Ispat Inland Inc.

Program of Insurance Benefits III For Eligible Pensioners and Surviving Spouses

Summary Plan Description

Wage Retired On and After August 1, 1993

Effective August 1, 1999

Foreword

This booklet is the Summary Plan Description ("SPD") for the Ispat Inland Inc. Program of Insurance Benefits III for Eligible Pensioners and Surviving Spouses ("the Program") for bargaining unit employees who retired on and after August 1, 1993 and their eligible surviving spouses which has been established pursuant to the Pensioners' and Surviving Spouses' Health Insurance Agreement dated August 1, 1999 between Ispat Inland Inc. (The "Company") and the United Steelworkers of America. This booklet is applicable to production and maintenance employees as defined in Exhibit A.

This SPD describes the benefits of the Program that are paid for in part by pensioners and surviving spouses electing such coverage and administered by the Company's designated claims administrators.

Important Information

You and your eligible dependents should enroll in Medicare Parts A and B as soon as you first become entitled since this Ispat Inland retiree plan will only pay the secondary portion of the benefit, if any, after that date. Failure to enroll in both Parts A and B could result in severe financial liabilities for you.

This Ispat Inland retiree plan does not automatically cover a procedure or service just because it is covered by Medicare. Get prior authorization by submitting a treatment plan from your provider to the claims administrator, to insure that coverage is available. This is especially true for Skilled Nursing Facility stays.

If you are covered under Medicare, use providers who accept Medicare assignment to minimize your out-of-pocket costs. Medicare-primary individuals are not required to use providers who are members of the Ispat Inland/USWA Health Care Network or the networks with whom Ispat Inland is contracted.

If you are not Medicare-primary, you should use providers who are members of the Ispat Inland/USWA Health Care Network provider network in Northwest Indiana or other contracted networks outside of Northwest Indiana so that you don't have to pay the provider the difference between what they charge and what this Ispat Inland retiree plan allows (in addition to any deductibles and/or copays that you might be responsible for).

If you are Medicare-primary, Medicare is the primary payer for any drugs or supplies that are covered under Medicare Part B.

Dental services and treatments are not covered under this Ispat Inland retiree plan.

Organ transplants are not covered under this Ispat Inland retiree plan except expenses related to and for kidney transplants are covered under this plan.

Please read the annual premium notification letter that is sent to you each November. The letter also includes vital information about your benefits and any changes in your plan.

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Section 1 - Life Insurance

General Information and Amount of Coverage

In the event of your death, life insurance in the amount of $25,000 will be paid to any person you designate as beneficiary provided you retired under the Company non-contributory pension plan applicable to you prior to age 62. This amount 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 $7,500.00.

If you retired under the Company non-contributory pension plan applicable to you at or after age 62, your life insurance is $7,500.00

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.

How to File a Claim

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

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 carrier 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 Compensation and Benefits, 3210 Watling Street, East Chicago, IN 46312. Your beneficiary will be advised by that office of the final decision within 60 days.

Section 2 - Health Care Benefits

Introduction

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's 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.

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.

How this Plan Works

This plan provides comprehensive medical coverage with covered medical expenses payable at either 70%, 80% or 90% of the allowed fee or contracted amount (where negotiated with the provider) after the annual deductible is satisfied. The benefit payment level depends on whether you use a provider that is in a plan sponsored provider network ("in-network") or one who is not ("out-of-network"), after you satisfy the annual deductible.

The plan has a $600 (in-network) or $750 (out-of-network) annual co-payment maximum. After reaching these amounts, covered medical expenses are paid at 100% of the allowed fee or contracted amount.

The allowed fee will be based on the following:

(a) For those geographic areas with provider networks or contracted provider arrangements, the allowed fee will be:

   (1) The lesser of the actual charge or contractual rate established for such medical service or procedure by providers who are in a plan sponsored provider network. Program participants will not be responsible for any amounts billed in excess of the allowed charge.

   (2) The lesser of the actual charge or rate established for providers who are not in a plan sponsored provider network. Program participants will be responsible for any amounts billed in excess of the allowed charge.

(b) For those geographic areas that do not have provider networks or contracted provider arrangements, the allowed fee will be the lesser of the providers actual charge or the usual and customary charge, at the time the service is rendered, at the 90th percentile as reported by the health Insurance Association of America (HIAA).

The claims administrator or the Company, as applicable, will make determination as to the allowed fee, with benefit payment made directly to you or, in the case where the covered medical service or procedure is provided by a plan sponsored network provider, directly to the provider unless the provider has already received reimbursement from a retiree, surviving spouse, or eligible dependent. Therefore, you should inform your provider of your coverage under this Program. If you become obligated to a provider for a charge in excess of the allowed fee as determined, this Program will not pay such excess.

Deductibles and Co-payments

When covered medical services are received in designated network areas (identified by geographic location and zip codes) the annual deductible and co-payment maximum for "in-network" services is:

Type of Service	Individual Deductible	Family Deductible	Company Paid Coinsurance %	Family Coinsurance Maximum	Balance Billing
Hospital and Free-Standing Surgical Centers	$150	$250	90%	$600	No
Physician and Other Medical Expenses	$150	$250	80%	$600	No

Program participants will not be responsible for any amounts billed in excess of the allowed fee.

When covered medical services are received in designated network areas (identified by geographic location and zip codes) the annual deductible and co-payment maximum for "out-of-network" services is:

Type of Service	Individual Deductible	Family Deductible	Company Paid Coinsurance %	Family Coinsurance Maximum	Balance Billing
Hospital and Free-Standing Surgical Centers	$150	$300	70%	$750	Yes
Physician and Other Medical Expenses	$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 hospital and free-standing surgical center charges, deductibles and co-insurance are applied to the lesser of the actual charge or rate established for providers who are not in a plan sponsored provider network. Program participants will be responsible for any amounts billed in excess of the allowed fee.

When covered medical services are received in non-designated network areas, the annual deductible and co-payment maximum is:

Type of Service	Individual Deductible	Family Deductible	Company Paid Coinsurance %	Family Coinsurance Maximum	Balance Billing
Hospital and Free-Standing Surgical Centers	$150	$250	80%	$600	Yes
Physician and Other Medical Expenses	$150	$250	80%	$600	Yes

For hospital and free-standing surgical center charges incurred in non-designated network areas, deductibles and co-insurance are applied to the lesser of the actual charge or contractual rate established for such service if the provider is in a plan sponsored network. For physician and other ancilary provider charges, deductibles and co-insurance are applied to the lesser of the actual charge, the contracted rate established for such service if the provider is in a plan sponsored network, or the 90th percentile amount as reported by the Health Insurance Association of America (HIAA).

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.

