
# *AK Steel Corporation*
# Insurance Benefits Plan II

# IAM Local 1943
# Hourly Employees

**Summary Plan Description**

**Effective June 1, 2007**

## FOREWORD

This booklet is the summary plan description required by the Employee Retirement Income Security Act of 1974 (ERISA) of the AK Steel Corporation Insurance Benefits Plan II which has been established pursuant to the Agreement dated March 15, 2007, between AK Steel Corporation and International Association of Machinists, AFL-CIO, IAM Local Lodge 1943. This booklet is applicable to hourly paid employees of AK Steel Corporation (hereafter, the “Company") whose headquarters are located at 9227 Centre Pointe Drive, West Chester, Ohio 45069, represented by the International Association of Machinists, AFL-CIO (hereafter, the "Union"), whose headquarters are located at Executive Plaza III, 135 Merchant Street, Suite 265, Cincinnati, OH 45246.

This booklet is intended only as an outline of the Plan for general information of employees designated by the Company as participating in the Plan and not as a full statement of the Plan. The policies and contracts with the carriers contain the complete terms and conditions and all statements in this booklet are subject to the detailed provisions of such policies and contracts.

The Plan is an employee welfare benefit plan which provides life insurance, medical, dental and vision care benefits for you and your eligible dependents. In addition, you are insured for sickness and accident benefits and for accidental death and dismemberment insurance.

The purpose of the AK Steel Corporation Insurance Benefits Plan is to provide protection against severe financial losses caused by death, illness, and injury. Although broad in scope, it does not attempt to pay all of the expenses which may arise from these emergencies. The benefits under this Plan should be considered as a supplement to your own provisions for the protection of your family and not as a complete substitute for your personal savings and insurance.

The name of the plan under which benefits are provided is the AK Steel Corporation Insurance Benefits Plan II for employees of AK Steel Corporation. The employer identification assigned by the Internal Revenue Service is 31-1267098 and the Plan Number is 501. This is a welfare benefit plan as defined by ERISA. Certain benefits under the plan are provided from special funds held by CIGNA.

The plan covers employees in bargaining units of AK Steel Corporation, represented by International Association of Machinists, AFL-CIO. Upon your written request, the plan administrator will advise you if a particular employer or employee organization is a sponsor of the plan, and the address of such employer or employee organization.

The benefits described herein are provided based on a premium share arrangement outlined in the Agreement between AK Steel Corporation and the International Association of Machinists, AFL-CIO. Records of the plan are kept on a calendar-year basis.

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# HIGHLIGHTS OF PLAN BENEFITS

This booklet contains detailed explanation of the benefits and related provisions of the Plan benefits. The administration of the Insurance Benefits Plan will be coordinated through the carriers under the direction of the Company.

## Life Insurance

If you should die while you are an active employee, or after retirement on other than a deferred vested pension before you reach age 62, the beneficiary named by you will receive life insurance of $62,500. If you die after you have retired with an immediate pension and have reached age 62, the amount of life insurance is reduced to $11,000.

## Sickness and Accident Benefits

If you are totally disabled because of sickness or accident, and meet certain requirements, you will receive a weekly benefit, subject to certain deductions. Benefits are provided during the continuance of your disability for a maximum of 104 weeks if you have 20 or more years of service, 52 weeks if you have two but less than 20 years of service and for shorter maximum periods if you have less than two years of service.

## Managed Care Program

Your medical benefits are covered under an Anthem program with the BlueCard Preferred Provider Organization (PPO).

## Mental & Nervous/Substance Abuse Program

All mental and nervous or substance abuse coverage will be provided through Anthem Behavioral Health.

## Prescription Drug Benefits

Prescriptions for retail drugs can be filled for up to a 30-day supply at a Network Pharmacy for a cost of $10.00 per prescription for generic, $20.00 per prescription for formulary (preferred) brand and $30.00 per prescription for non-formulary (non-preferred) brand.

## Mail Order Maintenance Prescription Drug Program

Prescriptions for maintenance drugs can be filled for up to a 90-day supply through your Mail Order Drug Program for a cost of $20.00 per prescription for generic, $40.00 per prescription for formulary (preferred) brand and $60.00 per prescription for non-formulary (non-preferred) brand.

## Dental Benefits

You will receive coverage for dental treatment through MetLife.

## Vision Care Benefits

You will receive coverage for vision care benefits through EyeMed Vision Care.

## Optional Continuation of Health Insurance

If you or your dependents lose health insurance coverage as a result of certain specified events, you may elect to continue coverage for up to 18 to 36 months, depending upon the event, at your own cost.

## Health Insurance Portability and Accountability Act

If you or your dependents lose health insurance coverage under this plan, you have the right to request a certificate of coverage from AK Steel Corporation in order to establish qualification with another plan that may have pre-existing conditions. You will be notified of your right to receive this certification with notification of Optional Continuance of Health Insurance.

## Conversion Privileges

If coverage under the Plan terminates, you may obtain an individual policy of life insurance with CIGNA and may obtain medical coverage with Anthem on a direct-pay basis.

The remaining sections of this booklet describe the general provisions of the Plan.

## DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

**Administrative Services Agreement -** The agreement between the Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

**Administrator** - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

**Alternate Recipient** - Any child of a Subscriber who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under the Plan with regard to such Subscriber.

**Authorized Service** - A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Administrator, on behalf of the Employer, to be paid at the Network level.

**Benefit Booklet** - This summary of the terms of your health benefits.

**Benefit Period** - The period of time that benefits for Covered Services are payable under the Plan. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

**Coinsurance** – A specific percentage of the Maximum Allowable Amount for Covered Services that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies to the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions.

**Copayment** - A specific dollar amount or percentage of Maximum Allowable Amounts for Covered Services indicated in the Schedule of Benefits for which you are responsible. The Copayment does not apply towards any Deductible. Your flat dollar Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

**Covered Services** - Services, supplies or treatment as described in this Benefit Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this

Benefit Booklet.

- Within the scope of the license of the Provider performing the service.

- Rendered while coverage under the Plan is in force.

- Authorized in advance by the Administrator, on behalf of the Employer, if such Prior Authorization is required in the Plan.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you.

**Covered Transplant Procedure** - Any Medically Necessary human organ and tissue transplant as determined by the Administrator, on behalf of the Employer, including necessary acquisition costs and preparatory myeloblative therapy.

**Covered Transplant Services** - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

**Custodial Care** - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value.

**Deductible** - The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before benefits are payable under the Plan for Covered Services each Benefit Period.

**Dependent** - A person of the Subscriber's family who is eligible for coverage under the Plan.

**Diagnostic Service -** A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition or a test performed as a Medically Necessary preventive care screening for an asymptomatic patient. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

**Domiciliary Care** - Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

**Effective Date** - The date your coverage begins under the Plan. The Effective Date of Coverage begins on the day you attain 520 hours of actual work (approximately three

months of uninterrupted employment with the company). No benefits are payable for services and supplies received before your Effective Date or after your termination date.

**Eligible Person** - A person who satisfies the Employer's eligibility requirements and is entitled to apply to be a Subscriber.

**Emergency Care** – In-network benefits cover you for emergency care wherever the emergency occurs. A medical emergency is the sudden and unexpected onset of a condition or illness with severe symptoms which requires immediate care. Examples of medical emergencies are:

- Severe chest pain,
- Severe breathing difficulties,
- Severe or multiple injuries,
- Obvious fractures, and
- Lacerations (deep, requiring sutures).

In these types of situations, seek treatment immediately at the nearest emergency facility.

If you go to an emergency facility without reference from an in-network provider and the condition is not considered a medical emergency, only out-of-network benefits will be payable.

Some examples of conditions usually not considered to be emergencies include:

- Colds,
- Influenza,
- Coughs,
- Earache,
- Pink eye,
- Sprains

If you feel the condition warrants emergency treatment, you should follow Anthem's appeals procedure outlined in this booklet.

**Employer** - The legal entity contracting with the Administrator for administration of group health care benefits.

**Enrollment Date -** The first day of any plan year, or the date you first become eligible for coverage under the Plan after completing 520 hours of work and after enrollment material is submitted to the Administrator.

**Experimental/Investigative** - Procedures or services which are still in the investigative or research state; which have not been adopted for general clinical usage and have not been approved by the appropriate review body; and are not generally accepted by the medical community as safe, effective treatment.

**Family Coverage –** Coverage provided by the Employer for the Subscriber and eligible Dependents.

**Fee(s)** - The periodic charges which are required to be paid by you and/or the Employer to maintain benefits under the Plan.

**Identification Card -** A card issued by the Administrator, on behalf of the Employer, that bears the Member's name, identifies the membership by number, and may contain information about your benefits under the Plan. It is important to carry this card with you.

**Inpatient** - A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

**Lifetime Maximum -** The maximum dollar amount for Covered Services paid by the Plan during your lifetime.

**Maximum Allowable Amount** - The amount that the Administrator or the Administrator's Subcontractor determines, on behalf of the Employer, is the maximum payable for Covered Services you receive, up to but not to exceed charges actually billed. Generally, to determine the Maximum Allowable Amount for a Covered Service, the Administrator or the Administrator's Subcontractor use internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with the Administrator, on behalf of the Employer, for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for the Plan.

For a Non-Network Provider which is a facility, the Maximum Allowable Amount is equal to an amount negotiated with that Non-Network Provider facility for Covered Services under this product or any other product. In the absence of a negotiated amount, the Administrator shall have discretionary authority to establish as the Administrator deems appropriate, the Maximum Allowable Amount for a Non-Network Provider facility. The Maximum Allowable Amount is the lesser of the Non-Network Provider facility's charge, or an amount determined by the Administrator, after consideration of any one or more of the following: industry cost, peer reimbursement, utilization data, previously negotiated rates, outstanding offers that the Administrator may have made, or other factors the Administrator, on behalf of the Employer, deems appropriate. It is your obligation to pay any Copayments and Deductibles, and any amounts which exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with the Administrator.

**Medically Necessary** or **Medical Necessity -** Health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;

- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

- Not primarily for the convenience of the patient.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

**Medicare** - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

**Member** - A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, and for whom Fee payment has been made. Members are sometimes called "you" or "your."

**Mental Health Conditions (including Substance Abuse)** – A condition identified as a mental disorder in the most current version of the International Classification of Diseases, in the chapter titled “Mental Disorders”.

- **Mental Health** is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical causes.

- **Substance Abuse** is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

**Mental Health/Substance Abuse Subcontractor** – an organization or entity that the Administrator, on behalf of the Employer, has a contract with to provide administrative and claims payment services and/or Covered Services regarding Mental Health/Substance Abuse services under this Plan. These administrative services may also be provided directly by the Administrator, on behalf of the Employer

**Network Provider** - A Provider who has entered into a contractual agreement or is otherwise engaged by the Administrator, or with another organization which has an agreement with the Administrator, regarding payment for Covered Services and certain administration functions for the Network associated with the Plan.

**Network Transplant Facility –** A Provider who has entered into a contractual agreement or is otherwise engaged by the Administrator, on behalf of the Employer, or with another organization which has an agreement with the Administrator, on behalf of the Employer, to provide Covered Services and certain administrative functions to you for the network associated with this Benefit Booklet. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or

- All Covered Transplant Procedures.

