After you have met your deductible, reimbursement of allowed charges is made at 80% until you have reached your co-payment maximum. Thereafter, you are reimbursed at 100% of allowed charges.

(a) Surgical and Organ Transplant Benefits and Services

Payment for necessary surgery is normally covered under the health care plan.

To be covered, all surgery and related procedures must be performed by a licensed surgeon or, when appropriate, by a podiatrist or doctor of dental surgery, and must be medically necessary.

If the same or related surgeries are performed in a doctor's office or outpatient setting for the same illness or injury, there is a $500 limit each calendar year for each illness or injury.

Payment is also provided for assistant surgeons and stand-by surgeons for angioplasties and caesarean sections.

Organ transplant benefits are provided under the health care plan. Organ transplants are covered as any other surgical procedure and are subject to plan deductibles, copayments and benefit maximums. Transplant benefits under the Plan are provided regardless of whether the individual covered under the Plan is the recipient or donor, and benefits for covered services will be provided for both. See Section 3.46 of the Agreement for additional information.

(b) Second Surgical Opinions

Benefits are provided under the health care plan for second or third surgical opinions when done by a doctor who does not perform the surgery. Any diagnostic laboratory tests or x-rays ordered as necessary to form the opinion are also covered.

(c) Diagnostic Examinations

Benefits are provided under the health care plan for most diagnostic examinations (such as metabolism testing, laboratory examinations, allergy testing, etc.) if performed or ordered by a licensed physician (see Sections 3.61 - 3.62 of the Agreement for more information).

(d) Diagnostic X-Ray And Ultrasound Benefits

Benefits are provided under the health care plan for diagnostic x-ray and ultrasound services when needed for the diagnosis of illness or injury (see Sections 3.59 - 3.60 of the Agreement for more information).

(e) Anesthesia

The health care plan covers the administration of anesthesia, provided either in or out of a hospital. All anesthetics must be administered and billed by a licensed physician or CRNA who is not an employee of, nor paid by, a hospital, laboratory or other institution that bills for the anesthesia (see Section 3.56 of the Agreement for more information).

(f) Radiation Therapy And Chemotherapy

You are covered under the health care plan for certain types of chemotherapy, treatment by x-ray, radium, external radiation or radioactive isotopes, including the cost of materials. To be covered, the services must be performed and billed by the licensed physician in charge of your case. Services can be provided either in or out of the hospital (see Sections 3.57 - 3.58 of the Agreement for more information).

(g) Emergency Treatment

In case of either an accidental or a medical emergency, you are covered under the health care plan if the treatment you receive is performed by a licensed physician (see Sections 3.63 - 3.64 of the Agreement for more details).

(h) Obstetrical Treatment

Benefits are provided under the health care plan for you or a female dependent for physicians' services related to having a baby. Benefits are also provided for the routine examination of a newborn (in the hospital after delivery) by a physician other than the one who made the delivery.

(i) Physicians' Services In A Skilled Nursing Facility

Benefits are provided under the health care plan for 2 visits by a physician in any seven-day period provided that the physician is not an employee of the facility (see Section 3.54 of the Agreement for more information).

(j) Home Health Care Agency Visits By A Physician

Benefits are provided under the health care plan for up to 10 home visits by a physician in a calendar year.

2. Hospital And Related Benefits Under The Health Care Plan

In order to maximize your hospital and related benefits, it is important that you follow the necessary managed care rules. These rules include such procedures as getting your admission pre-approved by the pre-admission review administrator for the health care plan and having certain surgeries performed on an outpatient basis (see Sections 3.7, 3.15, 3.21 of the Agreement for more details). After you have met the appropriate deductible and before you have reached your annual co-payment maximum, reimbursement is made at 90% of allowed in-network hospital charges, 70% of allowed out-of-network hospital charges, and 80% of allowed hospital charges in locations where no networks exist, until you have met your annual co-payment maximum. Thereafter, reimbursement is made at 100% of allowed charges.

(a) Inpatient Benefits

The health care plan covers the cost or the contracted amount (subject to deductible and co-payments) of a semi-private hospital room, board, medical services and supplies while you are in the hospital, including:

- special care units (e.g., intensive care or cardiac care unit);
- prescription drugs and prescription medicines dispensed by a licensed pharmacist and issued while you are in the hospital;
- diagnostic examinations for inpatient admission when diagnosing a specific illness or injury while you are in the hospital;
- x-ray and laboratory services while you are in the hospital; and
- anesthetics.

If you are an employee with less than 10 years of continuous service, hospital charges are covered up to a maximum of 365 days in a semi-private room for each confinement in a hospital.

If you are an employee with 10 or more years of continuous service with the Company, you are covered for up to 730 days in a semi-private room for each confinement in a hospital.

No matter what your length of service, if you leave the hospital and are readmitted within 90 days it is considered the same confinement -- whether it is for the same or a different condition.

If you take a private room in a hospital, you will be entitled to benefits equal to semi-private room rates. You will, however, have to pay the extra cost of the private room. If a private room is determined to be medically necessary the excess cost of the private room is covered.

(b) Outpatient Benefits

Sometimes you may require medical services and supplies without needing to be admitted to a hospital. Outpatient settings include the outpatient department of a hospital, an ambulatory care facility, a free-standing outpatient facility, or a doctor's office. Certain surgical procedures will be subject to a $300 penalty unless they are performed on an outpatient basis (see Section 3.15 of the Agreement for a list of these procedures).

Covered charges for outpatient surgery include facility charges and surgical supplies (including anesthesia supplies) (see Sections 3.13 - 3.17 of the Agreement for more details regarding covered benefits).

(c) Birthing Centers

Care in an accredited birthing center is also covered under the health care plan. (See Section 3.37 of the Agreement for further information.)

(d) Approved Skilled Nursing Facilities

If you are admitted to an approved skilled nursing facility, benefits will be provided for a semi-private room and all other services provided by the facility for up to 365 days, if you:
- are recovering from an acute illness or injury;
- are confined to a bed with a long-term illness or injury; or
- have a terminal condition.

If you take a private room in an approved skilled nursing facility, you will be entitled to benefits. You will, however, have to pay the extra cost of the private room.

The health care plan will pay for a second stay for the same or an unrelated cause once 90 days has passed since your last discharge (see Sections 3.23 - 3.28 of the Agreement for additional information, including a definition of an approved skilled nursing facility, and what is not covered under this benefit).

(e) Home Health Care Agency Benefits

Sometimes an individual is confined to the home and requires the services of a home health care agency. The health care plan pays for up to 100 home health care agency visits and 10 visits by a physician in a calendar year. The health care plan also covers most supplies and equipment required for home treatment.

To be covered, home health care services must be performed or supervised by a licensed registered nurse (RN) or a licensed practical nurse (LPN). The nurse must be administering a treatment established and reviewed by your doctor (see Section 3.29 of the Agreement for the complete list of covered home health care services).

The services of a home health care agency must be prescribed by your doctor. Keep in mind that your 100-visit limit includes visits for all home health care services combined. A visit is one contact by a professional for eight hours or less, therefore multiple visits can be charged on the same day.

(See Sections 3.29 - 3.32 of the Agreement for additional information, including a definition of an approved home health care agency, and what is not covered under this benefit.)

(f) Hospice Care Benefits

Hospice care refers to a coordinated plan of home and inpatient care specifically designed for a terminally ill patient. It is designed to help the family cope with the stress of dealing with a loved one's terminal illness.

The base plan limits the room benefit to $150 a day. Certain other expenses are covered at 100% (see Section 3.36 of the Agreement for details.)

It is important to remember to contact the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) to determine if a hospice is an approved facility.

(g) Kidney Dialysis Benefits

Kidney dialysis benefits are provided under the health care plan. If dialysis is due to end-stage renal disease, secondary coverage only will be provided once primary coverage is available through Medicare (enrollment is required) (see Sections 3.35 and 8.6 - 8.9 of the Agreement for additional information).

3. Other Expenses Covered Under The Health Care Plan

After you have met your deductible, reimbursement of charges is generally made at 80% of allowed charges until you have met your annual co-payment maximum. Thereafter, you are generally reimbursed at 100% of allowed charges.

(a) Ambulance - Ambulance transportation, if it is medically necessary (including transportation by air).

(b) Artificial Limbs or Artificial Eyes - An original artificial arm, leg or eye(s) and one replacement after five years if the original is not serviceable. For a dependent child, replacements will be covered more frequently if needed to keep up with the child's growth.

(c) Blood - Blood transfusions and blood administration costs, including the cost of blood and blood plasma above 3 pints unless it is donated or replaced.

(d) Durable Medical Equipment - The rental (or purchase, if it is more cost effective) of durable medical equipment, if it is medically necessary.

(e) Eyeglasses - Following cataract surgery, up to 2 pairs of eyeglasses or contact lenses and examinations.

(f) Hearing Examinations and Hearing Aids - Hearing aids and the related examinations. The benefit maximum is $1,000 per ear in any period of 5 consecutive years. Replacement hearing aid(s) if at least 5 years have passed since aid(s) being replaced were purchased, and previous aid(s) are unserviceable.

(g) Immunizations - Routine immunizations are covered. If the immunizations are being given for travel outside of the United States they are not covered.

(h) Physicians' Services - Received in an office setting and medical or surgical consultations, either in or out of the hospital. And the following when operating withing the scope of their license or certification and under the direction of a licensed physician: certified registered nurse anesthetists (CRNAs), physician's assistants (PAs), or nurse practitioners (NPs).

(i) Physical Therapy - Services performed in a doctor's office or clinical setting.

(j) Nursing Services - The services of a private-duty registered nurse (RN) whether in or out of a hospital. Services of a private-duty licensed practical nurse (LPN) are covered while in the hospital. If you are out of a hospital, LPN services are payable for the first 240 hours of service in a calendar year. After 240 hours of LPN service, services will be payable at 50%.
If the nurse (RN or LPN) is part of the patient's immediate family, there is no coverage.

(k) Oxygen - Oxygen and its administration.

(l) Well Baby Care - Charges for a newborn for routine pediatric checkups for the first 12 months of life.

D. What Is Not Covered Under The Health Care Plan

There are certain medical services and supplies which the health care plan does not cover (see Sections 3.40 and 3.66 of the Agreement for more details).

E. Right to Recovery

Individuals receiving benefits under provisions of the program are required to subrogate their rights to payment of any reimbursements received as a result of an action against a third party.

Any individual receiving benefits under the Plan agrees that his or her rights to any recovery or payment personally or for the account of such individual (including any covered dependent) arising out of any legal action of settlement (other than claims against the employee's or dependent's personal coverage for which he/she pays premiums) thereof (including any settlement prior to the institution of legal action) are subrogated to the rights of the Plan as provided hereunder. By filing a claim, he/she acknowledges and agrees (for themselves and any covered dependents) that the right to subrogation of the Plan is the right to be fully reimbursed for all payments paid by or on behalf of the Plan, from the first dollar paid by any source or sources of any recovery (whether deemed for personal injury or reimbursement of medical payments for any other reason) up to and including the full extent of payments made or benefits provided by or on behalf of the Plan, irrespective of whether any covered dependent has recovered for all or any part of his or her claim for personal injury or other damages and expenses arising therefrom or related thereto. He/she has the responsibility of (i) notifying the Plan promptly upon making claim against any party for any personal injuries, damages or expenses related in any way to the subrogation rights provided hereunder or receiving any settlement, court decision or payment related to such claim and (ii) cooperating with the Plan (including (a) promptly providing any information reasonable requested related to any such claim and (b) assisting the Plan in perfecting its subrogation rights). Any failure to promptly notify and cooperate with the Plan with respect to its subrogation rights hereunder shall make the participant subject to appropriate disciplinary action, including discharge.

F. Examples of How The Health Care Plan Works

Let's look at some examples of how the health care plan works.

In-Network

Suppose you incur the following expenses from in-network providers for a covered illness which requires surgery and a hospital stay:

	Kind of Expense	Allowed Charge
• Hospital room and board (5 days at the semi-private rate of $250/day)	$ 1,250	
• Other hospital charges	$ 500	
• Anesthesia	$ 400	
• Surgeon's fee	$ 1,000	
• Assistant surgeon's fee	$ 300	
• Doctor's visits in the hospital	$ 200	
• Radiologist's charges	$ 100	
• Injections charged by the doctor	$ 50	
• Total allowed charges	$ 3,800	

The total $3,800 of allowed charges for the above listed expenses would be paid by the health care plan, subject to deductibles and co-payments, provided you followed all of the managed care rules.

Now let's look at how much you pay and how much the health care plan pays:

• Total allowed charges	$ 3,800
• Less: individual deductible	$ (150)
• Remainder subject to co-payment	$ 3,650

You must pay:

• Hospital (10% x $1,600)	$	160
• Doctor/other (20% x $2,050)		$ 410
• Total co-payment		$ 570
• Total deductible	$	150
• Total payment		$ 720

The Plan pays:

• Hospital (90% x $1,600)	$	1,440
• Doctor/other (80% x $2,050)		$ 1,640
• Total payment		$ 3,080

Thus, of the total in-network charges of $3,800, the health care plan pays $3,080 and you pay $720. You have met your individual deductible for the calendar year, as well as $570 of the total $600 family co-payment maximum. Your family would still be subject to $100 of additional deductible ($150 for out-of-network providers in locations where networks exist) and $30 of additional co-payment (or $180 for out-of-network providers in locations where networks exist).

Out-of-Network

Now let's assume you incur the same types of expenses from out-of-network providers in a location where networks exist:

Kind of Expense	Allowed Charge
• Hospital room and board (5 days at the semi-private rate of $250/day)	$ 1,250
• Other hospital charges	$ 500
• Anesthesia	$ 400
• Surgeon's fee	$ 1,000
• Assistant surgeon's fee	$ 300
• Doctor's visits in the hospital	$ 200
• Radiologist's charges	$ 100
• Injections charged by the doctor	$ 50
• Total allowed charges	$ 3,800

The total $3,800 of allowed charges for the above listed expenses would be paid by the health care plan, subject to deductibles and co-payments, provided you followed all of the managed care rules (i.e., pre-admission review).

Now let's look at how much you pay and how much the health care plan pays:

• Total allowed charges	$ 3,800
• Less: individual deductible	$ (150)
• Remainder subject to co-payment	$ 3,650

You must pay:

• Hospital (30% x $1,600)	$	480
• Doctor/other (20% x $2,050)		$ 410
• Total co-payment		$ 890
• Maximum total co-payment		$ 750
• Additional expenses paid by Plan		$ 140
• Total deductible	$	150
• Total co-payment		$ 750
• Total payment		$ 900

The Plan pays:

• Hospital (70% x $1,600)	$	1,120
• Doctor/other (80% x $2,050)		$ 1,640
• Additional Payment		$ 140
• Total payment		$ 2,900

Thus, of the total in-network charges of $3,800, the health care plan pays $2,900 and you pay $900. You have met your individual deductible for the calendar year, as well as the $750 family co-payment maximum. Your family would still be subject to $100 of additional deductible ($150 for out-of-network providers in locations where networks exist).

This example assumes that all doctor's fees were within the allowed charges. If any of the doctors charged more than the allowed charge, the amount over the allowed charge would be the employee's responsibility and would not satisfy any of the deductible or co-payment responsibilities.

G. What Should I Do If...?

1. I Want To Go To An Out-Of-Network Doctor In An Area Where A Network Exists?

You should carefully review the disadvantages of your choice:

- If you select an out-of-network doctor or hospital, your benefits will be paid according to the allowed charges in the network area. If charges exceed the allowed charges, you will be responsible for paying the difference, in addition to any deductible and co-payment applied.
- If you use an out-of-network doctor or hospital in the network area, reimbursement will be made to you instead of to the provider and you will be responsible for paying the provider.
- The out-of-network family deductible is $300, the out-of-network coinsurance maximum is $750.

2. I Get A Divorce?

Contact the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover).

Provide them with the effective date of your divorce and a copy of your divorce decree. It will be used as the basis for making changes to your covered dependent(s) record.

3. I Have A Baby?

Telephone the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) with the name and date of birth of your newborn and provide a copy of your child's birth certificate as soon as it becomes available to you.

Note: Your child's newborn charges will automatically be paid; however, all subsequent charges will be pended until a birth certificate has been received by the claims administrator.

4. I Am Told I (Or One Of My Dependents) Need Surgery?

You must do 3 things:

- Make sure you (or your dependents) are covered;
- Make sure that the surgery is being performed in an appropriate setting; and
- Make sure you (or your dependents) comply with all of the health care plan's managed care provisions.

Here's how you accomplish these 3 things:

- Call the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) to confirm your (or your dependents) coverage under the health care plan.
- Call the pre-admission review administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) to determine if the surgery will be done on an inpatient basis, or if the surgery must be performed on an outpatient basis.
- If the pre-admission review administrator determines that your surgery is not covered under the health care plan, you have the opinion of obtaining additional written information from your physician regarding the planned procedure and medical necessity. This information should be sent to the attention of Medical Review at the claims administrator, which will determine if the planned surgery is covered under the health care plan.
- While it is not a plan requirement, benefits are provided for a second or, where necessary, a third surgical opinion.
- Check with your surgeon to see if he or she and the hospital they intend to use are in-network. If you are using an out-of-network doctor request his or her fee and procedure codes. The claims administrator can tell you if he or she is within the allowed charge fee schedule. Remember that your family deductible and copayment maximums are higher when using out-of-network doctors and hospitals. You will be responsible for all amounts above the allowed charges of other medical providers (anesthesiologist, radiologist, etc.) when you use an out-of-network primary (admitting) doctor and hospital.

5. I Go To The Mayo Clinic?

In order to be reimbursed for food and lodging expenses for medical services received at the Mayo Clinic in Rochester, Minnesota, you must collect and keep your receipts, attach them to a completed medical claim form and send them to the claims administrator. Keep a copy for your records.
Expenses will only be reimbursed for:

- food and lodging expenses related to medical services received at the Mayo Clinic, up to $100 per day.
- the patient receiving care (unless the patient is an eligible dependent child, in which case food and lodging for an adult who accompanies the child is also reimbursable under the $100 limit); and
- lodging for the number of days equal to the number of days you were registered at the Mayo Clinic.

Charges for other than food or lodging (e.g., telephone charges, cable television charges) are not covered by the health care plan.

Chapter 5
Prescription Drug Benefit Plan

A. How the Prescription Drug Plan Works

This chapter describes the benefits available to you and your family under the prescription drug plan, a managed care program that is a part of your health care benefit plan. If you elect to participate in a Health Maintenance Organization (HMO) then you are not eligible for the prescription drug benefits in this plan.

The Company has contracted with a prescription drug vendor (referred to as the prescription drug benefit manager) to provide a mail service program for the purchase of maintenance medication for up to a 60-day supply and a retail pharmacy network program for the purchase of drugs that will be taken for 30 days or less. The prescription drug benefit manager also reimburses you for any retail prescription drug purchases you make from out-of-network pharmacies.

The plan requires that you pay only a co-payment for each prescription at the time of your purchase, as long as you use the mail service program or you use your pharmacy card at a network pharmacy. The amount of your co-payment is based on whether you buy a generic drug, a brand name drug that doesn't have an identical generic equivalent available, or a brand name drug that has an identical generic equivalent. Your plan is a mandatory generic program. Since generic drugs cost generally two-thirds less than brand name drugs, the program provides a financial incentive for you to choose generic drugs whenever possible; your co-payment for generic drugs will be smaller. Your doctor must specify the generic or "OK to substitute" on the prescription and you must indicate your agreement to accept the generic drug when ordering.

B. Annual Deductible

There are no annual deductibles in this program.

C. Co-Payments Required

Drug	Mail Service	Stop Loss	Retail Pharmacy Program	Annual Stop Loss Person	Annual Stop Loss Family
Generic	$5.50	NONE	10%	$500	$750
Brand, No Generic Available	$13.75	NONE	30%	$500	$750
Brand, Generic Available*	100%	NONE	100%	NONE	NONE

*** Brand name drugs will not be covered unless the physician submits satisfactory clinical evidence to the prescription drug benefit manager that the person cannot take the generic.** If it is authorized by the prescription drug benefit manager, the co-payment is $18.00 at mail service and 40% at a participating retail pharmacy.

Out-of-Network purchases of generic or brand, no generic available, must be paid for in full at the time of purchase and are reimbursed at 50% of the full retail purchase price. The non-reimbursed portion does not apply to your annual prescription drug stop loss.

The co-payments and stop losses in this program do not reduce or satisfy those elsewhere in your health care benefit plan.

D. Lifetime Maximums

Unless otherwise noted, benefits for prescription drugs are subject to a lifetime maximum of $250,000, as well as the $1,250,000 lifetime maximum for all health care benefits ($500,000 out-of-network). Only benefits received on or after January 1, 1994 apply towards either lifetime maximum.

For example, if you have received medical benefits of $1,150,000, exclusive of prescription drug benefits, then your remaining lifetime benefit maximum is $100,000. Your overall lifetime maximum would be reached before you could use the $250,000 lifetime maximum for prescription drugs.

E. How to Use the Mail Service Program

1. Ask your doctor to prescribe ongoing medications for up to a 60-day supply, plus refills. If you need to begin taking the medication immediately, ask for two prescriptions — one for a 14-day supply to be filled at a retail pharmacy, and one to be sent to the mail service pharmacy. Ask your doctor to designate the prescriptions as "May Substitute".

2. Obtain a mail service order form and envelope by calling the prescription drug benefit manager's toll-free number (see "Who To Call For Benefit Information" phone numbers on inside front cover).

3. Complete the Health History section of the order form with your first order or anytime you need to update your existing information.

4. Send the completed mail service order form, your original prescription(s) and the appropriate co-payment(s) in the envelope. Please make sure you sign and complete all the information on the order form.

   You may charge your mail service co-payments to your charge card (see the mail service order form for details).

   Note: If you send prescriptions for multiple family members and list them on one order form, all prescriptions will be processed together and if one is delayed, all will be delayed. In order to avoid such a delay, be sure to fill out a separate order form for each family member.

5. The mail service pharmacy will promptly process your order and send your medications to you along with instructions for ordering refills.

6. With your original prescription medication, you will receive a refill notice showing the number of times your prescription may be refilled. To order refills send your refill notice and co-payment to the mail service pharmacy or you may order refills by calling the prescription drug benefit manager's toll-free number (see "Who To Call For Benefit Information" phone numbers on inside front cover) (you must have a valid existing refill available to phone-in your refill), or through the prescription drug benefit manager's website.

F. How to Use Your Retail Pharmacy Program

1. Ask your doctor to designate the prescription(s) as "May Substitute".

2. The nationwide retail pharmacy network includes major chains and independents. If you want to know if a particular pharmacy is included in the network, call the prescription drug benefit manager's toll-free number (see "Who To Call For Benefit Information" phone numbers on inside front cover), or visit the prescription drug benefit manager's website.
3. At a participating pharmacy, present your identification card. The pharmacist will use a computerized system to confirm your eligibility for benefits and determine your co-payment portion of the discounted cost of your medication.

4. The pharmacist will charge you a co-payment equal to a percentage of the discounted price.

5. At a non-participating pharmacy, you pay the full, non-discounted price of the prescription drug and then file a claim form to receive reimbursement.

G. When the Ispat Inland Plan is not Your Primary Plan

1. If the prescription drug plan is your covered dependent's secondary plan and prescription drugs are covered in their primary plan, benefits will be coordinated with the retail pharmacy program percentage schedule. Benefits otherwise payable will be reduced by benefits paid by the primary plan.

2. If your dependent has primary coverage under another plan, they may file a claim with the Ispat Inland plan by submitting a bill showing the full cost of the drug plus an EOB from the primary plan.

   Your dependent is not eligible to use the pharmacy card. Your dependent may purchase drugs from the mail service pharmacy by paying the full discounted cost.

H. What is Covered

The prescription drug plan covers medically necessary medications which require a prescription written by a licensed physician or other lawful prescriber and dispensed by a licensed pharmacist pursuant to Federal or State law. The prescription drug plan also covers prescriptions by licensed physicians for insulin, disposable insulin syringes, and blood glucose testing agents/ strips.

Certain drugs are subject to managed drug limitations (quantity) to ensure safe and appropriate use.

Also, certain drugs must receive prior authorization in order to be covered under the plan. For approval, the plan requires that clinical information provided by the prescribing physician meet prior authorization criteria.

The following drugs are subject to additional limitations:

(a) Coverage for non over-the-counter smoking cessation products, including nicotine skin patches and nicotine gum, is limited to $700 in benefits paid per lifetime, and

(b) benefit payments for drugs prescribed for treatment of infertility are limited to $5,000 per lifetime.

I. Exclusions

The following are excluded:

(a) drugs that can be purchased over-the-counter without a prescription (except for insulin),

(b) birth control pills, unless they are prescribed to treat a condition or illness,

(c) experimental drugs,

(d) diet pills without a physician's diagnosis of morbid obesity,

(e) vitamins,

(f) food and food supplements,

(g) refills of prescriptions older than one year, or

(h) drugs prescribed for cosmetic purposes.

Chapter 6
Mental Health and Alcohol/Substance Abuse Treatment Benefit Plan

A. How the Mental Health and Alcohol/ Substance Abuse Treatment Benefit Plan Works

This chapter describes the benefits available to you and your dependents under the mental health and alcohol/substance abuse treatment benefit plan (the MH/ASA plan). Coverage for these services is provided exclusively through a third party administrator, the "network manager" (see "Who To Call For Benefit Information" phone numbers on inside front cover).

If you or your covered dependents need services for mental health or alcohol/substance abuse problems, you must contact the network manager at their toll-free number. Medically trained counselors are available 24 hours a day, seven days a week, to evaluate employee and dependent situations and refer them to appropriate providers in their network.

If a patient is hospitalized in an emergency, without receiving a referral, the network manager must be contacted within 48 hours (or 72 hours if the patient is in detox).

Participants who receive treatment from out-of-network providers must file a claim with the network manager (see "Who To Call For Benefit Information" phone numbers on inside front cover) in order to receive a benefit (see Sections 5.1 and 5.2 of the Agreement).

B. What is Covered for Mental Health Treatment

1. In-Network

In-network, benefits are provided upon referral for treatment in a network hospital, alternate or other sub-acute care setting or approved treatment facility and the associated charges for services of licensed physicians.

Upon referral from the network manager, outpatient care is covered when treatment is performed by a physician, a clinical psychologist, a clinical social worker or psychiatric nurse specialist.

2. Out-of-Network

Out-of-network, benefits are provided for inpatient hospitalization in a legally constituted hospital and for services of licensed physicians; alternate or other sub-acute care is not covered.

Out-of-network, outpatient care is covered when treatment is performed only by a licensed physician or a licensed clinical psychologist.

Note: Services in connection with mental deficiency or retardation are not covered.

C. What is Covered for Alcohol and Substance Abuse Treatment

1. In-Network

In-network, benefits are provided upon referral for treatment in a network hospital or an Approved Rehabilitative Facility or alternate care facility (including: Residential Care Center, Halfway House, and Day Treatment Programs) and services of licensed physicians and medical services and supplies.

2. Out-of-Network

Out-of-network, benefits are provided for hospitalization in an accredited hospital and services of licensed physicians; alternate or other sub-acute care is not covered.

D. Medical Necessity

Prior to beginning any course of treatment, contact the "network manager." Medical necessity is a prerequisite to receiving benefits, in- or out-of-network.