If this plan is your secondary plan, covered medical services will be coordinated with the benefits of your primary plan as if the charges were incurred outside of the designated network zip codes.

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

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.

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.

Payment of Hospital Benefits

Payment for inpatient and outpatient hospital and free-standing surgical center benefits will be made as follows:

For in-network hospitals and free-standing surgical centers or hospitals and free-standing surgical centers in locations where a network does not exist, benefit will be paid directly to the provider.
For out-of-network hospitals or free-standing surgical centers, benefit will be paid directly to you and you are responsible for paying the provider.

Benefits Provided

When you are admitted for treatment as an inpatient to any legally constituted hospital for a covered condition, 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.

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, unless the private room is part of a contractual arrangement or if it is medically necessary that you occupy a private room because your condition requires isolation.

Pre-admission Review

If you or one of your dependents is to be admitted for an inpatient hospital stay or birthing center on a non-emergency basis, and that dependent is under age 65 or not Medicare eligible, it must be certified prior to the admission. Before the admission a call must be made by you, your admitting physician, or the hospital or birthing center to the pre-admission review administrator, who will make a determination if the admission is medically appropriate and necessary.

Failure to certify an inpatient admission will result in a $300 penalty if the stay is later determined to be medically necessary and appropriate. If the stay is determined not to be medically necessary or appropriate, the Program will not cover charges incurred by you or your eligible dependent for the inpatient stay.

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

Concurrent Utilization Review - After Admission

If an inpatient hospital or birthing center stay needs to extend beyond the number of days that were authorized, you, the physician, or the health care facility must call the pre-admission review administrator to obtain authorization for the additional days of inpatient confinement.

If the administrator is not contacted or the additional stay requested is not approved because it is no longer necessary or appropriate, the Program will not cover the charges incurred for the non-authorized days.

Friday or Saturday Admissions

Friday or Saturday admissions to a hospital are not allowed unless surgery is performed within 24 hours of admission or the admission is the result of an accident or life-threatening emergency. The admission must be certified as medically necessary and appropriate and approved as such by the pre-admission review administrator. Failure to abide by this procedure will result in the application of a $300 penalty.

Duration of Hospital Benefits

Hospital benefits described herein will be provided for a period not in excess of 730 days for each hospitalizaton. If you should be admitted to a hospital within 90 days after a previous hospitalization, the 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

The hospital benefits provided under this Program are available to you, if you are a female pensioner or surviving spouse, or to a female dependent of yours, for up to the number of days to which you are entitled to hospital benefits and for a period not exceeding 15 days of care for the newborn child.

Inpatient Admissions and Outpatient Visits – Dental Cases

The hospital benefits provided under this Program are available if you are admitted to a hospital (a) for extraction of impacted teeth, or (b) for extraction of teeth other than impacted teeth or for other dental processes, provided hospitalization is certified by a licensed physician or doctor of dental surgery as being necessary to safeguard the health of the person confined.

Benefits are also provided under this Program if you receive treatment in the outpatient department of an accredited hospital or free-standing surgical center (a) for extraction of impacted teeth, or (b) for extraction of teeth other than impacted teeth or for other dental processes, provided outpatient hospital or free-standing surgical center care is certified by a licensed physician or doctor of dental surgery as being necessary to safeguard the health of the person confined.

Outpatient Treatment - Emergency Cases

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

The hospital benefits under this Program 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 that requires immediate medical (nonsurgical) care.

Outpatient Treatment - Surgical Cases

The hospital benefits provided under this Program are available if you receive surgical treatment in the outpatient department of a legally constituted hospital, a free-standing surgical center, or a doctor’s office. Certain procedures however must be done on an outpatient basis for benefits to be paid under the Program. These procedures are:

- 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
- Carpel 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

If the procedure listed above 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.

The penalty described will not apply if:

(a) The inpatient stay is needed because of the patient's condition as determined by the preadmission review administrator, or

(b) No outpatient hospital or free-standing surgical center is available, or

(c) The necessary surgery is performed while you are already in the hospital for an unrelated cause that is covered by the Program and already approved by the pre-admission review administrator.

Outpatient Treatment - Radiation Therapy

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

Outpatient Treatments - Hydrotherapy and Physiotherapy

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

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.

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 the outpatient pre-admission testing provisions of this plan.

Hospital benefits are not provided under this section 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

Hospital benefits are provided for pre-admission testing. Standard pre-admission tests must be done prior to admission in an outpatient setting. Failure to abide by this 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

Catastrophic case management concentrates on those cases where the early identification of catastrophic and chronic illnesses or injuries can enhance the quality of care and recovery. 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

A case that typically requires catastrophic case management generally is identified through a referral by the Company, hospital, physician, claims administrator, or other provider.

Where the case manager determines that catastrophic case management is 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 will continue 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.

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 Program. Benefits will be payable under this Program 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 above;

- 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.

Skilled Nursing Facility Benefits

If you are admitted to an approved Skilled Nursing Facility, benefits will be provided for semi-private accommodations and all other services furnished during the period of confinement to the extent such services would otherwise qualify as covered medical expenses 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 your condition requires professional and practical nursing care provided by a Skilled Nursing Facility and you remain under active medical supervision of a licensed physician. A Skilled Nursing Facility could be part of a nursing facility, hospital, or rehabilitation facility providing skilled nursing care and/or skilled rehabilitation services.

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 a semi-private room.

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.

An approved facility is one that:

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

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

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

Prior to starting a confinement in a Skilled Nursing Facility, you, your admitting physician, a family member, or the facility should call the skilled nursing facility pre-certification administrator. A determination will be made as to whether your stay in a Skilled Nursing Facility meets plan requirements and whether the charges for services will be covered under provisions of the Program and for how long they will be covered if approved. This pre-certification requirement applies even if you are eligible for Medicare or covered as primary by another health care plan.

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.

Benefits are not payable for:

(a) confinement which is principally for custodial care;

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

(c) care for the deaf or blind;

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

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

(f) care not requiring continued professional and practical nursing care provided by a Skilled Nursing Facility even if such care is covered by Medicare;

(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

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 a health worker on the Agency's staff, or 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

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 claims 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.

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 where necessary,

(c) 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 inquire whether such agency meets the above requirements. You should also determine through the claims administrator, prior to starting services, whether or not the services that will be provided by the Home Health Care Agency meet Program requirements and whether or not the charges for their services will be covered under provisions of the Program.

Benefits are not payable 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, mental deficiency, dementia 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.