**New FDA Approved Drug Product or Technology -** The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- New formulations - a new dosage form or new formulation of an active ingredient already on the market;

- Already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);

- Already marketed drug product, but new use - a new use for a drug product already marketed by the same or a different firm; or

- Newly introduced Generic medication (Generic medications contain the same active ingredient as their counterpart brand-named medications).

**Non-Network Provider** - A Provider who has not entered into a contractual agreement with Administrator, on behalf of the Employer, or is not otherwise engaged by Administrator, on behalf of the Employer, for the network associated with this Plan. Providers who have not contracted or affiliated with Administrator's designated Subcontractor(s) for the services they perform under this Plan are also considered Non-Participating/Network Providers.

**Non-Network Transplant Facility -** Any Hospital which has not contracted with the transplant network engaged by Administrator, on behalf of the Employer, to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or

- All Covered Transplant Procedures.

**Out-of-Pocket Limit -** A specified dollar amount of expense incurred for Covered Services in a Benefit Period as listed in the Schedule of Benefits. Such expense does not include charges in excess of the Maximum Allowable Amount or any non-Covered Services. Refer to the Schedule of Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Coinsurance is required unless otherwise specified in this Benefit Booklet.

**Outpatient** - A Member who receives services or supplies while not an Inpatient.

**Pharmacy and Therapeutics Committee** - a committee, contracted by Anthem, of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

**Plan** - The group health benefit Plan provided by the Employer and explained in this Benefit Booklet.

**Prior Authorization** – The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered by Anthem. The drugs and criteria for coverage are defined by the Pharmacy and Therepeutics Committee.

**Provider -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities:

- **Alternative Care Facility -** A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

    1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);

    2. Surgery;

    3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A Provider that:

    1. Is licensed as such, where required;

    2. Is equipped mainly to do Surgery;

    3. Has the services of a Physician and a Registered Nurse (R.N.) at all times when a patient is present;

    4. Is not an office maintained by a Physician for the general practice of medicine or dentistry; and

    5. Is equipped and ready to initiate Emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:

    1. Constituted, licensed, and operated as set forth in the laws that apply;

2. Equipped to provide low-risk maternity care;

3. Adequately staffed with qualified personnel who:

   a. Provide care at childbirth;

   b. Are practicing within the scope of their training and experience; and

   c. Are licensed if required; and

4. Equipped and ready to initiate Emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider-constituted facility, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. Provides room and board and nursing care for its patients;

  2. Has a staff with one or more Physicians available at all times;

  3. Provides 24 hour nursing service;

  4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care;
2. Rest care;
3. Convalescent care;
4. Care of the aged;
5. Custodial Care;
6. Educational care;
7. Treatment of alcohol abuse; or
8. Treatment of drug abuse.

- **Physician** -

  1. A legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
  2. Any other legally licensed practitioner of the healing arts rendering services which are:
     a. Covered by the Plan;
     b. Required by law to be covered when rendered by such practitioner; and
     c. Within the scope of his or her license.
  3. Physician does not include:
     a. The Member; or
     b. The Member's spouse, parent, child, sister, brother, or in-law.

- **Skilled Nursing Facility** - A Provider-constituted facility, licensed, and operated as set forth in applicable state law, which:

  1. Mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. Provides care supervised by a Physician;

3. Provides 24-hour per day nursing care supervised by a full-time Registered Nurse;

4. Is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. Is not a rest, educational, or custodial Provider or similar place.

- **Urgent Care Center -** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care.

**Recovery** - A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist," "Underinsured Motorist," "Medical-Payments," "No-Fault," or "Personal Injury Protection," or other insurance coverage provision as a result of injury or illness caused by another.

**Service Area** - The geographical area within which Covered Services under the Plan are available.

**Single Coverage –** Coverage for the Subscriber only.

**Skilled Care -** Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

**Stabilize -** The provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- Your discharge from an Emergency department or other care setting where Emergency Care is provided to you;

- Your transfer from an Emergency department or other care setting to another facility; or

- Your transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

**Subcontractor** - The Administrator and/or Employer may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Administrator's or Employer's behalf.

**Subscriber -** An eligible employee or retired employee or Member of the Employer enrolled under the Plan, whose benefits are in effect and whose name appears on the Identification Card issued by the Administrator, on behalf of the Employer.

**Temporomandibular Joint (TMJ) / Temporomandibular disorder (TMD) -** The temporalmandibular joint is a complicated joint formed where the lower jaw bone attaches to the head. TMD refers to general class of disorder affecting the bones and muscles of this region. Symptoms range from tenderness and swelling to headaches and neck and back aches. Generally, a clicking or popping sound when the jaw is opened or closed is evidence or some form of one of the disorders.

**Therapy Services** - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

# LIFE INSURANCE

## General

In the event of your death, your life insurance will be payable to any person you designate as beneficiary. You have the right to change the beneficiary at any time by completing and returning the proper beneficiary change form to the employee benefits office at the plant or office where you work. The amount of your basic life insurance is $62,500. See below for life insurance after retirement.

## Payment of Benefits

In the event of your death from any cause, your life insurance will be payable to any person you designate as beneficiary. You have the right to change the beneficiary at any time, on a form provided by the company, and such change shall take effect only upon its entry on the insurance records maintained in connection with the policy. Benefits are payable in a lump sum or in installments.

## 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, should your death occur before you retire.

## Extended Benefits during Total Disability

If, while insured under the Program and before age 65, you become totally disabled for a period in excess of six months and thereafter submit satisfactory evidence of continuing total disability as required by CIGNA, your life insurance will be continued, without contributions from you, in the full amount as of your last day of work, until the end of the month in which you attain age 65. Thereafter, your basic life insurance will be reduced to $11,000.

## Life Insurance after Retirement

If you were hired prior to March 15, 2007, and retire under the Company pension plan applicable to you prior to age 62, and your life insurance is not being continued in accordance with the provisions relating to total disability described under **Extended Benefits during Total Disability**, your basic life insurance will be continued without contributions from you in the full amount until the end of the month in which you attain age 62. Thereafter, your basic life insurance will be reduced to $11,000.

If you were hired prior to March 15, 2007, and retire under the Company pension plan applicable to you on or after age 62, and your life insurance is not being continued in accordance with the provisions relating to total disability described under **Extended Benefits during Total Disability**, your basic life insurance amount will be $11,000.

If you become eligible for a deferred vested retirement pension, you will not be eligible for company provided group life insurance.

**Group Term Life Insurance**

The life insurance under the Plan is group term life insurance and has no cash, loan, or paid-up values. Its purpose is to protect your family against the loss of income resulting from your death, either before or after your retirement. If your insurance is terminated, you may convert to an individual policy by contacting your benefits administrator.

## DEPENDENT LIFE INSURANCE

### When and to Whom Benefits are Payable

Benefits are payable to you in the event of the death of your insured dependent (as defined in this booklet). If you are not living at that time, payment will be made:

1. In the case of the death of your spouse, to the spouse's executors or administrators,

2. In the case of the death of your child, to the first surviving class of the following classes of successive preference beneficiaries; the child's

    a. Surviving parent,

    b. Surviving brothers and sisters,

    c. Executors or administrators.

In the absence of the appointment of a legal guardian, any minor's share may be paid at a rate not exceeding $50 a month to such adult or adults as have, in CIGNA's opinion, assumed the custody and principal support of such minor.

### Amount of Dependent Life Insurance

| | |
|---|---|
| Your Spouse | $5,000 |
| Dependent Child | $3,000 |

Note: After retirement, on other than a deferred vested pension, your spouse will be covered for $1,000 provided he or she is covered under the Plan immediately prior to your retirement. Dependent child(ren) coverage is discontinued upon retirement.

### What Happens to Your Dependents' Insurance if You Die or Leave Our Employ

If you die while still in our employ, protection for your spouse and dependent children insured upon the date of your death will be continued for six months after your death.

If you leave our employ, become a Long Term Disability Benefits recipient, or retire on pension, your dependents' insurance will be continued in full for 31 days. During the 31-day period, the spouse can obtain, in replacement of discontinued or reduced coverage, individual life insurance. If the beneficiary named to receive the death benefit under such individual policy or in the application therefore is different from the beneficiary named under the group policy, any amount becoming payable under the group policy will be payable to the beneficiary so named with respect to such individual policy.

**How to File a Claim**

You will be provided the necessary forms for making a Dependent Life Insurance claim by notifying the plant or office location where you work.

## BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

### Amount of Benefits

The amount of your accidental death and dismemberment insurance is $31,500. In the event you sustain, while insured, occupational or non-occupational bodily injuries caused directly or exclusively by external, violent and purely accidental means, and, within ninety days after such injuries, and as a result, directly or independently of all other causes, of such injuries, sustain any of the losses enumerated below, this insurance, subject to the provisions and limitations of the policy, is payable to you or your beneficiary in an amount as directed below, for loss of:

| Bodily Injury Result | Percentage of Benefit Amount Payable |
|---|---|
| Loss of life | 100% |
| Loss of one hand and one foot<br>Loss of both hands or both feet<br>Loss of sight in both eyes<br>Loss of one hand and sight in one eye<br>Loss of one foot and sight in one eye | 100% |
| Loss of one hand or foot<br>Loss of sight in one eye | 50% |

If more than one of the losses is sustained as a result of any one accident, payment will be made only for the loss for which the larger amount of indemnity is payable.

Loss of hand or foot means by severance at or above the wrist or ankle joint, and loss of sight means total and irrecoverable loss of sight.

Payment will be made for the specific loss resulting from the accident without considering any previous loss.

### Payment of Claims

These benefits are in addition to any benefits which may be payable under other forms of group insurance. If you die as a direct result of such accidental injury, the benefits will be paid to your beneficiary. If you become blind or lose your hands or feet because of such accidental injury, benefits will be paid to you.

No payments will be made for any loss resulting from or caused directly or indirectly, wholly or partly by:

1. Bodily or mental infirmity, hernia, ptomaines, bacterial infections (except infections caused by pyogenic organisms which shall occur with and through an accidental cut or wound) or disease or illness of any kind, or

2. Self-destruction or self-inflicted injury, while sane or insane, or

3. War or an act of war, or service in any military, naval or air force of any country while such country is engaged in war, or performing police duty as a member of any military or naval organization, or

4. Participation in or in consequence of having participated in the committing of a felony.

**Proof of Claim**

Written proof of loss on which claim may be based must be given to CIGNA within 90 days after the date of the loss. Failure to furnish proof within the time specified will not invalidate or reduce any claim if it is shown not to have been reasonably possible to furnish proof within the time specified and that proof was furnished as soon as was reasonably possible.

CIGNA, at its own expense, has the right and opportunity to have a physician designated by it examine you when and as often as it may reasonably require while a claim is pending.

No action at law or in equity may be brought to recover under the Group Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Group Policy. No such action may be brought after the expiration of three years following the time written proof is required to be furnished.