E. Benefit Payment Levels

Level	Annual Loss/ Person	Coinsurance Deductible/ Person	Stop Co-payment
In-Network:			
Inpatient	$0	100%	—
Alternate Care (Inpatient or Outpatient)	$0	100%	—
Outpatient	$0	$10/Office Visit	—
Office Visits	$0	$10/Office Visit	—
Out-of-Network:			
Inpatient	$100*	50%/50%	$1,000
Alternate Care (Inpatient or Outpatient)	**NO COVERAGE FOR ALTERNATE CARE**		
Outpatient	$100*	50%/50%	None
Office Visits	$100*	50%/50%	None

* The total out-of-network deductible is $100/person.

F. Benefit Maximums

In-network, benefits for alcohol/substance abuse treatment are limited to a combined lifetime maximum of $150,000 per covered individual, including any out-of-network benefits paid. Mental health and alcohol/substance abuse treatment are part of your overall $1,250,000 lifetime maximum benefit for health care.

Out-of-network benefits are subject to the following limitations:

	ALCOHOL/SUBSTANCE ABUSE		MENTAL HEALTH
	Number Days Per Year	Number stays Per lifetime	Number Days Per Year
Inpatient	Up to 3 detox Up to 28 rehab	2	30 Days

G. If the MH/ASA Plan is Your Secondary Plan

If the plan is secondary to another group health care plan, in-network benefits will be coordinated only if the network manager (see "Who To Call For Benefit Information" phone numbers on inside front cover) is contacted prior to care being rendered. Failure to contact the network manager will result in benefits of the primary plan being coordinated with out-of-network benefits in the MH/ASA plan (see Section 5.7 of the Agreement).

H. Ispat Inland Employee Assistance Program

Ispat Inland's Employee Assistance Program (EAP) is available to counsel employees on a personal level. The Employee Assistance Program Coordinator is located in the Ispat Inland Clinic. The EAP works closely with the MH/ASA network manager to assure a coordinated activity for the employee's benefit.

Chapter 7
Dental Benefit Plan

A. How the Dental Plan Works

This chapter describes the benefits available to you and your family under the dental plan. The dental plan helps pay for the cost of dental care for you and your family.

The dental plan pays a certain percentage of the fees listed in the most current dental fee schedule:
- 100% for routine and preventive services, and oral surgeries;
- 85% for basic services (such as fillings and x-rays) and orthodontic services; and
- 50% for major services (such as crowns and bridges).

The dental payment schedule is available from the dental claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover). It lists procedure codes, descriptions and the amounts payable. For example:

Procedure Code	Description	In-Network Employee Amount Payable	Out-of Network Maximum Ispat Inland Pays
0120	Periodic oral examination	$0.00	$13.00
0270	X-rays		
	Bitewing - single film	$2.00	$ 5.00
0470	Diagnostic Casts	$22.00	$16.00

B. Annual Dental Plan Deductible

The deductible is the amount of covered dental expenses you pay each calendar year before benefits from the dental plan are payable. The annual deductible under the dental plan is $50 per family. For routine and preventive services (those covered at 100%) you do not have to pay the $50 deductible before coverage begins.

The $50 per family annual deductible which you have to pay under the dental plan cannot be used toward any other deductibles required by the Program (e.g., under the health care plan).

If you choose to visit an in-network dentist, the $50 deductible will be waived. (See D below.)

C. Annual Dental Plan Maximums

The maximum benefit which the dental plan will pay for any covered person in-network is $2,000 and out-of-network is $1,500 in any calendar year. There are, however, certain expenses which are not applied toward this maximum, including orthodontic services, oral surgery and expenses for dental services due to an accident.

There is a separate lifetime maximum for orthodontic services, which is $2,100 for each covered individual. Orthodontic services are covered for dependent children under age 19 only (see Section 6.6(f) of the Agreement for more information). Special rules apply to the calendar year and lifetime maximums in certain cases (see Section 6.1 of the Agreement).

Certain plan limitations apply to restorative, prosthodontic and orthodontic procedures (see Section 6.7 of the Agreement for more information).

D. In-Network Providers

The Company has taken steps to address dental cost increases without penalizing dental plan participants. The Company has engaged the services of a network of providers who are under contract. If you go to a dentist in this network, his or her charges for services will not exceed the amount allowed under the dental plan. You are not liable for amounts in excess of what is allowed on the fee schedule for the procedure(s) performed.

Payment for services within the network is made directly to the participating dentist. No deductible is applied when the services are performed by an in-network dentist. A complete listing of participating dentists in your area is available from the dental claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover).

Although receiving services from an in-network dentist can save you money, this does not prevent you from obtaining service from other providers. However, it generally will be more expensive if you do.

E. Charges The Dental Plan Pays

1. Routine and Preventive Procedures

The dental plan pays 100% of the charges listed in the fee schedule for routine and preventive services. Routine and preventive services are not subject to the $50 deductible. Routine and preventive services include routine oral examinations, space maintainers, fluoride treatment, and application of topical sealants on certain molars for eligible dependents up to age 14 (see Section 6.6(a) of the Agreement for a complete list of routine and preventive procedures).

These benefits count toward your $2,000/$1,500 yearly maximum.

2. Oral Surgeries

The dental plan pays 100% of the fee listed in the fee schedule for certain procedures related to oral surgery, subject to the $50 annual family deductible. These procedures include the partial or complete removal of impacted teeth (see Section 6.6(b) of the Agreement for a complete list of covered oral surgical procedures).

These procedures do not count toward your $2,000/$1,500 yearly maximum.

3. Basic Services

The dental plan pays 85% of the fee listed in the fee schedule for basic services. Basic services are subject to the $50 annual family deductible. Basic services include such procedures as full mouth x-rays, injection of antibiotic drugs and treatment of gum disease (see Section 6.6(c) of the Agreement for a complete list of covered basic services).

Basic services count toward satisfying your $2,000/$1,500 yearly maximum.

4. Major Services

The dental plan pays 50% of the fee listed in the fee schedule for major dental services. Major services are subject to the $50 annual family deductible. Major dental services include bridgework and dentures (see Section 6.6(e) of the Agreement for a complete list of covered major services).

Major services count toward satisfying your $2,000/$1,500 yearly maximum.

5. Orthodontic Services

The dental plan pays 85% of the fee listed in the fee schedule for the following orthodontic services for each dependent child under age 19, subject to the $50 annual family deductible:

- diagnostic procedures (including x-rays);
- appliance therapy; and
- surgical therapy (the surgical repositioning of the jaw, facial bones and/or teeth).

These charges are not applied toward the $2,000/$1,500 yearly maximum. Orthodontic services are, however, subject to an $2,100 lifetime maximum. To be covered, initial banding for orthodontic services must happen before the dependent child turns age 19. Payment for services received can continue, however, to the end of the month the patient reaches age 20 (see Section 6.6(f) of the Agreement for more information).

6. Dental Services Due To An Accident

Dental services due to an accident are covered at up to 85% of the usual, reasonable and customary charge after you have paid your $50 annual family deductible. Any routine and preventive services incurred as a result of an accident are paid at 100%.

Charges for services due to an accident are not applied toward the $2,000/$1,500 annual maximum. The accident must have happened while the patient was covered by the dental plan (see Section 6.6(d) of the Agreement for more information).

F. Charges That You Pay

You are responsible for paying:

- the $50 annual family deductible for services received from out-of-network providers;
- any co-payments (for example, 15% of the fee in the fee schedule for basic services and 50% for major services);
- charges above those listed in the fee schedule or usual, reasonable and customary charges if your dentist is not a participating provider;
- charges for non-covered items;
- charges above the $2,000/$1,500 per person annual maximum; and
- charges above the $2,100 per person lifetime maximum for orthodontic procedures.

G. Pre-Determination Of Benefits

If you expect charges for dental work to be $300 or more there is a special procedure to follow to (1) insure that the procedures are necessary, covered and authorized, and (2) determine how much out-of-pocket expense you will incur.

Your dentist must complete a dentist's pre-treatment estimate on a dental claim form and submit it to the dental claims administrator before treatment begins, unless emergency care is necessary. The dentist's treatment plan should include itemized services and charges, and all x-rays and diagnostic records pertaining to the treatment.

Generally, this predetermination section of the form must be completed any time you have charges for major services. The completed form must be submitted to the dental claims administrator as far in advance of the services as possible (see Section 6.3 of the Agreement). Its dental review staff will review the treatment, let you and your dentist know what is covered, and advise you as to how much the dental plan will pay. All this will be accomplished before any work is performed.

H. When A Charge Is Incurred

Benefits are provided only for covered dental expenses incurred on a date when coverage for you or your eligible dependents is in effect. Covered dental expenses are considered to have "been incurred" on the date when the applicable dental services, supplies or treatment are received (see Section 6.9 of the Agreement for details).

I. What Is Not Covered Under The Dental Plan

Although most dental services and supplies are covered under the dental plan, there are some which are not covered and for which the dental plan will not pay. For example, the dental plan will not pay for oral hygiene instruction or plaque control programs (see Section 6.8 of the Agreement for a complete list of non-covered expenses).

Treatment for any of these non-covered procedures will not count toward satisfying the $50 annual family deductible.

J. An Example Of How The Dental Plan Works

Let's look at an example of how the dental plan works:

Suppose you go to the dentist for a regular checkup and have not satisfied any portion of the annual family deductible. Your dentist bills you for the following procedures:

Type of Service	Amount Billed*	% Payable
Routine and Preventive Services		
Oral exam	$17.00	100%
Cleaning	$35.00	100%
Total	**$52.00**	
Basic Services		
2 bite-wing X-rays	$16.00	85%
Amalgam filling	$39.00	85%
Total	**$55.00**	

Here's how these expenses are covered if you go to an in-network dentist:

	Plan Pays	You Pay
No deductible for Routine and Preventive Services	$52.00	$0.00
No deductible for Basic Services ($55.00 x 85% = $46.75)	$46.75	$8.25
Total	**$98.75**	**$8.25**

Here's how these expenses are covered if you go to an out-of-network provider:

	Plan Pays	You Pay
No deductible for Routine and Preventive Services	$37.00	$15.00
Deductible is applied for Basic Services	$0.00	$55.00**
Total	**$37.00**	**$70.00**

* All amounts are within the fees listed in the dental plan fee schedule
** Applied to $50 out-of-network annual family deductible.

Thus, in this example, by going to an in-network dentist, you only pay $8.25 of the total of $107.00 in charges, but if you go to an out-of-network dentist, you will pay $70.00. You should also keep in mind that if the out-of-network dentist charges more than the amount in the fee schedule, you will be responsible for payment of the balance billing.

On your next visit 6 months later, suppose you need to have a tooth prepared for a crown. Your charges are as follows:

Type of Service	Amount Billed***	% Payable
Routine and Preventive Oral exam	$ 17.00	100%
Basic Services Acrylic crown	$450.00	85%
Total	**$467.00**	

Here's how these expenses are covered if you go to an in-network dentist:

Type of Service	Plan Pays***	You Pay
Routine and Preventive Services	$ 17.00	$ 0.00
Basic Services ($250.00 x 85%)	$382.50	$67.50
Total	**$399.50**	**$67.50**

Here's how these expenses are covered if you go to an out-of-network dentist:

Type of Service	Plan Pays***	You Pay
No deductible for Routine and Preventive Services	$ 13.00	$ 4.00
The Plan pays 85% x $276.00 = $235.00	$235.00	$215.00
Total	**$248.00**	**$219.00**

*** All amounts are within the fee listed in the dental plan fee schedule.

Thus, in this example, by going to an in-network dentist, you only pay $67.50 of the total of $467.00 in charges, but if you go to an out-of-network dentist you will pay $219.00. You should also keep in mind that if the out-of-network dentist charges more than the amount in the fee schedule, you will be responsible for paying those additional charges.

Chapter 8
Vision Benefit Plan

A. How the Vision Plan Works

The vision plan is intended to help you and your family meet the expenses of vision examinations, lenses and frames.

The vision plan pays benefits for the following vision care services once every 24 months when performed or furnished by a participating or non-participating optometrist or ophthalmologist (for a more complete list of covered benefits see Section 7.1 of the Agreement):

- complete vision examination;
- prescription lenses for eyeglasses;
- a frame for use with the prescribed lenses;
- contact lenses; and
- dispensing services.

You may select any licensed vision care provider as your supplier of vision care services. The Company has entered into agreements with a network of optometrists who have agreed not to charge more than the maximum amount under the vision plan for supplies and services. A list of these providers is available from the claims administrator. (Please note that benefits for a routine vision exam performed by an in-network ophthalmologist (M.D.) are limited to the schedule below; however, the amount charged over the cap is your responsibility.)

B. Vision Plan Maximums

The vision plan will pay for the actual amount charged for the supply or service once every 24 months, but not more than the following amounts:

Type of Service or Supply	Maximum Benefit Amount
Examination	$35
Frames	$60
Lenses	
- Single vision	$50 (pair)
- Bifocal	$60 (pair)
- Trifocal	$70 (pair)
- Lenticular	$80 (pair)
- Contact	$70 (pair)

C. What Is Not Covered Under The Vision Plan

There are certain types of lenses and procedures (e.g., sunglasses, monograms, vision training) which are not covered under the vision plan (see Section 7.5 of Agreement for a complete list of supplies and services not covered under the vision plan).

Chapter 9
Claiming Benefits

A. General

1. Medical, Dental and Vision Benefits

Claims for medical, dental and vision benefits should be filed as soon as possible, but not later than the calendar year following the year in which the expenses were incurred.

It is also a good idea to keep a record of expenses and to make sure that itemized bills show the patient's name, amount charged, plus other required information, such as diagnosis code, procedure code, provider's name and identification number, type and date of service or purchase.

When you use an out-of-network provider you are reimbursed directly for hospital and doctor's charges. You will, in turn, have to pay the provider (e.g., doctor, hospital).

Your coverage under the Program is coordinated with other plans to which you or your covered dependents belong. This is designed to prevent duplication of payments when you or a dependent can collect benefits from another plan (see Section 8.0 of the Agreement for more information). If your spouse is employed full-time and his/her employer offers health care coverage, he/she must take the coverage. (See Section 8.0 of the Agreement.)

2. Sickness and Accident Benefits

In order to file a claim for sickness and accident benefits obtain a claim form from your Employee Benefits Office, complete and sign the employee's portion and have your physician complete the rest of the form.

You must return the form to your Employee Benefits Office within 21 days of your disability. If it is over 21 days, you must also file a letter explaining the reasons for the delay or your claim will be denied.

To continue receiving sickness and accident benefits, you will have to complete a Continuation of Disability form, when requested, which your Employee Benefits Office will supply. (See Section 2.1 of the Agreement for more details.)

3. Basic Life Insurance Benefits

In order to initiate a claim for basic life insurance your survivors should contact your Employee Benefits Office.

Your Employee Benefits Office will provide the appropriate forms to your beneficiary in the event of your death. The completed forms should be returned to that office (see Section 1.6 of the Agreement for more details).

B. If Your Claim Is Denied

If your claim for medical, dental, vision, sickness and accident, or basic life insurance is not approved, you will receive written notice within 90 days (or within 180 days if special circumstances require an extension of time) stating the basis of the denial.

After receiving notice of the denial for any of the above benefits, except basic life insurance, you have 60 days to submit a written request to the Plan Administrator asking for a review of your claim. At that time, you also have the right to submit issues and comments in writing for the Plan Administrator's consideration.

The Plan Administrator is:
Manager, Employee Benefits
Ispat Inland Inc.
3210 Watling Street, Mail code 7-550
East Chicago, IN 46312

Once the Plan Administrator has received your appeal, a decision will be made within 60 days, unless special circumstances apply. If this occurs, an additional 60 days may be granted. The Plan Administrator is required to make a decision within 120 days of receiving your initial appeal.

After receiving notice of denial of a basic life insurance claim, your beneficiary will have 60 days to submit a written request to the benefits office asking for a review of your claim, including issues and comments in writing for consideration.

Your beneficiary's appeal will be reviewed, a decision will be made and your beneficiary will be notified within 60 days of the date the appeal is received. If your beneficiary is not satisfied with the reply, your beneficiary may further appeal the claim in writing to the Manager of Employee Benefits within 60 days.

The appeal should be sent to:
Manager, Employee Benefits
Ispat Inland Inc.
3210 Watling Street, Mail code 7-550
East Chicago, IN 46312

Once the Manager of Employee Benefits has received your appeal, a decision will be made within 60 days, unless special circumstances apply. If this occurs, an additional 60 days may be granted. A decision will be made within 120 days of receiving your initial appeal.

C. Tips On Filing Your Medical, Dental and Vision Claims

Your medical, dental and vision claims will be processed more effectively if you follow the filing tips listed below:

- File claims when you have met your annual deductible.
- Print legibly or type the information requested on your claim form.
- Do not use nicknames or initials on claim forms or bills.
- Fill out one claim form per patient. If more than one patient is listed on a bill, note the charges for each patient and include a copy with each claim form.
- If a claim for you or your dependent has been partially paid by another insurance plan or by Medicare, and you want the unpaid portion considered under the health care plan, follow these steps:
  - Complete a claim form
  - Attach a copy of the bill
  - Attach the other insurance company's or Medicare's explanation of benefits
- Send your completed claim form to the claims administrator at the address shown on the claim form.
- When the claims administrator requests additional information regarding your claim, respond as soon as possible.
- Keep copies of all bills and explanation of benefits (EOBs).
- Attach bills and/or receipts or have your provider fill out the "Provider's Statement" on the back of the claim form.

Chapter 10
Some Commonly Asked Questions and Their Answers

A. About Eligibility and Enrollment

Q. Am I limited as to the number of eligible dependents I can cover?
A. No, under PIB III you may cover all of your eligible dependents. Remember, dependents are covered at no cost to you under PIB III (see Chapter 1 for more details).

Q. I got married 2 months ago and did not enroll my spouse for medical, dental and vision coverage under PIB III at that time. Can I now enroll my spouse for coverage?
A. Yes, you may enroll your eligible dependents for coverage under PIB III at any time, providing you submit the proper proof (such as copies of a marriage certificate or birth certificate). Coverage under PIB III will be effective on the date you acquired your new dependents (e.g., your wedding day) (see Chapter 1 for more details).

Q. How do I change my address?
A. Contact the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) at the 800 number and notify them of the change.

Q. My spouse is employed full-time. Does my spouse have to take their employer's health insurance?
A. Yes, if your spouse's employer offers health insurance coverage they must take it. If there is a charge, Ispat Inland may reimburse part of the cost (see Chapter 1 for more details).

Q. We have a handicapped child who will turn 19 soon, is there anything special we must do?
A. To maintain your child's dependent status, even if he or she is a full-time student, beyond age 19 you must file a Disabled Dependent Certification within 90 days of the date your child turns 20. (See Section 8.1(d) and Section 9.36 of the Agreement.)

B. About The Basic Life Insurance Plan

Q. Can I increase my coverage under the basic life insurance plan?
A. No, your coverage under the basic life insurance plan is $25,000. You may, however, purchase additional insurance coverage through the Ispat Inland Optional Life Insurance Plan and/or the Ispat Inland Accidental Death and Dismemberment Plan.

Q. Do I need my spouse's permission to name someone other than my spouse as beneficiary?
A. No, you are entitled to name anyone you wish as your beneficiary under the basic life insurance plan unless you are prevented from doing so by a court order.

Q. Can I purchase coverage for my dependents?
A. There is no coverage available for dependents under the basic life insurance plan. You may, however, purchase coverage for your dependents under the Ispat Inland Optional Life Insurance Plan and/or the Ispat Inland Accidental Death and Dismemberment Plan.

Q. Are there any causes of death which are excluded under the basic life insurance plan?
A. No, your beneficiary will receive a benefit from the plan if you die for any reason.

C. About The Sickness And Accident Plan

Q. How are my weekly benefits under the sickness and accident plan determined?
A. Your benefits under the sickness and accident plan are determined based on your insurance classification (see Chapter 3.D. for more information).
Q. Are sickness and accident benefits paid in addition to benefits I may be eligible for from worker's compensation?
A. The benefits available to you under the sickness and accident plan will be coordinated with any benefits

you may be eligible to receive from worker's compensation or Social Security (see Chapter 3.D. for more information). These benefits will be greater than or equal to the Sickness and Accident benefits.

D. About Medical Benefits

Q. If I am injured on the job while working for the Company, am I covered under PIB III health care benefits?
A. No, if you are injured on the job, you will be covered under the Company's worker's compensation plan for that injury. Your health care coverage continues for all other illnesses (see Section 9.11 of the Agreement for more information).

Q. If I go into the hospital and have large expenses, what kind of coverage is available to me?
A. Generally, your hospital and related expenses are covered at the allowed charge, subject to deductibles and co-payments, if you follow the managed care rules and use in-network doctors and hospitals; obtain pre-admission review when required.

Q. If we choose to have our baby at a birthing center, will these expenses be covered?
A. Yes, PIB III medical benefits cover you at the same rate whether you choose to have your baby in a hospital or an approved birthing center (see Section 3.37 of the Agreement for more information).

Q. If I do not comply with more than one managed care provision, will I have to pay more than one $300 penalty?
A. Yes, if you do not follow all of the rules and advice of pre-admission review administration, which apply to your situation, you will be subject to a $300 reduction in what the health care plan will cover each time you fail to comply (see Sections 3.7, 3.15, 3.21 and 3.40(e) of the Agreement for more information).

For example, if you have your pre-admission tests performed as an in-patient and you do not pre-authorize your hospital stay with the pre-admission review administrator, you will be subject to two $300 penalties.

Q. What is medical pre-admission review?
A. Medical pre-admission review is a procedure designed to help you get the most for your medical dollars. Before you or one of your dependents are admitted to the hospital, you or your doctor must call the pre-admission review administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover). Medical experts will review information regarding your planned medical procedure and the length of hospital stay planned in order to "pre-certify" your hospitalization. If you do not get pre-admission review, you are subject to financial penalties (see Section 3.7 of the Agreement for more information).

Q. What if a medical emergency arises, must I still go through the medical pre-admission review procedure?
A. Yes, on a week day you must phone within 48 hours of your emergency admission to get medical pre-admission review. On weekends and holidays you must phone within 72 hours of your emergency admission to obtain medical pre-admission review (see Section 3.7 of the Agreement for more information).

Q. What happens if I or my doctor need information about the medical pre-admission review program?
A. Any questions you or your doctor may have concerning pre-admission review can be directed to the pre-admission review administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover).

Q. Which doctors are network members?
A. Many physicians in Northwest Indiana and the greater Chicago area are network members. Call the claims administrator to check on your doctor's network status. Directories of in-network doctors and hospitals are available at Local 1010's Union Hall or by calling the claims administrator.

Q. Why should I use a network doctor?
A. Network doctors have agreed to accept the lesser of their fee or the allowed charge, which helps control both your own and the Company's health care costs. They cannot bill you for charges above the allowed charge.

Q. How much will using a network doctor cost me?
A. You pay nothing over and above the plan's deductible and co-payment obligations up to the plan's maximum.

Q. How much will doctors be paid for services?
A. Charges of doctors in Northwest Indiana and the greater Chicago area will be paid at the lower of the doctor's charges or the allowed charge established by the Company.
Charges of doctors outside the network area will be paid at the lower of the doctor's charges or reasonable and customary for the area.

Q. What if I decide to use an out-of-network doctor?
A. If you use an out-of-network doctor or hospital, where a network exists, you are subject to a higher family deductible and higher co-payments.
Doctors who are out-of-network may choose to bill you for the difference between the Company's reimbursement and their charges (balance billing). You are responsible for these differences, which could amount to hundreds and even thousands of dollars.
The differences between doctor's charges and the allowed charge cannot be applied against deductibles or co-payments.

Q. What if I live in or am traveling in an area where no network exists?
A. Charges will be paid based on prevailing fees (reasonable and customary) in the area you receive services. If the charge exceeds the allowed charge, you should expect to be billed for the difference by your doctor.

E. About The Prescription Drug Plan

Q. I understand that generic drugs vary in quality, I don't want any second rate pharmaceuticals.
A. The mail service pharmacy and the retail drug program dispense only A-rated generics, where the compound is identical to the brand name drug.

Q. I forgot to order a refill on my maintenance prescription medication and I am almost out.
A. Call the mail service pharmacy at the 800 telephone number. Using your credit card for your co-payment, you can order refills by telephone or through the prescription drug benefit manager's website.

Q. I want the lower price, how do I get generic drugs?
A. Ask your doctor if he or she will prescribe generics for your prescription needs. Explain there is a mandatory generic program, so it is a substantial cost advantage for you to order generics. Always have the doctor stipulate "May Substitute".

Q. We have misplaced one of our Prescription Drug Cards.
A. Call the prescription drug benefit manager at the 800 telephone number (see "Who To Call For Benefit Information" phone numbers on inside front cover). You may also order additional cards for covered dependents who may be away from home.

Q. The prescription drug benefit manager says our 19 year old student son is not eligible. I thought students were covered.
A. Full-time students are covered as dependents to age 25. Student eligibility is continued when a current Student Dependent Certification has been received by the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover).

Q. How do I know a retail pharmacy is a network member?
A. Call the 800 telephone number for the prescription drug benefit manager (see "Who To Call For Benefit Information" phone numbers on inside front cover). They can tell you which chain and independent stores are in-network.

Q. One of the drugs I attempted to get filled had to be approved first through prior authorization.
A. Prior authorization is in effect for certain medications under the prescription drug program. For these medications, the prescribing physician must call the vendor toll free prior authorization number, and submit medical information about your need for the drug that meets prior authorization criteria in order for the drug to be covered under the plan.

F. About The Mental Health And Alcohol/Substance Abuse Plan

Q. What do I do if my dependent, who has a mental health problem, requires assistance while out of the area (on vacation, away at school)?
A. Call the MH/ASA network manager at the 800 number (see "Who To Call For Benefit Information" phone numbers on inside front cover), their network of care providers is nationwide. If you are in an area where no network provider is available, care will be treated as in-network if you obtain a referral from the network manager.

Q. My wife and our children are covered under her employer's insurance program. How can they receive maximum benefits for our MH/ASA needs?
A. Contact the MH/ASA network manager at the 800 number (see "Who To Call For Benefit Information" phone numbers on inside front cover) prior to beginning any treatment. The network manager will coordinate treatment with the primary plan to maximize benefits.

Q. Does Ispat Inland have mental health and alcohol/substance abuse assistance available at the Indiana Harbor Works?
A. Yes, Ispat Inland still maintains the Employee Assistance Program through the Medical Department. Contact the Clinic for assistance.

Q. The mental health provider I am using is out-of-network. How do I claim reimbursement?
A. All mental health and alcohol/substance abuse reimbursement claims must be filed with the MH/ASA network manager.

Q. In the past, I have gone to a clinical psychologist when I feel depressed. Do I need to contact the MH/ASA network manager when I go back?
A. Yes. If you do not receive a referral from the network manager you risk possibility of no benefit being available for a lack of medical necessity. Call the network manager (see "Who To Call For Benefit Information" phone numbers on inside front cover) before you make any arrangements for mental health or alcohol/substance abuse assistance.

G. About The Dental Plan

Q. Is there a deductible under the dental plan?
A. Yes, there is a $50 out-of-network annual family deductible. There are certain procedures and services, however, which are not subject to a deductible. To see if a particular expense is subject to the $50 deductible, see Section 6.0(a) of the Agreement for more information.