Chemotherapy

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

Kidney Dialysis

Benefits under the Program 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

Benefits are provided for home and in-patient hospice care that treats the terminally ill patient and family as a unit. The Program provides care to meet the special needs of the individual and 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 to help the individual and family unit cope with physical, psychological, spiritual, social, and economic stresses. The hospice care must be approved as meeting established standards including any legal licensing requirements of the state and locality in which it operates.
Covered hospice care services under the Program include:

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

(b) charges for doctor's service;

(c) home health services;

(d) emotional support services;

(e) homemaker services;

(f) bereavement services;

(g) drugs and medication.

This provision does not in any way amend, modify or otherwise affect the terms and conditions of the 1993 Insurance Agreement and the Program of Insurance Benefits.

Birthing Centers

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 whether such facility is approved.

What Is Not Covered

Benefits are not provided under all of the Sections listed above 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;

(d) Outpatient services, free-standing surgical center services, and hospitalization primarily for diagnostic study, dental processes, or foot ailments and procedures except as specifically provided in the above Sections;

(e) Hospital costs associated with any surgery defined as not covered by this Program;

(f) Services for treatment of mental illness or drug or alcohol abuse;

(g) Organ transplants or any type of services for or related to organ transplants except for kidney transplants;

(h) Cosmetic surgery;

(i) Prescription drugs and medications;

(j) Confinements, services, supplies or treatments furnished by any governmental body (subject to the provisions on Medicare in this Program for persons eligible for Medicare); or

(k) 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.

Payment of Physicians' Services Benefits

Payment for physicians' services described in the following Sections is made at an allowed fee or contracted amount. This means that, subject to certain maximums specified in these Sections, this Program provides benefits for covered services, but at not more than the allowed fee or contracted amount (where negotiated with the provider) for such service.

The provider's allowed fee will be based on the following:

(a) For those geographic areas with provider networks or contracted provider arrangements, the allowed fee will be:

  (1) The lesser of the actual charge or contractual rate established for such medical service or procedure by providers who are in a plan sponsored provider network. Program participants will not be responsible for any amounts billed in excess of the allowed charge.

  (2) The lesser of the actual charge or rate established for providers who are not in a plan sponsored provider network. Program participants will be responsible for any amounts billed in excess of the allowed charge.

(b) For those geographic areas that do not have provider networks or contracted provider arrangements, the allowed fee will be the lesser of the providers actual charge or the usual and customary charge, at the time the service is rendered, at the 90th percentile as reported by the health Insurance Association of America (HIAA).

The claims administrator or the Company, as applicable, will make determination as to the allowed fee, with benefit payment made directly to you or, in the case where the covered medical service or procedure is provided by a plan sponsored network provider, directly to the provider unless the provider has already received reimbursement from a retiree, surviving spouse, or eligible dependent. Therefore, you should inform your provider of your coverage under this Program. If you become obligated to a provider for a charge in excess of the allowed fee as determined, this Program will not pay such excess.

Surgical Benefits

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.

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.

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

Benefits are provided for obstetrical services, including necessary prenatal and postnatal care, furnished to you if you are a female 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

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.

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.

Physicians Services Benefits in the Hospital

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 (730) to which you are entitled. 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 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 during the later period.

Physicians Services Benefits in Skilled Nursing Facility

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.

Physicians Services Benefits for Home Health Care Agency Patients

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

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, but not the operating surgeon or surgical assistant, who is not an employee of, nor compensated by, a hospital, laboratory or other institution.

Radiation Therapy and Chemotherapy Benefits

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.

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

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.

Benefits under this Section will not be provided for 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

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.

Benefits under this Section will not be provided for 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

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).

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

Other Medical Expenses are those charges 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 a licensed physician or licensed podiatrist with respect to the services of a podiatrist for which benefits are payable under the Program.

Other Medical Expenses are paid at the applicable coinsurance amount (as described in the Deductibles and Co-Payments Section) of the allowed fee or contracted amount (where negotiated with the provider) for such service by which Other Medical Expenses described in this Section exceed the annual deductible.

The allowed fee will be based on the following:

(a) For those geographic areas with provider networks or contracted provider arrangements, the allowed fee will be:

    (1) The lesser of the actual charge or contractual rate established for such medical service or procedure by providers who are in a plan sponsored provider network. Program participants will not be responsible for any amounts billed in excess of the allowed charge.

    (2) The lesser of the actual charge or rate established for providers who are not in a plan sponsored provider network. Program participants will be responsible for any amounts billed in excess of the allowed charge.

(b) For those geographic areas that do not have provider networks or contracted provider arrangements, the allowed fee will be the lesser of the providers actual charge or the usual and customary charge, at the time the service is rendered, at the 90th percentile as reported by the health Insurance Association of America (HIAA).

The claims administrator or the Company, as applicable, will make determination as to the allowed fee, with benefit payment made directly to you or, in the case where the covered medical service or procedure is provided by a plan sponsored network provider, directly to the provider unless the provider has already received reimbursement from a retiree, surviving spouse, or eligible dependent. Therefore, you should inform your provider of your coverage under this Program. If you become obligated to a provider for a charge in excess of the allowed fee as determined, this Program will not pay such excess.

Other Medical Expenses covered by this Program are:

(a) Services of licensed physicians, certified registered nurse anesthetists (CRNAs), physician assistants (PAs) and nurse practitioners all operating within the scope of their license or certification;

(b) Services of licensed podiatrists (except for those services specifically excluded as defined under Expenses Not Covered);

(c) Other hospital services required for medical or surgical care or treatment including hydrotherapy and physiotherapy treatments in the outpatient department of an accredited hospital;

(d) Anesthetics and the administration thereof;

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

(f) X-ray and radium treatments;

(g) Oxygen and its administration;

(h) 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;

(i) Services of a qualified physiotherapist;

(j) Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) in or out of a hospital when required. Services rendered by an L.P.N. out of the hospital 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;

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

(l) Local professional ambulance services for emergency treatment only;

(m) 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);

(n) Initial purchase, fitting and adjustment of artificial limbs, braces, or other prosthetic appliances including replacement of such appliances if not serviceable five or more years from installation;

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

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

(q) 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;

(r) 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;

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

(t) Expenses in connection with elective abortions where permitted by law and sterilizaton procedures whether or not medically necessary;

(u) Services of a chiropractor, but only those procedures performed within the scope of his or her license;

(v) Prescription drugs as specifically provided in Section 3; and

(w) Medical expenses in connection with the surgical removal of a kidney from a donor to a transplant recipient who is insured for this coverage, or a donor if either the recipient or the donor is insured for this coverage, but only to the extent benefits are not payable for such services under any other insurance.