**How to File a Claim**

You or your designated beneficiary will be provided the necessary forms for claiming the Accidental Death and Dismemberment insurance proceeds by notifying the Employee Benefits Office.

# SICKNESS AND ACCIDENT BENEFITS

## Amount of Benefits

If you become wholly and continuously disabled as a result of sickness or accident which prevents you from performing the duties of your employment, and a licensed physician certifies your disability, you will be eligible to receive weekly sickness and accident benefits. Benefits will not be payable for any period during which you are not under the care of a licensed physician. In order for you to be eligible for benefits the company must receive written notice of your claim within 21 days after your disability commences, but this requirement will be waived upon showing of good and sufficient reason that you were unable to furnish such notice or have it furnished by someone else on your behalf.

See below for the amount of weekly benefits based on labor grade.

### SCHEDULE OF SICKNESS AND ACCIDENT BENEFITS

| ***Sickness and Accident Weekly Benefit*** | | | |
|---|---|---|---|
| **Labor Grade*** | **3/15/2007** | **9/15/2008** | **3/15/2010** |
| 1 | $414 | $426 | $439 |
| 2 | $445 | $459 | $473 |
| 3 | $496 | $510 | $525 |
| 4 | $516 | $531 | $547 |
| 5 | $543 | $558 | $575 |

* To determine your labor grade, see the **Schedule of Labor Grades** at the end of this booklet.

In the event you become wholly and continuously disabled due to sickness or accident arising out of or in the course of your employment with the company or any other employer, the amount of benefits otherwise payable will be reduced by any benefits which you are or could become entitled to receive during the period of your absence from work due to such disability pursuant to any workers' compensation law or any occupational disease law or other applicable law. Payments under any such law for hospitalization or medical expense or specific allowances for any loss of members or disfigurements in excess of the portion of such allowances attributable to temporary total disability will not reduce the amount of your sickness and accident benefits.

If you are otherwise entitled to sickness and accident benefits and there is a dispute as to your entitlement to payments for which you are making claim pursuant to any workers' compensation or occupational disease law or other similar applicable law, the sickness and accident benefits will be paid in full if satisfactory arrangements are made

to assure that any overpayment of sickness and accident benefit as a result of your success in pursuing such claim shall be reimbursed by you. Such arrangements shall include the execution by you of necessary documents authorizing the deduction of any such overpayment from any payments becoming due as a result of such claim or from any amount payable to you by or on behalf of the company, including benefits and wages.

If you are entitled to receive disability benefits under any state plan, or would upon application become eligible to receive such benefits, the sickness and accident benefits under the Plan will be reduced by the amount of the benefits provided under the state plan.

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

The company will assume that you are receiving a benefit under the Social Security Act, in an estimated amount, and your sickness and accident benefits will be reduced by such estimated Social Security benefit until the company is furnished a copy of your Social Security award so that it may determine the exact amount of reduction.

If, however, you are eligible for sickness and accident benefits for a period in excess of 26 weeks and you furnish to the company written proof within the initial 15 weeks of disability that you have applied for disability benefits under the Social Security Act and do not receive such benefits when they are initially due, full weekly benefits will be continue to the earlier of;

1. The date such Social Security disability benefits commence; or

2. The date 34 weeks of weekly benefits are paid;

*You must make satisfactory arrangements with the company to assure that any overpayment of weekly benefits which may result by reason of receipt of Social Security benefits will be repaid to the company.* To be eligible for this arrangement you will be required to sign an agreement to reimburse the company promptly upon receipt of any retroactive payment of Social Security disability benefits and authorize deduction of such overpayment from any amount payable to you by or on behalf of the company, including benefits and wages. You will also be required to sign an authorization for the Social Security Administration to release relevant information to the company.

In any event, you will be paid the full weekly benefit amount if:

1. You are not old enough to qualify for an unreduced primary old-age benefit; and

2. You furnish satisfactory evidence that in the judgment of a licensed physician your condition is such that you will be able to engage in substantial gainful employment prior to the expiration of 12 months from the commencement of your disability; or

3. You inform the company that your application for Social Security disability benefits has been denied; or

4. You have not been disabled for a period sufficient to qualify for Social Security disability benefits.

**Duration of Benefits**

Benefits begin with the first day of total disability resulting from an accident and with the eighth consecutive day of total disability resulting from a sickness or the first day of treatment by a physician, whichever is later. If you are admitted to a hospital prior to the eighth day of sickness or if you have out-patient surgery which renders you unable to work, as certified by the attending licensed physician, benefits will begin on the first day of hospital confinement. Benefits are payable:

1. If you have less than two years of continuous service on the date a period of disability commences, for a period not to exceed 26 weeks for any one continuous period of disability; provided that, if you have less than 26 weeks of continuous service, the period for which benefits are payable in the case of a non-occupational disability shall not exceed the number of full weeks of continuous service you had on the date such continuous period of disability commenced; or

2. If you have two or more years of continuous service on the date a period of disability commences, for a period not to exceed 52 weeks for any one continuous period of disability. Additionally, if, on your last day worked you had 20 or more years of continuous service, benefits will be continued for a period not to exceed 52 additional weeks.

Sickness and accident benefits terminate when you retire under the AK Steel Corporation Noncontributory Pension Plan or become a benefit recipient under the AK Steel Corporation Long Term Disability Benefits Plan.

Successive periods of disability separated by less than two weeks of continuous active employment with the company will be presumed to be one continuous period of disability unless it is clear that they arise from unrelated causes. If you complete two years of continuous service after the onset of one continuous period of disability and before the onset of a succeeding period of disability which is considered to be part of the initial period of disability, your benefits are payable for a period not to exceed 52 weeks. Similarly, if you complete 20 years of continuous service after the onset of one continuous period of disability and before the onset of a succeeding period of disability which is considered to be part of the initial period of disability, your benefits are payable for a period not to exceed 104 weeks.

## Transplant Benefits

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

## Administration of Benefits

To be eligible for sickness and accident benefits, the company must receive written notice of your claim within 21 days after disability commences, however this requirement will be waived upon showing of good and sufficient reason that you were unable to furnish such notice or have it furnished by someone else on your behalf.

Normally it is anticipated that a disabled employee will obtain, or have someone on his/her behalf obtain, a sickness and accident claim form from the company. The disabled employee or someone on his/her behalf must complete his/her portion of the form, have his/her physician complete the attending physician's portion of the form and return it to the company within 21 days of commencement of his/her disability. To remind the employee of the notice requirement, appropriate instructions have been included on the claim form. If an employee is unable to comply with this procedure, he/she is expected to notify the company in writing of his/her disability before the end of the 21-day period.

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

In determining fractional periods of benefits, one-seventh of the weekly benefits will be paid for each day of disability.

# PPO PROGRAM

## Introduction

This section describes the Managed Health Care Insurance Program, called Anthem BlueCard Preferred Provider Organization (PPO). When reviewing it, there are several important things to remember:

1. The Program pays for the diagnosis and treatment of a health problem. Preventive care is paid for only when specifically stated in this Benefit Booklet.

2. In-network benefits are provided for treatment which is Medically Necessary and appropriate as determined by the Administrator. For example, certain procedures such as minor surgery, or removing a cyst or mole, can generally be done safely in a doctor's office or on an Outpatient basis at a hospital without hospitalization. The Program therefore, would not pay for those hospital room and board charges, if they are deemed inappropriate or unnecessary.

3. For purposes of this Plan, "Network" and "Administrator" refer to Anthem BlueCard PPO, or in the case of Mental and Nervous/Substance Abuse treatment, Anthem Behavioral Health.

For information regarding your claims, to find forms, or to find a list of providers, you may go online to www.anthem.com or call 1-800-891-9212.

## Network Services and Benefits

Network Providers include Physicians, Professional Providers, Hospitals and Facility Providers who contract with the Administrator, on behalf of the Employer, to perform services for you. Benefits will be provided at the Network level if the Administrator determines the services or supplies are Medically Necessary.

If a Provider is not included in the Network, contact the Administrator prior to obtaining services from the Provider (except for Emergency care which may be authorized after the service is rendered). The Administrator, on behalf of the Employer, may approve a Non-Network Provider as an Authorized Service.

For services rendered by Network Providers:

1. You will not be required to file claims for services you obtain directly from Network Providers;

2. Network Providers will seek compensation from you for approved Copayments and/or Deductibles;

3. You may also be billed by your Network Provider(s) for any non-Covered Services you receive; and

4. Network Providers will be responsible for services performed that are not Medically Necessary.

**Non-Network Services**

Services which are obtained from a Non-Network Provider will be considered a Non-Network Service unless you obtain advance authorization to obtain services from the Non-Network Provider from the Administrator. The only exceptions are Emergency Care and Urgent Care. In addition, certain services are not covered unless obtained from a Network Provider; see your **Schedule of Benefits.**

For services rendered by a Non-Network Provider, you are responsible for:

1. Obtaining any precertification which is required;

2. Filing claims; and

3. Higher cost sharing amounts.

If there is no Network Provider who is qualified to perform the treatment you require, contact the Administrator prior to receiving the service or treatment and the Administrator will, if appropriate, approve a Non-Network Provider for that service as an Authorized Service.

Members must obtain approval or precertification from the Administrator before incurring expenses for certain Covered Services. Refer to the **Precertification** section for details.

**Coronary Services Centers**

You are encouraged to use the Coronary Services Centers when you require non-Emergency cardiac care. Hospitals that are selected to participate as a Coronary Services Center have undergone a rigorous evaluation process.

If, at any time, you experience life-threatening cardiac symptoms, such as chest pains or shortness of breath, seek care immediately at the nearest Hospital. Please refer to the **Emergency Care** section for further information.

**Relationship of Parties (Administrator - Network Providers)**

The relationship between the Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Administrator, nor is the Administrator, or any employee of the Administrator, an employee or agent of Network Providers.

The Administrator shall not be responsible for any claim or demand as a result of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including Network Providers, Non-Network Providers and disease management programs. If you have questions regarding such incentive or risk sharing relationships, please contact your Provider or the Administrator.

**Not Liable for Provider Acts or Omissions**

The Administrator and/or the Employer are not responsible for the care you receive from any person or Provider. The Plan does not give anyone any claim, right, or cause of action against the Administrator and/or the Employer based on what a person or Provider of health care, services or supplies, does or does not do.

**Identification Card**

When you receive care from your Network Provider or other Provider, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under the Plan. To be entitled to such services or benefits you must be a Member on whose behalf all applicable Fees under the Plan have been paid. Any person receiving services or other benefits to which he or she is not then entitled under the provisions of the Plan will be responsible for the actual cost of such services or benefits.

**Right to Services and Benefits**

When you receive care from your Network Provider or other Provider, you must show your Identification Card. Possession of an Identification Card does not guarantee any right to services or other benefits under the Plan. To be entitled to services or benefits under the Plan, you must be a Member on whose behalf all applicable Fees have been paid and comply with all applicable procedural and administrative requirements including Precertification if necessary. Any person receiving services or other benefits to which he or she is not entitled under the provisions of the Plan will be responsible for the actual cost of such services or benefits.