Q. If my dentist charges less than the amount listed in the fee schedule for a particular service, what will the dental plan pay?
A. The dental plan will always figure their payment based on the lesser of the dentist's actual charge or the amount listed in the fee schedule.

Q. If I use a dentist whose charge is greater than the amount listed in the fee schedule, am I responsible for the difference?
A. If you use an in-network dentist, you are not responsible for the difference. If however, you go to a dentist who is out-of-network, you are responsible for the difference.

Q. Are different procedures covered if I do not use an in-network dentist?
A. The procedures covered are the same. The only difference is in the amount you and the plan pay for the procedure.

Q. I know the dental plan does not cover all dental and related expenses, but for those supplies and services which are not covered, can the expenses be used to satisfy my deductible?
A. No, you cannot use expenses incurred for services and supplies not covered by the dental plan to satisfy your deductible (see Section 6.0 (a) of the Agreement for more information).

Q. Why are dental services covered at different amounts (100%, 85% and 50%)?
A. The dental plan was designed to encourage you to obtain routine and preventive dental services at little cost, (e.g., those paid at 100%) in order to avoid more extensive and expensive services.

Q. Why should I use an in-network dentist?
A. In-network dentists have agreed to accept the lesser of their charge or the plan's allowed charges. This helps to control both your own and the Company's cost for dental care. Also, you will not be subject to a $50 annual family deductible when services are provided by an in-network dentist.

Q. How much will it cost me to use an in-network dentist?
A. You pay nothing over and above the plan's co-payment obligations.

Q. What happens if I decide to use an out-of-network dentist?
A. You will be subject to a $50 annual family deductible. You will also be responsible for the difference between the allowed charge and the billed charge, in addition to any co-payment amount.

Q. If I am out of town and use an out-of-network dentist for an emergency, will I still be subject to the $50 annual family deductible?
A. Yes.

H. About The Vision Plan

Q. Can I get new lenses and eye examinations as often as I like?
A. No, examinations and new lenses will only be covered under the vision plan once every 24 months (see Section 7.4 of the Agreement for more information).

Q. Am I covered at 100% for any type of glasses or contact lenses I choose?
A. The vision plan has certain maximum limits for frames, lenses and eye examinations (see Section 7.2 of the Agreement for more information).

Q. If I am eligible for safety glasses under the Company's safety glass program, am I still eligible for coverage under the vision plan?
A. Yes, as long as you follow the rules under both plans, you are eligible for both types of coverage.

Q. Are sunglasses a covered expense?
A. No, sunglasses are not covered under the vision plan.

Q. How can using an in-network provider save me money?
A. In-network providers have agreed to provide examinations and lenses and to make frames available at a cost within the plan's maximum benefit amount. Specialty items such as designer frames, tints, or certain types of contact lenses are the employee's responsibility.

I. About Claiming Benefits

Q. How long should I wait for my medical, dental or vision claim to be processed?
A. Most claims are processed within 3 to 4 weeks after the claims administrator receives them.

Q. Do I need to complete a claim form every time I send in a bill?
A. Yes, information on the claim form helps the claims administrator process your claim promptly and efficiently.

Q. Is there anything I can do to ensure my claim will be processed as soon as possible after surgery?
A. To facilitate the processing of your claim following surgery, have your physician attach an operative report to the completed claim form.

Q. What should I do if I suspect a claim was paid incorrectly?
A. Contact the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover). Be sure to have all your documentation (such as your copy of the EOB and a copy of the bill in question), your Social Security number, and your claim number ready before you call.

Q. When should I file claims for medical, dental or vision bills that I have paid myself?
A. All claims for services received in the current calendar year must be submitted by the end of the following calendar year. For example, all claims for services received in 2000 must be submitted by December 31, 2001 to be considered for payment.

Since Ispat Inland pays the claims administrator a fee per covered individual, it is to everyone's advantage to process claims as soon as possible after service is received.

Q. What should I do with my copy of the EOB?
A. We suggest that you attach your EOBs to copies of any correspondence and bills and keep them for future reference and tax purposes.

Q. What is an itemized bill?
A. An "itemized bill" is the bill submitted by your physician or hospital, which includes the patient's name, the illness being treated (including the diagnosis), the date and type of service being rendered (including the CPT-4 procedure code(s)), as well as the fee.

Ispat Inland Inc.
Program of Insurance Benefits III (PIB III)

For Wage Employees of Ispat Inland Inc.

Effective August 1, 1999

Pursuant to Agreement with
United Steelworkers of America

Part B: Agreement

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SECTION 1.
COMPANY PROVIDED LIFE INSURANCE

General Information and Amount of Coverage

1.0 In the event of your death, life insurance in the amount of **$25,000** will be payable to any person you designate as beneficiary. You have the right to change the beneficiary at any time by completing and returning the proper beneficiary-change form to the Employee Benefits Office at the plant where you work.

Total Disability

1.1 If, while insured under the Program, you become totally disabled for a period in excess of six months and thereafter submit satisfactory evidence of continuing disability as required by the carrier, your life insurance will be continued, without contributions from you, in the full amount until your retirement or until you attain age 65, whichever comes first. Thereafter, your life insurance will be continued according to the provisions in paragraphs 1.2 through 1.4.

Life Insurance After Retirement

1.2 If you retire under the Company non-contributory pension plan applicable to you prior to age 62, the full amount of your life insurance will be continued until the end of the month in which you attain 62. At the end of the month in which you attain age 62 the amount of your life insurance will then be reduced to **$7,500**.

1.3 If you retire under a deferred vested pension, you will not be eligible for life insurance either before or after age 62.

1.4 If you retire under the Company non-contributory pension plan applicable to you at or after age 62, your life insurance thereafter will be reduced to **$7,500**.

Conversion Privilege

1.5 When your life insurance is reduced or terminated as a result of layoff, leave of absence, termination of employment, or retirement, you will have the right to convert to an individual policy as explained in paragraphs 9.20 through 9.23.

How to File a Claim

1.6 Your designated beneficiary will be provided the necessary forms for claiming the life insurance proceeds by notifying the Employee Benefits Office at the plant or office where you last worked, when your death occurs.

How to Appeal a Claim

1.7 If your designated beneficiary has any questions concerning a denial in whole or in part of life insurance benefits, your beneficiary should write within 60 days from the date the claim was denied to the insurance office which denied the claim, furnishing all pertinent data. Your beneficiary's appeal will be reviewed by that office and reply made within 60 days of the date the appeal is received. If your beneficiary is not satisfied with the decision rendered by that office, your beneficiary may further appeal the claim by writing within 60 days from the date of the reply to the initial appeal to the **Manager of Employee Benefits**, Ispat Inland Inc., 3210 Watling Street, East Chicago, IN 46312. Your beneficiary will be advised by that office of the final decision within 60 days.

SECTION 2.
SICKNESS AND ACCIDENT BENEFIT PLAN

Eligibility

2.0 If you become totally disabled as a result of sickness or accident so as to be prevented from performing the duties of your employment and **an authorized provider** certifies thereto, you will be eligible to receive weekly sickness and accident benefits. **An "authorized provider", as defined under this plan, is limited to a licensed medical doctor (M.D.), a licensed doctor of osteopathy (D.O.), a licensed doctor of podiatric medicine (D.P.M.), or any provider authorized by the mental health/substance abuse managed care administrator to provide treatment, and operating within the scope of their license(s)**. Benefits will not be payable for any period during which you are not under the care of an **authorized provider**.

NOTE: If an employee after consultation with the Company's physician or other clinical staff is required to see a treating physician prior to returning to work, and does so within three days excluding Saturday, Sunday, and holidays, the seven-day waiting period referred to in paragraph 2.2 will begin on the day after his or her consultation with the Company's physician or staff.

Filing of Claims

2.1 In order for you to be eligible for benefits the Company must receive written notice of your claim within 21 days after your disability commences but this requirement will be waived upon showing of good and sufficient reason that you were unable to furnish such notice or have it furnished by someone else on your behalf. The following applies in the administration of this provision:

Normally it is anticipated that you will obtain or have someone on your behalf obtain a sickness and accident claim form from the Employee Benefits Office at the plant or office where you work and complete your portion of the form and have your physician complete the attending physician's portion of the form and return it to the Company within 21 days of commencement of your disability.

To remind you of the notice requirement, appropriate instructions have been included on the claim form. If you are unable to comply with this procedure, you are expected to notify the S&A administrator in writing before the end of the 21-day period.

It is the intent of this provision to encourage prompt notice of your claim for sickness and accident benefits so that the evaluation of the claim, including any necessary investigation of medical and other factual aspects of the claim can be made in an expeditious manner. It is not the intent of this provision that your claim be denied for failure to comply with the notice requirement if such failure did not interfere with the ability of the claims administrator to establish the medical and other factual aspects of the claim.

Duration of Benefits

2.2 Sickness and accident benefits begin with the first day of total disability resulting from an accident, or with the first day of inpatient hospitalization regardless of cause, **the first day following an outpatient surgery**, or with the eighth (except that under certain circumstances, benefits are payable with the seventh) day of total disability resulting from a sickness (see Paragraph 2.9) and are payable according to the following schedule:

A Years of Continuous Service When Absence Begins	B Weeks of **Benefit**
Less than 6 months	*****
6 months but less than 2 years	**26**
2 years but less than 20 years	**52**
20 or more	**52****

Note: the first two weeks of total disability are considered at 60% of the weekly benefit; a 100% weekly benefit payment begins the third week of your disability and continues, as long as you are totally disabled, **for the number of weeks shown above, according to your years of service.**

* Benefits are payable for up to one week for each full week of continuous service.

** If (1) you have 20 or more years of continuous service as of your last day worked, and (2) you are not permanently disabled, benefits will be continued for a period not to exceed 52 additional weeks; provided that sickness and accident benefits terminate when you retire under the Company non-contributory pension plan applicable to you.

2.3 In determining the maximum period for which sickness and accident benefits are payable, successive periods of disability separated by a period of continuous active employment with the Company of less than 2 weeks will be considered to be one continuous period of disability, unless it is clear that they arise from unrelated causes; provided that if you complete (a) two years or (b) 20 years of continuous service after the start of one continuous period of disability and before the start of a succeeding period of disability which is considered to be part of such continuous period of disability under the foregoing provision your benefits are payable for a period not to exceed 52 or 104 weeks, respectively, for such continuous period of disability.

Amount of Benefits

2.4 The amount of weekly sickness and accident benefits for which you are eligible is shown in the following schedule:

SCHEDULE OF SICKNESS AND ACCIDENT BENEFITS
Schedule Effective 1/1/94

Insurance Classification*	Weekly Benefit at 100%	Weekly Benefit at 60%
1-4	$472	$283.20
5-10	$498	$298.80
11-16	$524	$314.40
17-23	$550	$330.00
24-29	$576	$345.60
30+	$602	$361.20

* Based on Job Class in effect on August 1, 1999. See paragraph 9.9.

For Fleet employees represented by Local 5000 of USWA the following rate applies:

All Classifications	$498 (or $298.80 @ 60%)

Reduction of Benefits

2.5 In the event you become totally disabled due to sickness or accident arising out of or in the course of your employment, the amount of weekly sickness and accident benefits otherwise payable will be reduced by any weekly benefits which you are or could be entitled to receive during the period of your absence from work due to such disability pursuant to any workers' compensation law or any occupational disease law or other similar applicable law. However, if your continued eligibility for benefits continues beyond 6 weeks for the same compensable illness or injury, the reduction will be limited to 75% of such weekly benefits **for weeks 7-26 and 85% for weeks beyond 26**. No benefits are payable in the event of total disability due to accident or sickness arising out of or in the course of employment by other than the Company. Payments under any such law for hospitalization or medical expense or specific allowances attributable to temporary total disability will not reduce the amount of your sickness and accident benefits.

If you are otherwise entitled to sickness and accident benefits and there is a dispute as to your entitlement to payments for which you are making claim pursuant to any workers' compensation or occupational disease law or other similar applicable law, the sickness and accident benefits will be paid in full if satisfactory arrangements are made to assure that any overpayment of sickness and accident benefits which may result by virtue of your success in pursuing such claim shall be reimbursed by you. Such arrangements shall include the execution by

you of necessary documents authorizing the deduction of such overpayments from any payments becoming due as a result of such claim or from any amount payable to you or on behalf of the Company, including benefits, wages, and pension payments.

2.6 The amount of weekly sickness and accident benefits otherwise payable will be reduced for each week of disability by the amount of any primary disability benefits or unreduced primary old-age benefits under the Social Security Act which you are entitled to receive or could become entitled to receive by making proper application, except that no reduction for such unreduced primary old-age benefits will be made for the first 26 weeks of sickness and accident benefits during any one continuous period of disability.

The Company will assume that you are receiving a benefit under the Social Security Act, in an estimated amount, and your sickness and accident benefits will be reduced by such estimated Social Security benefit until the Company is furnished a copy of your Social Security award so that it may determine the exact amount of reduction. If, however, you are eligible for sickness and accident benefits for a period in excess of 26 weeks and you furnish to the Company written proof within the initial 15 weeks of disability that you have applied for disability benefits under the Social Security Act and do not receive such benefits when they are initially due, full weekly benefits will be continued until the earlier of:

(a) the date such Social Security disability benefits commence, or
(b) the date 34 weeks of weekly benefits have been paid, provided you make satisfactory arrangements with the Company to assure that any overpayment of weekly benefits which may result by reason of receipt of Social Security benefits will be repaid to the Company. To be eligible for this arrangement you will be required to sign an agreement to reimburse the Company promptly upon receipt of retroactive payment of Social Security disability benefits. You will also be required to sign an authorization for the Social Security Administration to release relevant information to the Company.

In any event, you will be paid the full weekly benefit amount if you are not old enough to qualify for an unreduced primary old-age benefit and if

(a) you furnish satisfactory evidence that in the judgment of a licensed physician your condition is such that you will be able to engage in substantial gainful employment prior to the expiration of 12 months from the commencement of your disability, or
(b) you have not been disabled for a period sufficient to qualify for Social Security disability benefits, or
(c) you inform the Company that your application for Social Security benefits has been denied; however, weekly sickness and accident benefits will be paid beyond 34 weeks only if within four weeks of the date of the denial letter you request reconsideration of such denial.

Note: If you fail to request reconsideration of a denial within four weeks of the date of the denial letter, sickness and accident benefits will not be paid beyond 34 weeks until Social Security disability benefits have been awarded or your request for reconsideration has been denied. The Company will notify you of your responsibility to apply for Social Security disability benefits and to request reconsideration of any denial of such application on a timely basis.

The applicable Social Security monthly benefit will be converted to its equivalent weekly (or daily) rate. If the Social Security benefit ultimately determined is more or less than the amount of reduction (or Social Security benefits are received for a period as to which no reduction was made), there will be a retroactive adjustment in the amount of your sickness and accident benefits, with repayment by you of any overpayment or payment to you of any underpayment. You will be required to give any necessary authorization to permit deduction of any such overpayment from any amounts payable to you by or on behalf of the Company, including benefits, wages and pension payments.

In connection with the foregoing provisions, you may be required to furnish copies of relevant correspondence and documents.

Transplant Donor Benefits

2.7 If you are a donor of a human organ or tissue transplant requiring surgical removal of the donated part from the donor, disability resulting in the surgical removal of such transplant will be deemed to be a disability due to sickness. In no event, however, will disability be considered to have commenced prior to the date of hospital confinement.

Disability During Suspension

2.8 If during a suspension, which is not converted into discharge, you satisfy all the eligibility conditions for receipt of sickness and accident weekly benefits and

(a) promptly notify the Company of your disability, and
(b) if requested to do so, report for examination to the medical department of the plant or office where you work, or to such other physician as may be designated by the Company or the insurance company (unless you are unable to do so for good and sufficient reason),

sickness and accident weekly benefits will be payable in accordance with paragraph 2.2, except that days during the suspension period will not count toward any applicable waiting period nor will benefits be paid for any days during the period of suspension.

Outpatient Pre-admission Testing/Surgery

2.9 (a) Sickness and Accident benefits are payable on the seventh day if the employee had outpatient pre-admission testing prior to surgery if the tests are performed within five (5) days of the hospital confinement (unless such confinement is delayed by the attending physician or the hospital), the tests are not repeated during the confinement, and the employee is not admitted to the hospital any earlier than the day prior to the date of surgery.

(b) Sickness and Accident benefits are payable on the **first** day following outpatient surgery performed by a physician when:
(i) the physician certifies that the individual is totally disabled because of the outpatient surgery; and
(ii) this method of treatment is more economical than other methods available.

Administration of Benefits

2.10 The payment of sickness and accident benefits is an obligation of the Company, but the Agreement with the Union permits the Company to provide the payment in accordance with a policy with an insurance company. The Company performs important administrative functions in connection with the handling of claims, including the issuance of benefit checks. In the typical case, such handling is routine and a claim is paid within two weeks after it is reviewed by the Company. The Company is authorized to make benefit payments on claims without prior approval of the insurance company when Company personnel engaged in claims work determine the claim meets the standards established by **the Company and/or** the insurance company. If you have a claim which does not meet these standards, **the S&A administrator or** the insurance company may take reasonable steps to investigate the medical and other factual aspects of the claim.

SECTION 3.
HEALTH CARE BENEFIT PLAN
Effective August 1, 1999

General Information

Introduction

3.0 The Program provides benefits for you and your eligible dependents which protect you from the cost of major health care expenses. This plan covers hospital charges, physician charges and associated charges such as prescription drugs, lab work and x-rays, anesthesia and its administration, and charges for covered medical services and supplies.

Special provisions apply for care received from an Approved Skilled Nursing Facility, Home Health Care Agency or Hospice.

The Program offers comprehensive medical coverage with a total maximum benefit of $1,000,000 per individual per lifetime, beginning January 1, 1994 **and increased, effective August 1, 1999, by an additional $250,000**, for benefits received from network providers in locations where networks exist, or in locations where networks are not available, and including any out-of-network benefits received. Out-of-network benefits are limited to $500,000 per individual per lifetime. These lifetime maximums do not apply where otherwise annual or lifetime maximums are specifically provided under other provisions of this plan.

Effective August 1, 1999 any individual who meets their lifetime benefit maximum who has had an organ transplant procedure on or after August 1, 1999, will have their lifetime maximum increased by the amount of benefits paid for the transplant procedure.

How this Plan Works

3.1 This plan offers comprehensive medical coverage with covered medical expenses payable at either 70%, 80% or 90% of the allowed charge, depending upon whether you use a provider who has contracted to provide services to Company employees and their eligible dependents at negotiated rates in locations where contracts exist ("in-network"), or a non-contract provider ("out-of-network"), after you satisfy the annual deductible. After you reach the $600 (in-network) or $750 (out-of-network) annual co-payment maximum, covered medical expenses are payable at 100% of the allowed charge.

Deductibles and Co-payments

3.2 (a) Contractual agreements under a Managed Care Program provide hospital and physician networks in certain geographic locations, identified by zip codes, whereby services will be provided at negotiated rates. When services are received from such providers, services are considered to be "in-network" and benefits are paid as follows:

Type of Service	Deductible/ Individual	Deductible/ Family	Company Paid Coinsurance %	Family Coinsurance Maximum	Balance Billing
Hospital	$150	$250	90%	$600	No
Physician	$150	$250	80%	$600	No

In-network, deductibles and co-insurance are calculated according to the lower of the actual billed amount or the negotiated rate (the "allowed charge"). Payments are made directly to the in-network provider, unless you have already paid the bill. The employee is not responsible for the excess of the provider's billed amount over the negotiated rate. The employee is responsible for paying the provider any deductible or co-insurance amounts applied against the allowed charge.

(b) When services are received from providers who are not members of the networks in geographic locations that have been identified as having such networks, services are considered to be "out-of-network" and benefits are paid as follows:

Type of Service	Deductible/ Individual	Deductible/ Family	Company Paid Coinsurance %	Family Coinsurance Maximum	Balance Billing
Hospital	$150	$300	70%	$750	Yes
Physician	$150	$300	80%	$750	Yes

For out-of-network inpatient hospital charges, deductibles and co-insurance are applied to the actual billed charge; **for out-of-network outpatient and ambulatory surgical center charges, deductibles and co-insurance are applied to the lower of the allowance established for similar network facilities or the actual billed amount**. For out-of-network physician charges, deductibles and co-insurance are applied to the lower of the negotiated rates applied to in-network physician services or the actual billed amount (see Sec. 3.43 (a) (ii)).

(c) For services performed in locations where no networks exist, this plan pays as follows:

Type of Service	Deductible/ Individual	Deductible/ Family	Company Paid Coinsurance %	Family Coinsurance Maximum	Balance Billing
Hospital	$150	$250	80%	$600	Yes
Physician	$150	$250	80%	$600	Yes

For hospital charges incurred outside of the network zip codes, deductibles and co-insurance are applied to the actual billed amount. For out-of-network physician charges, where no networks exist, deductibles and co-insurance are calculated according to the lower of the prevailing fee or the actual billed amount (see Sec. 3.43 (b)).

The above schedule also applies to classes of health care providers in network zip codes (other than hospitals and physicians) which the Company has not included in the network. As classes of providers are added to the network they will be subject to the physician payment provisions outlined in 3.2(a) and (b) above.

NOTE: The maximum deductible for any calendar year applicable to an individual shall be $150.00; $300.00 per family. The maximum amount of co-insurance payable by an individual or a family shall be $750.00 in a calendar year.

(d) If this plan is your secondary plan, both hospital and physician charges will be coordinated with the benefits of your primary plan as if the charges were incurred outside of the network zip codes.

NOTE: This plan will not cover any out-of-network penalties applied by the primary plan.

(e) If two or more persons in a family are in the same accident, only one cash deductible will apply to all covered charges for such persons due to that accident.

(f) Penalties applied due to noncompliance with cost containment features explained later in this section are not counted towards the deductible requirements or the co-insurance limits which are commonly referred to as "out-of-pocket" maximums.

Hospital Benefits

Payment of Benefits

3.3 Payment for hospital benefits will be made as follows:

(a) In-network hospital:
Benefit will be paid directly to the hospital.

(b) Hospital in location where a network does not exist:
Benefit will be paid directly to the hospital.

(c) Out-of-network hospital:
Benefit will be paid directly to the employee and employee is responsible for paying hospital bill.

Benefits Provided

3.4 When you are admitted for treatment as an inpatient to any legally constituted hospital, upon the recommendation and approval of a physician licensed to practice medicine, benefits will be provided based upon the actual amount charged you (or contracted amount) at the hospital's regular charge for semi-private room accommodations and all other services provided by the hospital for the diagnosis and treatment of your condition including treatment in an intensive care unit.

3.5 If you occupy a private room in the hospital, you will be entitled to all of the above-described benefits but you will be required to pay the hospital the excess, if any, of its regular charge for the private room over the hospital's most common charge for semi-private rooms.

3.6 If you are confined to an intensive care unit of the hospital, benefits will be provided based upon the actual amount charged you at the hospital's regular charge.

Pre-admission Review

3.7 As added protection for you, both financially and for your health, pre-admission review and concurrent utilization review are an integral part of hospitalization and reduce costly lengths of stay in the hospital.

(a) Pre-admission Review/Certification

Whenever you or one of your dependents is to be admitted as an inpatient on a non-emergency basis to a hospital or birthing center, a pre-admission request must be processed prior to the admission. If you or your dependent is eligible for and covered by Medicare, the pre-admission procedure does not apply to that person.

When a licensed physician recommends an admission to a facility or use of a service requiring pre-admission, a telephone call must be made to the pre-admission review administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) who will make a determination as to medical necessity and the appropriate level of care.

When you call, the pre-admission review administrator will ask for the following information:

- Your name and Social Security Number
- Name, address and telephone number of your physician
- Nature of your illness or injury
- Name of the health care facility you propose to enter.

If you are admitted on an emergency basis to any facility requiring pre-certification, the certification process must begin no later than 48 hours after admission.

If the admission is approved by the pre-admission review administrator, an approval determination will be sent to you, your physician and the hospital. Also, see paragraph 3.8 for concurrent review after admission.

If the pre-admission review administrator cannot approve an admission immediately, additional information will be sought in an effort to obtain all pertinent data to make a decision. If the review process results in the admission not being approved, both you and your physician will be notified by letter of the disapproval and of the applicable appeal procedure. (See paragraph 3.9.) If the precertification is not approved, but you follow the course of treatment recommended by your physician, a $300 ($100 birthing center) penalty will be incurred by you which cannot be used to satisfy deductibles or co-payments elsewhere in the Program.

Concurrent Utilization Review—After Admission

3.8 (a) When you are confined as an inpatient to a facility or use services requiring precertification, a review of the type of services and the length of time services are provided will be performed. This type of review is called concurrent utilization review.

(b) Concurrent utilization review follows precertification and is a process which continues throughout an admission or period of treatment. If additional days of care are necessary, you, your physician or a facility representative must contact the pre-admission review administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) by telephone to request such additional confinement. The decision to certify additional days of care or continued services will be made based on a need to stay, appropriateness of service and level of care.

(c) You will be told about the decisions reached concerning your care and your health care benefits. If continued confinement is determined to be no longer necessary, the utilization review personnel and your doctor will discuss plans for discharge or a continued course of treatment in an alternative setting, provided an alternative setting for less acute care is immediately available. If a less acute care setting is not immediately available, or if such setting is beyond a reasonable distance, full benefits will continue to be provided under this plan until such care is available.

(d) You will be notified in writing that your confinement is no longer authorized or that an alternative setting is available. While the decision to end your confinement is up to you and your physician, if you continue to stay in the facility beyond the date specified by the pre-admission review administrator, you will be responsible for all in-patient facility charges incurred subsequent to such date.

Appeal of Pre-admission Review Administrator

3.9 If you disagree with the outcome of any of the review functions or procedures performed by the pre-admission review administrator (under paragraphs 3.7 or 3.8), you may request an additional review of your case by the pre-admission review administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) within 60 days from the date you receive notification from the pre-admission review administrator pursuant to paragraph 3.7. The pre-admission review administrator will arrange for additional benefit payments under this plan if appropriate. The pre-admission review administrator will reply within 60 days from the date your appeal is received unless there are special circumstances, in which event reply will be made within 120 days.

Duration of Benefits

3.10 If, at the commencement of a period of hospitalization, you have less than 10 years of continuous service with the Company, you will be entitled to the hospital benefits described herein for a period not in excess of 365 days for each hospitalization. If you have 10 or more years of continuous service at the commencement of a period of hospitalization, you will be entitled to such benefits for a period not in excess of 730 days for each hospitalization. In either case, if you should be admitted to a hospital within 90 days after previous hospitalization, days of hospital benefits provided during the earlier period will be deducted in determining the maximum number of days for which you will be entitled to benefits during the later period.

Maternity Benefits

3.11 The hospital benefits provided under this plan are available to you, if you are a female employee, or to a female dependent of yours for up to the number of days to which you are entitled as provided in paragraph 3.10 and for a period not exceeding 15 days of care for the newborn child.

Inpatient Admissions and Outpatient Visits — Dental Cases

3.12 The hospital benefits provided under this plan are available:

(a) if you are admitted to a hospital (i) for extraction of impacted teeth, or (ii) for extraction of teeth other than impacted teeth or for other dental processes provided hospitalization is certified by a licensed physician or a doctor of dental surgery as being necessary to safeguard the health of the person confined, or

(b) if you receive treatment in the outpatient department of an accredited hospital for (i) extraction of impacted teeth, or (ii) extraction of teeth other than impacted teeth or for other dental processes, provided hospital outpatient care is necessary to safeguard the health of the patient.