Expenses Not Covered

The following are medical expenses that are not covered under the Program:

(a) Dental services, treatments and appliances;

(b) Eyeglasses or contact lenses and examinations for the prescription or fitting thereof, except as provided under Vision Care Benefits of this Program;

(c) Health check-ups and routine physical examinations except as specifically provided under the Other Medical Expenses of this Program;

(d) Cosmetic surgery or treatment, except as specifically provided under Other Medical Expenses of this Program;

(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 on Medicare in this Program with respect to persons 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 while insured for this coverage or under any other medical program toward the cost of which the Company contributes;

(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 specifically provided;

(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 type of service, supply or treatment not specifically listed as a medical expense under this Program;

(n) Expenses for which benefits are not payable for failure to abide by the pre-admission review, concurrent utilization review, Friday or Saturday admissions, and outpatient testing provisions of this Program;

(o) Expenses incurred as a result of confinement in a Skilled Nursing Facility except as specifically provided under Skilled Nursing provisions of this Program;

(p) Expenses for services provided through a Home Health Care Agency except as specifically provided under Home Health Care Agency provisions of this Program;

(q) Prescription drugs except as provided under Prescription Drug Benefits of this Program;

(r) Mental health and alcohol/substance abuse treatment except as provided under Mental Health and Alcohol/Substance Abuse Treatment Benefits of this Program;

(s) Charges by covered health care service providers, as defined under this Program, in excess of the allowed fee;

(t) Custodial or personal type services or care regardless of where care is received;

(u) Expenses incurred in connection with transexual operations;

(v) Organ transplants or organ transplant services of any kind except for kidney transplants;

(w) Any type of therapy, service, or supply for or relating to delays in physical or mental development, learning, reading, or language skills;

(x) Professional ambulance transportation or services for other than emergency purposes; or

(y) Confinements, services, supplies, or treatments that are not necessary according to accepted standards of medical practice.

Date Expenses Are Incurred

Covered medical expenses are considered to have been incurred on the date the medical services, supplies or treatments are received.

Continuation of Benefits after Termination of Coverage

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.

Benefits for Dependents

Benefits are provided under this Program 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).

Section 3 - Prescription Drug Benefit Plan

Introduction

Coverage for medically necessary medications requiring a prescription written by a licensed physician and dispensed by a licensed pharmacist pursuant to Federal or State law are provided as a covered benefit under the Prescription Drug Benefit Plan of the Program. Prescription drug coverage is also provided for insulin, disposable insulin syringes, and blood glucose testing agents/strips.

Prescription drug benefit coverage will be administered by a prescription drug benefit manager who will be responsible for developing and maintaining a network of retail pharmacies, offering a mail service option for the purchase of maintenance medications for chronic or long-term conditions, managing drug utilization, and making payments for covered prescription drugs.

There are specific co-payment and stop losses that apply only to prescription drugs (as defined below). These do not reduce or satisfy any other co-payments or stop losses elsewhere in the Program.

Prescription Drug Costs and Benefit Payments

Your copayment for covered prescription drugs, by drug type and where purchased is:

	Type of Retail Pharmacy		
Type of Drug	Network	Out-of-Network	Mail Service Pharmacy
Generic	10%	50%	$ 5.50
Brand, no generic available	30%	50%	$13.75
Brand, generic available*	100%	100%	100%

* - brand name drugs with generic equivalents will not be covered unless the prescribing physician submits satisfactory clinical evidence to the prescription drug benefit manager that there is a specific 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 40% at a network retail pharmacy and $18.00 at mail service pharmacy.

Prescription Drug Stop Loss

There is a yearly stop loss of $500.00 per covered individual that is applied to network retail pharmacy purchases only of generic and brand no generic available drugs. When your individual out-of-pocket expense totals $500.00 for the year, these drugs will then be covered at 100% by the Program. The stop loss does not apply to any network retail pharmacy or mail service purchases of brand where a generic is available or out-of-network purchases.

Coverage Limits

Unless otherwise noted, benefits for prescription drugs are subject to a lifetime maximum of $250,000 per covered individual, including any out-of-network benefits paid. Benefits paid for prescription drugs for a covered individual under the Program since Jan. 1, 1994 count towards the $250,000 lifetime maximum.

Any benefits received under this 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.

Cost of Coverage

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

How the Prescription Drug Plan Works

Retail Pharmacy

> You can purchase up to a 30-day supply of medication. If the drug is purchased at a network pharmacy, the pharmacist will charge you your co-payment only. No claim forms are required and you do not file the claim with the prescription drug benefit manager for payment. If the drug is purchased at an out-of-network pharmacy, the pharmacist will charge you the entire amount of your prescription purchase. You must then complete a prescription drug claim form and submit it along with your receipt to the prescrip0tion drug benefit manager. The prescription drug benefit manager will pay you the benefit for your drug purchase.

Mail Service Pharmacy

> You can order a 14-60 day supply of medication prescribed to treat a chromic condition or long-term illness through the mail from the prescription drug benefit manager. When you purchase drugs through the mail service, include the appropriate co-payment along with your prescription in an order envelope. If you are not sure of the co-payment amount, submit the maximum co-payment with your order. A refund will be sent to you or a credit will be issued for you if the co-payment is less.

The Prescription Drug Plan as Secondary Payer

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

Prescription Drug Limitations and Exclusions

The following drugs are subject to limitations:

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

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

Prescription Drug benefits are not payable for:

(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 (obtained over-the-counter or by prescription);

(f) food and food or nutritional supplements;

(g) refills of prescriptions older than one year;

(h) drugs prescribed for cosmetic purposes; or

(i) drugs prescribed in amounts greater than the manufacturers recommended dosing or for diagnoses for which the drug is not FDA approved.

Prior Authorization

Some prescription drugs require review by the prescription drug benefit manager before certain quantities or an extended duration of therapy will be covered under the Program. Prescription drugs that are subject to review and prior authorization are those that cause potentially serious side effects, are costly, or have a high potential for inappropriate use. A listing of drugs requiring prior authorization is available on the Ispat Inland Benefits web site at www.benefits.ispatinland.com. Select "Prescription Drug Plan", then select "Drug Reference List."

Section 4 - Mental Health and Alcohol/Substance Abuse Treatment Benefit Plan

Introduction

Coverage for mental health and alcohol/substance abuse treatment will be provided exclusively through the Mental Health and Alcohol/Substance Abuse Treatment Benefit Plan ("MH/ASA Plan"). The MH/ASA Plan will be administered by a MH/ASA Plan benefit manager who responsible for developing and maintaining a network of designated providers, managing care, making payments to providers, and reimbursing employees for out-of-network expenses.

Designated Provider Concept

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

To access services, the patient (or other family member, patient representative, or provider) contacts the MH/ASA Plan manager via a toll-free number. 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 MH/ASA Plan manager during the resultant course of treatment.