**Schedule of Benefits**

The Schedule of Benefits is a summary of the Copayments and other limits that are applicable when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of ths Plan. This Schedule of Benefits lists the Member's responsibility for Covered Services and supplies.

**Benefit Period** Calendar Year

**Dependent Age Limit** To the end of the month in which the child attains age 21; or to the end of the month in which the child attains age 25 if the child is a Full-Time Student or an eligible Disabled Dependent as described under the **Full-Time Student** and **Disabled Dependent** sections.

| Deductible | Network | Non-Network |
|---|---|---|
| Per Person | N/A | $500 |
| Per Family | N/A | $1,000 |

| Out-of-Pocket Limit | Network | Non-Network |
|---|---|---|
| Per Person | $1,000 | $3,000 |
| Per Family | $2,000 | $6,000 |

**Note:** The Out-of-Pocket Limit includes all Deductibles and/or Coinsurance you incur in a Benefit Period. However, Prescription Drug Copayments and flat dollar Copayments (if applicable) do not apply toward the Out-of-Pocket Limit. Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period except for Prescription Drug Copayments and flat dollar Copayments (if applicable).

Network and Non-Network Deductibles, Copayments, and Out-of-Pocket Limits **are separate and do accumulate toward each other.** The Deductible(s) apply only to Covered Services with a percentage Copayment.

**Lifetime Maximum**

The Lifetime Maximum for All Covered Services is $2,000,000, with a $10,000 annual restoration. Network and Non-Network services, up to $500,000 of the Lifetime Maximum can be used for Non-Network services.

| Covered Services | Network (You Pay) | Non-Network (You Pay) |
|---|---|---|
| **Preventive Care** | Covered in full up to the Maximum Allowable Amount | Not Covered |
| **Physician Office Services** | $15 Copayment | 30% Coinsurance subject to Deductible |
| Allergy Injections and Serum | Covered in full up to the Maximum Allowable Amount | 30% Coinsurance subject to Deductible |
| Allergy Testing and Other Services | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |

| Covered Services | Network (You Pay) | Non-Network (You Pay) |
|---|---|---|
| **Inpatient Services** | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |
| *Maximum days per Benefit Period for Physical Medicine and Rehabilitation / Skilled Nursing Care Facility* | Unlimited | |
| **Outpatient Facility Services** | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |
| **Clinic (Facility)** | $15 Copayment | 30% Coinsurance subject to Deductible |
| **Therapy Services** | | |
| Physician's Office Services | $15 Copayment | 30% Coinsurance subject to Deductible |
| Outpatient Facility Sercices | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |
| ***Maximum Visits per Benefit Period*** | | |
| *Spinal Manipulations* | Unlimited | |
| *Physical, Occupational and Speech Therapy* | Unlimited | |
| Other Therapy Services (when rendered as Physician's Office Services or Outpatient Facility Services) | Network Copayment based on setting where Covered Services are received | Non-Network Copayment based on setting where Covered Services are received |
| **Diagnostic Services** | | |
| Office Services | $15 Copayment | 30% Coinsurance subject to Deductible |
| Outpatient Services | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |
| **Emergency Room Services** (If admitted directly from the Emergency Room, the Emergency Room Copay for that visit is waived if services are performed within 72 hours of onset date) | $50 Copayment | $50 Copayment |
| **Urgent Care Center Services** | $25 Copayment | $25 Copayment |
| **Ambulance Services** | 10% Coinsurance subject to Deductible | 10% Coinsurance subject to Deductible (covered at Network benefit level) |

| Covered Services | Network (You Pay) | Non-Network (You Pay) |
|---|---|---|
| **Home Care Services** | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |
| *Maximum Visits per Benefit Period* | Unlimited | |
| **Hospice Services** | 10% Coinsurance subject to Deductible | 10% Coinsurance subject to Deductible (covered at Network benefit level) |
| **Medical Supplies, Durable Medical Equipment and Appliances** | 10% Coinsurance subject to Deductible | 10% Coinsurance subject to Deductible |
| **NOTE:** Physician Office Copayments are applied rather than the Network Copayment listed above if medical supplies, Durable Medical Equipment or appliances are obtained in a Network Physician's office. | | |
| **Maternity Services** | | |
| Inpatient/Outpatient Services | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |
| Physician Office Services | First office visit subject to $15 Copayment | 30% Coinsurance subject to Deductible |
| **Mental Health Services** | | |
| Inpatient Services | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |
| *Maximum days per Benefit Period* | 28 days | |
| *Maximum days per Lifetime* | 55 days | |
| Outpatient Services | $15 Copayment | 30% subject to Deductible |
| *Maximum visits per Lifetime* | 118 visits | |
| **Substance Abuse Services** | | |
| Lifetime Maximum | Two Inpatient Substance Abuse rehabilitation programs | |
| Inpatient Services | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |
| *Maximum Amount per Benefit Period* | $25,000 (Inpatient and Outpatient combined) | |
| Outpatient Services | $15 Copayment | 30% Coinsurance subject to Deductible |
| *Maximum Amount per Benefit Period* | $25,000 (Inpatient and Outpatient combined) | |
| **Hearing Aids** | $1,500 over three-year period | |
| **Bariatric Surgery** (Medically Necessary only). | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |

| Covered Services | Network (You Pay) | Non-Network (You Pay) |
|---|---|---|
| **Temporomandibular or Craniomandibular and Joint Disorder (TMJ) Services** (Medically Appropriate Surgical Procedures only) | 10% Coinsurance subject to Deductible | 30% Coinsurance subject to Deductible |
| **Note:** TMJ Dental Conditions are Not Covered | | |
| **Human Organ and Tissue Transplant Services** | | |
| Human Organ Transplants | 10% Coinsurance subject to Deductible | Not Covered |
| Tissue Transplants | Copayment based on setting where Covered Services are received | Not Covered |
| *Transportation, Lodging and Meals Maximum* | $10,000 per Transplant | Not Covered |

# HEALTH CARE MANAGEMENT

Health Care Management is included in your health care benefits to encourage you to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by assuring the use of appropriate procedures, setting (place of service), and resources through Case Management and through Precertification review requirements which may be conducted either prospectively (Prospective Review), concurrently (Concurrent Review), or retrospectively (Retrospective Review).

If you have any questions regarding Health Care Management or need to determine which services require Precertification, call the Precertification telephone number on the back of your Identification Card or refer to the Administrator's web site, www.anthem.com.

Members are entitled to receive upon request and free of charge reasonable access to and copies of documents, records, and other information relevant to the Member's Precertification request. Your right to benefits for Covered Services provided under the Plan is subject to certain policies, guidelines and limitations including, but not limited to, the Administrator's medical policy.

A description of each Health Care Management feature, its purpose, requirements and effects on benefits is provided in this section.

## Clinical Guidelines

The Administrator, on behalf of the Employer, uses clinical guidelines to assist in the interpretation of Medical Necessity. The clinical guidelines include the Administrator's Corporate medical policy, nationally recognized utilization review guidelines, Administrator developed Medical Review/Utilization Review Criteria, Medicare Guidelines, and other decision support material. However, the Benefit Booklet takes precedence over the clinical guidelines. Medical technology and standards of care are constantly changing and the Administrator, on behalf of the Employer, reserves the right to review and update the clinical guidelines periodically.

## Precertification

Precertification is a Health Care Management feature which requires that an approval be obtained from the Administrator before incurring expenses for certain Covered Services. The Plan's procedures and timeframes for making decisions for Precertification requests differ depending on when the request is received and the type of service for which the Precertification is requested.

*Urgent Review* means a review of medical care or treatment that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function based on a prudent layperson's judgment, or, in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without such care or treatment. Applying the prudent layperson standard, the Administrator, on behalf of the Employer, may determine that an Urgent Review should be conducted. Concurrent Reviews of continued Hospital stays will always be considered urgent.

When care is evaluated, Medical Necessity and appropriate length of stay for Inpatient admissions will be determined. Medical Necessity includes a review of the services and the setting. For certain services you will be required to use the Provider designated by the Administrator's Health Care Management staff. The care will be covered according to your benefits for the number of days approved unless the Administrator's Concurrent Review determines that the number of days should be revised. If a request is denied, the Provider may request a reconsideration. The Administrator's Physician reviewer will be available by telephone for the reconsideration within one business day of the request. An expedited reconsideration may be requested when the Member's health requires an earlier decision.

For all Network services, the ordering Provider, facility or attending Physician will call to request a Precertification review ("Requesting Provider"). The Administrator, on behalf of the Employer, will work directly with the Requesting Provider for the Precertification request. For Urgent Reviews, the Requesting Provider will be your authorized representative. For more information on the Plan's process for designating an authorized representative, call the *Precertification telephone number* on the back of your Identification Card.

For Non-Network services, it is your responsibility to obtain Precertification. You should verify that the Non-Network Provider obtains the required Precertification or obtain the required Precertification yourself. If you do not obtain any required Precertification, you are responsible for all charges for services the Administrator, on behalf of the Employer, determines are not Medically Necessary and a non-compliance penalty of $300. If you do not obtain the required Precertification, a Retrospective Review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services the Administrator, on behalf of the Employer, determines are not Medically Necessary.

When you go to a Non-Network Provider, you are responsible for obtaining Precertification for the following services:

<u>Inpatient Admissions</u>

1. Elective Admissions;

2. Emergency Admissions;
3. OB Related Medical Stay (OB complications, excludes childbirth);
4. Newborn stays beyond mother;
5. Inpatient Skilled Nursing Facility; or
6. Rehabilitation facility admission.

Outpatient Admissions

1. UPPP (Uvulopalatopharyngoplasty) surgery;
2. Plastic/Reconstructive surgeries for:
    a. Blepharoplasty,
    b. Rhinoplasty,
    c. Hairplasty,
    d. Panniculectomy and Lipectomy/Diatasis Recti Repair,
    e. Insertion/Injection of Prosthetic Material Collagen Implants,
    f. Chin Implant/Mentoplasty/Osteoplasty Mandible.
3. DME/Prosthetics (Medical necessity for all DME must be verified):
    a. Wheelchairs, special size, motorized or powered, and accessories,
    b. Hospital Beds, Rocking Beds, and Air Beds,
    c. Electronic or externally powered prosthetics,
    d. Custom made orthotics and braces.
4. PET (Positron Emission Tomography);
5. Private Duty Nurse services in the home setting; or

Human Organ and Bone Marrow/Stem Cell Transplants

1. All Inpatient admits for the following:

a. Heart transplant

b. Liver transplant

c. Lung or double lung transplant

d. Simultaneous Pancreas/Kidney

e. Pancreas transplant

f. Kidney transplant

g. Small bowel transplant

h. Multi-visceral transplant

i. Stem cell/Bone Marrow transplant (with or without myeloablative therapy)

2. All Outpatient services for the following:

a. Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)

b. Donor Leukocyte Infusion

Mental Health/Substance Abuse (MH/SA)

Only Inpatient MH/SA admissions will require authorizations.

Referrals

Out of Network Referrals (may be pre-authorized, based on network availability and/or Medical Necessity).