Outpatient Treatment — Emergency Cases

3.13 The hospital benefits provided under this plan are available if you receive emergency outpatient treatment in a legally constituted hospital as the result of an accident.

3.14 The hospital benefits under this plan are also provided in the outpatient department of a legally constituted hospital for the initial visit when the patient receives Emergency Medical Care. "Emergency Medical Care" means services rendered for the sudden and unexpected onset of a condition or illness with severe symptoms which requires immediate medical (nonsurgical) care.

Outpatient Treatment — Surgical Cases

3.15 Benefits under this plan for the listed procedures will be provided if conducted in the outpatient department of a hospital, an Ambulatory Care Facility or a doctor's office:

List of Procedures

- Abdominal paracentesis
- Antrum Irrigations
- Arthrocentesis
- Arthrography and arthroscopy
- Aspiration of Douglas' cul-de-sac
- Bartholin cyst excision, marsupialization of I & D
- Bladder puncture aspiration
- Blepharoplasty, non-cosmetic
- Breast biopsy
- Bronchoscopy with or without biopsy
- Carpal tunnel
- Cervical biopsies or polypectomies
- Circumcision, male (excluding newborns)
- Closed reduction of complete dislocations or fractures
- Culdoscopy with or without biopsy
- Cyst aspiration
- Cystogram
- Cystoscopy with or without retrograde pyelogram
- Digit amputation
- D & C, diagnostic and therapeutic
- Dorsal split or prepuce
- Esophageal dilation
- EUA (examination under anesthesia)
- Excision of soft tissue lesions (nervus, verrucus, epithalami, scar)
- Fiberoptic endoscopy with or without biopsy
- Foreign body removal

- Frenulotomy of tongue
- Ganglionectomy
- Gastroscopy with or without biopsy
- Hammertoe
- Herniorrhaphy (up to age 14)
- Hydrocelectomy
- Hymenectomy
- Hysterosalpingography
- I & D (incision and drainage of superficial lesions)
- Kidney needle biopsy
- Laceration suture of skin and tendons
- Laparoscopy with or without tubal ligation
- Laryngoscopy with or without biopsy
- Lipoma removal
- Liver needle biopsy
- Lumbar puncture
- Mammoplasty, non-cosmetic
- Meatotomy
- Minor eyelid procedures
- Minor rectal surgery (not under spinal)
- Morton's neuroma
- Muscle biopsy
- Myringotomy
- Nasal fracture reduction, open and closed
- Nasal polypectomy
- Nerve blocks
- Node biopsy (superficial)
- Otoplasty, non-cosmetic
- Otoscopy with or without biopsy
- Pacemaker insertion, transvenous
- Pin and screw removals
- Proctosigmoidoscopy with or without biopsy
- Skin biopsy
- Skin graft (small)
- Submucous resection of nasal septum
- Synovial cyst removal
- Tear duct probing
- Thoracentesis for fluid aspiration
- Trigger finger
- Triple upper endoscopy
- Tubal ligation
- Urethral dilation
- Varicocelectomy
- Vasectomy
- Vein sclerosing injection
- Venography

(a) If the procedure listed is not performed on an outpatient basis, the benefits for an inpatient hospital confinement will be limited to charges for which benefits would otherwise have been paid in accordance with the Program reduced by the lesser of $300.00 or what otherwise would have been paid had the procedure been done on an outpatient basis. Such penalty shall not be used to reduce deductibles or copayments elsewhere in the Program.

(b) The penalty in (a) above will not apply if:

(i) the inpatient stay is needed because of the patient's condition as determined by the precertification program or

(ii) no outpatient surgical facility is available or

(iii) the surgery is done during an inpatient stay that is for a cause not related to the surgery or for which benefits are payable under this plan.

Outpatient Treatment — Radiation Therapy

3.16 If you receive radiation treatments in the outpatient department of a legally constituted hospital, hospital benefits are provided for such treatments to the extent that they are provided as a hospital service.

Outpatient Treatments — Hydrotherapy and Physiotherapy

3.17 The hospital benefits provided under this plan are also available for hydrotherapy and physiotherapy treatments performed in the outpatient department of a legally constituted hospital.

Inpatient Admissions and Outpatient Visits for Diagnostic Study

3.18 Hospital benefits are provided for inpatient admissions for diagnostic study when the study is directed toward the diagnosis of a definite condition of illness or injury.

3.19 Hospital benefits are also available for the following diagnostic services performed in the outpatient department of a legally constituted hospital which provides such services, when directed toward the diagnosis of a definite condition of illness or injury (including pregnancy):

X-ray examinations with films, ultrasound when used as a substitute for x-rays with films, metabolism testing, radioactive isotope studies, cardiographic and encephalographic examinations, laboratory examinations, electromyography, pulmonary function testing, and allergy testing, but excluding work-up procedures performed in the outpatient department when the patient is to be admitted as an inpatient unless provided for under paragraph 3.21.

3.20 Hospital benefits are not provided under paragraph 3.18 and 3.19 for the following services:

Audiometric testing; eye refractions; examinations for the fitting of eyeglasses or hearing aids; dental examinations; pre-marital examinations; research studies; screening; or routine physical examinations or check-ups.

Outpatient Pre-admission Testing

3.21 Hospital benefits are provided for pre-admission testing. Standard pre-admission tests must be done prior to admission in an outpatient setting. Normally your doctor will arrange such outpatient testing routinely but if assistance is required employees may call the toll free number for pre-admission review. Failure to abide by this procedure will result in the application of the lesser of a $300.00 penalty or the actual cost of such tests. Such penalty may not be used to satisfy deductibles or co-payments elsewhere in the Program.

Catastrophic Case Management

3.22 Catastrophic Case Management, which concentrates on those cases where the early identification of catastrophic and chronic illnesses or injuries can enhance the quality of care and recovery.

(a) A catastrophic case typically includes the following types of illnesses or injuries:

Illnesses	Injuries
Neonatal High Risk Infant	Major Head Trauma
Cerebrovascular Accident	Spinal Cord Injury
Cardiac Surgery	Amputations
Multiple Sclerosis	Multiple Fractures
Muscular Dystrophy	Severe Burns
Cerebral Palsy	Chronic Back Injuries
Acquired Immune Deficiency Syndrome	Knee Injuries

(b) In catastrophic or chronic illness cases, there often arises a need for medical and non-medical services and supplies for which benefits are not normally provided under this plan. Benefits will be payable under this plan for any service, supply, equipment or treatment which otherwise is not covered as long as:
- The condition of the patient, in the sole judgment of the case manager, falls into one of the profiles described in paragraph 3.22 (a);
- The services, supplies, equipment or treatment have been identified by the case manager as an acceptable care alternative, with the final approval of the patient, the patient's family, or the attending physician; and
- The services represent a less costly means of providing health care benefits required by the patient.

(c) A typical case requiring catastrophic case management generally is identified through a referral by the Company, hospital, physician, claims administrator, or other provider.

(d) Where the case manager determines that Catastrophic Case Management benefits are appropriate, the case manager will prepare an action plan outlining suggested alternatives for using these benefits to your advantage. The case manager will continue to monitor the patient's performance, including: updating the recommendations as the patient progresses, helping the family prepare for the patient's return home, and offering support during transition periods. Catastrophic Case Management benefits are available until the case manager determines that the patient has reached medical stability. Even after that point, the case manager is available to assist the patient, family, or physician, where appropriate.

(e) Benefits are provided under this Section for dependents on the same basis as for you. Such dependent benefits are provided only if the dependent is covered under the Program when services are received (the date of admission if confined in a hospital, approved rehabilitative or skilled nursing facility).

Skilled Nursing Facility Benefits

3.23 If you are admitted to an approved Skilled Nursing Facility, benefits will be provided for semi-private accommodations and all other services provided by the facility for up to 365 days provided you:

(a) are recovering from an acute illness or injury;

(b) are confined to bed with a long-term illness or injury; or

(c) have a terminal condition;

and provided (i) your condition requires professional and practical nursing care provided by a Skilled Nursing Facility and (ii) you remain under active medical supervision of a licensed physician.

3.24 If you occupy a private room in a Skilled Nursing Facility, you will be entitled to all of the above-described benefits but you will be required to pay the facility the excess, if any, of its regular charge for the private room over the facility's most common charge for semi-private rooms.

3.25 The need for confinement in a Skilled Nursing Facility must be certified by the licensed physician in charge of the case, in a form satisfactory to and as required from time to time by the claims administrator. The initial determination as to whether or not the condition is a covered condition and is of the nature to require care or continued care in such facility will be made by the claims administrator.

Definition of "Approved" Facility

3.26 A facility will be approved if:

(a) it qualifies as a Skilled Nursing Facility under Medicare, or

(b) it is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Hospitals or it meets the standards for such accreditation, and

(c) where necessary, it has been approved by the applicable area-wide Health Care Planning Agency.

Before you or your dependent enters a Skilled Nursing Facility, you should ask whether such facility meets the above requirements.

Renewal of Benefits

3.27 A new maximum benefit period will commence only when there has been a lapse of at least 90 days between the date of last discharge from a Skilled Nursing Facility and the date of the next admission to a Skilled Nursing Facility due to the same or related causes, whether or not benefits were provided for the prior admission.

Exclusions

3.28 Benefits are not payable under this provision for:

(a) confinement which is principally for custodial care;

(b) care for tuberculosis, alcoholism or drug abuse except as may be provided in Section 5;

(c) care for the deaf or blind;

(d) care for senility or mental deficiency or retardation;

(e) care for mental illness, other than for short-term convalescent care where the prognosis for recovery or improvement is deemed favorable provided that such short-term convalescent care is not provided for in Section 5;

(f) care not requiring continued professional and practical nursing care provided by a Skilled Nursing Facility;

(g) care that could be managed by an approved Home Health Care Agency where such Agency is available;

(h) expenses for which payment or reimbursement is received by or for the account of the individual as a result of a legal action or settlement;

(i) confinements, services, supplies or treatments which are not necessary according to accepted standards of medical practice;

(j) confinements, services, supplies or treatments for which no charge is made that you are legally obligated to pay or for which no charge would be made in the absence of this coverage; or

(k) confinements, services, supplies or treatments received for illness or injury due to war (declared or undeclared) or any act of war, if such illness or injury occurred while insured for this coverage.

Home Health Care Agency Benefits

3.29 If you are essentially confined to your home and require, on an intermittent basis, nursing services, therapy or other services provided by a Home Health Care Agency, and provided that the services in question are performed by or under the direct supervision of a licensed registered or practical nurse in accordance with a plan established and periodically reviewed by the physician in charge of the case, benefits will be provided for up to 100 visits in a calendar year for services provided through an approved Home Health Care Agency and for medical and surgical supplies and durable medical equipment for treatment of your condition so long as you have not used 100 visits. One visit is a personal contact in your home by (i) a health worker on the Agency's staff, or (ii) a person who is under contract or arrangement with such Agency, for the purpose of rendering one of the following types of services:

(a) nursing service by either an R.N. or an L.P.N.;

(b) physical, occupational, speech and respiratory therapy;

(c) medical social service;

(d) home health aid service;

(e) nutritional guidance;

(f) diagnostic services;

(g) oxygen and its administration; and

(h) hemodialysis

3.30 The need for the services of a Home Health Care Agency must be certified by the licensed physician in charge of the case, in a form satisfactory to and as required from time to time by the administrator. The initial determination as to whether or not the condition is a covered condition and is of the nature to require or continue to require care through such an agency will be made by the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover).

Definition of "Approved" Agency

3.31 An agency will be approved if:

(a) it qualifies as a Home Health Care Agency under Medicare, or

(b) it meets the standards of Medicare certification, and

(c) where necessary, it has been approved by the applicable area-wide Health Care Planning Agency.

Before you or your dependent arranges for services provided through a Home Health Care Agency, you should ask whether such agency meets the above requirements.

Exclusions

3.32 Benefits are not payable under this provision for:

(a) custodial care;

(b) meals;

(c) physicians' services;

(d) housekeepers' services;

(e) drugs and biologicals;

(f) services of relatives or members of patient's household;

(g) care for tuberculosis, alcoholism or drug abuse;

(h) care for the deaf or blind;

(i) care for senility or mental deficiency or retardation;

(j) care for mental illness, other than for short-term convalescent care where the prognosis for recovery or improvement is deemed favorable;

(k) expenses for which payment or reimbursement is received by or for the account of the individual as a result of a legal action or settlement;

(l) services, supplies or treatments which are not necessary according to accepted standards of medical practice;

(m) services, supplies or treatments for which no charge is made that you are legally obligated to pay or for which no charge would be made in the absence of this coverage; or

(n) services, supplies or treatments received for illness or injury due to war (declared or undeclared) or any act of war, if such illness or injury occurred while insured for this coverage.

Ambulatory Surgical Facility

3.33 If you receive surgical services in an ambulatory surgical facility, benefits under this Section are provided for operating room, recovery room and other hospital-type facility charges. Before you or your dependent undergoes treatment in an ambulatory surgical facility, you should ask the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) whether the facility is a covered ambulatory facility.

Chemotherapy

3.34 If you receive chemotherapy for treatment of malignant diseases, benefits under this Section are provided regardless of the type of facility in which treatment is rendered.

Kidney Dialysis

3.35 Benefits under this Section are provided if you receive kidney dialysis in the outpatient department of a hospital or in a kidney dialysis unit which is not connected to a hospital and for supplies and rental of home dialysis equipment used in connection with kidney dialysis when treatment is received in your home.

Hospice

3.36 Benefits are provided for hospice care. Hospice means a coordinated plan of home and in-patient care that treats the terminally ill patient and family as a unit. The plan provides care to meet the special needs of the family unit during the final stages of a terminal illness and during bereavement. Care is provided by a team made up of trained medical personnel, homemakers, and counselors. The team acts under an independent hospice administration; and it helps the family unit cope with physical, psychological, spiritual, social, and economic stresses. The hospice administration must be approved as meeting established standards including any legal licensing requirements of the state and locality in which it operates. Benefits include:

— charges for inpatient hospice care. This does not include private room charges over $150 per day;

— charges for doctor's service;

— home health services;

— emotional support services;

— homemaker services;

— bereavement services;

— drugs and medication.

This provision does not in any way amend, modify or otherwise affect the terms and conditions of the **1999** Insurance Agreement and the Program of Insurance Benefits.

Birthing Centers

3.37 Benefits are provided for services received in approved birthing centers.

An approved birthing center is:

(a) a hospital based center; or,

(b) a free-standing center which is approved by the claims administrator and meets all of the state health requirements.

Before you or your dependent enters a birthing center, you should ask the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) whether such facility is approved.

Benefits for Dependents

3.38 Benefits are provided under this section for dependents on the same basis as for you. Such dependent benefits are provided only if the dependent is covered under the Program when services are received (the date of admission if confined in a hospital, Approved Rehabilitative or Skilled Nursing Facility).

Continuation of Benefits After Termination of Coverage

3.39 If you or one of your eligible dependents is confined in a hospital, an Approved Rehabilitative Facility or a Skilled Nursing Facility on the date coverage terminates benefits continue to be provided subject to all the provisions of this Section until discharge from such hospital or facility.

What Is Not Covered

3.40 Benefits are not provided under this Section for:

(a) Convalescent or rest cures;

(b) Services not furnished by the hospital, approved facility or approved Home Health Care Agency.

(c) Personal services such as barber services, guest meals or rental of radio or television; or,

(d) Except as specifically provided in this Section, outpatient services, hospitalization primarily for diagnostic study, or hospitalization for dental processes.

(e) Friday or Saturday hospital admissions are inappropriate unless surgery is performed within 24 hours of admission or unless the admission is the result of an accident or life threatening emergency. The admission must be certified as medically necessary and approved as such under the precertification program. Failure to abide by this procedure will result in the application of a $300 penalty which may not be used to satisfy deductibles elsewhere in the Program.

(f) Hospital costs associated with any surgery defined as not covered under paragraph 3.66(d) of this plan.

(g) Services for treatment of mental illness or drug or alcohol abuse, except as may be provided in Section 5.

How to File a Claim

3.41 In order to receive benefits for covered services, you or one of your dependents should obtain claim forms from the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) or at designated pick up locations. After completion by you the form should be submitted to the hospital, approved facility or Home Health Care Agency. Generally, the provider of service will then submit your claim for benefits directly to the claims administrator for processing and payment. If the person who received the services is eligible for Medicare, it is also necessary to present the person's Health Insurance (Medicare) Card to the hospital, facility or agency.

Physicians' Services and Other Medical Expense Benefits

Payment of Benefits for Physicians' Services

3.42 Full payment, on a prevailing fee or contract basis, subject to deductibles and co-payments in paragraph 3.2, is made for the physicians' services described below. This means that, subject to certain maximums specified in this Section, this plan provides benefits for covered services, but at not more than the prevailing fee or contracted amount (where negotiated with the provider) for such service.

3.43 The prevailing fee referred to in 3.42 will be based on the following considerations:

(a) For those geographic areas of the Company which have been identified as having the Managed Care Program, the prevailing fee will be determined as follows:

(i) For physicians who are members of the Managed Care Program, benefits will be provided for the covered medical service or procedure provided you or your dependents at the contracted rate established for such medical service or procedure. Employees will not be responsible for any amounts billed in excess of the allowed charge.

(ii) For physicians who are not members of the Managed Care Program, benefits will be provided for the covered medical service or procedure provided you or your dependents at the lower of their actual billing or the rate of payment as described in 3.43 (a) (i). Employees will be responsible for all amounts over the rate of payment made for such covered services.

(b) **For those geographic areas of the Company** which have not been identified as having the Managed Care Program, the prevailing fee will be based on the lesser of **(i) the actual charge or (ii) the usual and customary charge as reported, at the time the service is rendered, by the 90th percentile** of the Health Insurance Association of America (HIAA), which collects and reports charges by procedure code, date of service and zip code.

3.44 These provisions are designed to recognize that there will be differences in physicians' charges because of such factors as the prevailing fees or charges in the geographical locality, skill of the physician, and complexity of the service performed.

3.45 The claims administrator or the Company, as applicable, will make determination as to the prevailing fee, with benefit payment made directly to you or, in the case where the covered medical service or procedure is provided by a physician enrolled in the Managed Care Program, directly to the Managed Care physician unless the physician has already received reimbursement from the employee. Therefore, you should inform your physician of your coverage for prevailing fees under this plan. If you become obligated to a physician for a charge in excess of the prevailing fee as determined, this plan will not pay such excess.

Surgical and Organ Transplant Benefits

3.46 Benefits are provided for surgical services consisting of operative and cutting procedures (including the usual post-operative care) for the treatment of illnesses, injuries, fractures or dislocations, which are performed in or out of a hospital by a licensed physician and, in the case of reduction of fractures and dislocations of the jaw, which are performed either by a licensed physician or by a doctor of dental surgery. Benefits are also provided for operative and cutting procedures for the treatment of diseases and injuries of the jaw if the surgical service is performed by a licensed physician or a doctor of dental surgery. If you are an inpatient in a legally constituted hospital, benefits will also be provided for the services of a licensed physician who actively assists the operating surgeon in the performance of such surgical services when the condition of the patient and type of surgical service requires such assistance and when the hospital does not employ surgical interns, residents or house staff who are utilized for such assistance. Benefits are also provided for stand-by physicians for angioplasty and, if approved by the pre-admission review administrator, certain Caesarean sections. Organ transplant benefits are provided under the health care plan as follows:

(a) Benefits for organ transplant procedures are provided only if the procedure is accepted in health care practice, is not experimental or investigational or its efficacy is clearly supported by the medical community and documented by a substantial body of medical research. Organ transplants are covered as any other surgical procedure and are subject to Plan deductibles, copayments and benefit maximums.

(b) For organ or tissue transplants requiring surgical removal of the donated part from a living donor to a transplant recipient, payment for covered benefits will be provided for the donor to the extent that charges for such services are not payable under any other group or individual health care plan. Benefits payable on behalf of the donor are charged to the recipient's benefit copayments and maximums under the Plan. Transplant benefits under the Plan are provided regardless of whether the individual covered under the Plan is the recipient or the donor, and benefits for covered services will be provided for both.

3.47 Surgical services which would be covered if performed by a licensed physician shall also be covered when performed by a duly licensed podiatrist acting within the scope of his or her license.

3.48 When a series of recurrent or related operations is performed in the home, the physician's office, the outpatient department of a hospital or an ambulatory surgical facility for the treatment of the same illness or injury, the maximum payment for each illness or injury shall not exceed $500.00 during any calendar year.

Obstetrical Benefits

3.49 Benefits are provided for obstetrical services, including necessary prenatal and postnatal care, furnished to you if you are a female employee or to a female dependent of yours, either in or out of a hospital, by the licensed physician in charge of the case.

Second Surgical Opinion

3.50 If you or one of your dependents is advised to have surgery, benefits are provided for a second, and, if desired, a third surgical opinion.

Covered charges for a second or third surgical opinion include:

(a) charges of the doctor who offers the second or third opinion, provided this doctor does not perform the surgery;

(b) charges for diagnostic x-ray and laboratory exams used by the doctor to form the opinion.

3.51 You or your dependent may obtain a second and a third surgical opinion from any physician you choose, other than a physician who is in practice with or has a financial association with the initial physician.

In-Hospital Medical Benefits

3.52 If you are confined as an overnight patient in a legally constituted hospital because of an illness or injury such as heart attack, pneumonia, diabetes, or contagious disease, benefits are provided for the services of the licensed physician in charge of your case up to a maximum of the number of hospital benefit days (365 or 730) to which you are entitled as provided in paragraph 3.10. Such benefits will also be provided concurrently with benefits for surgical, obstetrical and radiation therapy services when a patient has a separate and complicated condition, the treatment of which requires skills not possessed by the physician who is performing the surgical, obstetrical or radiation therapy services. If you are hospitalized for pulmonary tuberculosis, benefits are payable up to maximums provided in 3.10.

3.53 If you should be admitted to a hospital within 90 days after previous hospitalization, days of hospitalization during the earlier period will be deducted in determining the maximum number of days for which benefits are provided under paragraph 3.52 during the later period.

Benefits in Skilled Nursing Facility

3.54 If benefits are payable for confinement in a Skilled Nursing Facility, benefits are also provided during such confinement for treatment by the licensed physician in charge of the case; provided, however, that benefits will not be payable for physicians' visits in excess of two in any seven-day period, and provided further that such licensed physician is not an employee of the Skilled Nursing Facility.

Benefits for Home Health Care Agency Patients

3.55 If benefits are payable for services received from an approved Home Health Care Agency, benefits are also provided for home visits by the licensed physician in charge of the case; provided, however, that benefits will not be payable for physicians' home visits in excess of ten in any calendar year.

Anesthesia Services

3.56 Benefits are provided for the administration of anesthetics, except local infiltration anesthetic, provided either in or out of a hospital in surgical or obstetrical cases, when administered and billed by a licensed physician or CRNA, other than the operating surgeon or surgical assistant or CRNA, who is not an employee of, nor compensated by, a hospital, laboratory or other institution. Benefits will not be provided under this paragraph for anesthesia administered in connection with dental procedures for which Dental Benefits are payable under Section 6.

Radiation Therapy and Chemotherapy Benefits

3.57 Benefits are provided for treatment by X-ray, radium, external radiation or radioactive isotopes (including the cost of materials unless supplied by a hospital), provided either in or out of a hospital, when performed and billed by the licensed physician in charge of the case.

When your condition requires radiation therapy services in conjunction with medical, surgical or obstetrical services, payment will be made for such radiation therapy services in addition to the payment for such other types of services.

3.58 Benefits are also provided for expenses incurred in the treatment of malignant diseases by chemotherapy provided either in or out of the hospital when prescribed and billed for by a licensed physician.

Diagnostic X-ray or Ultrasound Services

3.59 Benefits are provided as specified below for a diagnostic X-ray examination or ultrasound when used as a substitute for X-rays with films, either in or out of a hospital, which is required in the diagnosis of any condition of illness or injury, which is customarily billed by the physician who made such examination, and which is:

(a) Ordered by a licensed physician or a doctor of dental surgery who is engaged in general or special practice other than radiology, and, when so ordered, is made by a licensed physician (excluding a doctor of dental

surgery or the doctor ordering X-ray or ultrasound examination) whose practice is limited to radiology;

(b) Made by a licensed physician (excluding a doctor of dental surgery) qualified to undertake radiological examinations within the confines of a single specialty; or

(c) Made by a licensed physician in an emergency or emergency traumatic case.

3.60 Benefits will not be provided under paragraph 3.59 for the following:

X-ray and ultrasound examinations in connection with care of teeth, research studies, screening, routine physical examinations or check-ups, pre-marital examinations, routine procedures provided on admission to a hospital, fluoroscopy without films, or any examination not necessary to diagnose an illness or injury.

Diagnostic Examinations

3.61 Benefits are provided for metabolism testing, radioactive isotope studies, cardiographic and encephalographic examinations, laboratory examinations, electromyography, pulmonary function testing, and allergy testing, either in or out of a hospital, when made or ordered and customarily billed by a licensed physician.

3.62 Benefits will not be provided under paragraph 3.61 for the following diagnostic examinations:

Examinations in connection with research studies, screening, routine physical examinations or check-ups, pre-marital examinations, routine procedures provided on admission to a hospital, or any examination not necessary to diagnose an illness or injury.

Emergency Treatment

3.63 Benefits are provided for emergency treatment received in case of an accident, if the treatment is performed by a licensed physician (except that if performed in the outpatient department of a legally constituted hospital, payment is made only to a physician who is not an employee of the hospital).

3.64 Benefits are also provided for initial treatment when the patient receives Emergency Medical Care and treatment is performed and billed by a licensed physician. "Emergency Medical Care" means services rendered for the sudden and unexpected onset of a condition or illness with severe symptoms which require immediate medical (nonsurgical) care.

Other Medical Expenses

3.65 The term "Other Medical Expenses" means the reasonable and customary charges,* as determined by the claims administrator, incurred by you or one of your dependents for the following types of medical services, supplies, and treatments which are performed or prescribed as necessary by (i) a licensed physician or (ii) a licensed podiatrist with respect to the services of a podiatrist for which benefits are payable under this plan:

*In the case of physicians' services, the prevailing fee or contract amount (where negotiated with the provider), as described in paragraphs 3.42 to 3.45 of this booklet.

(a) Services of licensed physicians **and the following specialty medical personnel operating within the scope of their license or certification and under the direction of a licensed physician:**
(i) certified registered nurse anesthetists (CRNAs)
(ii) licensed and/or certified physician's assistants (PAs) or nurse practitioners (NPs)

(b) Services of licensed podiatrists; see exclusions in paragraph 3.66(k);

(c) When private room accommodations are medically necessary, the excess of the private room rate over the hospital's most common semi-private room rate will be considered a covered medical expense, (a private room will be considered medically necessary when (i) the patient's condition requires isolation for the patient's health or that of others or (ii) the hospital has semi-private or less expensive accommodations but they are occupied and the patient's condition requires immediate hospitalization); see exclusions in paragraphs 3.66(o) and 3.66(p);

(d) Other hospital services required for medical or surgical care or treatment; see exclusions in paragraphs 3.66(o) and 3.66(p);

(e) Anesthetics and the administration thereof, except that benefits will not be provided under this paragraph for anesthesia administered in connection with dental procedures for which Dental Benefits are payable under Section 6;

(f) Laboratory services for one routine pap smear (Papanicolaou test) and an associated office visit during any calendar year;

(g) Radium treatments;

(h) Oxygen and its administration;

(i) Blood transfusions and blood administration costs, including cost of blood and blood plasma in excess of 3 pints to the extent it is not donated or replaced through a blood bank or otherwise, or cryoprecipitate;

(j) Services of a qualified physiotherapist;

(k) Services of a registered graduate nurse (R.N.), other than a nurse who ordinarily resides in the patient's home or who is a member of the patient's immediate family;

(l) Services of a licensed practical nurse (L.P.N.) under the following circumstances:

(i) in a hospital when required;

(ii) out of a hospital when required; provided, however, that services in excess of 240 hours in any calendar year will be limited to a 50% reimbursement rate.