If emergency hospitalization is required, the MH/ASA Plan manager must be contacted within 48 hours of admission (or 72 hours if the patient is in detoxification for substance abuse).
If these procedures are not followed, that is, if any mental health or alcohol/substance abuse services are not certified and approved by the MH/ASA Plan manager, the treatment is considered "out-of-network" and a lesser benefit will be provided for the period of non-compliance.

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

Participants who receive treatment from out-of-network providers must file a claim with the MH/ASA Plan manager in order to receive a benefit.

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

Benefits for Mental and Nervous Care

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.

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:

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

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

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

(d) Psychological testing by a psychologist;

(e) Professional and other necessary ancillary services, other than services of physicians, when received in a legally constituted hospital outpatient department or approved psychiatric facility 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 MH/ASA Plan manager;

(f) Drugs and medications dispensed and charged for by such hospital or facility as a part of regular institutional care programs;

(g) Electroshock therapy and anesthesia related thereto.

Out-of-network inpatient benefits are provided for hospitalization in a legally constituted hospital. Out-of-network 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.

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 (a) through (g) above are also covered when performed by these providers.

Covered mental health services must be rendered for treatment of certain emotional or mental conditions or illnesses that are amenable to favorable modification. Services in connection with mental deficiency, dementia, language or learning disabilities and retardation are not covered.

Benefits for Alcohol/Substance Abuse Treatment

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.

An Approved Rehabilitative Facility means a facility approved by the MH/ASA Plan manager that is specifically engaged in rehabilitation of those suffering from alcoholism or drug addiction. Determination by the MH/ASA Plan manager as to whether or not a facility is an Approved Rehabilitative Facility shall be conclusive.

Out-of-network benefits are provided for hospitalization in an accredited hospital. Out-of-network 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 Benefits Payment Levels

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 from the MH/ASA Plan manager and service rendered by a network provider. Benefit payment levels are:

In-Network	Annual Deductible Per Person	Coinsurance/ Co-payment Level	Annual Stop Loss Per Person
Inpatient Hospital	$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 Hospital	$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.

The deductibles, co-payments and stop losses that apply to the MH/ASA Plan do not reduce or satisfy those elsewhere in the Program.

In-network, the copayment for office visits will be waived for 120 days following an inpatient stay.
Participants are not responsible for any charges in excess of allowed charges when treatment is rendered certified and approved by the MH/ASA Plan manager and provided by in-network providers.

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 fees.

Coverage Limits

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.

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 for Eligible Pensioners and Surviving Spouses Effective January 1, 1994.

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

	MENTAL HEALTH	ALCOHOL/SUBSTANCE ABUSE
Inpatient Hospital	30 days per year	3 days per year for detox 28 days per year for rehab 2 stays per lifetime

The MH/ASA Plan as Secondary Payer

If this plan is secondary to another group health care plan or Medicare, in-network benefits will be coordinated only if the MH/ASA Plan manager is contacted prior to care being rendered. Failure to contact the MH/ASA Plan 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 or Medicare is also a managed care plan, the MH/ASA Plan manager will make certain any participant who has secondary coverage under the MH/ASA Plan is following the rules of his/her primary plan or Medicare and therefore receiving maximum benefits under the primary plan or Medicare. 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.

Continuation of Benefits After Termination of Coverage

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.

Section 5 - Vision Care Benefits

Benefits for Vision Care

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 for these services.

Covered Vision Expenses are those incurred for 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 as defined by this Vision Care Benefit plan 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; and

(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.

Payment of Vision Care Benefits

Benefit payment for a vision examination as defined above will be made at the providers actual charge not more than $35 per examination.

Benefit payment for lenses will be made at the providers actual charge but not more than:

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

Benefit payment for a frame will be made at the providers actual charge but not more than $60 per frame.

Note: Benefit payments for lenses and a frame include the allowance for dispensing services.

Providers of Services

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

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.

Expenses Not Covered

The following are not Covered Vision Expenses:

(a) Services or supplies for which the insured person is entitled to benefits under any other Section of this plan;

(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) 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 before the person became eligible for Vision Care Benefits coverage or 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 plan frequency limitations;

(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; and

(n) Services or supplies which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body.

Section 6 - General Provisions

Eligibility

You are eligible to participate in the Program of Insurance Benefits III for Eligible Pensioners and Surviving Spouses if you:

(a) retired under the Company non-contributory pension plan on or after August 1, 1993 on other than a deferred vested pension, or

(b) receive a Surviving Spouse's benefit under the Company non-contributory pension plan as the Surviving Spouse of an employee

  (1) who retired under the Company non-contributory pension plan on or after August 1, 1993 on other than a deferred vested pension, from a group of employees designated by the Company as covered by the Program, and dies thereafter, or

  (2) who died on or after August 1, 1993, at a time when the employee is accruing continuous service in a group of employees designated by the Company as covered by the Program and after he or she has completed 15 years of continuous service;

(c) authorize deduction of premiums for such coverage from your pension or Surviving Spouse's benefit or, in the event your pension or benefit is insufficient to cover the premium, sent a check or money order payable to Ispat Inland Inc. in the care of the pension administrator each quarter in an amount equal to three (3) times the monthly cost applicable to you; such payment is to be mailed to the pension administrator and must be received not later than the 10th day of the calendar quarter for which payment is due (Jan. 10, April 10, July 10, Oct. 10);

provided, however, that you are not insured under any other group insurance plan or program providing health care benefit coverage toward the cost of which the Company contributes and are a resident of the United States or Puerto Rico.

Monthly Cost

Retirees, eligible spouses, and surviving spouses pay a monthly premium equal to 10% of the projected cost of these benefits (using reasonable trend rates and assumptions confirmed by an actuary designated by the Company), up to a designated maximum. The required monthly premium will also depend on whether the retiree, eligible spouse, or surviving spouse is eligible for Medicare or not. The premium for benefit coverage includes coverage for any eligible dependent children.

The monthly premium maximums are:

Year	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

Monthly premiums may change on an annual basis. Notification of such change will be provided to plan participants.

Definition of Dependents

The term "dependents" includes only:

(a) The spouse of a pensioner;

(b) The pensioner's or surviving spouse's unmarried children under 19 years of age. Such children include (1) a blood descendent 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) The pensioner's or surviving spouse's 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;

(d) The pensioner's or surviving spouse's children after attainment of age 19, if, in addition to otherwise meeting the definition of dependent children as contained in (b), such child is 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.

To be eligible for dependent coverage, proof may be required that the dependent meets the requirements stated above. You will be required to complete and file with the claims administrator a Student Dependent Certification form each semester a dependent enrolls as a full-time student or a Disabled Dependent Certification form to qualify such dependents for coverage under the Program.