Inpatient Admissions Following Emergency Care

Precertification is not required for Inpatient admissions following Emergency Care. However, you must notify the Administrator, or verify that your physician or someone on your behalf has notified the Administrator of your admission *within 48 hours or as soon as possible within a reasonable period of time*. When the Administrator, on behalf of the Employer, is contacted, you will be notified whether the Inpatient setting is appropriate and, if appropriate, the number of days considered Medically Necessary. By calling the Administrator when you use a Non-Network Provider, you may avoid financial responsibility for any Inpatient care which is determined to be not Medically Necessary under the Plan. If your Provider does not have a participation agreement with the Administrator, or is a Blue Card Provider, you will be financially responsible for any care the Administrator, on behalf of the Employer, determines is not Medically Necessary.

Precertification is not required for childbirth admissions unless there is a complication and/or the mother and baby are not discharged at the same time.

**Note:** Precertification does NOT guarantee coverage for the service or procedure reviewed.

Prospective Review

Prospective Review means a review of a request for Precertification that is conducted prior to a Member's Hospital admission or course of treatment. For Prospective Reviews, a decision will be made and telephone notice of the decision will be provided to the Requesting Provider as soon as possible taking into account the medical circumstances, but not later than two business days from the time the request is received by the Administrator, on behalf of the Employer.

For Urgent Reviews, telephone notice will be provided to the Requesting Provider as soon as possible taking into account the medical circumstances, but not later than two calendar days from the time the request is received by the Administrator, on behalf of the Employer.

If additional information is needed before the Precertification decision can be made, the Administrator, on behalf of the Employer, will notify the Requesting Provider by telephone and send written notification to you or your authorized representative and the Requesting Provider regarding the specific information necessary to complete the review as soon as possible, but not later than two business days after receipt of the request for Precertification. For Urgent Reviews, the Administrator, on behalf of the Employer, will notify the Requesting Provider by telephone of the specific information necessary to complete the review within 24 hours after receipt of the Precertification request by the Administrator. Written notice will be sent following the request by telephone.

The requested information must be provided to the Administrator, on behalf of the Employer, within 45 calendar days from receipt of the Administrator's request for information. If the 45$^{th}$ day falls on a weekend or holiday, the time frame for submission is extended to the next business day. For Urgent Reviews, the requested information must be provided within 48 hours after the Administrator's request for information.

A decision will be made and telephone notice of the decision will be provided to the Requesting Provider as soon as possible, but not later than two business days (two calendar days for Urgent Reviews) after the Administrator's receipt of the requested information.

If a response to the Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Administrator's possession. Telephone notice of the decision will be provided to the Requesting Provider not later than two business days (two calendar days for Urgent Reviews) after

the expiration of the period to submit the requested information.

Written notice of Prospective Review decisions will be sent to you or your authorized representative and the Requesting Provider within one business day of the date the decision is rendered.

Concurrent Review

Concurrent Review means a review of a request for Precertification that is conducted during a Member's Inpatient Hospital stay or course of treatment. A Concurrent Review may result in an approval for benefits which exceed the benefit(s) originally authorized by the Administrator.

When a request for a Concurrent Review also qualifies for Urgent Review, and the request for a Concurrent Review is received within 24 hours before the expiration of the approved care, a decision will be made and telephone notice of the decision will be provided to the Requesting Provider as soon as possible, taking into account the medical urgency of the situation, but not later than 24 hours from the time the request is received by the Administrator. If the request is not received within 24 hours prior to the end of your approved care, the decision will be made and telephone notice of the decision will be provided to the Requesting Provider as soon as possible, but not later than two calendar days from the time the request is received by the Administrator. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

When a request for a Concurrent Review does not qualify for Urgent Review, the decision will be made and telephone notice will be provided to the Requesting Provider within two business days from the time the request is received by the Administrator. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within two business days from the time the request is received by the Administrator.

If additional information is needed to certify benefits for services for a Concurrent Review that does not qualify for Urgent Review, the Administrator will notify the Requesting Provider by telephone and will send written notice to you or your authorized representative and the Requesting Provider of the specific information necessary to complete the review within two business days after receipt of the request.

All information requested by the Administrator during a Concurrent Review must be provided within 45 calendar days from your receipt of the Administrator's request for information. If the 45$^{th}$ day falls on a weekend or holiday, the time frame for submission is extended to the next business day. A decision will be made and telephone notice of the decision will be provided to the Requesting Provider not later than two business days after the requested information is received by the Administrator.

If a response to the Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Administrator's

possession. Telephone notice of the decision will be provided to the Requesting Provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) not later than two business days after the expiration of the period to submit the requested information.

The Administrator will not reduce or terminate a previously approved on-going course of treatment until you or your authorized representative receive telephone notice of the Administrator's decision and have an opportunity to appeal the decision and receive notice of the appeal decision**.**

Retrospective Review

Retrospective Review means a Medical Necessity review that is conducted after health care services have been provided to a Member. If Precertification is required but not obtained prior to the service being rendered, the Administrator, on behalf of the Employer, will conduct a Retrospective Review. Further, if a service is subject to a clinical guideline but Precertification is not required for that service, the Administrator, on behalf of the Employer, may conduct a Retrospective Review.

Retrospective Review may be completed before a claim is submitted (pre-claim) or after a claim is submitted (post-claim). It does not include a post-claim review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

A decision on a pre-claim Retrospective Review will be made and notice will be provided to you or your authorized representative and the Provider(s) within two business days from the time the request is received by the Administrator, on behalf of the Employer. If additional information is needed to certify benefits for services, the Administrator, on behalf of the Employer, will notify you or your authorized representative and the Provider(s) in writing of the specific information necessary to complete the review within two business days after receipt of the request. All information requested by the Administrator, on behalf of the Employer, during a pre-claim Retrospective Review must be provided within 45 calendar days from receipt of the Administrator's request for information. If the 45$^{th}$ day falls on a weekend or holiday, the time frame for submission is extended to the next business day.

A decision will be made and notice will be provided to you or your authorized representative and the Provider(s) within two business days from the time the requested information is received by the Administrator, on behalf of the Employer. If a response to the Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Administrator's possession. Notice will be provided to you and your authorized representative and the Provider(s) not later than two business days after expiration of the period to submit the requested information.

Post-claim Retrospective review decisions will be made within 30 calendar days from the time the claim is received by the Administrator, on behalf of the Employer. Written

notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 30 calendar days from the time the claim is received by the Administrator, on behalf of the Employer.

If additional information is needed, the Administrator will notify you or your authorized representative and the Requesting Provider in writing of the specific information necessary to complete the review within 30 calendar days after receipt of the claim.

You or your authorized representative and the Requesting Provider have a reasonable amount of time taking into account the circumstances, but not less than 45 calendar days from the date of the Administrator's request to provide the additional information to the Administrator, on behalf of the Employer. A decision will be made within 15 calendar days from the time the requested information is received by the Administrator, on behalf of the Employer. Written notice of the decision will be provided to you or your authorized representative and the Requesting Provider within five business days of the date the decision is rendered, but not later than 15 calendar days of receiving the requested information.

Case Management (includes Discharge Planning)

Case Management is a Health Care Management feature designed to assure that your care is provided in the most appropriate and cost effective care setting. This feature allows the Administrator, on behalf of the Employer, to customize your benefits by approving otherwise Non-Covered Services or arranging an earlier discharge from an Inpatient setting if your care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Administrator, in behalf of the Employer. In managing your care, the Administrator, on behalf of the Employer, has the right to authorize substitution of Outpatient Services or services in your home to the extent that benefits are still available for Inpatient Services.

## COVERED SERVICES

This section describes the Covered Services available to you under your health care benefits whan provided and billed by Providers. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider. *Care must be received from a Network Provider to be covered at the Network level, except for Emergency Care and Urgent Care. Services which are not received from a Network Provider will be considered a Non-Network Service, unless otherwise specified in this Benefit Booklet*.

If you use a Non-Network Provider, you are responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount in addition to any applicable Copayment or Deductible. The Administrator or the Plan Sponsor cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

All Covered Services and benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Plan, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not in itself qualify the service, treatment or supply as a Covered Service and does not guarantee payment.

To receive maximum benefits for Covered Services, you must follow the terms of the Plan. Use your Network Provider to be sure that prior authorization or Precertification has been obtained prior to receiving services.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Plan. Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Plan payment for Covered Services will be limited by any applicable Copayment, Deductible, Benefit Period Maximum, or Lifetime Maximum stated in this Booklet.

### Preventive Care Services

Preventive Care benefits may vary based on the age, sex, and personal history of the individual, and as determined appropriate by the Administrator's clinical coverage guidelines. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. *Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition. Benefits will be considered under the Diagnostic Services benefit.*

Some examples of Preventive Care Covered Services are:

1. Routine or periodic exams, including school enrollment physical exams. *Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.* Examinations include, but are not limited to:

    a. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines.

    b. Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests;

    c. Adult routine physical examinations;

    d. Pelvic examinations;

    e. Routine EKG, Chest X-ray, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis;

    f. Annual dilated eye examination for diabetic retinopathy; and

    g. Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follow the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians. These include, but are not limited to:

        1) Hepatitis A vaccine

        2) Hepatitis B vaccine

        3) Hemophilus influenza b vaccine (Hib)

        4) Influenza virus vaccine

        5) Rabies vaccine

        6) Diphtheria, Tetanus, Pertussis vaccine

7) Mumps virus vaccine

8) Measles virus vaccine

9) Rubella virus vaccine

10) Polio virus vaccine

2. Screening examinations:

   a. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts;

   b. Routine hearing screening.

   c. Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for screening of breast cancer, if determined Medically Necessary by your Physician, are also covered;

   d. Routine cytologic and chlamydia screening (including pap test);

   e. Routine bone density testing for women;

   f. Routine prostate specific antigen testing;

   g. Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

3. Diabetes self management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

   a. Medically Necessary;

   b. Ordered in writing by a Physician or a podiatrist; and

   c. Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a “Health Care Professional” means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

**Physician Office Services**

Office Services include care in a Physician's office that is not related to Maternity and Mental Health Conditions, except as specified. Refer to the sections entitled **Maternity Services** and **Mental Health/Substance Abuse Services** for services covered by the Plan. **For Emergency Accident or Medical Care** refer to the **Emergency Care and Urgent Care** section.

Physician Office Services include:

1. *Office visits* for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include injections, serum and allergy testing and management of medication for any mental health condition (example: ADD/ADHD). When allergy injection, testing or serum is the only charge from a Physician's office, Coinsurance may apply as stated in the Schedule of Benefits under Physician Office Services.

2. *Diagnostic Services* when required to diagnose or monitor a symptom, disease or condition.

3. *Surgery* and Surgical services, including anesthesia and supplies. The surgical fee includes normal post-operative care.

4. *Therapy Services* for Physical Medicine Therapies and Other Therapies when rendered in the office of a Physician or other professional Provider.