In any event, the nurse cannot be a member of the patient's immediate family or a nurse who ordinarily resides in the patient's home and the licensed physician in charge of the case must certify that private duty nursing is required;

(m) Immunization injections, except any such injections received for the purpose of travel outside the United States;

(n) Local professional ambulance services;

(o) Rental of respiratory devices or other durable medical equipment, required for therapeutic use (in any case where durable medical equipment is needed for long-term care, you should inquire of the claims administrator as to whether the purchase of such equipment would be covered);

(p) Artificial limbs or other prosthetic appliances including replacement of such appliance if not serviceable five or more years from installation;

(q) Cosmetic surgery or treatment to the extent necessary for correction of damage caused by accident or injury while insured for this coverage;

(r) Two pairs of eyeglasses or contact lenses and examinations for the fitting and prescription thereof following a cataract operation;

(s) Any medical services, supplies, and treatments for which benefits are provided under paragraphs 3.0 to 3.64 whether or not specifically enumerated above;

(t) Benefits for hearing aids, and the examination for the prescription or filling thereof and their repair, are limited to **$1,000 per ear** in a five-year period. **Replacement hearing aid(s) will be covered if at least five years have passed since the aid(s) being replaced were purchased, provided the previous hearing aid(s) are unserviceable;**

(u) Well baby care provided to a newborn child that is incurred during the first 12 months of the child's life for routine pediatric check-ups;

(v) Benefits up to $150.00 for routine health exams
   a) every 3 years if the covered person is under age 45, or,
   b) every 2 years if the covered person is age 45 or older.

Expenses Not Covered

3.66 The following are not covered medical expenses:
(a) Dental services, treatments and appliances;
(b) Eyeglasses or contact lenses and examinations for the prescription or fitting thereof, except as provided in paragraph 3.65(r);
(c) Health check-ups and routine physical examinations except as provided in paragraph 3.65(u) and (v);
(d) Cosmetic surgery or treatment, except as provided in paragraph 3.65(q);
(e) Confinements, services, supplies or treatments covered by any workers' compensation laws or employer's liability acts, or which an employer is required by law to furnish in whole or in part;
(f) Confinements, services, supplies or treatments furnished by any governmental body (subject to the provisions of paragraphs 8.6—8.9 with respect to employees and dependents eligible for Medicare);
(g) Confinements, services, supplies or treatments received for illness or injury due to war (declared or undeclared) or any act of war, if such illness or injury shall have occurred after the most recent effective date of coverage for the major medical benefits of the Program;
(h) Confinements, services, supplies or treatments for which the individual is not required to make payment;
(i) Expenses for which payment or reimbursement is received by or for the account of the individual as a result of a legal action or settlement;
(j) Services of surgical assistants except as provided in paragraph 3.46;
(k) Treatment of corns, bunions (except capsular or bone surgery therefor), calluses, nails of the feet except surgery for ingrown nails, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except when surgery is performed;
(l) Services of any practitioner who is not legally licensed to practice medicine and surgery, except to the extent specifically provided in this plan or as required by law;
(m) Any types of services, supplies or treatments not specified as covered medical expenses in paragraph 3.65.
(n) Expenses for which benefits are not payable pursuant to paragraphs 3.8 and 3.22;
(o) Expenses incurred as a result of confinement in a Skilled Nursing Facility except as provided in paragraphs 3.23—3.28;
(p) Expenses for services provided through a Home Health Care Agency except as provided in paragraphs 3.29—3.32;
(q) Prescription drugs (benefits are provided in Section 4);
(r) Mental health and alcohol/substance abuse treatment (benefits are provided in Section 5);
(s) Any other medical service or treatment except as provided in this Section.

Date Expenses Are Incurred

3.67 Benefits are provided only for Physicians' Services and Other Medical Expenses incurred on a date when coverage by the provisions in this Section is in effect for you or your dependent who incurs such expenses. Expenses are considered to have been incurred on the date when the applicable medical services, supplies, or treatments are received.

Continuation of Benefits After Termination of Coverage

3.68 If you or one of your dependents is totally disabled when coverage for other medical benefits terminates for any reason and you are not eligible for the hospital and medical coverage for pensioners and surviving spouses pursuant to paragraphs 9.24-9.26, benefits are payable solely with respect to Other Medical Expenses incurred for the illness or injury which caused the total disability. Such benefits will be payable during the uninterrupted continuance of such total disability, as if coverage for other medical benefits had not terminated, but not beyond one year from the date such coverage terminates. In determining the amounts payable pursuant to this paragraph, benefits payable for such expenses under paragraphs 3.0 through 3.64 and under Medicare, if applicable, shall be deemed to have been paid, even though coverage under paragraphs 3.0 through 3.64 was not in effect.

How to File a Claim

3.69 Claim forms may be obtained from the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) or designated pick up location. Detailed instructions for the filing of the claim are provided on the claim form.

3.70 Since the payment of your medical claim depends upon your submitting the bills received by you for various types of expenses, it is important that you keep a record of all such expenses and all bills, receipts, and other documents relating to them.

3.71 A claim may be submitted when you or one of your dependents is required to pay more than the deductible amount, as described in paragraph 3.2, in any calendar year for Physicians' Services and Other Medical Expenses. Additional claims for which benefits are provided may be submitted periodically during the calendar year as expenses are incurred. However, in order to expedite handling of your claim it is suggested that claims involving continuing expenses such as repetitive laboratory charges, charges involving a series of visits to your physician, etc. should be presented at two- or three-month intervals. All claims should be submitted within 90 days following the end of the calendar year for which benefits are provided. In any event, all claims must be submitted no later than the end of the calendar year following the calendar year for which the benefits are provided.

Benefits for Dependents

3.72 Benefits are provided for dependents on the same basis as your own. Such dependent benefits are provided only if the dependent is covered under the Program when the services are performed.

SECTION 4
PRESCRIPTION DRUG BENEFIT PLAN

Introduction

4.0 (a) Coverage for prescription drugs will be provided exclusively through the Ispat Inland Inc. Prescription Drug Benefit Plan (the Prescription Drug Plan). The Prescription Drug Plan will be established and administered in accordance with the USWA/ISPAT INLAND Agreement on Managed Care. A third party administrator, referred to as the prescription drug benefit manager, will be responsible for (1) developing and maintaining a network of designated retail pharmacies, (2) offering a mail service option for the purchase of maintenance medications prescribed for treatment of chronic conditions or long-term illnesses, (3) managing drug utilization, (4) making payments to providers, and (5) reimbursing employees for out-of-network expenses (see "Who To Call For Benefit Information" phone numbers on inside front cover).

(b) In the event that the Prescription Drug Plan is discontinued during the period covered by the Insurance Agreement, the benefits of the former Program of Insurance Benefits II (PIB II) will apply to any prescription drug expenses incurred during the period until a replacement program is mutually designed and implemented by the Joint Union/Management Managed Care Steering Committee. Any deductibles, co-payments or stop losses that apply to prescription drug expenses incurred during the period of PIB II coverage will also be applied to the co-payments and stop losses that apply to hospital and medical expenses in PIB III.

Benefit Payment Levels and Cost of Prescription Drugs

4.1 (a) Co-payments effective 1/1/2000, by type of drug and where purchased, are shown below:

Type of Drug	Mail Service	Stop Loss	Participating Pharmacy	Yrly Stop Loss /Ind.*	Yrly Stop Loss /Fam.*	Out-Of Network Pharmacy	Yrly Stop Loss
Generic	**$5.50**	None	10%	$500	$750	**50%**	None
Brand, No Generic Available	**$13.75**	None	30%	$500	$750	**50%**	None
Brand, Generic Available**	**100%**	None	**100%**	None	None	**100%**	None

* Where it applies, the maximum total stop loss is $500 per individual and $750 per family.

****Brand name drugs that have generic equivalents will not be covered under either the mail service program or the retail pharmacy program unless the participant's physician submits satisfactory clinical evidence to the prescription drug benefit manager that there is a pharmacological or medical reason why a brand must be dispensed and the prescription drug benefit manager authorizes purchase of the brand name drug. If approved by the prescription drug benefit manager, the co-payment is $18.00 at mail service and 40% at a participating pharmacy.**

(b) The co-payments and stop losses that apply to the Prescription Drug Plan do not reduce or satisfy those elsewhere in the Program.

Coverage Limits

4.2 (a) Unless otherwise noted, benefits for prescription drugs are subject to a lifetime maximum of $250,000 per covered individual per lifetime, including any out-of-network benefits paid. Benefits paid for prescription drugs under the former Program do not count towards the $250,000 lifetime maximum.

(b) Any benefits received under the Prescription Drug Plan are also limited by the **$1,250,000** ($500,000 out-of-network) maximum for all health care benefits per covered individual per lifetime in the Program of Insurance Benefits III (PIB III).

Cost of Coverage

4.3 There is no additional cost (premium) for coverage under the Prescription Drug Plan.

How the Prescription Drug Plan Works

4.4 (a) Mail Service

(i) You can order a 14-60 day supply of medication prescribed to treat a chronic condition or long-term illness through the mail from the prescription drug benefit manager (see "Who To Call For Benefit Information" phone numbers on inside front cover).

(ii) When you purchase prescription drugs through the mail service program, include the appropriate co-payment along with your prescription in an order envelope. If you have approved a generic substitution but are not sure if it is available, include a **$13.75** co-payment with your order. A refund or credit will be sent to you if the co-payment is **$5.50.**

(b) Retail Pharmacy

(i) You can purchase up to a 30 day supply of medication.

(ii) When you purchase prescription drugs at a participating pharmacy, the pharmacist will ask you for your co-payment at the time you make your purchase.

(iii) No claim forms are required for in-network purchases.

(iv) This is a national network but if you are in a location where a network pharmacy is not available, the benefit will be paid as if in-network. You will have to pay for the drug at the time of purchase and submit a claim for reimbursement, along with a letter of explanation to the prescription drug benefit manager (see "Who To Call For Benefit Information" phone numbers on inside front cover).

(c) Your co-payments are not eligible for reimbursement under any other Ispat Inland health care plan.

The Prescription Drug Plan as Secondary Payer

4.5 If the Prescription Drug Plan is a covered dependent's secondary plan and prescription drugs are covered in their primary plan, benefits will be coordinated with the retail pharmacy program percentage schedule. Benefits otherwise payable will be reduced by benefits paid by the primary plan.

What is Covered

4.6 (a) The Prescription Drug Plan covers medically necessary medications which require a prescription written by a licensed physician and dispensed by a licensed pharmacist pursuant to Federal or State law. The Prescription Drug Plan also covers prescriptions by licensed physicians for insulin, disposable insulin syringes, and blood glucose testing agents/strips.

(b) The following drugs are subject to additional limitations:

(i) coverage for non over-the-counter smoking cessation products is limited to $700 in benefits paid per lifetime, and

(ii) benefit payments for drugs prescribed for treatment of infertility are limited to $5,000 per lifetime.

Exclusions

4.7 (a) drugs that can be purchased over-the-counter without a prescription (except for insulin),
(b) birth control pills, unless they are prescribed to treat a condition or illness,
(c) experimental drugs,
(d) diet pills without a physician's diagnosis of morbid obesity,
(e) vitamins,
(f) food and food supplements,
(g) refills of prescriptions older than one year, or
(h) drugs prescribed for cosmetic purposes.

Continuation of Benefits After Termination of Coverage

4.8 If you or one of your dependents is totally disabled when coverage for other medical benefits terminates for any reason and you are not eligible for coverage under the Program of Insurance Benefits for Eligible Pensioners and Surviving Spouses effective August 1, 1999 pursuant to paragraphs 9.24-9.26, benefits are payable solely with respect to Other Medical Expenses incurred for the illness or injury which caused the total disability except that expenses for prescription drugs will be payable under the Prescription Drug Plan. Such benefits will be payable during the uninterrupted continuance of such total disability, as if coverage for other medical benefits had not terminated, but not beyond one year from the date such coverage terminates.

SECTION 5
MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE TREATMENT BENEFIT PLAN

Introduction

5.0 (a) Coverage for mental health and alcohol/substance abuse treatment will be provided exclusively through the Mental Health and Alcohol/Substance Abuse Treatment Benefit Plan (the MH/ASA Plan). The MH/ASA Plan will be established and administered in accordance with the USWA/ ISPAT INLAND Agreement on Managed Care. A third party administrator (hereafter known as the "network manager") (see "Who To Call For Benefit Information" phone numbers on inside front cover) will be responsible for (1) developing and maintaining a network of designated providers, (2) managing care, (3) making payments to providers, and (4) reimbursing employees for out-of-network expenses.

(b) Any benefit provided in the former Program of Insurance Benefits II (PIB II) that is not specifically provided for in the MH/ASA Plan shall be covered elsewhere in PIB III.

(c) Any change in the network manager must be mutually agreed to by the Company and the Union.

(d) In the event that the MH/ASA Plan is discontinued during the period covered by the Insurance Agreement, the benefits of the former Program of Insurance Benefits II (PIB II) will apply to any mental health and alcohol/substance abuse expenses incurred during the period until a replacement plan is mutually designed and implemented by the joint Union/Management Managed Care Steering Committee. Any deductibles, co-payments or stop losses that apply to mental health and alcohol/substance abuse expenses incurred during the period of PIB II coverage will also be applied to the deductibles, co-payments and stop losses that apply to hospital and medical expenses in PIB III.

Designated Provider Concept

5.1 The MH/ASA Plan is a designated provider arrangement. Maximum coverage for any mental health and alcohol/substance abuse care is provided only when a referral is made by the network manager and the services are performed by a designated network provider. Maximum coverage will also be provided if services are rendered in a geographic area where network providers are not available, as long as a referral has been obtained.

How this Plan Works

5.2 (a) To access services, the patient (or other family member or patient representative such as the EAP coordinator) contacts the network manager's trained medical staff via a toll-free number (see "Who To Call For Benefit Information" phone numbers on inside front cover). An assessment is made, and, when medically necessary, the patient is referred for treatment to a designated network provider. The designated network provider handles all further communication with the network manager during the resultant course of treatment.

(b) If emergency hospitalization is required, the network manager must be contacted within 48 hours of admission (or 72 hours if the patient is in detoxification for substance abuse).

(c) If these procedures are not followed, the treatment is considered "out-of-network" and a lesser benefit will be provided for the period of non-compliance.

(d) Participants who receive treatment from network providers after obtaining a referral will not be required to submit a claim form.

(e) Participants who receive treatment from out-of-network providers must file a claim with the network manager in order to receive a benefit.

(f) There is no additional cost (premium) for coverage under the MH/ASA Plan.

Benefits for Mental and Nervous Care

5.3 (a) In-network, inpatient benefits are provided for hospitalization in a legally constituted hospital, or alternate or other sub-acute care in a legally constituted hospital or approved treatment facility.
Alternate care facilities include: Residential Care, Halfway House, Day Treatment Programs and Home Health Care Agency Programs. Charges of a licensed physician and medical services and supply charges associated with the hospitalization or stay in an approved facility are also covered.

(b) In-network, outpatient care is covered when treatment is performed or prescribed by a licensed physician, a licensed clinical psychologist, a licensed clinical social worker or psychiatric nurse specialist and includes the following types of services:

(i) Visits for individual psychotherapeutic treatment in the provider's office or in an approved outpatient psychiatric facility.

(ii) Visits by members of the patient's family for counseling in the provider's office or in an approved outpatient psychiatric facility.

(iii) Visits for group psychotherapeutic treatment in the provider's office or in an approved outpatient psychiatric facility.

(iv) Psychological testing by a psychologist.

(v) The following services when received in a legally constituted hospital outpatient department or approved psychiatric facility:

- Professional and other necessary ancillary services, other than services of physicians, if such service is provided through a day or night care program and is charged for by such hospital or facility as a part of regular institutional care and such program is approved by the network manager.
- Drugs and medications dispensed and charged for by such hospital or facility as a part of regular institutional care programs.
- Electroshock therapy and anesthesia related thereto.

(c) Out-of-network, inpatient benefits are provided for hospitalization in a legally constituted hospital; alternate or other sub-acute care is not covered. Charges of a licensed physician and medical services and supply charges associated with the covered hospitalization are also covered.

(d) Out-of-network, outpatient care is covered when treatment is performed or prescribed by a licensed physician or a licensed clinical psychologist. The services listed in paragraph 5.3 (b) (i), (ii), (iii), (iv), and (v) above are covered when performed by these providers.

(e) Covered psychiatric services must be rendered for treatment of certain emotional or mental conditions or illnesses which are amenable to favorable modification. Services in connection with mental deficiency or retardation are not covered.

Benefits for Alcohol/Substance Abuse Treatment

5.4 (a) In-network, benefits are provided for hospitalization in an accredited hospital or an Approved Rehabilitative Facility (including detoxification in an Approved Rehabilitative Facility), alternate or other sub-acute care from an accredited hospital or approved treatment facility. Alternate care facilities include: Residential Care Centers, Halfway House, and Day Treatment Programs. Charges of a licensed physician and professional and other services and supply charges required for your medical care and treatment are also covered.
NOTE: "Approved Rehabilitative Facility" means a facility approved by the network manager (see "Who To Call For Benefit Information" phone numbers on inside front cover) which is specifically engaged in rehabilitation of those suffering from alcoholism or drug addiction. Determination by network manager as to whether or not a facility is an Approved Rehabilitative Facility shall be conclusive.

(b) Out-of-network, benefits are provided for hospitalization in an accredited hospital; alternate or other sub-acute care is not covered. Charges of a licensed physician and professional and other services and supply charges required for your medical care and treatment are also covered.

In-Network and Out-of-Network Benefit Payment Levels

5.5 (a) Benefit payment levels for both mental health and alcohol/substance abuse treatment are contingent upon whether or not a referral for service has been obtained and service rendered by a network provider.

(b)

	Annual Deductible/ Person	Coinsurance/ Co-payment Level	Annual Stop Loss/ Person
In-Network:			
Inpatient	$0	100%	None
Alternate Care (Inpatient or Outpatient)	$0	100%	None
Outpatient		$0	$10/Office Visit None
Office Visits	$0	$10/Office Visit	None
Out-Of-Network:			
Inpatient	$100*	50%/50%	$1000
Alternate Care (Inpatient or Outpatient)	----------NO COVERAGE FOR ALTERNATE CARE-------		
Outpatient		$100*	50%/50% None
Office Visits	$100*	50%/50%	None

* The total out-of-network deductible is $100/person.

(c) The deductibles, co-payments and stop losses that apply to the MH/ASA Plan do not reduce or satisfy those elsewhere in the Program of Insurance Benefits III.

(d) In-network, the copayment for office visits will be waived for 120 days following an inpatient stay.

(e) participants are not responsible for any charges in excess of allowed charges when treatment is rendered in-network.

(f) Participants who use out-of-network providers may be required to pay the bill in full at the time service is received and will be responsible for any charges in excess of the MH/ASA Plan's allowed charges.

Coverage Limits

5.6 (a) In-network benefits for alcohol/ substance abuse treatment are limited to a lifetime maximum of $150,000 per covered individual, including out-of-network substance abuse benefits paid.

(b) Any benefits received under the MH/ASA Plan are also limited by the **$1,250,000** maximum for all health care benefits per covered individual in the Program of Insurance Benefits III (PIB III) and the Program of Insurance Benefits for Eligible Pensioners and Surviving Spouses Effective January 1, 1994.

(c) Out-of-network benefits are subject to the following limitations:

	MENTAL HEALTH	ALCOHOL/SUBSTANCE ABUSE	
	#DAYS/YR	#DAYS/YR	#STAYS/LIFETIME
Inpatient	30 Days	Up to 3 Detox Up to 28 Rehab	2 Stays/Lifetime

The MH/ASA Plan as Secondary Payer

5.7 If this plan is secondary to another group health care plan, in-network benefits will be coordinated only if the network manager is contacted prior to care being rendered. Failure to contact the network manager will result in benefits of the primary plan being coordinated with out-of-network benefits in the MH/ASA Plan. If the primary plan is also a managed care plan, the network manager will make certain any participant who has secondary coverage under the MH/ASA Plan is following the rules of his/her primary plan and therefore receiving maximum benefits under the primary plan. If maximum benefits are not received then in-network benefits will be coordinated with benefits from the primary plan as if maximum benefits had been received. If the primary plan is not a managed care plan, then the guidelines of the MH/ASA Plan must be followed in order for the MH/ASA Plan to coordinate the benefits of the primary plan with in-network benefits; otherwise, out-of-network benefits will apply.

Relationship to the Employee Assistance Plan

5.8 (a) It is the intent of this agreement to build a partnership between the network manager and the Company Employee Assistance Plan and the Union's Member Assistance Committee. The MH/ASA Plan does not replace any of the current Employee Assistance Plan services.

(b) The EAP will make every effort to coordinate referrals through the network manager. Any hospital admission authorized through the EAP without the knowledge or approval of the network manager will be treated as an in-net-work admission. The network manager will be fully cognizant of the services offered through the EAP and will seek to use them when appropriate. Prior to implementation, the network manager, Union Member Assistance Committee representatives and EAP personnel will meet to train, agree on providers (including doctors and hospitals), and insure cooperation among all parties.

Continuation of Benefits After Termination of Coverage

5.9 (a) If you or one of your eligible dependents is confined in a hospital, an Approved Rehabilitative Facility or a Skilled Nursing Facility on the date coverage terminates, benefits will continue to be provided subject to all of the provisions of the MH/ASA Plan until discharge from such hospital or facility.

(b) If you or one of your dependents is totally disabled when coverage for other medical benefits terminates for any reason and you are not eligible for coverage under the Program of Insurance Benefits for Eligible Pensioners and Surviving Spouses effective January 1, 1994 pursuant to paragraphs 9.24-9.26, benefits will be provided solely with respect to Other Medical Expenses incurred for the illness or injury which caused the total disability. Such benefits will be provided during the uninterrupted continuance of such total disability, as if coverage for other medical benefits had not terminated, but not beyond one year from the date such coverage terminates.

SECTION 6.
DENTAL BENEFIT PLAN

Payment of Benefits

6.0 If you or one of your dependents while covered for Dental Benefits incurs Covered Dental Expenses, as described in paragraph 6.6 benefits will be provided, subject to the co-insurance and maximums specified in this section in accordance with an agreed upon fee schedule, copies of which are available to employees from the dental claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover). Effective January 1, 1987 dental care may be rendered and will be covered under Section 6 under either of the following programs:

(a) Employees and/or dependents may seek service from any dental provider of their choice subject to a $50.00 deductible for each family during any year (January 1 - December 31) except for preventive care procedures which are reimbursed at 100%. Such deductibles will not be used to reduce deductibles elsewhere in the Program. Employees will be responsible for co-insurance amounts defined in this Section. The Company's coverage is limited to the maximums of this Section and those stated in the schedule.

(b) Employees and/or dependents may seek service from dental providers who are part of a preferred provider organization which has agreed to provide service for the rates stated in the schedule of benefits. Employees will be responsible for co-insurance amounts and subject to the maximums defined in this Section but will not be subject to any deductibles. The Company will make every reasonable effort to identify preferred provider organizations to offer such coverage.

Maximum Benefits

6.1 (a) The maximum benefit payable for all Covered Dental Expenses incurred during any calendar year, except for services described in paragraphs 6.6(b), 6.6(d) and 6.6(f) below, shall be **$2,000** for services performed by dental providers who are part of the participating provider organization and **$1,500** for services performed by all other dental providers, for you and each of your covered dependents.

(b) The maximum benefit payable for covered dental expenses in connection with orthodontic diagnostic procedures and treatment described in paragraph 6.6(f) below shall be **$2,100** during the lifetime of each individual.

NOTE: If the former **$1,800** maximum lifetime orthodontia benefits have been paid on behalf of a dependent child whose course of treatment will extend beyond **August 1, 1999**, and who has not attained age 20, you may file a claim for expenses incurred on and after **August 1, 1999**, to the extent of the higher lifetime maximum (see paragraph 6.9).

(c) In applying the calendar year and lifetime maximums referred to in (a) and (b) above, benefits for Covered Dental Expenses paid under any other group insurance plan or program toward the cost of which the Company contributes shall be considered to have been paid under the Program.

Claims Not Requiring Predetermination of Coverage

6.2 When Covered Dental Expenses under 6.1(a) above are incurred by you or one of your dependents for emergency treatment, routine oral examination, x-rays, prophylaxis, fluoride treatments, or a course of treatment, the charge for which is not expected to exceed $300, predetermination of benefits (paragraphs 6.3—6.5) is not required. For those services not payable at 100%, the remaining 15% or 50% of the rate prescribed in the fee schedule is your responsibility. If you incur a charge which is in excess of the rate(s) prescribed in the fee schedule for a procedure not requiring predetermination of benefits, the program will not pay such excess charge.

Claims Requiring Predetermination of Coverage

6.3 If a course of treatment under 6.1(a) above for you or one of your dependents can reasonably be expected to incur Covered Dental Expenses of $300 or more, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with the claims administrator prior to the commencement of the course of treatment.

As used herein "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more dentists for the treatment of a condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct

or treat such diagnosed dental condition.

6.4 For treatment covered under 6.1(a) above, the dental claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) will notify you and your dentist of the benefits certified as covered for such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services, or courses of treatment that may be performed for such dental condition in order to accomplish the desired result. The amount included as certified dental expenses will be the appropriate amount determined in accordance with the rate(s) prescribed in the dental fee schedule subject to the maximums set forth in paragraph 6.1 above and the limitations set forth in paragraph 6.7 below. If you and your dentist agree to a charge higher than the amount prescribed in the dental fee schedule, such excess will not be paid by this plan.

6.5 If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, the dental claims administrator reserves the right to make a determination of benefits payable taking into account alternate procedures, services or courses of treatment, based on accepted standards of dental practice.