The term dependents does not include any person who, is covered under any other group insurance plan or program toward the cost of which the Company contributes, is covered as a pensioner or surviving spouse under the Program, resides outside the United States or Puerto Rico, or is a dependent of an employee who retires on or after August 1, 1993 and who was a part-time participant as defined in the pension agreement under which he or she retired.

Enrollment and Effective Date of Coverage

You have the opportunity to elect and enroll in the Program at the time of your retirement from employment with the Company or at the time you received a Surviving Spouse's benefit under the Company non-contributory pension plan.

Coverage of a pensioner or surviving spouse becomes effective on the first day of the month in which you commence to receive a pension under the Company pension plan, or if you are a surviving spouse, the first day of the month following the month in which your spouse died provided you make application for a Surviving Spouse's benefit within 90 days of the date of death of your spouse.

Coverage of a dependent becomes effective on the date your coverage becomes effective or the date you acquire such dependent.

If you have eligible dependents, you will be enrolled for dependent coverage. However, should you and your spouse both be eligible for coverage under the Program, or any other plan toward the cost of which the Company contributes, each will be enrolled for single coverage under their respective plan. In any event, any dependent children will be enrolled under the husband's coverage. In the event coverage of either you or your spouse is

terminated, that individual and that individual's eligible dependents will be enrolled as dependents of the covered person.

Health Maintenance Organizations

You may, in certain geographical areas, be given the opportunity to elect health care coverage through a Health Maintenance Organization (HMO) or prepaid group practice plan in lieu of benefits under the Program. If this option is available, you will be furnished with descriptive material to enable you to make such election. This material will describe the nature of services provided, conditions pertaining to eligibility to receive such services, the services that are covered and those that are not, the procedures to follow to obtain such services, and the procedures for the review of claims for services which are denied in whole or in part.

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, which will upon authorization by you be deducted from your pension or Surviving Spouse's benefit.

Whether you elect services provided through such alternative or coverage under the Program, the provisions relating to effective date of coverage and eligibility as defined in the Program apply to you and your dependents.

You may elect to terminate coverage for yourself and your dependents under such alternative and be covered by the Program. Coverage under the Program will become effective on the first of the month following receipt of notification by the claim administrator that you want to terminate alternative coverage because you no longer reside in the geographical area serviced by the coverage alternative. If you wish to terminate alternative coverage for any other reason, coverage under the Program will become effective on Jan. 1 next following the date written notice is received by the claim administrator from you requesting termination of this coverage.

Change in Family Status

Prompt written notice 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, should be sent to the claim administrator. When sending such notice, include complete information and copies of documents such as marriage certificates, birth certificates, divorce decrees, death certificates, etc., and include your full name and social security number.

If you are a pensioner 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 claim administrator promptly. If you do not notify the claim administrator within 30 days after the date you acquire the dependent, you may be required to submit proof of such date.

Nonduplication (Coordination of Benefits)

The health care benefits provided under this Program will not be payable to the extent they are provided under any other group plan if the other plan

(a) does not include a coordination of benefits or nonduplication provision, or

(b) includes a coordination of benefits or nonduplication provision and is the primary plan as compared to the Program.

In determining whether the Program or another group plan is primary, the following will apply:

(a) The plan covering the patient other than as a dependent, will be the primary plan.

(b) 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 male parent will be the primary plan.

(c) Where both plans cover the patient as a dependent child of divorced parents, benefit determination will be as follows:

(1) if there is a court decree which establishes financial responsibility for the medical 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;

(2) 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;

(3) 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;

(d) Where the determination cannot be made in accordance with (a), (b), or (c) above, the plan that has covered the patient for the longer period of time is the primary plan.

In any case where the Program is determined to be secondary, benefits otherwise payable under the Program are reduced by benefits paid by the other plan.

As used herein, "group plan" means (a) any plan covering individuals as members of a group and providing hospital or medical care benefits or services through group insurance or a group prepayment arrangement, or (b) any plan covering individuals as employees of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

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 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 may make reimbursement direct to the insurance company or other organization providing benefits under the other plan.

For the purpose of this provision, the claims administrator 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, expenses, and benefits.

Any person claiming benefits under the Program must furnish the claims administrator such information as may be necessary for the purpose of administering this provision.

Right to Recovery

Individuals receiving benefits under 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 Program 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 retiree's, surviving spouse'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 Program is the right to be fully reimbursed for all payments paid by or on behalf of the Program, 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 Program, 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 Program 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 Program (including (a) promptly providing any information reasonably requested related to any such claim and (b) assisting the Program in perfecting its subrogation rights).

No-fault

The benefits otherwise payable under the Program will be offset by similar benefits payable for 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.

Overpayments

In the event that an overpayment of any Program benefits occurs as a result of the application of the nonduplication, subrogation or no-fault provisions, the claim administrator will have the right to recover any payment already made which is in excess of its liability. Whenever benefits which are payable under the Program have been provided under another group plan, the claim administrator may make reimbursement direct to the insurance or other organization providing benefits under the other group plan.

Termination of Coverage

Coverage under the Program of a pensioner or an individual receiving a surviving spouse's benefit under the Company non-contributory pension plan terminates on the earliest of the:

(a) day on which such person ceases to be eligible for coverage under the Program;

(b) end of the month in which notice from such person is received by the claim administrator requesting termination of coverage under the Program;

(c) day immediately preceding the date on which an individual receiving a surviving spouse's benefit under the Company non-contributory pension plan remarries;

(d) end of the month in which notice from the pensioner or surviving spouse is received by the claims administrator requesting termination of such coverage; or

(e) end of the month for which you last paid the required monthly premium.

Program coverage of a dependent of a pensioner or surviving spouse terminates on the earliest of the:

(a) day immediately preceding the date such person ceases to be an eligible dependent except as provided in (b) below;

(b) end of the month in which a dependent child attains age 19 unless such dependent qualifies as a full-time student or is totally disabled; or

(c) date coverage terminates for the pensioner or surviving spouse except that coverage of a dependent continues until the end of three months following the month in which a pensioner or surviving spouse dies.

Once you voluntarily terminate Program coverage, you will not have the opportunity to again enroll, except that if you voluntarily terminate such coverage because you are eligible for coverage under any other employer's insurance

program, you may again elect Program coverage provided you notify the claim administrator and follow all policies and procedures for cancellation and enrollment.

Medicare

If you or a dependent of yours is, or upon proper application would be, entitled to Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) by reason of attainment of age 65, disability, or end-stage renal disease, you or such dependent shall be considered to be so entitled on the first day on which you or such dependent is or upon proper application would become so entitled, whether or not proper application has been made or enrollment in Part A and B has been established.