**Inpatient Services**

Inpatient Services do not include care related to Maternity and Mental Health Conditions, except as specified. Refer to the sections entitled **Maternity Services** and **Mental Health/Substance Abuse Services** for services covered by the Plan. Inpatient Services include:

1. Charges from a Hospital or other Provider for room, board and general nursing services;

2. Ancillary services; and

3. Professional services from a Physician while an Inpatient.

*Room, Board, and General Nursing Services include:*

1. A room with two or more beds;

2. A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available;

3. A room in a special care unit approved by the Administrator, on behalf of the Employer. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

*Ancillary Services include:*

1. Operating, delivery and treatment rooms and equipment;

2. Prescribed drugs;

3. Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider;

4. Medical and surgical dressings, supplies, casts and splints;

5. Diagnostic Services; and

6. Therapy Services.

*Professional Services include:*

1. *Medical care visits* limited to one visit per day by any one Physician;

2. *Intensive medical care* for constant attendance and treatment when your condition requires it for a prolonged time;

3. *Concurrent care* for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians;

4. *Consultation* which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded;

5. *Surgery* and the administration of general anesthesia; and

6. *Newborn exam:* A Physician other than the Physician who performed the obstetrical delivery must do the examination.

*Copayment Waiver:*

A Copayment Waiver occurs when a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day and any Copayment stated in dollars per admission in the Schedule of Benefits is waived for the second admission. Copayments stated as a percentage are not waived.

## Outpatient Services

Outpatient Services include **both facility and professional charges** when rendered as an Outpatient at a Hospital, Alternative Care Facility or other Provider as determined by the Plan. Outpatient Services do not include care that is related to Maternity or Mental Health/Substance Abuse Services, except as otherwise specified. Professional charges include services billed by a Physician or other professional.

## Emergency Care and Urgent Care Services

Emergency Care (including Emergency Room Services)

Medically Necessary Services, which the Administrator determines to meet the definition of Emergency Care, will be covered whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered and reimbursed by the Plan at the Network level. If you contact your Physician and are referred to a Hospital Emergency room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Whenever you are admitted as an Inpatient directly from a Hospital Emergency room, the Emergency Room Services Copayment for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify the Administrator, or verify that your physician or someone on your behalf has notified the Administrator of your admission *within 48 hours or as soon as possible within a reasonable period of time*. When the Administrator is contacted, you will be notified whether the Inpatient setting is appropriate and, if appropriate, the number of days considered Medically Necessary. If your Provider does not have a participation agreement with the Administrator or is a Blue Card provider, you will be financially responsible for any care the Administrator determines is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as Non-Network unless the Administrator authorizes the continuation of care and determines that the care is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. All Covered Services obtained at Urgent Care Centers are

subject to the Urgent Care Copayment. Urgent Care services can be obtained from a Network or Non-Network Provider. If you experience an accidental injury or a medical problem, the Administrator will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an Emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an Emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See your **Schedule of Benefits** for benefit limitations.

**Ambulance Services**

Ambulance Services are transportation by a vehicle designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals (other vehicles which do not meet this definition, including but not limited to Ambulettes, are not Covered Services):

1. From your home, scene of accident or medical Emergency to a Hospital;

2. Between Hospitals;

3. Between Hospital and Skilled Nursing Facility;

4. From a Hospital or Skilled Nursing Facility to your home.

Ambulance Services are a Covered Service only when Medically Necessary, except:

1. When ordered by an employer, school, fire, or public safety official and the Member is not in a position to refuse;

2. When a Member is required by the Administrator to move from a Non-Network Provider to a Network Provider.

Trips must be to the closest local facility that can give Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non-Covered Services for Ambulance include but are not limited to, trips to:

1. A Physician's office or clinic;

2. A morgue or funeral home.

**Diagnostic Services**

Diagnostic Services are tests or procedures administered to detect or monitor your condition, and are generally performed when you have specific symptoms. Coverage for Diagnostic Services, including when provided as part of Preventive Care Services and Physician Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

1. X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;

2. Magnetic Resonance Imaging (MRI);

3. CAT scans;

4. Laboratory and pathology services;

5. Cardiographic, encephalographic, and radioisotope tests;

6. Ultrasound services;

7. Allergy tests;

8. Electrocardiograms (EKG);

9. Electromyograms (EMG) except that surface EMG's are not Covered Services;

10. Echocardiograms;

11. Bone density studies; and

12. Positron emission tomography (PET scanning).

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

**Surgical Services**

Coverage for Surgical Services when provided as part of Physician Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

1. Performance of generally accepted operative and other invasive procedures;

2. The correction of fractures and dislocations;

3. Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;

4. Usual and related pre-operative and post-operative care; and

5. Other procedures as approved by the Administrator.

Covered Surgical Services include, but are not limited to:

1. Operative and cutting procedures;

2. Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy; and

3. Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

**Sterilization**

Regardless of Medical Necessity, sterilization is a Covered Service.

**Mastectomy Notice**

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's

attending Physician and will be subject to the same annual Deductible and Copayment provisions otherwise applicable under the Plan.

**Therapy Services**

Coverage for Therapy Services when provided as part of Physician Office Services, Inpatient Facility Services, Outpatient Services, or Home Care Services is limited to the following:

Physical Medicine Therapy Services

Physical Medicine Therapy Services qualify as Covered Services if the expectation exists that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. The Administrator has the sole discretion to determine whether a Physical Medicine Therapy Service is a Covered Service. Some types of Physical Medicine Therapy Services that may qualify as Covered Services include but are not limited to:

1. *Physical therapy***,** which includes treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part;

2. *Speech therapy* for the correction of a speech impairment;

3. *Occupational therapy* for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts); and

4. *Spinal manipulation services* to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulation whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Spinal Manipulations as specified in the Schedule of Benefits.

Other Therapy Services

1. *Cardiac rehabilitation* to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning and maintenance are not covered.

2. *Chemotherapy* for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.

3. *Dialysis treatments* of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

4. *Radiation therapy* for the treatment of disease by X-ray, radium, or radioactive isotopes.

5. *Inhalation therapy* for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement within a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Certain Therapy Services rendered on an Inpatient or Outpatient basis are limited. See the **Schedule of Benefits**.

**Home Care Services**

Home Care Services are services performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services include but are not limited to:

1. Intermittent Skilled Nursing Services (by an R.N. or L.P.N.);

2. Diagnostic Services;

3. Medical/Social Services;

4. Nutritional Guidance;

5. Home Health Aide Services;

6. Therapy Services (Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home);

7. Medical/Surgical Supplies;

8. Durable Medical Equipment;

9. Prescription Drugs (only if provided and billed by a Home Health Care Agency);

10. Private Duty Nursing.

*Home infusion therapy* will be paid only if you obtain prior approval from the Administrator's Home Infusion Therapy Subcontractor (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous and continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

**Hospice Services**

Hospice care may be provided in the home or Hospice for medical, social and psychological services used as palliative treatment for patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.

Covered Services include the following only when authorized by your Network Provider:

1. Skilled Nursing Services (by an R.N. or L.P.N.);

2. Diagnostic Services;

3. Physical, speech and inhalation therapies;

4. Medical supplies, equipment and appliances;

5. Counseling services (except bereavement counseling);

6. Inpatient confinement at a Hospice; and

7. Prescription Drugs obtained from the Hospice.

**Human Organ and Tissue Transplant Services**

For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. Human Organ and Tissue Transplant Services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.

Covered Transplant Procedure

A Covered Transplant Procedure is any Medically Necessary human organ and tissue transplant as determined by the Administrator including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services

Covered Transplant Services include all Covered Transplant Procedures and all Covered Services directly related to a disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Notification

The Plan strongly encourages the Member to call the Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. The Administrator will assist you with maximizing your benefits by providing you with coverage information including details regarding what is covered and whether any Medical Policies, network requirements or Plan exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for you.

Covered Transplant Benefit Period

The Covered Transplant Benefit Period starts one day prior to a Covered Transplant Procedure and continues for 364 days. If, within this time frame, a second Covered Transplant Procedure occurs, the Covered Transplant Benefit Period will begin one day prior to the second Covered Transplant Procedure and continue for 364 days.

Transportation, Meals and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Administrator when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility, lodging and meals for the Member and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging and meals may be allowed for two companions. The Member must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to the Administrator when claims are filed. Contact the Administrator for detailed information.

**Medical Supplies, Durable Medical Equipment, and Appliances**

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Covered Services include, but are not limited to:

1. *Medical and surgical supplies* **-** Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose; prescription drugs and biologicals that cannot be self administered and are provided in a Physician's office. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

2. *Durable medical equipment* - The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. *Non-covered* items include but are not limited to air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports, and corsets or other articles of clothing.

3. *Prosthetic appliances* – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

    a. Replace all or part of a missing body part and its adjoining tissues; or

    b. Replace all or part of the function of a permanently useless or malfunctioning body part.

Covered Services for prosthetic appliances include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body

surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;

2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant);

3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act;

4. Minor devices for repair such as screws, nails, sutures and wire mesh;

5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;

6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session);

7. Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract - formulae and supplies are also covered);

8. Cochlear implant;

9. Electronic speech aids in post-laryngectomy or permanently inoperative situations;

10. "Space Shoes" when used as a substitute device when all or a substantial portion of the forefoot is absent; and

11. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth;

2. Dental appliances;

3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;

4. Artificial heart implants;

5. Hairpieces for male pattern alopecia (baldness); and

6. Wigs (except as described above following cancer treatment);

Covered Services for orthotic devices are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included.

Covered orthotic devices include, but are not limited to, the following:

1. Cervical collars;

2. Ankle foot orthosis;

3. Corsets (back and special surgical);

4. Splints (extremity);

5. Trusses and supports;

6. Slings;

7. Wristlets;

8. Built-up shoe; and

9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

**Non-Covered Services** include but are not limited to:

1. Orthopedic shoes;

2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;

3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies); and

4. Garter belts or similar devices.

**Accident Related Dental Services**

Outpatient Services, Physician Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

1. Oral examinations;

2. X-rays;

3. Tests and laboratory examinations;

4. Restorations;

5. Prosthetic services;

6. Oral surgery;

7. Mandibular/maxillary reconstruction; and

8. Anesthesia.

Dental/Oral Surgery

Charges for Outpatient Facility Services are covered when the patient's medical condition or the dental procedure requires a hospital setting to ensure the safety of the patient. Inpatient facility services would be subject to Precertification. Extraction of full or partial bony impaction or extraction of teeth other than impacted if concurrent hazardous condition exists.

**Maternity Services**

Maternity Services include Inpatient Services, Outpatient Services and Physician Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn. If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well

newborn are also not covered.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

1. The antepartum, intrapartum, and postpartum course of the mother and infant;

2. The gestational stage, birth weight, and clinical condition of the infant;

3. The demonstrated ability of the mother to care for the infant after discharge; and

4. The availability of postdischarge follow-up to verify the condition of the infant after discharge.

Covered Services include at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage includes, but is not limited to:

1. Parent education;

2. Physical assessments;

3. Assessment of the home support system;

4. Assistance and training in breast or bottle feeding; and

5. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office.

*Elective Abortion* **-** Regardless of Medical Necessity, the Plan pays Covered Services from a Provider for elective abortion accomplished by any means.

**Mental Health/Substance Abuse Services**

Covered Services include but are not limited to:

1. *Inpatient services* – individual or group psychotherapy, psychological testing, family counseling with family Members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy. Room and board charges are Covered Services only when an Inpatient stay is authorized by the Administrator or the Administrator's Subcontractor.