Covered Dental Expenses

6.6 Covered Dental Expenses are those incurred in connection with the following dental services which are performed by (i) a licensed dentist practicing within the scope of his or her license, or (ii) a licensed physician authorized by his or her license to perform the particular dental services rendered but only to the extent such charges are for services and supplies customarily employed for treatment of that dental condition and only if rendered in accordance with accepted standards of dental practice:

(a) Benefits for the following Covered Dental Expenses are payable at 100% of the rate prescribed in the dental fee schedule:
   (1) Routine oral examinations and prophylaxis (scaling and cleaning of teeth), but not more than twice in any period of 12 consecutive months;
   (2) Oral examinations performed to determine the need for and, if required, to plan a course of orthodontic treatment. Periodic examinations used to monitor the progress of such treatment are not considered "oral examinations" for the purpose of this paragraph;
   (3) Topical application of fluoride (the direct application of fluoride to the exposed surfaces of the teeth to inhibit or retard the incidence of cavities);
   (4) Topical application of sealants to the first and second permanent molars for eligible dependents up to age 14 limited to one per lifetime;
   (5) Space maintainers (a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost teeth for dependent children under 19 years of age;
   (6) Emergency treatment for temporary relief of pain which does not effect a definite cure;
   (7) Administration of general anesthetics, intravenous sedation, analgesia, and substances or agents which are administered to minimize fear (except local infiltration anesthetic) if the patient is handicapped by cerebral palsy, mental retardation or spastic disorders; and
   (8) Administration of general anesthetics, when medically necessary, and intravenous sedation (except local infiltration anesthetic) provided either in or out of a hospital, and administered in connection with oral or dental surgery, except as provided in paragraph 6.6(b)(7). Benefits are not provided for substances or agents which are administered to minimize fear, or for analgesia, except as provided in (a)(7) above.

(b) Benefits for the following Covered Dental Expenses are also payable at 100% of the usual, reasonable and customary charge and are not subject to the maximum benefit referred to in paragraph 6.1(a):
   (1) Surgical removal of impacted teeth if you are admitted as an inpatient to an accredited hospital or an accredited dental hospital; and surgical removal of impacted teeth if partially or completely covered by bone, either in or out of the hospital;
   (2) Dental root resection (apicoectomy);
   (3) Excision of radicular or dentigerous cyst;
   (4) Alveolectomy on an area covering at least six consecutive tooth sockets when performed (i) during an inpatient hospital confinement, either as an independent procedure or at the time of extraction of teeth, or (ii) out of the hospital as an independent procedure (not at time of extraction of teeth); alveolectomies not covered herein are covered under 6.6(c)(3);
   (5) Excision of tori;
   (6) Frenectomy when performed as an independent procedure; and
   (7) Administration of anesthetics in accordance with paragraphs 6.6(a)(7) and 6.6(a)(8) when required in

connection with the Covered Dental Expenses referred to in (1) through (6) above.

(c) Benefits for the following Covered Dental Expenses are payable at 85% of the rate prescribed in the dental fee schedule:

(1) Full mouth X-rays (but not more than once in any period of 36 consecutive months), supplementary bite-wing X-rays (but not more than twice in any period of 12 consecutive months) and such other dental X-rays as are required in connection with the diagnosis of a specific condition requiring treatment except X-rays provided in connection with orthodontic diagnostic procedures and treatment;

(2) Extractions, except those described in (b)(1) above;

(3) Oral surgery, except as described in (b) above;

(4) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased teeth;

(5) Treatment of diseases of the gums and other tissues of the mouth;

(6) Endodontic treatment (those procedures usually employed for prevention and treatment of diseases of the dental pulp and the area surrounding the tip of the tooth root), including root canal therapy, except as described in (b)(2) above;

(7) Injection of antibiotic drugs by the attending dentist;

(8) Repair or recementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months; and

(9) Inlays, onlays, gold fillings, or crown restoration to restore diseased teeth, but only when the tooth, as result of extensive caries, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration.

(d) Benefits for Covered Dental Expenses incurred for correction of damage caused by an accident occurring while covered for the Dental Benefits of this plan are payable at 85% [100% in case of Covered Dental Expenses described in paragraph 6.6(a)] of the usual, reasonable and customary charge and are not subject to the maximum benefit referred to in paragraph 6.1(a) and (b).

(e) Benefits for the following Covered Dental Expenses are payable at 50% of the rate prescribed in the dental fee schedule:

(1) Initial installation of fixed bridgework to replace missing natural teeth (including inlays and crowns as abutments except periodontal splinting), and implants payable to the extent of the least expensive alternate process;

(2) Initial installation of partial or full removable dentures to replace missing natural teeth and adjacent structures (including precision attachments which can be justified as functionally necessary with study models and radiographs) and any adjustments during the six-month period following installation;

(3) Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

(i) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or

(ii) the existing denture or bridgework cannot be made serviceable and it was installed at least five years prior to its replacement; or

(iii) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place with in 12 months from the date of initial installation of the immediate temporary denture.

Normally, dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a Covered Dental Expense.

(f) **Benefits for the following Covered Dental Expenses are payable at 85% of the rate prescribed in the dental fee schedule:**

Orthodontic diagnostic procedures (including X-rays) and treatment consisting of appliance therapy and surgical therapy (the surgical repositioning of the jaw, facial bones and/or teeth to correct malocclusion) for dependent children under 19 years of age. If orthodontic treatment commences prior to the dependent child's attainment of age 19, benefits will be payable for services thereafter, but not beyond the end of the month in which the child attains age 20. (Related oral examinations, surgery and extractions are covered under paragraphs 6.6(a)(2), 6.6(b) and 6.6(c)(2) and (3), and are not considered "orthodontic diagnostic procedures and treatments".)

NOTE: If benefits terminated because your dependent child attained age 19 and such dependent child is not yet age 20, you may file a claim for expenses incurred on and after August 1, **1999** (see paragraph 6.9). **Also, if the former 50% orthodontic benefit has been paid on behalf of a dependent child whose course of treatment will extend beyond August 1, 1999, and who has not attained age 20, you may file a claim for expenses incurred on and after August 1, 1999, to the extent of the higher percentage (see paragraph 6.9).**

Orthodontic treatment means preventive and corrective treatment of all those dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as a result of accidental injury and which require repositioning (except for preventive treatment) of teeth to establish normal occlusion.

Limitations

6.7 The following limitations apply:

(a) Restorative:

(1) Gold, baked porcelain restorations, crowns and jackets — If a tooth can be restored with a material such as amalgam, payment of the applicable percentage of the charge for that procedure will be made toward the charge for another type of restoration which you and your dentist may select. In such case, you are responsible for the balance of the treatment charge.

(2) Reconstruction — Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to alter vertical dimension in restoring occlusion are considered optional and their cost remains your responsibility.

(b) Prosthodontics:

(1) Partial Dentures — If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision appliance that you and your dentist may choose to use; the balance of the cost remains your responsibility.

Precision Attachments — Benefits will not be provided for precision attachments when used for cosmetic purposes.

(2) Dentures — If, in the provision of denture services, you and your dentist decide on personalized or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment and the balance of the cost remains your responsibility.

(3) Replacement of Existing Dentures or Fixed Bridgework — Replacement of an existing denture or fixed bridgework will be a Covered Dental Expense only if the existing denture or fixed bridgework is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a Covered Dental Expense only if at least five years have elapsed since the date of the initial installation of that appliance.

(c) Orthodontics:

(1) If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services shall be resumed to the extent of the remaining maximum lifetime benefit applicable to such individual.

(2) The benefit payment for orthodontic services shall be only for months that coverage is in force.

(d) Courses of Treatment in Progress on Effective Date of Dental Benefits:
Benefits are not provided for treatment received prior to commencement of coverage. Claims for a course of treatment which was started prior to commencement of coverage but completed while coverage is in force will be investigated to determine the amount of the entire fee which should be allocated to the treatment which was actually received while covered. Only that portion of the total fee which can be allocated to treatment received while covered will be included as a Covered Dental Expense.

Exclusions

6.8 The following are not Covered Dental Expenses:

(a) Services other than those specifically covered herein;

(b) Charges for treatment by other than a licensed dentist or licensed physician, except that (1) charges for scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the dentist; and (2) charges by a dental school if (i) the services are not experimental, (ii) the dental school customarily charges for services and (iii) the services are performed under the supervision of a licensed dentist;

(c) Charges for veneers (the coating or covering of plastic or porcelain on the outside of and bonded to a crown or false tooth to cause it to blend with the color of surrounding teeth) or similar properties of crowns and pontics placed on or replacing teeth, other than the 10 upper and lower anterior teeth;

(d) Charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;

(e) Charges for prosthetic devices (including bridges), crowns, inlays and onlays, and the fitting thereof which were ordered while the individual was not covered for Dental Benefits, or which were ordered while the individual was covered for Dental Benefits but are finally installed or delivered to such individual more than 60 days after termination of coverage;
As used herein "ordered" means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays and onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.

(f) Charges for the replacement of a lost, missing, or stolen prosthetic device if less than 5 years old;

(g) Charges for replacement or repair of an orthodontic appliance;

(h) Services, supplies or treatments covered by any workers' compensation laws or employer's liability acts, or which an employer is required by law to furnish in whole or in part;

(i) Charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer;

(j) Charges for services or supplies for which no charge is made that you are legally obligated to pay or for which no charge would be made in the absence of dental coverage;

(k) Charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;

(l) Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature;

(m) Charges for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;

(n) Services, supplies or treatments which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body (subject to the provisions of paragraphs 9.6—9.9 with respect to employees and dependents eligible for Medicare);

(o) Charges for any duplicate prosthetic device or any other duplicate appliance;

(p) Charges for any services to the extent for which benefits are payable under any health insurance program supported in whole or in part by funds of the Federal Government or any state or political subdivision thereof;

(q) Charges for sealants (materials, other than fluorides, painted on the grooves of the teeth in an attempt to prevent future decay) except as provided for in paragraph 6.6(a)(4) and for oral hygiene and dietary instruction;
(r) Charges for a plaque control program (a series of instructions on the care of the teeth);
(s) Charges for periodontal splinting.

Date Expenses Are Incurred

6.9 Benefits are provided only for Covered Dental Expenses incurred on a date when coverage by the Dental Benefits provisions in this Section is in effect for you or your dependent who incurs such expenses. Covered Dental Expenses are considered to have been incurred on the date when the applicable dental services, supplies, or treatments are received, except as otherwise provided in paragraph 6.8(e).

How to File a Claim

6.10 You should obtain a claim form, which includes instructions for filing a claim, from the dental claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) or designated pick-up locations.

Proof of Claim

6.11 The insurance carrier reserves the right at its discretion to accept, or to require verification of, any alleged fact or assertion pertaining to any claim for Dental Benefits. As part of the basis for determining benefits payable, the dental claims administrator may require submission of X-rays and other appropriate diagnostic and evaluative materials. When these materials are unavailable, and to the extent that verification of Covered Dental Expenses cannot reasonably be made by the carrier based on the information available, benefits for the course of treatment may be for a lesser amount than that which otherwise would have been payable.

SECTION 7.
VISION CARE BENEFIT PLAN

Payment of Benefits

7.0 If you or one of your dependents while covered for Vision Care Benefits incur Covered Vision Expenses, benefits are payable under this plan subject to the frequency limitations and maximums set forth in this Section.

Covered Vision Expenses

7.1 "Covered Vision Expenses" are those incurred in connection with the following vision care services:

(a) Vision examination performed by an ophthalmologist (or other physician licensed to perform vision examinations and prescribe lenses) or optometrist to evaluate the health and visual status of the eyes. An examination usually includes: case history, visual acuity (clearness of vision), external examination and measurement, interior examination with ophthalmoscope, pupillary reflexes and eye movements, retinoscopy (shadow test), subjective refraction, coordination measurements (far and near), tonometry (glaucoma test), medicating agents for diagnostic purposes, if applicable, and analysis of findings with recommendations and a prescription if required.

(b) Two glass lenses when prescribed by an ophthalmologist (or other physician licensed to perform vision examinations and provide lenses) or optometrist. At your option, plastic lenses, tints equal to Tints #1 and #2, or contact lenses may be substituted for glass lenses. Lenses should meet the Z80.1 or Z80.2 standards of the American National Standards Institute.

(c) Frame adequate to hold lenses.

(d) Dispensing services performed by an ophthalmologist (or other physician licensed to perform vision examinations and prescribe lenses), optometrist or optician who, based on the prescription, prepares or orders the eyeglasses or contact lenses selected, verifies the accuracy of the lenses and assures that the eyeglasses or contact lenses fit properly.

Note: You may utilize duplicate copies of a prescription for which a vision examination benefit is payable under either this plan or a Company safety glass program to obtain lenses and frames under both programs if you are otherwise eligible under both programs and comply with the procedures of each.

Schedule of Benefits

7.2 Subject to the frequency limitations of paragraph 7.4:

(a) Benefit payment will be made for the actual charge for a vision examination as outlined in paragraph 7.1(a), but not more than **$35** per examination.

(b) Benefit payment will be made for the actual charge for lenses as outlined in paragraph 7.1(b), but not more than:

Type of Lens	Benefits Per Lens
Single Vision	**$25**
Bifocal	**$30**
Trifocal	**$35**
Lenticular	**$40**
Contact	**$35**

(c) Benefit payment will be made for the actual charge for a frame as provided in paragraph 7.1(c), but not more than **$60** per frame.

Note: Benefit payments for lenses and a frame set forth in paragraph 7.2(b) and (c) include the allowance for dispensing services.

Providers of Services

7.3 This plan does not restrict your choice as to whom you select to provide vision care services; [however, the Company will identify providers of such services who are willing to perform the above services for the amounts identified in the schedule.]

Frequency Limitations

7.4 If you or one of your dependents had previously received a vision examination, lenses or a frame, benefits will be payable for a subsequent vision examination, lenses or a frame only if two or more years have elapsed since the date of the previous examination for which benefits were paid under this plan or the date the prior lenses or frame were ordered and for which benefits were paid under this plan.

Exclusions

7.5 Covered Vision Expenses do not include and benefits are not payable for:

(a) Services or supplies for which the insured person is entitled to benefits under any other Section of this plan or as provided under a Company safety glass program;

(b) Sunglasses (tinted lenses with a tint other than Tints #1 or #2 are considered to be sunglasses for the purposes of this exclusion);

(c) Extra charges for photosensitive or anti-reflective lenses;

(d) Drugs or any other medication not administered for the purpose of a vision examination;

(e) Medical or surgical treatment of the eye;

(f) Special or unusual procedures such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonic lenses and tonography;

(g) Vision examination rendered and lenses or frames ordered:
   (1) before the person became eligible for Vision Care Benefits coverage; or
   (2) after termination of Vision Care Benefits coverage;

(h) Lenses or frames ordered while covered for Vision Care Benefits, but delivered more than 60 days after termination of such coverage;

(i) Services or supplies not prescribed as necessary by a licensed physician, optometrist or optician;

(j) Charges for services or supplies which are experimental in nature;

(k) Replacement of lenses or frames which are lost or broken unless at the time of such replacement the covered person is otherwise eligible under the frequency limitations set forth in paragraph 7.4;

(l) Services or supplies covered by any workers' compensation laws or employer's liability acts, or which an employer is required by law to furnish in whole or in part;

(m) Services or supplies for which no charge is made that you are legally obligated to pay or for which no charge would be made in the absence of Vision Care Benefits coverage;

(n) Services or supplies which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body (subject to the provisions of paragraphs 9.6-9.9 with respect to employees and dependents eligible for Medicare).

NOTE: Certain of the services and supplies excluded above may be payable under other Sections of the Program.

How to File a Claim

7.6 Obtain a vision care claim form, which includes instructions for filing a claim, from the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) or other specified location at the plant or office where you work. Complete your portion of the claim form following instructions provided.

SECTION 8.
GENERAL PROVISIONS RELATING TO HEALTH CARE BENEFITS

Nonduplication (Coordination of Benefits)

8.0 The health care benefits (Hospital and Related Benefits, Physicians' Services, Other Medical, Prescription Drugs, Mental Health and Alcohol/Substance Abuse Treatment, and Dental and Vision Care) otherwise provided under this Program are subject to the following nonduplication provisions:

(a) The health care benefits of the Program will not be payable to the extent they are or could be provided for upon proper application and/or payment of appropriate premium under any other group plan if the other plan
   (1) does not include a coordination of benefits or nonduplication provision, or
   (2) includes a coordination of benefits or nonduplication provision and is the primary plan as compared to the Program.

(b) Any spouse who is required to pay premiums to his/her employer or employer's carrier for primary coverage in excess of **$120** per year will be reimbursed by the Company for such excess on a quarterly basis upon proper application by the employee on a form provided by the Company.

NOTE: No provision of this agreement shall be construed to require your spouse to pay premiums for dependent coverage under any other employer group plan **or to pay premiums for his/her health care under any other employer group plan if your spouse works part-time (defined as less than 32 hours per week)**. However, if your spouse pays premiums for dependent child(ren) coverage under his/her employer's group plan and that coverage is the primary coverage, the premiums will be eligible for reimbursement under (b) above.

(c) In determining whether the Program or another group plan is primary, the following will apply:
   (1) The plan, whether group or prepayment, covering the patient other than as a dependent, will be the primary plan.
   (2) Where both plans cover the patient as the natural or adopted dependent child of parents who are not divorced from each other, the plan of the parent whose birthday occurs first in the year will be the primary plan, except if the other plan has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan shall determine the order of benefits.

NOTE: If both parents are covered under any group insurance plan toward the cost of which the Company contributes at the locations listed in Exhibit A, the parents may elect to cover their dependent children under either parent's plan.

   (3) Where both plans cover the patient as a dependent child of divorced parents, benefit determination will be as follows:
      (i) if there is a court decree which establishes financial responsibility for the medical, dental, vision or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other plan which covers the child as a dependent;
      (ii) if there is no court decree and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody;
      (iii) if there is no court decree and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers that child as a dependent of the stepparent, but the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.
   (4) Where the determination cannot be made in accordance with (1), (2), or (3) above, the plan which has covered the patient for the longer period of time will be the primary plan.
   NOTE: In any case where the Program is determined to be secondary pursuant to (a) above, or this paragraph (c), benefits otherwise payable under this Program are reduced by benefits payable by the

other plan.

(d) As used herein, "group plan" means (1) any plan covering individuals as members of a group and providing health care benefits or services through group insurance or a group prepayment arrangement, or (2) any plan covering individuals as employees of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

(e) If it is determined that benefits under the Program should have been reduced because of benefits provided or available under another group plan, the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) or carrier will have the right to recover any payment already made which is in excess of its liability. Similarly, whenever benefits which are payable under the Program have been provided under another group plan, the claims administrator or carrier may make reimbursement direct to the insurance company or other organization providing benefits under the other plan.

(f) For the purpose of this provision, the claims administrator or carrier may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage.

(g) Any person claiming benefits under the Program must furnish the claims administrator or carrier such information as may be necessary for the purpose of administering this provision.

Definition of Dependents

8.1 The term "dependents" includes only:

(a) Your spouse.

(b) Your unmarried children under 19 years of age. Such children include (1) a blood descendant of the first degree, (2) a legally adopted child (including a child living with the adopting parents during the period of probation), (3) a stepchild residing in your household, or (4) a child permanently residing in the household of which you are the head and actually being supported solely by you, provided you are related to the child by blood or marriage or are the child's legal guardian.

(c) Children after attainment of age 19 but not beyond attainment of age 25, if, in addition to otherwise meeting the definition of dependent children as contained in (b), such dependent is: a full-time student in a recognized course of study or training, not employed on a regular full-time basis, and not otherwise covered under any other employer group insurance or prepayment plan. Also, to be eligible for coverage as a dependent under this provision, the child must have been eligible for coverage as a dependent prior to attainment of age 19. (See paragraph 9.32)

(d) Children after attainment of age 19 while incapable of self-support because of a disabling illness or injury that commenced prior to age 19 provided such child was eligible for coverage as a dependent prior to attainment of age 19. Such children must otherwise meet the definition of dependent children as contained in (b) and must be principally supported by you. (See paragraph 9.36)

8.2 To be eligible for dependent coverage, proof may be required that the dependent meets the requirements stated above; special certification will be required to qualify dependents under paragraph 8.1(c) and (d).

8.3 The term dependents does not include a person who is covered under any other group insurance plan or program toward the cost of which the Company contributes or who is covered as an employee under this Program.

Change in Family Status

8.4 It is important that you give prompt written notice on the prescribed form of any change in your family status, such as marriage or divorce, birth of a child, marriage of any of your dependent children, or death of any dependent.

8.5 If you are enrolled for personal coverage only and thereafter marry or otherwise acquire a dependent, dependent coverage will become effective on the date you acquire the dependent, if you notify the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) promptly. If you do not notify the claims administrator within 30 days after the date you acquire the dependent, you may be required to submit proof of such date.

Medicare

8.6 You or a dependent of yours may, upon proper application, be entitled to Medicare Part A and Medicare Part B by reason of attainment of age 65, disability or end-stage renal disease. The Company will consider you or your dependent to be entitled to Medicare coverage on the first day of the month of entitlement whether or not proper application has been made, except as set forth in paragraph 8.7.

8.7 If, while you are an active employee, you or your dependent is age 65 or over, the Company will consider you or your dependent to be entitled to Medicare coverage on the first day of the month you retire. The Program will be considered to be the primary plan if you are an active employee, unless you or your dependent elect Medicare coverage prior to your retirement. If Medicare coverage is elected the Company will not reimburse you for any Medicare premiums charged or provide any benefits under the Program.

8.8 Medicare coverage will be considered to be the primary coverage if you or your dependents become eligible for such coverage by reason of end-stage renal disease. Benefits under the Program will continue to be paid for the first 30 months of dialysis treatment, since Medicare benefits are not payable for the first 30 months. Subsequently, benefits under the Program will be reduced by benefits which you receive under Medicare.

8.9 It is most important that if you or a dependent of yours becomes eligible for primary coverage under Medicare by reason of end-stage renal disease, you or your dependent enrolls in Medicare Parts A & B. The Company will reimburse you for any Medicare B premiums charged for primary Medicare coverage. Timely enrollment will avoid the loss of valuable protection against medical expenses. You must also immediately advise the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) of the effective date of Medicare coverage applicable to you or one of your eligible dependents. Failure to do so could result in an overpayment of benefits which you would have to repay.

Benefits While Traveling Outside the United States or Puerto Rico

8.10 If you are hospitalized and/or treated by a physician while traveling outside the United States or Puerto Rico, you will probably be required to pay the provider for such services since hospitals and physicians in foreign countries generally do not accept assignments or Medicare identification cards. Be sure to obtain itemized receipts detailing the dates and types of services performed and the charges incurred. Such receipts are then to be submitted for reimbursement on the same basis as if the expenses were incurred in the United States. If you are eligible for Medicare but Medicare benefits are not payable because Medicare does not cover care outside the United States (except for certain services incurred in Canada or Mexico), benefits will be provided under the Program as if you were not eligible for Medicare.

Other Provisions

8.11 Notwithstanding any contrary provision of the Program, the following will apply:

(a) Regardless of medical necessity, sterilization and reversal procedures will be covered under Section 3 of the Program.

(b) The maternity and obstetrical benefits of the Program are provided for elective abortions where permitted by law.

(c) For any type of human organ or tissue transplant requiring surgical removal of the donated part from a living donor to a transplant recipient, benefits under Section 3 of the Program are payable as follows:

(1) When the transplant recipient and donor are both covered under the Program, payment for covered services will be provided for both.

(2) When the transplant recipient is covered under the Program but the donor is not, payment for covered services will be provided for both the recipient and the donor to the extent that charges for such services are not payable under any other insurance. Benefits payable on behalf of the donor are charged to the recipient's claim.

(3) When the transplant donor is covered under the Program but the recipient is not, payment for covered services attributable to the donor will be provided to the extent that charges for such services are not payable under any other insurance. Payment will not be provided for services attributable to the recipient.

Joint Managed Care Committee

8.12 The USWA recognizes the importance of joint Union-Management participation in the implementation of a Managed Care Program* for active employees and future retirees.

8.13 The parties agree to establish a Joint Managed Care Steering Committee comprised of an equal number of representatives of each party accountable for the development and implementation of the Managed Care Program. The Joint Managed Care Steering Committee will direct a Working Committee charged with the following responsibilities:

(a) Design of the Managed Care Program, Section 12.1.
(b) Selection of networks, network managers, managed care vendors and health care providers, (hereafter referred to as "vendors") where appropriate.
(c) Agree on the standards and criteria set forth in Section 12.2 below and ensure that all segments of the Managed Care Program achieve substantial compliance with same.
(d) Ensure successful implementation of the Managed Care Program, including development of communication materials for participants.
(e) Provide ongoing management and monitoring of the Managed Care Program, including meeting regularly with vendors.
(f) Promptly resolving issues concerning the ongoing compliance of all segments of the Managed Care Program with the proposed standards and criteria.

8.14 In addition to the aforementioned responsibilities of the Working Committee, a number of protocols will be utilized to guide the Working Committee and serve as ground rules concerning the implementation of a Managed Care Program. These protocols are included in Section 12.1.

8.15 In recognition of the importance of the Program, the Company will pay the expenses of the Joint Managed Care Steering Committee and the Working Committee, including the reasonable use of jointly selected outside sources experienced in Managed Care and/or Health Care Cost Containment to assist the Working Committee with their efforts. If members of the Working Committee fail to agree on the selection of such outside sources, the issue shall be referred to the Joint Managed Care Steering Committee for resolution. If the issue cannot be resolved by the Joint Managed Care Steering Committee, it will be referred to the Co-Chairmen of the Negotiating Committee for resolution.

* As used herein, Managed Care Program is the sum of all the networks and managed care efforts that will be put in place to address different covered health care benefit categories, e.g. prescription drugs, dental, vision, etc.

Medical Necessity

8.16 Health Care Benefits under the Program are payable only if the services rendered are medically necessary.

MEDICALLY NECESSARY means that the services and supplies in question are medically reasonable and necessary for the diagnosis or treatment of an illness or accidental injury and are given at the appropriate level of care. The fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary. In determining questions of reasonableness and necessity, due consideration shall be given to the customary practices of physicians in the community where the service is performed. Services which are not reasonable and necessary shall include, but are not limited to the following:

(1) procedures which are experimental or of unproven or questionable current usefulness;
(2) procedures which tend to be redundant when performed in combination with other procedures;
(3) diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly;
(4) procedures which are not ordered by a physician or which are not documented in timely fashion in the patient's medical record; and
(5) procedures performed in an inpatient setting which could be performed with equal safety and effectiveness in an outpatient setting or treatment which can be performed with equal efficiency and quality at a lower level of care.

SECTION 9
GENERAL

Eligibility

9.0 You will be eligible to participate in the Program if you are actively at work on or after the date the Program becomes effective, in the regular service of the Company in a group of employees designated by the Company as covered by the Program. If you are enrolled in the Program more than once because you are in more than one of such groups, you will be deemed to have only that coverage which provides you the highest benefits.

Part-Time Employees

9.1 If you are a part-time employee (an employee who for the mutual convenience of the employee and the Company is regularly scheduled to work fewer hours than the straight-time schedule of full-time employees), the following applies to you:

(a) The amount of your life insurance and the amount of your sickness and accident weekly benefit, as determined from the amount as specified in Sections 1 and 2, will be reduced to amounts equitably related to the hours worked by you in comparison to hours worked by full-time employees.

(b) Your dependents will not be eligible for hospital, physicians' services, other medical, dental and vision care benefits of the Program.

(c) In applying the provisions of paragraph 9.0 concerning nonduplication of benefits, any other group plan providing you benefits will be deemed to be the primary plan as compared to the Program. If at any time you become a full-time employee, the provisions applicable to full-time employees will apply to you.

Enrollment and Effective Date of Coverage

9.2 If you are a new employee, you will be enrolled in the Program at the time of your employment with coverage becoming effective as of the dates specified below.