Payment under the Program shall be the benefit which would otherwise be payable under the Program reduced by the amount of benefits which you or your dependent receives, or would receive upon proper application for Medicare Part A and B.

It is most important that when you or a dependent of yours approaches age 65 or becomes eligible by reason of disability or end-stage renal disease, you or such dependent enrolls in Medicare Parts A and B. Timely enrollment will avoid the loss of valuable protection against medical expenses. You must also advise the claims administrator of the effective date of Medicare coverage applicable to you or one of your eligible dependents. Failure to do so could result in overpayment of benefits that you would have to repay.

Any premiums paid by you or any of your eligible dependents for Medicare Part A or Part B will not be reimbursed by the Company.

Once you or an eligible dependent of yours becomes entitled to Medicare, the Managed care penalties and in-network and out-of-network benefit differentials under the Program are no longer in effect.

Benefits While Traveling Outside of the United States or Puerto Rico

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 of benefits or Medicare. 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 to the claim administrator 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.

Continuous Service

Wherever the term “continuous service” is used in this booklet, it means your continuous service as determined for pension purposes under the Company pension plan applicable to you.

Medical Necessity

Health care benefits under the Program are payable only if the services rendered are medically necessary. Medically necessary means that the services and supplies provided 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:

(a) procedures that are experimental or of unproven or questionable current usefulness;

(b) procedures which tend to be redundant when performed in combination with other procedures;

(c) diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly;

(d) procedures that are not ordered by a physician or that are not documented in timely fashion in the patient's medical record; and

(e) 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.

State or Federal Laws

If any 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.

Full-time Students

In order for a dependent child to be eligible for 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;

(b) Must not be employed on a regular full-time basis;

(c) Must not be paid by another employer while in school at the request of that employer;

(d) Must not be covered under any other employer group insurance or prepayment plan;

(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.

Since the determination of eligibility for benefits must necessarily be made at the time a claim for a covered service is made, eligible full-time students will not be formally enrolled or re-enrolled in the Program. Each semester, the Student Dependent Certification form must be completed and along with any supporting enrollment documents, forwarded to the claims administrator. A determination will then be made as to whether your dependent qualifies as an eligible full-time student under the Program. No dependent will be eligible for coverage as a full-time student until the Student Dependent Certification and form and supporting documentation is filed by you, each semester, and a determination on the dependents' status is made by the claims administrator.

The eligibility of 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.

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, or

(d) the end of the month in which the student attains age 25.

Disabled Children

In order for a dependent child to be eligible for health care benefits of the Program 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 obtain from the claims administrator the Disabled Dependent Certification form, complete it along with the dependent's attending physician, and return it to the claims administrator within 90 days of the date such dependent attains age 19. The form and any supporting information will be reviewed by the claims administrator and the Company to determine if such a dependent is eligible for benefits under the Program. You will be notified by the Company as to whether or not the dependent is eligible for benefit coverage under the Program as a disabled child. If eligibility is approved, you will be required, usually not more 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.

How to File a Claim

Claims for services covered under the Program are to be submitted to the designated claims administrator and must be filed no later than December 31 of the calendar year following the year in which the service(s) was incurred. Ispat Inland claim forms are available from the claims administrator. A provider may on your behalf file a claim directly with the claim administrator.

To ensure prompt and accurate processing of your claim, note the following:

(a) File a claim only when you have enough bills to satisfy the Program's deductible requirements.

(b) Print legibly or type the information requested on the Ispat Inland claim form. Complete both sides, answer all questions, and sign the form.

(c) Have your provider complete the "Provider's Statement" on the back of the claim form. Itemized bills may be attached if they include a valid and applicable current procedural terminology code (CPT code), facility revenue code or HCPCS code, diagnosis code, and the amount charged for each service.

(d) File a separate claim for each patient.

(e) Do not combine charges of different calendar years on the same claim form.

(f) Keep copies of all bills, submitted claim forms, and explanation of benefit statements.

(g) If you are enrolled in Medicare, or a claim for you or your dependent has been partially paid by another insurance plan, you must do the following:

  (1) Complete an Ispat Inland claim form or have the provider submit a claim on an acceptable form for you.

  (2) Attach a copy of the provider's bill that lists procedure or service codes, diagnosis, and amount charged.

  (3) Attach a copy of your Medicare Explanation of Benefits Statement, or the other plan's explanation of benefits statement with your claim.

(h) Send your completed form to the claim administrator at the address shown on the claim form.

If you file a claim in accordance with the provisions of the Program, you will receive an Explanation of Benefits (EOB) from the claims administrator who will tell you if your claim has been paid or denied or if additional information is needed. If additional information is requested, it is your responsibility to provide it, along with a copy of the EOB, to the claim administrator so that your claim can be processed with the additional information. If you claim is denied, the EOB will tell you the reason for the denial and how you can have the decision reviewed.

If you choose to have the denial reviewed, you, or your authorized representative, may file a request for review of benefits with the claims administrator. Under normal circumstances, a decision on your claim for benefits will be made within 90 days after receipt of your properly filed claim. However, in some cases more time might be needed to process your claim for benefits. If this happens, you will be notified that an additional 90-day processing period is required.

If your claim for benefits is denied, you will be notified in writing by the claims administrator. This written notice will tell you the reason for the denial, the provisions of the Program on which the denial is based, and what additional information is needed, if any, which could change the decision. The notice will also tell you how you can have the decision reviewed.

If you receive a written notice denying your claim for benefits, or if you have not heard anything within 90 days (180) days, if you received notice that an additional 90-day processing period was required) after you submitted your claim for benefits, you can have your claim reviewed. If you want your claim reviewed, you, or your authorized representative, must file a written request for review with the Plan Administrator within 60 days after you received the written notice of denial of your claim for benefits. If you did not receive a written notice of the denial of your claim for benefits, your written request for review must be filed within 60 days after the end of the 90-day period (180-day period if you were notified an additional 90-day processing period was required) after you filed your claim for benefits.

Under normal circumstances, the Plan Administrator will render a decision on your request for review within 60 days after receipt of your request for review. However, in some cases more time might be needed to process your request for review. If this happens, you will be notified that an additional 60-day processing period is required. If you do not receive a written decision on your request for review within the 60-day period (120 day period if you were notified an additional 60-day processing period is required) after receipt of your request for review, your claim shall be deemed denied.

No legal action may be commenced with respect to your claim for benefits later than one year after you originally filed a proper claim for benefits in accordance with this summary plan description. Further, you may not commence legal action with respect to a claim for benefits hereunder before you have exhausted these claim review procedures.