2. *Partial hospitalization* - a structured, intensive, multidisciplinary treatment program that provides psychiatric, medical, and nursing care. The program usually is offered in an acute setting, but the patient goes home in the evening and on weekends. The program delivers a highly structured environment of at least 4 to 6 hours of treatment per day. Patients are expected to participate up to 5 days per week.

3. *Intensive Outpatient treatment or day treatment* - a structured program, offered at least three times per week for at least three hours per day. The program may be managed by a licensed Mental Health professional with a psychiatrist on staff. Therapy is provided by a licensed Mental Health professional.

4. *Outpatient treatment, or individual or group treatment* - office-based services, for example diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed Mental Health professional and is coordinated with the psychiatrist.

Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

<u>Non-Covered Mental Health/Substance Abuse Services:</u>

1. Residential Treatment services. Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities;

2. Custodial or Domiciliary care;

3. Supervised living or half-way houses; and

4. Room and board charges unless the treatment provided meets the Administrators Medical Necessity criteria for Inpatient admission for your condition.

Copayments and limits are specified in the Schedule of Benefits.

**Member Rights and Responsibilities**

As a Member, you have the right to:

1. Receive information about the organization and its services, practitioners and Providers, and Members' rights and responsibilities;

2. Be treated respectfully, with consideration and dignity;

3. Receive all the benefits to which you are entitled under the Plan;

4. Obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;

5. Receive quality health care through your Provider in a timely manner and in a medically appropriate setting;

6. Have a candid discussion with your Provider about treatment options, regardless of their cost or whether they are covered under the Plan;

7. Participate with your Physician in decision making about your healthcare treatment;

8. Refuse treatment and be informed by your Provider of the medical consequences;

9. Receive wellness information to help you maintain a healthy lifestyle;

10. Express concern and complaints about the care and services you received from a Provider, or the service you received from the Administrator, and to have the Administrator investigate and take appropriate action;

11. File a complaint with the Administrator, on behalf of the Employer, to appeal that decision as outlined in the **Complaint & Appeals** section of this Benefit Booklet, and to appeal a decision without fear of reprisal;

12. Privacy and confidential handling of your information;

13. Make recommendations regarding the Administrator's rights and responsibilities policies; and

14. Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.

As a Member, you have the responsibility to:

1. Understand your health issues and be wise consumers of health care services;

2. Use Providers who will provide or coordinate your total health care needs, and to

maintain an ongoing patient-Physician relationship;

3. Provide complete and honest information we need to administer benefits and that Providers need to care for you;

4. Follow the Plan and instructions for care that you and your Provider have developed and agreed upon;

5. Understand how to access care in routine, Emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Coinsurance, Copayments, etc.;

6. Notify your Provider or the Administrator about concerns you have regarding the services or medical care you receive;

7. Keep appointments for care and give reasonable notice of cancellations;

8. Be considerate of other Members, Providers and the Administrator's staff;

9. Read and understand your Benefit Booklet and Schedule of Benefits, and other materials from the Administrator or Employer concerning your health benefits;

10. Provide accurate and complete information to the Administrator, on behalf of the Employer, about other health care coverage and/or insurance benefits you may carry; and

11. Inform the Employer of changes to your name, address, phone number, or if you want to add or remove Dependents.

**Claims Payment**

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Therefore, provisions below regarding "Claim Forms" and "Notice of Claim" do not apply, unless the claim was not filed by the Provider.

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you.

How Benefits Are Paid

The Plan shares the cost of your medical expenses with you up to the amount of the Maximum Allowable Amount. For services subject to a Deductible, you pay a portion of the bill before the Plan begins to pay its share of the balance. Some services are also subject to a Copayment and/or Coinsurance.

Network Providers will seek compensation from the Plan for Covered Services. When using a Network Provider you are only responsible for Copayments, Deductibles, and non-covered charges. Network Providers have agreed to accept the Maximum Allowable Amount as payment in full. If you receive Covered Services from a Non-Network Provider, you are responsible for the difference between the actual charge billed and the Maximum Allowable Amount plus any Deductible, Copayments, and non-covered charges.

Copayments are your share of the cost for particular health services, and are generally due at the time you receive the medical service. The amount you pay may differ by the type of service you receive, or by Provider. For Covered Services subject to a Copayment, you pay a portion of the bill and the Plan pays its share of the balance. Refer to the **Schedule of Benefits** to see what Copayment is required for each Covered Service. Claims for Covered Services do not need to be sent to the Administrator in the same order that expenses were incurred.

If you receive Covered Services in a Network Provider facility from a Non-Network Provider such as an anesthesiologist who is employed by that Network Facility, benefits will be paid. Payment will not exceed the Maximum Allowable Amount that would constitute payment in full under a Network Provider's participation agreement for this Plan. You may be liable for the difference between the billed charge and the Maximum Allowable Amount. This does not apply if your treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

The Administrator, on behalf of the Employer, will deny that portion of any charge which exceeds the Maximum Allowable Amount.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowable Amount. **If services are performed by Non-Network Providers,** then you are responsible for any amounts charged in excess of the Plan's Maximum Allowable Amount with or without a referral or regardless if allowed as an Authorized Service. Contact the Administrator for more information.

Continuous Coverage

If you were previously covered by a Plan with the Employer and with the Administrator with no break in coverage, you will receive credit for any accrued Deductibles and Out-of-Pocket amounts. However, any maximums used under that Plan will be carried over and charged against the maximums of the Plan.

Payment of Benefits

As a Member of this Plan, you authorize the Administrator to make payments directly to Providers for Covered Services. The Administrator also reserves the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by the Administrator will discharge the Employer's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by ERISA or any other applicable state or Federal law.

Once a Provider performs a Covered Service, the Administrator will not honor a request to withhold payment of the claims submitted.

Assignment

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

Notice of Claim

The Plan is not liable for benefits, unless the Administrator, on behalf of the Employer, receives written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given. The notice must be given to the Administrator by the end of the year following the calendar year in which the claim was incurred, and must contain the data the Administrator needs to determine benefits. If the submitted notice does not include sufficient data the Administrator needs to process the claim, then the necessary data must be submitted within the timeframe specified in this provision or no benefits will be payable except as otherwise required by law.

If the Administrator has not received the information needed to process a claim, the Administrator will request the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, the Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator generally will make its request for additional information within 30 days of the Administrator's initial receipt of the claim and will complete its processing of the claim within 15 days after the Administrator's receipt of all requested information.

Failure to give notice to the Administrator by the end of the year following the calendar year the claim was incurred will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than the end of the year following the calendar year the claim was incurred, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

## Claim Forms

Network Providers will file claims for you. Some Non-Network Providers may file claims for you, but it is your responsibility to see that claims are filed when using a Non-Network Provider. If the forms are not available, either send a written request for claim forms to the Administrator or the Employer, or contact customer service and ask for claim forms to be sent to you. The forms will be sent to you within 15 days of the date of your request. If you do not receive the forms, written notice of services rendered may be submitted to the Administrator, on behalf of the Employer, without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

1. Name of patient;

2. Patient's relationship with the Subscriber;

3. Identification number;

4. Date, type and place of service;

5. Your signature and the Physician's signature.

## Time Benefits Payable

The Plan will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. A "clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

At the Administrator's or the Employer's discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, the Plan may reimburse those other parties and be fully discharged from that portion of its liability.

## Member's Cooperation

Each Member shall complete and submit to the Administrator, on behalf of the Employer, such authorizations, consents, releases, assignments and other documents as may be requested by the Administrator, in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive.

The EOB is not a bill, but a statement sent by the Administrator to help you understand the coverage you are receiving. The EOB shows:

1. Total amounts charged for services/supplies received;

2. The amount of the charges satisfied by your coverage;

3. The amount for which you are responsible (if any); and

4. General information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

BlueCard

When you obtain health care services through BlueCard outside of the geographic area which the Administrator serves, the amount you pay for Covered Services is calculated as the **lower** of:

1. The billed charges for your Covered Services; or

2. The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto the Administrator, on behalf of the Employer.

Often this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any contingent payment arrangements, and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an *average* expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim, or to add a surcharge. Should any state statute mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Administrator would then calculate your liability for any Covered Services in accordance with the applicable state statutes in effect at the time you received your care.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card or go to www.anthem.com for more information about such arrangements.

**Exclusions**

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. This list of Exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The Plan does not provide benefits for:

1. Procedures, equipment, services or supplies which are determined not Medically Necessary or do not meet the Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines;

2. Procedures, equipment, services or supplies received from an individual or entity that is not a Provider, as defined in this Benefit Booklet or recognized by the Plan;

3. Procedures, equipment, services or supplies which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Administrator;

4. Any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply;

5. Procedures, equipment, services or supplies to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation;

6. Illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces;

7. A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident;

8. Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation;

9. Prescription Drug Copayments or Deductibles for which you are responsible under other coverage with other carriers or health plans;

10. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results;

11. Court ordered testing or care unless Medically Necessary;

12. Procedures, equipment, services or supplies that you have no legal obligation to pay in the absence of this or like coverage;

13. Procedures, equipment, services or supplies received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group;

14. Procedures, equipment, services or supplies prescribed, ordered, or referred by, or received from a Member of your immediate family, including your spouse, child, brother, sister, parent, or self;

15. Completion of claim forms or charges for medical records or reports unless otherwise required by law;

16. Missed or canceled appointments;

17. Mileage costs or other travel expenses, except as authorized by the Administrator;

18. Procedures, equipment, services or supplies for which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if a Member had applied for Parts A and/or B, except, as specified elsewhere in this Benefit Booklet or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions;

19. Charges in excess of the Maximum Allowable Amount;

20. Charges incurred prior to your Effective Date;

21. Charges incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet;

22. Any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or

body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law;

23. Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable;

24. Custodial Care, Domiciliary Care or convalescent care, whether or not recommended or performed by a professional;

25. Foot care only to improve comfort or appearance including, but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails except when Medically Necessary including, but not limited to, foot care for diagnosis of diabetes or for impaired circulation to the lower extremities;

26. Any treatment of teeth, gums or tooth related service except as otherwise specified as covered in this Benefit Booklet;

27. Procedures, equipment, services or supplies related to weight loss or weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig and LA Weight Loss) or fasting programs;

28. Procedures, equipment, services or supplies related to smoking cessation or smoking cessation programs, whether or not they are under medical or Physician supervision;

29. Sex transformation surgery and related services, or the reversal thereof;

30. Marital counseling;

31. Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition;

32. Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein;

33. Reversal of sterilization;

34. Artificial insemination; fertilization (such as in vitro or GIFT) or procedures and testing related to fertilization; infertility drugs and related services following the diagnosis of infertility;

35. Personal hygiene and convenience items;

36. Care received in an Emergency room which is not Emergency Care, except as specified in this Benefit Booklet;

37. Expenses incurred at a health spa or similar facility;

38. Self-help training and other forms of non-medical self care, except as otherwise provided herein;

39. Examinations relating to research screenings;

40. Stand-by charges of a Physician;

41. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes;

42. Procedures, equipment, services or supplies related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy;

43. Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility;

44. Private Duty Nursing Services except when provided through the Home Care Services benefit;

45. Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing;

46. Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology;

47. Procedures, equipment, services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris;

48. Drugs, devices, products, or supplies available over the counter;

49. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy;

50. Treatment of telangiectatic dermal veins (spider veins) by any method; and

# PRESCRIPTION DRUG BENEFITS

## Benefits

You have prescription drug coverage through Medco Health Solutions, Inc. The prescription drug coverage has two parts:

- A drug card program administered by Medco Health Solutions, Inc., and
- A mail-order service administered by Medco Health Solutions, Inc.