9.3 If you have dependents you will be enrolled for dependent coverage, except that if both man and wife are eligible for enrollment under the Program, each will be enrolled for personal coverage only unless there are dependent children, in which case the dependent children may be enrolled under either parent's plan, at their election. In the event that the coverage of either the husband or wife is terminated for any reason, that individual and that individual's enrolled dependents will automatically be enrolled as dependents of the other covered employee.

9.4 All of your coverage under the Program will become effective **60 calendar days from the date of last hiring with the Company**. If you are a student hired on or after May 1 for summer employment, however, you will not be covered for the Dental Benefits of the Program unless such employment extends beyond September 30, in which case you will then be covered for Dental Benefits as provided above. Dependent coverage becomes effective on the same date as your coverage.

Health Maintenance Organizations

9.5 The Company and the Union have established a procedure whereby employees who reside within a geographical area serviced by a Company-Union approved health maintenance organization are given an opportunity to elect the services provided through the HMO in lieu of certain benefits otherwise provided under the Program. If you live in such an area, you will be furnished with descriptive material to enable you to make such election. This descriptive material will indicate (a) the nature of services provided, (b) conditions pertaining to eligibility to receive such services, including circumstances under which services may be denied, (c) the procedures to be followed in obtaining such services, and (d) the procedures available for the review of claims for services which are denied in whole or in part.

9.6 In the event the cost of services provided through such alternatives exceeds the cost the Company would incur if you and your dependents were covered under the Program, you will be advised as to the amount of contribution, if any, required from you.

9.7 If you elect services provided through an HMO, you and your dependents will nevertheless be covered under the Program for any coverage(s) outside the scope of coverage(s) provided through the HMO. For example, if the HMO provides only medical services, the Life Insurance, Sickness and Accident, Dental and Vision Care Benefits described in this booklet will continue to be applicable to you. Whether you elect services provided through an HMO or coverage under the Program, the general provisions relating to effective date of coverage, continuation of coverage during absence from work and termination of coverage as outlined in this Section apply to you and your dependents.

9.8 There will be a specified enrollment period during which you will be permitted to change your election. If you elect services through an HMO and move from the geographical area serviced by the HMO, you and your dependents will be covered for all of the benefits of the Program on the later of the date you move or the date you notify the claims administrator of your change of address. If you were covered under the Program of Insurance Benefits in effect prior to this Program (the Former Program), your insurance classification will remain the same.

Change in Insurance Classification

9.9 There will be a review of your insurance classification each calendar year. Your classification will be changed on each August 1st to that applicable to the job class on which you worked the greatest number of hours during the first twelve weeks beginning in that year, provided you were paid for at least 240 hours in that period. (If during that period you did not work some hours solely because of a compensable disability incurred during course of employment by the Company, such hours shall be deemed to be hours for which you were paid for the purpose of determining whether you were paid for 240 hours during that period.) If on such August 1st you are absent from work, such change will take effect as of the first day of the calendar month following your return to work.

The amounts of insurance will not be reduced as a result of such review.

Provisions Applicable to Coverage If You Cease Active Work Because of Certain Specified Reasons

9.10 If you cease work because of non-occupational disability, the following provisions will be applicable to your coverage under the Program:

(a) If you have two or more years of continuous service on the date you cease work, all your coverage will be continued during absence due to such disability up to a maximum of 12 months from the end of the month in which you last worked, subject to the provisions relating to total disability as described in paragraph 1.1; provided that if you have 20 or more years of continuous service on the date you cease work, all coverage will be continued until the end of the last month during which you are eligible for sickness and accident benefits.

(b) If you have less than two years of continuous service on the date you cease work, all your coverage will be continued during absence due to such disability up to a maximum of six months from the end of the month in which you last worked. If you continue to be disabled beyond such period and your life insurance is not being continued in accordance with the provisions relating to total disability as described in paragraph 1.1, your life insurance will continue in effect for an additional period not to exceed six months.

9.11 If you cease work because of occupational disability, all your coverage under the Program will be continued during absence due to such disability, but not beyond one month following the end of the month for which statutory compensation payments terminate, except that sickness and accident coverage will terminate (a) at the end of the last month during which you are eligible for sickness and accident benefits pursuant to paragraph 2.2, if you have 20 or more years of continuous service on the date you cease work; (b) at the end of 12 months following the month in which you last worked, if you have two but less than 20 years of continuous service on the date you cease work; or (c) at the end of six months following the month in which you last worked, if you have less than two years of continuous service on the date you cease work.

9.12 If you cease work because of layoff, the following provisions will be applicable to your coverage under the Program:

(a) Your sickness and accident coverage will terminate on the date you cease work.

(b) If you have 20 or more years of continuous service on the date you cease work, your remaining coverage will be continued during such layoff up to the later of (i) 12 months from the end of the month in which you last worked or (ii) the number of weeks from your date last worked equal to the number of your credit units under the Supplemental Unemployment Benefit Plan as of the date you cease work provided, however, that if your remaining coverage will terminate pursuant to (ii) above on a date other than the last day of the month, such remaining coverage will be continued through the end of that month. Notwithstanding the above, if you become disqualified from receiving Weekly Benefits under paragraph 3.6 of the Supplemental Unemployment Benefit Plan, your remaining coverage will terminate as of the later of (i) 12 months from the end of the month in which you last worked or (ii) the date you first become so disqualified. In addition, if you receive a Weekly Benefit as a result of an additional SUB credit unit granted pursuant to Section IV of Appendix A of the Company's pension plan applicable to you, your remaining coverage will be continued during a week for which such Weekly Benefit is paid. You may elect, on or before the 15th day of the month next following the month in which your coverage otherwise terminates, to continue your life insurance until the end of the month in which you incur a break in continuous service provided you make payments of 60¢ per month per $1,000 of life insurance. Failure to make your life insurance payments on or before the 15th day of any month will terminate such insurance at the end of the last month for which payment has been made.

(c) If you have 10 but less than 20 years of continuous service on the date you cease work, your remaining coverage will be continued during such layoff up to a maximum of 12 months from the end of the month in which you last worked. If your layoff continues beyond that period, you may elect, on or before the 15th day of the 13th month of layoff, to continue your life insurance for not more than the next 12 months of layoff, provided you make payments in the same manner and amount as outlined in (b) above.

(d) If you have two or more but less than 10 years of continuous service on the date you cease work, your remaining coverage will be continued during such layoff up to a maximum of six months from the end of the month in which you last worked. If your layoff continues beyond that period, you may elect, on or before the 15th day of the seventh month of layoff, to continue your life insurance for not more than the next 18 months of layoff, provided you make payments in the same manner and amount as outlined in paragraph 9.12 (b).

(e) If you have less than two years of continuous service on the date you cease work, your life insurance will be continued on the same basis as in (d) above, but your health care benefits coverage will terminate at the end of the month in which you last worked, except you may elect to continue such coverage for up to three months, provided you make full premium payment by the 15th day of each month.

The following provisions of paragraph 9.12 apply only to Fleet employees represented by Local 5000 of USWA:

(f) If a laid-off employee of the Fleet has exhausted insurance continuation and is then recalled, additional months of insurance continuation will be provided at the time of such employee's next layoff on the basis of one month's continuation for each full or partial month worked during the recall period, up to the limits provided under the Program.

(g) If a laid-off employee of the Fleet is recalled prior to having exhausted insurance continuation and is subsequently laid off, such employee shall have added to the remaining months of insurance continuation at time of recall an additional month for each full or partial month worked during the recall period, up to the limits provided under the Program.

(h) In either event the recalled employee of the Fleet will receive the full insurance continuation level to which such employee would otherwise be entitled by reason of seniority after having actually worked a cumulative total of 3 months within a calendar year. In calculating the three (3) cumulative months, a month shall be defined as a calendar month or a portion thereof. It is also understood that in no event will the total of any continuation benefits provided by the above provisions exceed the limits set forth under the Program.

If coverage is lost under (b)(c)(d) or (e) above, the Company will make reasonable efforts to insure the availability of one or more Health Maintenance Organizations in which the employee and dependents may enroll at the then existing active employee rates. Such application must be made in a timely fashion in accordance with procedures agreed upon by the parties. The Company also intends to comply with C.O.B.R.A. legislation which requires that the Company provides you and your eligible dependents with the option of continuing your health care coverage (see Section 10).

9.13 If you cease work because of suspension, the provisions set forth in the case of an employee who ceases work because of layoff are applicable except that sickness and accident coverage will be continued during a period of suspension which is not converted into discharge.

9.14 If you cease work for one of the reasons specified in paragraphs 9.10, 9.11, 9.12 or 9.13 and you do not return to active work because of another one of such reasons, your coverage under the Program will be continued for the unexpired portion, if any, of the period which would have been applicable if the reason for not returning to active work had been the original reason for cessation of work. However, in no event will any coverage which has terminated for any reason during your absence be reinstated until you return to work (vacation is same as return to work). Notwithstanding the above, if you have 20 or more years of continuous service on the date you cease work due to layoff and do not return to work due to disability, the provisions set forth in the case of an employee who ceases work due to layoff will continue to apply to you.

9.15 If you cease work because of a leave of absence that is not covered under The Family and Medical Leave Act of 1993, all your coverage under the Program, except for life insurance, will cease at the end of the month in which you last worked. Your life insurance will continue in effect during such leave of absence for a further period not to exceed six months. If earlier termination of coverage is required by federal or state election laws, Program coverage will terminate earlier. You may elect to continue the health care benefits coverage for up to three months provided you make full premium payment by the 15th day of each month after which you may elect a continuation option under C.O.B.R.A. (See Section 10).

9.16 If you return to work after the first calendar day in any month, no claim shall be made by you or on your behalf for a refund of insurance premiums paid by you for such month.

Termination of Insurance Coverage

9.17 If your employment is terminated by other than retirement, all your coverage under the Program will end on the date of such termination. In addition, for the purpose of this paragraph only, you will be considered to have terminated your employment if you are absent from work for a period of five or more calendar days for reasons other than disability, layoff, leave of absence, suspension, vacation, jury duty, witness duty or any other specifically authorized absence and all your coverage under the Program will terminate at the end of the 5th day of such absence.

9.18 Dependent coverage under the Program terminates on the earlier of:

(a) the date your coverage terminates, except that dependent coverage will be continued until the end of the third month following the month in which you die; or

(b) the end of the day immediately preceding the date any individual ceases to be an eligible dependent, except that coverage for a dependent child will be continued until the end of the month in which such person (i) attains age 19 if not a full-time student nor disabled, (ii) ceases to be a full-time student (or attains age 25, if earlier), or (iii) ceases to meet the disabled dependent criteria.

Retirement

9.19 If you retire under the Company non-contributory pension plan applicable to you and your life insurance was in effect on your last day of work, your life insurance will be continued as set forth in paragraphs 1.2 and 1.4. Any other coverage then in effect under the Program terminates at the end of the month in which employment terminates due to such retirement. See paragraphs 9.24, 9.25 and 9.26 with respect to hospital and medical coverage following retirement.

Life Insurance Conversion Privilege

9.20 Upon application to the carrier within 31 days after your life insurance coverage terminates as provided in paragraphs 9.10 through 9.18, you may arrange to continue your life insurance protection under an individual policy, for an amount not greater than the amount of life insurance you have under the Program at the time of such termination, without medical examination. Such individual policy may be on any one of the forms of policy then customarily issued by the carrier other than a policy of term insurance or one which provides disability benefits or special benefits in the event of accidental death, and will be issued at the rate applicable to your age and class of risk at that time.

9.21 If your life insurance coverage terminates under the Program as a result of your transfer to other employment which makes you eligible for life insurance under another group insurance plan toward the cost of which the Company or one of its subsidiaries contributes, the amount of life insurance which you may continue under an individual policy as referred to in paragraph 9.20 shall in no event exceed the amount of life insurance terminated under the Program less the amount of life insurance for which you become eligible under such other plan.

9.22 Furthermore, whenever your life insurance under the Program is reduced, you may apply for an individual policy, in accordance with paragraph 9.20, in an amount not greater than the amount of the reduction. Such application must be made within the 31-day period commencing with the effective date of the reduction.

9.23 Any such individual life insurance policy referred to in paragraphs 9.20, 9.21, or 9.22 will become effective at the end of the 31-day conversion period. If you should die during such period, whether or not you have applied for such a policy, an amount equal to the amount of life insurance in force under the Program immediately prior to termination or reduction, less any amount of life insurance for which you became insured under any other group insurance plan as referred to in paragraph 9.20, will be payable to your beneficiary. If any such amount is payable, no life insurance will be payable under paragraph 9.19.

Health Care Benefits

(Hospital, Physician's Services, and Other Medical Coverage) for Eligible Pensioners and Surviving Spouses

9.24 If you retire on or after August 1, 1999 under the Company non-contributory pension plan applicable to you on other than a deferred vested pension and at the time of such retirement have 10 or more years of continuous service, you and your eligible dependents will be enrolled in the Program of Insurance Benefits for Eligible Pensioners and Surviving Spouses effective 1/1/94, for which you will be required to make a contribution. The contribution level will depend upon whether the retiree and/or dependent spouse is eligible for Medicare.

Retirees, spouses and surviving spouses will pay a monthly premium equal to 10% of the projected cost of the health care benefits (using reasonable trend rates and assumptions confirmed by an actuary designated by the Company), up to a maximum of the following schedule.

Year Ending	Not Eligible for Medicare	Eligible for Medicare
2000	**$46.53**	**$10.74**
2001	**$50.35**	**$11.53**
2002	**$54.48**	**$12.38**
2003	**$58.96**	**$13.30**
2004	**$63.78**	**$14.28**

You may obtain a copy of the booklet describing the Program of Insurance Benefits for Eligible Pensioners and Surviving Spouses effective January, 1994 above from the claims administrator. If you are thinking of retiring you should ask for a copy of such booklet. In any event, you will be given a copy of the booklet shortly before you retire.

9.25 If during active employment you were entitled to elect services provided through a Health Maintenance Organization or prepaid group practice plan (HMO) and HMO services are available to retirees, you may elect at the time of retirement to be covered through such HMO.

9.26 A person who becomes eligible to receive a Surviving Spouse's benefit under the Company non-contributory pension plan applicable to you is also eligible for the other coverage described in paragraphs 9.24 and 9.25.

Reinstatement or Re-employment

9.27 If you return to work following an absence on account of layoff, leave of absence or disability during which some or all of your coverage under the Program shall have terminated and prior to a break in continuous service, all your coverage under the Program will be reinstated on the day you return to work.

9.28 If you return to work after a break in continuous service, you will be enrolled in the Program as a new employee and, except as otherwise specified below, you will not be covered by the Program until **60 days following your re-employment**. However, (a) if you sustained a break in continuous service and at such time you were eligible for an immediate or deferred vested pension under the Company pension plan applicable to you, (b) if your break in continuous service was removed at the time of your re-employment, or (c) if you sustained your break in continuous service prior to completing **60 calendar days of employment** because of lack of work and you are rehired at the same plant within one year from the date of termination and given credit for prior hours worked for purposes of completing your probationary period, calendar days completed by you prior to your break in service will be counted towards the **60 calendar days** which you must complete under paragraph 9.4 prior to becoming covered under the Program.

Continuous Service

9.29 Wherever the term "continuous service" is used in this booklet, it means your continuous service as determined for pension purposes under the Company non-contributory pension plan applicable to you.

Laws Affecting Program Benefits

9.30 Employees in certain states are subject to state laws regarding disability benefits. The Program is modified, as described in this booklet, to reflect the provisions of such laws. The Program has also been modified, as described in this booklet, because of the provisions of Federal law concerning Medicare. If any such law shall be amended, or if any other state or federal legislation shall be enacted to provide benefits similar to those described in this booklet, appropriate adjustments will be made in the provisions of the Program. If, under any such state or federal law, any benefits are now or in the future provided which are in excess of the Program's benefits, any contribution required for such excess benefits shall be paid entirely by the employees covered for such benefits.

9.31 The benefits otherwise payable under the Program will be offset by similar benefits payable for wage loss or medical expenses or which would be payable upon timely and proper submission of claim (unless good and sufficient reason is shown for your inability to submit such claim or to have such claim submitted by someone else on your behalf), under any insurance policy, bond, fund, or other arrangement required by any motor vehicle insurance law requiring the provision of benefits for personal injury without regard to fault. The benefits of the Program will not be offset if the provisions of such law require that other insurance benefits be utilized before benefits are available pursuant to such law or you have obtained no-fault insurance at a lower cost because of your coverage under the Program.

Full-Time Students

9.32 In order for a dependent child to be eligible for the health care benefits of the Program as a full-time student after attainment of age 19, the child:

(a) Must be under 25 years of age and otherwise meet the Program's definition of a dependent child under 19 years of age; and
(b) Must not be employed on a regular full-time basis; and
(c) Must not be paid by another employer while in school at the request of that employer; and
(d) Must not be covered under any other employer group insurance or prepayment plan; and
(e) Must be enrolled full time in a recognized course of study or training and in active, full-time attendance at an institution such as
    (1) High school or vocational school supported or operated by state or local governments, or by the Federal Government.
    (2) State university or college or community college.
    (3) Licensed private school, college or university.
    (4) Licensed technical school, nurses' training school, beautician school, automotive school, or similar training school; and
(f) Must have been under age 19 when you were last enrolled in the Program and must have been eligible for coverage as a dependent immediately prior to attainment of age 19. However, in the case of an employee who loses insurance coverage as a result of a layoff or disability and returns to work at a later date, an

otherwise eligible full-time student will not be considered ineligible for coverage solely by reason of his or her being over age 19 at any time during the period in which loss of benefit continuation occurred.

Although the determination of eligibility for benefits must necessarily be made at the time a claim for a covered service is incurred, should your child qualify under the above criteria such child will automatically be insured for the hospital, physicians' services, other medical, dental and vision care benefits under the Program. However, you should determine such eligibility at this time or at such time your child attains age 19 so that you may decide whether or not you need to continue any individual policy he or she may have or may be eligible to obtain under the conversion privilege as defined in the Program.

9.33 At the time such full-time student dependent attains age 19, you should obtain a Student Dependent Certification form from the claims administrator. The completed certification form, along with supporting enrollment documents, should be forwarded to the claims administrator as early as possible each semester. The certification form will provide the necessary information to permit a determination as to whether your dependent qualifies as an eligible full-time student under the Program.

9.34 The eligibility of a dependent who qualifies as a full-time student will continue during:

(a) A regularly scheduled vacation period or between-term period as established by the institution. Work limited to such period is not considered employment on a regular full-time basis.
(b) A period of absence from class due to disability for up to four months following the end of the month in which such disability occurred provided that the student continues to be disabled.

9.35 The student's eligibility will terminate at the end of the month in which full-time student status ends either by;

(a) failure to return to class after a regularly scheduled vacation period or between-term period
(b) graduation or completion of the course
(c) other termination of full-time attendance at the institution
(d) at the end of the month in which the student attains age 25.

Upon such termination, you have the right to continuing coverage under C.O.B.R.A.

Disabled Children

9.36 In order for a dependent child to be eligible for health care benefits of the Program of Insurance Benefits as a disabled child after attainment of age 19, the child:
(a) Must otherwise meet the Program's definition of a dependent child under 19 years of age;
(b) Must be incapable of self-support because of continuously disabling illness or injury which commenced prior to age 19;
(c) Must be principally supported by you; and
(d) Must have been under age 19 when you were last enrolled in the Program and must have been eligible for coverage as a dependent immediately prior to attainment of age 19.

If you believe that a dependent of yours meets the disability criteria above, you should secure from the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) the Disabled Dependent Certification form which must be completed by you and the attending physician and returned to the claims administrator within 90 days of the date such dependent attains age 20. That form will be reviewed by the claims administrator and the Company to determine the eligibility of such a dependent for benefits under the Program and you may be required to submit additional information in connection with such eligibility determination. You will be notified by the Company as to whether or not the dependent is eligible for hospital, physicians' services, other medical, dental and vision care benefits of the Program as a disabled child. If such eligibility is approved, you will be further required, usually not more frequently than once a year, to furnish the claims administrator satisfactory evidence to substantiate the continued eligibility of such a dependent for benefits under the Program.

Right to Recovery

9.37 Individuals receiving benefits under provisions of the program are required to subrogate their rights to payment of any reimbursements received as a result of an action against a third party.

Any individual receiving benefits under the Plan agrees that his or her rights to any recovery or payment personally or for the account of such individual (including any covered dependent) arising out of any legal action of settlement (other than claims against the employee's or dependent's personal coverage for which he/she pays premiums) thereof (including any settlement prior to the institution of legal action) are subrogated to the rights of the Plan as provided hereunder. By filing a claim, he/she acknowledges and agrees (for themselves and any covered dependents) that the right to subrogation of the Plan is the right to be fully reimbursed for all payments paid by or on behalf of the Plan, from the first dollar paid by any source or sources of any recovery (whether deemed for personal injury or reimbursement of medical payments for any other reason) up to and including the full extent of payments made or benefits provided by or on behalf of the Plan, irrespective of whether any covered dependent has recovered for all or any part of his or her claim for personal injury or other damages and expenses arising therefrom or related thereto. He/she has the responsibility of (i) notifying the Plan promptly upon making claim against any party for any personal injuries, damages or expenses related in any way to the subrogation rights provided hereunder or receiving any settlement, court decision or payment related to such claim and (ii) cooperating with the Plan (including (a) promptly providing any information reasonably requested related to any such claim and (b) assisting the Plan in perfecting its subrogation rights). Any failure to promptly notify and cooperate with the Plan with respect to its subrogation rights hereunder shall make the participant subject to appropriate disciplinary action, including discharge.

SECTION 10.
OPTIONAL CONTINUATION OF HEALTH INSURANCE AND OTHER LEGAL ISSUES

Official Plan Documents

10.0 This section of your handbook summarizes the major provisions of the Program. It is provided for informational purposes only and is not a contract of employment between the Company and you. It does not cover all provisions, limitations and exclusions. There are official Plan agreements (documents) that govern in all cases. These agreements which are included in the booklet and other documents which are not included, are incorporated herein by reference. If there is a conflict between the Plan and/or the Agreement and your booklet (or any other description of the Plan), the text of the Plan and/or Agreement controls. If you would like to review the official Plan documents, contact the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover). The Company intends that the terms of the Plan, including those relating to coverage and benefits, be legally enforceable. The Plan is maintained for the exclusive benefit of the bargaining unit employees of the Company.

ERISA Information (Employee Retirement Income Security Act of 1974, as Amended)

10.1 The Program is part of single welfare benefit plan called the Ispat Inland Inc. Welfare Benefit Plan II

The Employer Identification Number assigned to Ispat Inland Inc. by the Internal Revenue Service is 36-1262880. The Plan Number assigned to the Ispat Inland Inc. Welfare Benefit Plan II is 506.

The Plan Administrator is the Ispat Inland Inc. Manager, Employee Benefits. The day-to-day operation of the Plan is handled by the claims administrator.

The Plan Administrator has the responsibility to the Plan to make and enforce any necessary rules for the Plan, and to interpret the Plan provisions uniformly for all employees. If it is necessary for you to communicate with the Plan Administrator or appeal a claim, you should submit your written comments or requests to the Plan Administrator, in care of Ispat Inland Inc. at the following address:

Manager, Employee Benefits
3210 Watling Street
East Chicago, Indiana 46312

The records of the Program are kept on the basis of a plan year which is the 12-consecutive-month period beginning each January 1.

The Corporate Secretary of Ispat Inland Inc. is the designated agent for the service of legal process.

The Corporate Secretary's address is:

3210 Watling Street
East Chicago, Indiana 46312

Service of legal process may also be made upon the Company.

Statement of ERISA Rights

As a participant in the Program, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

(a) Examine without charge, at the Plan Administrator's office (and at other specified locations, such as work sites and union halls), all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U. S. Department of Labor, such as detailed annual reports and Plan descriptions.

(b) Obtain copies of all Plan documents and other Program information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Program. The people who operate the Program, called "fiduciaries" of the Program, have a duty to do so prudently and in the interests of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the claim reviewed and your claim reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this summary or your rights under ERISA, you should contact the nearest Area Office of the U. S. Department of Labor Management Service Administrator, Department of Labor.

COBRA

10.2 (a) The Program offers you and your family the opportunity for a temporary extension of Medical, Dental and Vision coverage at group rates in certain instances where coverage would otherwise end. This is called COBRA continuation coverage. You must pay the cost of this coverage.

(b) As an employee of the Company covered by the Program, you have the right to elect COBRA continuation coverage if you lose your group health coverage because of:
   i. a reduction in your hours of employment,
   ii. layoff, or
   iii. the termination of your employment (for reasons other than gross misconduct on your part).

(c) Your covered dependents also have the right to choose COBRA continuation coverage if they lose group health coverage under the Program for any of the following reasons:
   i. you die; or
   ii. you retire without retiree health care coverage; or
   iii. your employment is terminated (for reasons other than gross misconduct) or you experience a reduction in the number of hours you work; or
   iv. you divorce; or
   v. your child ceases to be qualified as an eligible dependent; or
   vi. you become eligible for Medicare.

(d) Under COBRA continuation coverage, you or a member of your family have the responsibility to inform the Plan Administrator within 60 days of a divorce or a child losing dependent status under the Program. The Company has the responsibility to notify the claims administrator of your death, termination of employment, reduction in hours or Medicare eligibility.

(e) When the Plan Administrator is notified that one of these events has happened, he or she will in turn notify you and your qualified beneficiaries, such as your covered dependents and spouse, of your right to elect COBRA continuation coverage. You have at least 60 days from the date you would lose coverage because of one of the events described above to inform the claims administrator (see "Who To Call For Benefit Information" phone numbers on inside front cover) that you want COBRA continuation coverage.

(f) If you elect COBRA continuation coverage, you are entitled to coverage which, as of the time coverage

is being provided, is identical to the coverage provided under the Program to similarly situated employees or family members.

(g) If you lost group health coverage under the Program because of a termination of employment or reduction in hours, you may generally participate in COBRA continuation coverage for up to 18 months after your termination or reduction in hours.

(h) It is important to remember that if your coverage is being continued because of a leave of absence, a layoff, or a disability, this continuation is used as part of your allowable COBRA coverage. For example, if you are eligible to continue your benefits under COBRA for a maximum of 18 months and the Company pays for the first 6 months of continued coverage, you can continue your coverage, at your own expense, under COBRA for an additional 12 months.

(i) If you are disabled and become eligible for COBRA continuation coverage either through termination or a reduction in scheduled work hours, you are eligible for COBRA continuation coverage for up to 29 months from the date of your qualifying event.

(j) If your dependents lose coverage under the Program because of your death, your entitlement for Medicare, a divorce, or because a child is no longer an eligible dependent under the Program, they may generally participate in COBRA continuation coverage for up to 36 months after the event that caused them to lose coverage.

(k) In addition, if certain events occur within 18 months after the date of an initial termination or reduction in hours, your qualified dependents will be eligible to elect COBRA continuation coverage for up to 36 months from the date of the initial termination or reduction in hours if any of the following events occur:
   i. you die;
   ii. you become entitled to receive Medicare;
   iii. you are divorced;
   iv. your dependent ceases to be an eligible dependent under the Program; or
   v. your employment is terminated following an earlier reduction in hours.

(l) COBRA continuation coverage may be cut short for any of the following reasons:
   i. the Company no longer provides group health coverage to any of its employees;
   ii. the premium for COBRA continuation coverage is not paid;
   iii. the covered individual becomes covered under another group health plan that does not provide for a pre-existing condition; or
   iv. the covered individual becomes entitled to receive Medicare.
   v. if you were disabled at the time you became eligible for COBRA, the date on which you are no longer disabled with respect to the extended coverage.