Other Provisions

Notwithstanding any contrary provision of the Program, the following will apply:

(a) Regardless of medical necessity, sterilization and reversal procedures will be covered under the Program; and

(b) The maternity and obstetrical benefits of the Program are provided for elective abortions where permitted by law.

Section 7 – Other Information

Official Plan Documents

Your Summary Plan Description (SPD) is the official Program document which has been established pursuant to the Pensioners' and Surviving Spouses' Health Insurance Agreement dated Aug. 1, 1993, and subsequent amendments as agreed to, between Ispat Inland Inc. ("Company") and the United Steelworkers of America ("Union"). 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 Program 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 Program and/or the Agreement and your booklet (or any other description of the Program), the text of the Program and/or Agreement controls.

ERISA Information (Employee Retirement Income Security Act of 1974, as Amended)

The Program is a welfare benefit plan called the Ispat Inland Inc. Program of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses.

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. Program of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses is 501.

The Plan Administrator is the Ispat Inland Inc. Manager, Employee Benefits. The day-to-day operation of the Program is handled by the claims administrator.

The Plan Administrator has the responsibility to the Program to make and enforce any necessary rules for the Program, and to interpret the Program provisions uniformly for all pensioners and surviving spouses. If it is necessary for you to communicate with the Plan Administrator or appeal a claim, you submit written comments or requests to the Plan Administrator, in care of Ispat Inland Inc. at the following address:

Manager, Employee Benefits
Ispat Inland Inc.
3210 Watling St.
East Chicago, IN 46312

The records of the Program are kept on the basis of a plan year, which is the 12-consecutive-month period beginning each Jan. 1.

The Corporate Secretary of Ispat Inland Inc. is the designated agent for the service of legal process.

The Corporate Secretary's address is:

Corporate Secretary
Ispat Inland Inc.
3210 Watling St.
East Chicago, IN 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 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 Program documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Program with the U. S. Department of Labor, such as detailed annual reports and Plan descriptions.

(b) Obtain copies of all Program 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 Program'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 Program 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 Program 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 you 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

The Program offers you and your family the opportunity for a temporary extension of medical 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.

As a retiree of the Company or eligible surviving spouse covered by the Program, your covered dependents have the right to choose COBRA continuation coverage if they lose group health coverage under the program for any of the following reasons:

(a) you die; or

(b) you divorce; or

(c) your child ceases to be qualified as an eligible dependent.

Under COBRA continuation coverage, you or members of your family have the responsibility to inform the Plan Administrator within 60 days of a divorce or a child losing dependant status under the Program. The Company has the responsibility to notify the claims administrator of your death.

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 that you want COBRA continuation coverage.

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 retirees, surviving spouses, or family members.

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.

COBRA continuation coverage may be cut short for any of the following reasons:

(a) the Company no longer provides group health coverage to any of its retirees or surviving spouses;

(b) the premium for COBRA continuation is not paid;

(c) the covered individual becomes covered under another group health plan that does not provide for a pre-existing condition; or

(d) the covered individual becomes entitled to Medicare.

(e) 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.

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.

When you become eligible for COBRA coverage, more specific information will be provided.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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). The12-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 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.

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 Acts of 1998

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)

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 Jan. 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.

Newborn's and Mother's Health Protection Act (NMHPA)

The United States Department of Labor enacted the NMHPA effective Jan. 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.

Pensioners' and Surviving Spouses'

Health Insurance Agreement

Between

Ispat Inland Inc.

and the

United Steelworkers of America

Effective August 1, 1999

Agreement

Agreement dated August 1, 1999 between Ispat Inland Inc. (the "Company") and the United Steelworkers of America (the "Union").

Definitions

Wherever used herein

(a) "Pensioner" means an individual who retired under the Company non-contributory pension plan, on other than a deferred vested pension, on or after August 1, 1993 from one of the bargaining units in Exhibit A, and at the time of retirement had 15 or more years of continuous service.

(b) "Surviving Spouse" means an individual who is receiving a Surviving Spouse's benefit under the Pension Agreement effective Aug. 1, 1999 between the Company and the Union by reason of the death of a person (hereinafter "Decedent") who at the time of death was in or retired from one of the bargaining units in Exhibit A.

(c) "Program" means the Program of Insurance Benefits III for Eligible Pensioners and Surviving Spouses established by this Agreement and described in the booklet adopted by the parties, such booklet being applicable to the Pensioners and Surviving Spouses referred to in its title and constituting a part of this Agreement as though incorporated herein.

(d) "Prior Program" means the Program of Insurance Benefits III for Eligible Pensioners and Surviving Spouses which was established by an Agreement dated August 1, 1993 between the Company and the Union.

Program of Insurance Benefits

The Program shall be applicable to Pensioners and Surviving Spouses in accordance with the provisions of this Agreement, subject to the following provisions:

(a) Except as provided in (b) and (c) below, in no event shall any benefit provisions of the Program be applicable (i) to any period prior to August 1, 1999, nor (ii) to any part of a period of continuous hospitalization or skilled nursing facility care which commenced prior to the later of August 1, 1999 or the effective date of coverage under the Program.

(b) The benefits of the Prior Program shall be applicable to any occurrence prior to August 1, 1999, subject to any occurrence prior to August 1, 1999, subject to all of the provisions of the Prior Program, except that to the extent Program 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.

Cost of Benefits

The cost of the benefits under the Program shall be paid in part by the Company and in part by the Pensioner or Surviving Spouse who elect such coverage as provided in the Program. In the event services are provided through an HMO and the cost of those services 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.

Requirements of Law

It is intended that the provisions for the insurance benefits which shall be included in the 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 benefits under the Program are provided under law rather than under the Program, the Company will pay any direct contribution required of any pensioner or surviving spouse by law on account of such benefits, except as otherwise provided in the Program with respect to the Medicare Part B premium. The Company shall, after consultation with the Union, reduce the benefits of the Program to the extent that benefits provided under any law would otherwise duplicate any of the Program benefits.

Administration of the Program

The Program shall be administered by the Company or through arrangements provided by it. Any contracts entered into by the Company with respect to the benefits of the Program shall be consistent with this Agreement and shall provide benefits and conditions conforming to those set forth in this document.

Life Insurance after Retirement

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.

Continuation of Coverage

Any Pensioner or individual receiving a Surviving Spouse's benefit who shall become covered by the Program established by this Agreement shall not have such coverage terminated or reduced (except as provided in this Program) so long as the individual remains retired from the Company or receives a Surviving Spouse's benefit, notwithstanding the expiration of this Agreement, except as the Company and the Union may agree otherwise.

Term of this Agreement

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.	UNITED STEELWORKERS OF AMERICA
/s/	/s/
William P. Boehler	Thomas Hargrove
Director, Industrial Relations	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

* - Includes full-time officers.