Program of Insurance Benefits III
Wage Retired and Eligible Surviving Spouses
Summary of Healthcare Benefits
Effective 1/1/09

Monthly Cost (Premium)	Not Medicare Eligible	Medicare Eligible
Pensioner	$70.00	$35.00
Dependent Spouse	$70.00	$35.00
Surviving Spouse	$70.00	$35.00

Medical Benefits	Participant Copayments and Maximums *Network*	*Non-Network*
Deductible (annual)		
Individual	$150	$150
Family	$250	$300
Coinsurance/copayment	10% hospital and ambulatory/free-standing surgical facility, 20% all other after deductible	30% hospital and ambulatory/free-standing surgical facility, 20% all other after deductible
Coinsurance Maximum (annual)		
Individual	All-inclusive for Individual and Family	
Family	$600	$750
Lifetime Maximum	$5,000,000 $1,000,000 organ and tissue transplant services	
Preventive Care and Wellness	20% after deductible	30% after deductible
Hospital Services		
Inpatient	10%	30%
Outpatient	10%	30%
Pre-Admission Review	All inpatient hospital stays of participants under age 65 or not Medicare eligible must be certified prior to admission or within 48 hours after an emergency admit. Call the pre-certification administrator at 1-800-499-1688	
Ambulatory/Free-Standing Surgical Facilities	10%	30%
Outpatient Diagnostic Services	20% after deductible	30% after deductible
Emergency Care		
Hospital Emergency Room	10% after deductible	30% after deductible
Emergency Room Physician	20% after deductible	30% after deductible
Urgent Care Facility/Center	20% after deductible	30% after deductible
Physician Services		
In-Office	20% after deductible	30% after deductible
Hospital Inpatient/Outpatient and Other Facility Services	20% after deductible	30% after deductible
Spinal Manipulations (Chiropractic)	20% after deductible	30% after deductible
	18 visits per year combined Network and Non-Network	
Physical & Occupational Therapy	20% after deductible	30% after deductible
	Occupational therapy not covered	
	Physical therapy services require certification prior to starting treatment. Contact the pre-certification administrator prior to the start of treatment. The pre-cert requirement applies even if you are eligible for Medicare. Phone: 1-888-287-7863	
Speech Therapy (Professional)	20% after deductible	20% after deductible
Skilled Nursing Facility Services	20% after deductible	20% after deductible
	365 days maximum	
	Prior to starting a confinement is a skilled nursing facility, the pre-certification administrator must be contacted. A determination will be made if the charges for services will be covered under the Plan and for how long if approved. The pre-cert requirement applies even if you are eligible for Medicare. Phone: 1-800-499-1688	
Durable Medical Equipment	20% after deductible	20% after deductible
Orthotics	20% after deductible	20% after deductible
Prosthetics	20% after deductible	20% after deductible
Home Health Care	20% after deductible	20% after deductible
Hospice	$150/day room and board All other services paid at 100%	
Transplant Services	20% after deductible	20% after deductible
Ambulance Services	20% after deductible	20% after deductible
Hearing Aids	$1,500 per ear in any period of 3 consecutive years, subject to deductible and coinsurance. Replacement under certain conditions.	
Claim Administrator for Medical Benefits	To confirm eligibility, obtain benefit information, confirm network providers, and file all medical claims: UMR P.O. Box 30781 Salt Lake City, UT 84130-0781 Phone: 1-800-654-6208	

Prescription Drug Benefits	Participant Copayments and Maximums	
	Network	*Non-Network*
Retail		
Maximum supply	Up to 30 days	Up to 30 days
Copayments		
Generic	10% copayment	50% copayment
Brand No Generic Available	30% copayment	50% copayment
Brand Generic Available	100% copayment	100% copayment
Mail Order		
Maximum supply	60 days	Not covered
Copayments		
Generic	$10.00	Not covered
Brand No Generic Available	$25.00	Not covered
Brand Generic Available	100% copayment	Not covered
Copayment Maximum (annual)	$600 per individual mail order only	none
Mandatory Generics	Yes	
Managed Care	Aggressive managed care. Prior auth is criteria based.	
Claim Administrator for Prescription Drug Benefits	For benefit information and to confirm network pharmacies: CVS Caremark Phone: 1-800-925-5795	