(m) You and your qualified beneficiaries do not have to show proof of insurability to choose COBRA continuation coverage. You will have to pay the entire cost for COBRA continuation coverage. At the end of the maximum COBRA continuation period, you will also be allowed to enroll in an individual conversion health plan provided under the Program.

(n) When you become eligible for COBRA coverage, more specific information will be provided.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

10.3 Recent changes in Federal Law may effect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion. Contact your State insurance department for further information.

For employer group health plans, these changes generally take effect at the beginning of the first plan year starting after June 30, 1997. For example, if your employer's plan year begins on January 1, 1998, the plan is not required to give you credit for your prior coverage until January 1, 1998.

You have the right to receive a certificate of prior health coverage back to July 1, 1996 if you were covered under

your employer's plan as of that date. You may need to provide other documentation for earlier periods of health care coverage. Check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

To get a certificate, contact the medical claims administrator:

Harrington Benefit Services
P.O. Box 1818
Dayton, OH 45401-1818
Phone: (800) 654-6208

The certificate must be provided to you promptly. Keep a copy of this completed form. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage.

Women's Health and Cancer Rights Act of 1998

10.4 In compliance with Title IX, the Women's Health and Cancer Rights Act, added to ERISA by the 1998 Omnibus Budget Bill, requires plans that provide medical and surgical benefits with respect to mastectomies also cover reconstructive surgery. A group health plan generally must, under federal law, make available the following services complementing medical and surgical benefits for a mastectomy that is covered under the Plan:

- **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**
- **Treatment of physical complications of mastectomy.**

The extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. All relevant Plan provisions regarding annual deductibles, coinsurance, and copayments apply to these services.

Mental Health Parity Act (MHPA)

10.5 Through the MHPA, the United States Department of Labor mandated that lifetime and annual dollar limits for mental health benefits be the same as other health care benefits. Effective January 1, 1998, there are no separate dollar limits for mental health. Mental health benefits are now subject to the lifetime benefit dollar maximum of the Plan.

The requirements of this Act do not apply to the treatment of substance abuse and chemical dependency.

Newborns' and Mothers' Health Protection Act (NMHPA)

10.6 The United States Department of Labor enacted the NMHPA effective January 1, 1998. The Act requires that a mother and newborn can remain in the hospital for at least 48 hours following a vaginal delivery and 96 hours following a cesarean delivery. However, the mother can choose early discharge if approved by the attending physician.

SECTION 11.
INSURANCE GRIEVANCES

11.0 If a difference relating to the Program arises between you and the Company and such difference is not resolved by discussion with a representative of the Company at the location where it arises, the difference may be processed as an insurance grievance under the provisions of the basic labor agreement applicable to insurance grievances. Such provisions do not apply to a beneficiary's claim for life insurance (see paragraph 1.7).

SECTION 12.
MANAGED CARE PROGRAM PROTOCOLS

12.1 A Managed Care Program shall be designed jointly by the Company and the Union via a Joint Managed Care Working Committee under the direction of a Joint Managed Care Steering Committee. The protocols for the major responsibilities of the committees are as follows:

a. Design an effective program and make the appropriate selections of vendors for Northwest Indiana and other geographic locations that have large employee and, where applicable, retiree populations.
b. Ensure selected components of the Managed Care Program achieve substantial compliance with the standards and criteria set forth in Section 12.2 below.
c. Ensure the right to perform on-site evaluations of selected vendor facilities.
d. If the parties fail to agree on the selection of vendors, the issue shall be referred to the Joint Managed Care Steering Committee for resolution. If the issue cannot be resolved by the Joint Managed Care Steering Committee, it will be referred to the Co-Chairmen of the Negotiating Committee for resolution.
e. The Company shall execute an indemnification agreement which shall hold the Union harmless for its role in the selection of vendors and/or its recommendations concerning the inclusion of any health care provider in a network.
f. Provide that network directories shall be printed and distributed at least 30 days prior to enrollment.
g. Provide that vendor(s) establish a toll-free telephone number at least 30 days prior to enrollment.
h. Provide that the Company effectively communicate the Managed Care Program to employees (with the opportunity for participation of the spouse).
i. Where appropriate, vendors shall make professionals available to participants by telephone to answer medical inquiries (patient advocacy).
j. Require a timely turnaround of complaints with the initial response within 48 hours.
k. Create a written procedure for documentation and resolution of participant complaints.
l. Where appropriate, vendors shall provide a dedicated customer service unit to service participants.
m. A member satisfaction survey shall be conducted by the Working Committee at appropriate intervals following enrollment.
n. If the Working Committee cannot determine whether a vendor is in compliance with the attached standards and criteria, the issue will be immediately referred to the Joint Managed Care Steering Committee for resolution. Steps to resolve this issue will entail remedial actions by the vendor to comply with the established standards and criteria. During this interim period for individuals covered by the concerned network, benefits will be provided as defined in the Program of Insurance Benefits III (PIB III) or Program of Insurance Benefits for Eligible Pensioners and Surviving Spouses Effective 1/1/94 or Program of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses (as applicable). In the event the issue of whether the vendor is in compliance with the standards and criteria cannot be resolved by the Joint Managed Care Steering Committee, it will be referred to the Co-Chairman of the Negotiating Committee and, if necessary, to a mutually agreeable third party for binding arbitration.
o. The Joint Managed Care Steering Committee shall investigate the interest and availability of other area employers to participate in the development of one or more segments of the Managed Care Program.
p. Provide in-network benefits for covered services if, in locations where hospital and physician networks exist, the following occurs:
   (i) a participant's provider withdraws from the network within sixty days preceding the delivery of health care services, as long as the patient was under the care of the provider prior to withdrawal, or
   (ii) an in-network provider was not available, or
   (iii) a physician specialty or specialized hospital service is not included in the network.

12.2 MANAGED CARE PROGRAM EVALUATION CRITERIA

A. Managed Care Vendor Organization
   1) Financially strong organization
   2) Managed care is a profitable line of business
   3) Experience in operating managed care programs.
   4) Commitment to the managed care product:
      - significant part of carrier's revenues.
      - involvement of managed care personnel in top levels of the organization.
   5) Strong client references.
   6) Adequate resources to sustain growth of existing networks or to develop networks in key areas.

B. Network Organization
   1) Clear delineation of accountability between corporate management and local management.
   2) Primary responsibility for medical management delegated to the local level, e.g. local Medical Director in the geographical area.
   3) Experienced local operations management with demonstrated understanding of local medical market and strong relationships with key area provider organizations.
   4) Functioning Peer Review Committee and Quality Assurance Committee at local level.

C. Provider Selection and Organization
   1) Physicians should be board certified.
   2) Network size large enough to service virtually all members.
   3) Sufficient number of specialists:
      - all specialties included in network.
      - at least 4-5 physicians to choose from in each major specialty.
   4) Access to care:
      - participant demographics considered when making vendor selection.
      - emergency care anytime at nearby facilities.
      - urgent care on same day, walk-in basis.
   5) Sufficient number of hospitals:
      - must provide full rate of acute care services.
      - must include some high volume hospitals.
   6) The Managed Care Program should have a "centers of excellence" segment. The Managed Care Program will also provide appropriate transportation and lodging benefits.
   7) Committee/Vendors must utilize rigorous objective criteria to select hospitals and physicians. Process should include:
      - review of physician and facility credentials.
      - on-site office visits.
      - review of medical records.
      - reference checks.

D. Provider Monitoring
   1) Well documented and rigorous standards for credentials of network providers.
   2) Formal Peer Review process for assessment of individual provider performance, with procedures for removal of substandard providers.
   3) Strong oversight of medical practice by a qualified Medical Director, residing locally.
   4) Use of a written Quality Assurance plan to monitor performance, resolve problems and implement improvements in program operation. Also, all Quality Assurance activities should be routinely and fully documented.
   5) Regular re-accreditation of all providers, at least every three years.

E. Member Satisfaction
   1) Written procedures for documentation and resolution of member complaints.
   2) Adequately staffed Member Services function.
   3) Medical professionals (e.g. Registered Nurse) available by telephone to answer general medical inquiries.

4) Timely turnaround of complaints (limited response within 48 hours; final resolution within 30 days).
5) Twenty-four hour toll free telephone service for member inquiries.
6) Routine surveys of membership to assess satisfaction level.
7) Regular procedure for review of complaints, including appeals procedure.

F. Claim Administration
1) Single platform system - all claims processed uniformly through one system regardless of member geographic location.
2) System integration of utilization review and claims processing functions - for example, claims system will automatically know, while processing a hospital bill, that pre-admission approval had been given.
3) Online, real time claim processing - customer service personnel will have direct access to claims history files which speeds up problem resolution.
4) Well designed, easy to read Explanation of Benefit (EOB) statements.
5) Client specific, customized EOB notes and member correspondence.
6) Dedicated (client specific) claims examiners and customer service personnel.
7) Carrier's system has demonstrated experience and reliability in adjudicating claims in managed care environment.
8) All network and non-network claims stored in single database.
9) Paper less claims system for in-network provider encounters.
10) Timely claim processing: 95% paid in 30 days: 99% in 60 days, 100% in 90 days.

ADDITIONAL INFORMATION ON PRIOR PROGRAM
GROUP INSURANCE BENEFITS OF EMPLOYEES INSURED UNDER THE PRIOR PROGRAM

Employees insured for life insurance under the Prior Program on December 31, 1980, are covered as outlined in their Insurance Certificate. The insurance schedule applicable to those covered by the Prior Program for life insurance is $1,000 to $19,500 (the Basic Amount) plus $500 funeral benefit.

Effective December 31, 1962, the amounts of life insurance for those covered for life insurance under the Prior Program were frozen and there will be no further escalation of such insurance under the provisions of the Prior Program, subsequent to December 31, 1962. After December 31, 1962, however, such employees not already insured for the maximum amount of insurance of $20,000 (including funeral benefit) shall be entitled to an increase in life insurance on the same review date and on the same basis as is provided for employees hired on or after January 1, 1960, based on changes in their standard hourly wage rate due to increases as a result of permanent promotions made after December 31, 1962. With certain exceptions such increase in coverage will be at the rate of $500 for any permanent promotion or promotions resulting in any one higher level of standard hourly wage rate insurance classification.

Employees insured for life insurance under the Prior Program who cease work because of a nonoccupational disability will continue to be covered for such life insurance amount during that disability for a period not to exceed two (2) years from the end of the calendar month in which they last worked.

The amount of life insurance in force on retired employees is reduced, on the first of the month following attainment of age 65 or thereafter at retirement, by 2% on the first day of each month beginning with the first month following normal retirement date or actual retirement date, if later, for 16 months and 1% each month for an additional 32 months, but not less than the greater of 20% of the Basic Amount plus the $500 funeral benefit, or $1,250.

Insurance Agreement
Between
Ispat Inland Inc.
and the
United Steelworkers
of America

Effective August 1, 1999

INSURANCE AGREEMENT

AGREEMENT dated **August 1, 1999** between Ispat Inland Inc.* (the "Company") and the United Steelworkers of America (the "Union").

Definitions

1. Wherever used herein
   (a) "Employee" means an employee in one of the bargaining units in Exhibit A attached hereto;
   (b) "Program" means the program of insurance benefits effective **August 1, 1999** established by this Agreement and described in the booklet adopted by the parties, such booklet being applicable to the Employees referred to in its title and constituting a part of this Agreement as though incorporated herein;
   (c) "Prior Program" means the program of life insurance benefits in effect immediately prior to January 1, 1960;
   (d) "Former Program" means the program of insurance benefits in effect as of **July 31, 1999**.

Program of Insurance Benefits

2. This Program shall be applicable to Employees while this Agreement is in effect (the period starting **August 1, 1999**), in accordance with the provisions of this Agreement, subject to the following provisions:

   (a) Any coverage which as of **August 1, 1999** is being continued in accordance with the provisions of the Former Program during an Employee's absence because of layoff, leave of absence or disability shall be continued after **July 31, 1999** for the maximum period provided by the Program, reduced by the period such coverage was continued prior to **August 1, 1999**. Any such coverage which was terminated under the Former Program prior to **August 1, 1999** shall be reinstated under the Program as of the date the Employee returns to active work.
   (b) The benefits of the Former Program shall be applicable to any occurrence prior to **August 1, 1999**, subject to all of the provisions of the Former Program, except that to the extent hospital, physicians' service, major medical, dental and vision care benefits related to such occurrence are payable for a period extending beyond **July 31, 1999**, the benefits otherwise payable shall be conformed to the benefits provided under the Program, and will be payable for the period provided under the Program reduced by the amount of or the period for which benefits were paid prior to **August 1, 1999**.
   (c) Benefit provisions of the Program not contained in the Former Program shall not be applicable to any period prior to **August 1, 1999**.

   *Where used herein, unless otherwise specified, "**Ispat** Inland Inc." refers to Indiana Harbor Works, **Ispat** Inland Lime & Stone Company, and **Ispat** Inland Mining Company.

   (d) During the term of this Agreement the Company will provide, for Employees who were covered for life insurance by the Prior Program on December 31, 1980, the benefits of that part of the Prior Program and the sickness and accident and health care benefits of the Program as provided in the booklet attached hereto. The benefits of the Prior Program shall be applicable for any occurrence for which benefits were provided under the Prior Program prior to January 1, 1960, subject to all the provisions applicable to such Prior Program, except that contributions shall not be required for insurance coverage after December 31, 1959, for Employees whose insurance is being continued as of that date during absence due to occupational or nonoccupational disability.

Cost of Benefits

3. The cost of the benefits under the Program (or Prior Program) shall be paid by the Company, except as provided below in this paragraph 3 and paragraph 6 hereof:
   (a) Any Employee on layoff who elects to continue life insurance after the last month of layoff for which such life insurance is continued without Employee contribution will be required to pay $0.17 month per $1,000 of life insurance for each month as to which he or she is eligible in order to continue such insurance.
   (b) The amounts required to be paid for benefits provided under law in excess of Program benefits (or Prior Program benefits when covered thereby) shall be paid entirely by the Employees.
   (c) In the event of a strike resulting from failure of the parties to reach an agreement following proper notice given by either party under the provisions of any collective bargaining agreement, the Program (and the Prior Program), with the exception of sickness and accident coverage, will be continued for 30 days. The Company will advance the premiums for coverage during such 30 days, which premiums will be repaid by the employees. During such 30 days the parties will discuss procedures and arrangements with respect to further continuation of insurance coverage and the repayment of premiums advanced.

Participation by Employees

4. Each Employee shall be a participant in the Program (and the Prior Program if eligible) and the amount, if any, which the Employee shall be required to contribute to the cost thereof shall be deducted by the Company from his or her pay. Each Employee shall furnish to the Company any such written authorization or assignment (in a form agreed to by the Company and the Union) as shall be necessary to authorize the deduction from his or her pay of the amount of any contributions.

Requirements of Law

5. It is intended that the provision for the insurance benefits which shall be included in the Program (or Prior Program) shall comply with and be in substitution for the provisions for similar benefits which are or shall be made by any applicable law or laws. Where, by agreement, certain basic benefits under the Program (or Prior Program) are provided under law rather than under the Program (or Prior Program), the Company will pay the amount required to be paid therefor, including any Employee contribution required by law on account of such benefits. The Company shall, after consultation with the Union, reduce the benefits of the Program (or Prior Program) to the extent that benefits provided under any law would otherwise duplicate any of the Program (or Prior Program) benefits.

Additional and Alternate Benefits

6. (a) The Program (and the Prior Program where applicable) shall be in substitution for any and all insurance benefits or payments to or on behalf of Employees for death, sickness, or accident, hospitalization, (including less acute care alternatives and outpatient services), dental, medical, surgical or vision care service provided by the Company in whole or in part, except as the Company and the Union have agreed or may agree in writing.
   (b) The Union and the Company may agree that benefits may be provided in addition to those which are to be financed by the arrangements set forth in paragraph 3, provided that the full cost of such additional benefits shall be paid by the Employees covered for such additional benefits and provision may be made by agreement between the Company and the Union to deduct the cost of such additional benefits from the pay of such Employees.

Administration of the Program

7. The Program (and the Prior Program) shall be administered by the Company or through arrangements provided by it. Except as may otherwise be provided in the Agreement, the Company will arrange to have benefits (hospitalization, less acute care alternatives, outpatient services and physicians' services) and major medical benefits under the Program provided through contracts with carriers and/or administrators mutually agreed to by the Company and the Union. Sickness and accident benefits, life insurance, dental and vision care benefits shall be provided by such method and through such carriers, if any, as the Company in its sole discretion shall determine. Any contracts entered into by the Company with respect to the benefits of the Program (and the Prior Program) shall be consistent with this Agreement and shall provide benefits and conditions conforming to those set forth in the booklets.

Life Insurance after Retirement

8. Any Employee who shall have retired and who shall have become entitled to life insurance after retirement

pursuant to the provisions of the insurance agreement and booklet, applicable to such Employee at the time of retirement shall not have such life insurance terminated or reduced (except as provided in such booklet) so long as he or she remains retired from the Company, notwithstanding the expiration of such agreement or booklet or of this Agreement, except as the Company and the Union may agree otherwise.

Extent of Company Obligation

9. The failure of any carrier to provide for benefits under the Program (or Prior Program) shall not result in any liability to the Company, nor shall such failure be considered a breach by the Company of any of the obligations which it has undertaken by this or any other agreement with the Union. In the event of any such failure, the Company and the Union shall immediately take action to provide substitute coverage in accordance with the provisions of this Agreement. Notwithstanding the foregoing, any decision reached with respect to a grievance processed under the provisions of the basic labor agreement applicable to insurance grievances shall be binding on the Company, and, to the extent such decision requires the provision of benefits which the carrier fails to pay, the Company will provide such benefits.

Insurance Reports

10. The Union shall be furnished annually a report regarding the Program (and the Prior Program). From time to time during the term of this Agreement, the Union shall be furnished such additional information as shall be reasonably required for purpose of enabling it to be properly informed concerning the operation of the Program (and the Prior Program). Any accounting under the Program (and the Prior Program) shall make no distinction between the experience with respect to Employees and other employees who may be covered, except that experience of employees who participate in the Program (or the Prior Program) on a different basis or are entitled to different benefits from those provided for Employees represented by the Union shall be included in such accounting only to the extent that the Company and the Union agree to such inclusion. The Company will continue the present arrangements under which it undertakes the keeping of insurance records of individual employees, the recording of changes in insurance classifications and a major portion of the investigation and payment of claims. The cost to the Company of performing such work will not, for any accounting under the Program (or the Prior Program), be deemed to be a cost of such programs.

Continuation of Benefits after Expiration

11. Any employee who is on layoff or absent from work due to disability and entitled to benefits under the provisions of the Insurance Agreement and Program applicable at the time the layoff or absence commenced shall receive such benefits for the duration specified in such Agreement or Program, notwithstanding the expiration or termination of this Agreement or the Program or the collective bargaining agreement between the Company and the Union.

Terms of Agreement

12. This Agreement shall become effective as of **August 1, 1999**, and shall remain in effect until **December 31, 2004** and thereafter subject to the right of either party on 120 days' written notice served on or after **September 3, 2004** to terminate this Agreement.

ISPAT INLAND INC.
/s/

William P. Boehler
Director, Industrial Relations

UNITED STEELWORKERS
OF AMERICA

/s/
Thomas Hargrove
President

EXHIBIT A

Bargaining Units Covered By Insurance Agreement

Following are the groups of employees, and their locations, in bargaining units to which the Insurance Agreement is applicable.

Local 1010*—USWA—Indiana Harbor Works,
East Chicago, Indiana.
Local 4302—USWA—Ispat Inland Lime and Stone
Company, Gulliver, Michigan.
Local 6115—USWA—Ispat Inland Mining
Company, Virginia, Minnesota.
Local 5000—USWA—Great Lakes Seamen,
Middleburg Heights, Ohio.
**Bricklayers and Allied Craft Workers
Local No. 4 of Indiana and Kentucky, Merrillville, Indiana.

*Includes full-time officers.
**The Health Care Benefit Plan, as described in this Plan Agreement, does not apply to this covered group.

EXHIBIT B

Letter Agreements

August 1, 1999

Mr. Jack Parton
Director, District 31
United Steelworkers of America
First National Bank Building
720 Chicago Avenue, Room 211
East Chicago, IN 46312

Dear Mr. Parton:

This is to confirm our understanding that in the event that the Internal Revenue Code is amended prior to **August 1, 1999**, to limit or repeal the current total exclusion from an employee's gross income of the value of employer provided medical insurance, the Company and the International Union ("Union") may thereafter meet to discuss the advisability of changing the benefits provided under the various insurance agreements between the Company and the Union to reduce the amount of imputed income otherwise attributable to employees while maximizing the value of the benefits received by the employee under this insurance agreement. No changes shall be made in such benefits as a result of such legislation except as such changes are agreed to by the Company and the Union.

/s/
W. P. Boehler
Director, Industrial Relations

August 1, 1999

Mr. Lynn Williams, President
United Steelworkers of America
Five Gateway Center
Pittsburgh, Pa. 15222

Dear Mr. Williams:

The United Steelworkers of America and the Inland Steel Company, recognizing the fact that excessive health care charges and over utilization are detrimental to all parties, have in the past engaged in cooperative efforts to control rising health care costs. Inland Steel Company and the United Steelworkers of America have agreed to joint efforts on a case-by-case basis when possible abuses of our health care programs are identified. The Parties recognize that only by working together can the Program of Insurance Benefits be administered on a cost-effective basis without adversely affecting the interests of covered employees and dependents. In that respect, the following is understood:

1. The Company will instruct its claims administrators that hospital bills for services rendered to all the Company's employees (including retirees) and dependents in Lake and Porter Counties in Indiana are to be reviewed, and when necessary, subjected to line-by-line audits to determine for each billed item whether (a) it was in fact provided to the patient, (b) it was appropriate for the condition being treated, (c) the charge is reasonable and (d) it is a covered benefit. Charges not meeting these criteria will not be payable. The audit procedure guidelines will be available to the Union, and the Company will keep the Union advised of results of significance.
2. The Company and the Union will undertake, both jointly and individually, communication efforts to all employees advising them of the above described audit, the basis for such audit and subsequent payments, and the cooperative nature of the undertaking.
3. It is agreed that any grievance arising out of or resulting from the actions described above will be reviewed at the District and International levels. No such grievance will be appealed to arbitration without the specific approval of the District Director and the International Union.
4. In the event that a disagreement arises between any provider of medical services and the claims administrator as a consequence of actions taken as a result of the above audit, the Company will take whatever action may be necessary to protect the employee, including the provision of legal representation.
5. If the Union is sued and the suit arises out of Inland Steel's conduct of its claims audit program, the Company will indemnify it and hold it harmless against costs (including attorneys fees) incurred by it as a result of such suit provided, however, that the Union shall give the Company written notice of such suit immediately upon being served and that the Union shall at all times give the Company the opportunity to consult with it and its counsel concerning the defense of such suit.
6. This understanding does not in any way amend, modify or otherwise affect the terms and conditions of the 1999 Insurance Agreement and Program of Insurance Benefits and it shall not serve to establish precedent. This understanding may be terminated at any time upon written notice to the other party.

Very truly yours,
INLAND STEEL COMPANY

/s/
W. P. Boehler
Director, Industrial Relations

Confirmed:
/s/
_____

Lynn Williams, President
United Steelworkers of America

June 9, 1999

Jack Parton, Director
District 31, USWA
720 W. Chicago Avenue
Room 211
East Chicago, IN 46312

Dear Mr. Parton:

In the event that a National Health Care program is enacted, and such program provides insurance benefits which had been provided by the Programs of Insurance Benefits for both active employees and Eligible Pensioners and Surviving Spouses (PIBs) and/or the Programs of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses (PHMBs) in effect at the time of enactment, the parties will meet to discuss the impact of the legislation and any modifications to the insurance programs which may be necessary or desirable.

Where, by agreement, certain benefits under the insurance programs are provided under law rather than under the PIBs or PHMBs, the Company will pay the amount required to be paid to insure that participants' coverage is no less than their coverage under the PIBs and PHMBs in which they were enrolled that are in effect at the time of enactment. The company shall, after consultation with the Union, reduce the benefits under the PIBs or PHMBs to the extent that benefits provided under law would otherwise duplicate any of the benefits provided under the PIBs or PHMBs in effect at the time of enactment. Except as specifically excluded under the PIBs or PHMBs (for example, Medicare Part B premiums, for a Medicare-eligible retiree), this shall not result in persons covered by the PIBs or PHMBs having to pay additional deductibles, copayments, or contributions in excess of the amounts provided for in the PIBs or PHMBs. Any resulting personal tax liability is the responsibility of the employee, retiree or surviving spouse; however, the Company and the Union will meet thereafter to explore methods of reducing this liability.

If the Company is required under the law to provide benefits to participants in excess of the benefits provided under the PIBs or PHMBs in which they are enrolled or as required by law at the time of enactment, the amounts required to be paid for these benefits shall be paid entirely by employees or retirees/surviving spouses.

As soon as practicable following enactment, an actuary selected by the Company will perform a calculation using reasonable actuarial assumptions and methods to determine the amount of savings realized. These savings will be reduced by any premiums, payroll taxes or contributions specifically designated for the purpose of financing the national program which are required of the Company by law. The resulting net savings, if any, will be used to offset the increased employee and retiree/surviving spouse costs referenced in the preceding paragraphs via methods mutually agreed to by the Company and the Union. Any net savings in excess of the offset amount will be shared equally between the Company and the employees and retirees/surviving spouses.

If any differences shall arise between the Company and the Union regarding the implementation of the matters described above, such matters shall be referred to the Chairperson of the Union's Negotiating Committee and the Chairperson of the Company's Negotiating Committee for resolution. If the chairpersons are unable to resolve the disputes, the disputes shall be referred to a mutually agreeable third party for binding arbitration.

Furthermore, the parties agree that during the negotiations for a successor Labor Agreement to the 1999 Labor Agreement they shall attempt to reach agreement regarding the application of any cost savings to the Company resulting from benefits being provided under law which would otherwise duplicate any of the benefits provided under the PIBs or PHMBs in effect at the time of the enactment.

Very truly yours,
INLAND STEEL COMPANY

William P. Boehler, Director
Industrial Relations

Confirmed:

_____
Jack Parton, Chairman
Negotiating Committee
United Steelworkers of America

August 1, 1999

Mr. Jack Parton
Director, District 31
United Steelworkers of America
First National Bank Building
Room 211
720 W. Chicago Avenue
East Chicago, IN 46312

Dear Mr. Parton:

During the course of these negotiations the USWA bargaining committee has expressed concerns with regard to employees injured on the job for whom "light duty" work cannot be identified thus causing prolonged time off with or without Sickness and Accident Benefits (S&A). In recognition of this concern as it relates to the income stream of impacted employees, the Company agrees to cease offsetting from S&A, 75% of the value of the Workmen's Compensation weekly award commencing with the seventh compensable week following the injury.

Very truly yours,

/s/
W. P. Boehler
Director, Industrial Relations

INDEX

ATTENTION

Please retain this booklet; do not discard.

You will be required to pay a charge for each additional copy provided.

[Reference: Section 10 “Statement of ERISA Rights” on pages B52-B53 in this booklet.
(b) Obtain copies of all Plan documents and other Program information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.]