Mental Health and Alcohol/Substance Abuse Benefits	Participant Copayments and Maximums	
	Network	*Non-Network*
Mental Health		
Inpatient	Paid at 100%	$100 per person deductible. 50% co-insurance. $1,000 annual stop-loss. Limited to 30 days/year
Alternate Care (Inpatient or Outpatient)	Paid at 100%	Not covered
Outpatient	$10/visit	$100 per person deductible. 50% co-insurance.
Ofice Visits	$10/visit	$100 per person deductible. 50% co-insurance.
Alcohol/Substance Abuse		
Inpatient	Paid at 100%	$100 per person deductible. 50% co-insurance. $1,000 annual stop-loss. 3 days/year detox. 28 days /year rehab. 2 stays/lifetime
Alternate Care (Inpatient or Outpatient)	Paid at 100%	Not covered
Outpatient	$10/visit	$100 per person deductible. 50% co-insurance.
Ofice Visits	$10/visit	$100 per person deductible. 50% co-insurance.
Claim Administrator for Mental Health and Alcohol/Substance Abuse Benefits	To obtain benefit information, access mental health/substance abuse services, obtain a referral and file all mental health/substance abuse claims: ValueOptions Attn: ArcelorMittal USA Claims P.O. Box 1347 Latham, NY 12110-8847 Phone: 1-800-332-2214	

Vision Benefits	Maximum Benefit Amount Paid by the Plan	
	Network	*Non-Network*
Exam	$60.00	
Lens (per lens)		
Single	$50.00	
Bifocal	$55.00	
Trifocal	$60.00	
Lenticular	$65.00	
Contact	$60.00	
Frame	$85.00	
Claim Administrator for Vision Benefits	To confirm eligibility, obtain benefit information, confirm network providers, and file all vision claims: UMR P.O. Box 30781 Salt Lake City, UT 84130-0781 Phone: 1-800-654-6208	

Health Care Eligibility

Coverage for over age 19 dependents	Coverage discontinued at the end of the month in which they turn 19 (unless full-time students or disabled)
Coverage for over age 19 full-time student dependents	Coverage discontinued at the end of the semester the dependent is no longer a full-time student or to the end of the semester in which they turn age 25 if a full-time student

Coordination of Benefits

If the Plan is the secondary plan to another or Medicare, benefits are coordinated by determining the benefits that would be paid by the Plan is it were primary, reduced by the benefits that were paid by the primary plan or Medicare.

By example, let's assume your dependent spouse has $1,800 in medical expenses that are covered under her plan or Medicare as the primary plan and your ArcelorMittal Plan as secondary. Of this expense, the primary plan or Medicare pays $1,440. Your ArcelorMittal Plan, as secondary, takes this and calculates the benefit it would pay if the Plan was primary. Shown as follows:

- Charge $1,800
- ArcelorMittal Allowed Fee $1,600
- Deductible $ 150
- Allowed Fee Less Deductible $1,450
- If It Were Primary, ArcelorMittal Plan Would Pay $1,160 =

Since the Primary plan's or Medicare's benefit payment is more than what the ArcelorMittal Plan would have paid if it was primary ($1,160 vs. $1,440), there is no additional payment from the ArcelorMittal Plan as the secondary plan. Note though that $150 of the Plan deductible and $290 (20%x$1,450) of the copayment maximum has been satisfied. The Plan participant remains responsible for all applicable deductible, copayments, coinsurance, and amounts charged in excess of the allowed fee.

This is a summary of benefits of services covered under the plan, deductibles, copayments, and other limits for covered services under the Plan.
Please refer to the Summary Plan Description for a more complete description of services covered by the Plan.
This summary show's the member's responsibility for covered services and the benefit amount paid by the plan for vision services.