## Eligibility

Employees and dependents enrolled for coverage under the Anthem PPO managed health insurance program are eligible for prescription drug coverage.

## How to Use the Program

Whenever you or an eligible dependent requires a prescription drug, you have the following options for filling your prescription:

1. Mail Order - you can order up to a 90-day supply of maintenance medications prescribed for treatment of chronic or long-term illness (such as arthritis, diabetes, high blood pressure) through the mail from Medco Health Solutions, Inc. Rx Services.

2. Non-Network pharmacy - you can purchase up to a 30-day supply from a non-Network pharmacy.

3. Network Pharmacy - you can purchase up to a 30-day supply plus refills from any Network Pharmacy.

## Network Pharmacy Advantages

Advantages to using a network pharmacy are convenience and in most cases, less cost. You obtain your medication by presenting your Medco Rx Identification Card and paying a small co-pay when you use a Network Pharmacy. However, if you obtain medication from a non-network pharmacy, you must pay the pharmacy their charge, complete a claim form (you and the pharmacist), attach your receipts, send the claim to the address listed on the claim form and wait for reimbursement.

## Network Pharmacies

Network Pharmacies currently include many national chains such as Drug Emporium, Fruth Pharmacy, K-Mart, Kroger, Phar-Mor, Revco, Rite Aid, Shop-Rite, Thrift, Wal-Mart, and selected local drugstores. To determine which drugstores in your area are

network pharmacies under the AK Steel Corporation Plan, call the following national toll-free number: 1-800-251-7690.

**Quantity to be Dispensed**

- Purchases at local pharmacies - up to a 30-day supply;
- Through the mail - up to a 90-day supply.

**Cost**

When you use a local network pharmacy, your cost for up to a 30-day supply is:

- $10.00 per prescription for generic drugs,
- $20.00 per prescription for formulary (preferred) brand drugs, and
- $30.00 per prescription for non-formulary (non-preferred) brand name drugs.

**Covered Drugs**

Covered Drugs are all non-excluded state and federal legend drugs which require a written prescription and which are prescribed by a doctor, dentist, osteopath or podiatrist. The following items are also included as covered drugs:

- Insulin, insulin needles and syringes,
- OTC diabetic supplies,
- Injectable medications, and syringes,
- Prescription vitamins.

**Excluded Drugs**

Drugs in quantities which exceed the limits established by the Plan are excluded from coverage .

Drugs related to sex transformation or male or female sexual or erectile dysfunction or inadequacies, regardless of the origin or cause, are excluded drugs. This exclusion also includes all prescription drugs for or used in the treatment of impotency.

Drugs used for artificial insemination or fertilization (such as invitro or GIFT) are excluded. This includes fertility drugs following the diagnosis of infertility.

The following are also excluded from covered drugs:

- Cosmetic drugs,
- Appliances, devices, bandages, heat lamps, braces, splints, and artificial appliances,
- Health and beauty aids,
- Cosmetic and dietary supplements,
- Anti-obesity drugs,
- OTC products (except as noted above).

**Generic Drugs**

The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When you and your doctor authorize generic substitution, it permits the pharmacy to dispense a generic drug. Unless your physician indicates otherwise, Medco Health Solutions, Inc. Rx Services will dispense a generic equivalent when available and permissible under the law.

**Mail Order Maintenance Prescription Drug Program**

This program allows you and your eligible dependents to receive your maintenance prescription drugs by mail for a cost of $20.00 generic, $40.00 formulary (preferred) brand and $60.00 non-formulary (non-preferred) brand per prescription refill. Each prescription can be filled for up to a maximum of 90 days.

How to Use This Program

1. Ask your physician to prescribe needed medication for up to a 90-day supply plus refills. If you are presently taking medication, ask your doctor for a new prescription.

2. Complete the Patient Profile Questionnaire (part of the literature of the AK Steel Corporation Mail Service Prescription Drug Program) with your first order only. Be sure to answer all the questions.

3. Send the completed Patient Profile Questionnaire, your original prescription(s) and a $20.00 co-payment for each generic prescription, $40.00 per prescription for formulary (preferred) brand drugs, or $60.00 per prescription for non-formulary (non-preferred) brand name drugs, to Medco Health Solutions, Inc., using the envelope supplied with the literature on the program.

4. Medco Health Solutions, Inc. Rx Services will process your order and return your medications to you via First Class Mail or UPS, along with instructions for future prescriptions and/or refills. Allow up to 14 days for delivery.

How to Order Refills

With your original prescription medication, you will receive a notice showing the number of times it may be refilled. You may mail this refill notice and applicable co-payment to Medco Health Solutions, Inc. Rx Services in the pre-addressed order envelope. You may also order refills by telephone at 1-800-759-1089 or online at www.medco.com. To avoid the risk of running out, order your refills two weeks before you need them.

Emergency Situations

Obviously, there will be times when you need a prescription immediately and/or you will need less than a 30-day supply. On these occasions, you should have your prescription filled at a local pharmacy. If you need medication immediately but will be taking it on an ongoing basis, ask your doctor for two prescriptions. The first should be for a 14-day supply that you can have filled at a local pharmacy. The second prescription should be for the balance up to a 90-day supply. Send the large prescription with the applicable co-payment to Medco Health Solutions, Inc. Rx Services, immediately.

Quantity to Be Dispensed

Your doctor must prescribe a 90-day supply for you to receive that quantity. The law requires that pharmacies dispense no more than the quantity prescribed by the physician. If your doctor authorizes refills, they can only be dispensed when your initial order has nearly expired. So be sure to ask your doctor to prescribe a 90-day supply, plus refills, whenever appropriate.

## DENTAL BENEFITS

This section describes the covered dental services available to you and your eligible dependents.

**Schedule of Benefits**

***Benefit Period:*** Calendar Year

***Deductible:***
(excluding preventive and orthodontia)

| | |
|---|---|
| Individual | $ 50 |
| Family | $100 |

***Co-Insurance:*** 20%

***Maximums:***

| | |
|---|---|
| Annual | $1,000 |
| Orthodontia (lifetime) | $1,500 |

**Purpose of Benefits**

This coverage is designed to help defray the cost of necessary dental expenses resulting from a non-work related disease or defect or accident causing injury to teeth..

**Covered Expenses**

Covered expenses are the charges for services, supplies and treatments. They must be prescribed or performed by a Doctor of Dental Surgery or a Doctor of Medical Dentistry and conform to the generally accepted standards of dental practice. The amount will be the reasonable and customary charge, or the fair and reasonable value as determined by the insurance carrier. The cost of such services and supplies will be reimbursed or paid as follows:

1. The following preventive covered expenses with the deductible waived shall be paid at 100% of the reasonable and customary charge:

    a. Routine oral examinations and prophylaxis (scaling and cleaning of teeth), up to a maximum of two in any calendar year. Periodic examinations used to monitor the progress of orthodontic treatment are not considered routine oral exams;

    b. Topical application of fluoride (the direct application of fluoride to the exposed surfaces of the teeth to inhibit or retard the incidence of cavities);

c. Space maintainers (a fixed or removable application designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost teeth are only covered for dependent children under the age of 19;

d. Emergency treatment for temporary relief of pain which does not result in a definite cure; and

e. Sealants are covered for dependent children under the age of 19, once every three calendar years.

2. The following covered expenses shall be paid at 80% of the reasonable and customary charge after the deductible has been satisfied:

a. Dental X-rays, including supplementary bite-wing X-rays up to a maximum of two in any calendar year and such other dental X-rays as are required in connection with the diagnosis of a specific condition requiring treatment;

b. Full mouth dental X-rays are allowed up to a maximum of two per calendar year;

c. Extractions (except surgical removal of impacted teeth if partially or completely covered by bone);

d. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased teeth;

e. Inlays, onlays, gold fillings, crown restorations to restore diseased teeth, but only when the tooth, as a result of extensive caries, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, and composite filling restoration;

f. Endodontic treatment including root-canal therapy, is allowed one time per 24 consecutive months for the same tooth;

g. Periodontal treatment for scaling/root planning is allowed one time per 24 consecutive months for the same tooth;

h. Periodontal surgery is allowed one time per 36 consecutive months for the same tooth;

i. Periodontal cleanings, including regular cleanings, are allowed two times per calendar year;

j. To replace missing natural teeth, the initial installation of fixed bridgework (including inlays and crown abutments) and of partial or full removable dentures (including precision attachments and any adjustments during the six-month period after the installation of an initial or replacement denture) and repair, adjustment and replacement of bridgework or dentures as follows:

1) Repair or re-cement of bridgework or dentures; or relining or re-basing of dentures more than six months after the installation of an initial replacement denture, but not more than one relining or re-basing in any period of 36 consecutive months;

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

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

b) The existing denture or bridgework cannot be made serviceable and at least five years has elapsed prior to its replacement; or

c) The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture;

k. Oral surgery;

l. Injection of antibiotic drugs by the attending dentist or drugs requiring a prescription by a dentist;

m. Dental implants;

n. Harmful habit appliances;

o. Occlusal guards;

p. Consultations, but not more than two times per calendar year; and

q. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other covered services, when the insurance carrier determines such anesthesia is necessary in accordance with generally accepted dental standards.

3. The following orthodontic covered expenses with the deductible waived shall be paid at 80% of the reasonable and customary charge:

a. Pre-orthodontic diagnostic procedures and treatments consisting of surgical therapy and functional/myofunctional therapy including related oral examinations, surgery and extractions; or

b. Orthodontic appliances and therapy treatment for a course of treatment for children under age 19. If orthodontic treatment commences prior to the dependent child's attainment of age 19, benefits will be payable for services thereafter, but not beyond the end of the month in which the child attains age 20.

4. An expense is incurred and covered when the dental service is performed while covered under the Plan except as follows:

   a. Regarding dentures and bridgework, the expense is deemed to have been incurred when an impression is taken for preparation of a denture or bridgework;

   b. Regarding crowns, expenses will be deemed incurred on the date each tooth is prepared for treatment;

   c. Regarding root canal therapy, charges will be deemed incurred on the date work on each individual tooth is begins; or

   d. In connection with appliance therapy, the day the first appliance is inserted commences the course of treatment, but any covered charges related to (3a) and (3b) above, are charged to the orthodontic benefit maximum. Orthodontic benefit payments for expenses incurred under (3b) will be calculated based on the charge to the patient, but the initial payment cannot be more than one-fourth of the total charge for the full course of treatment. Benefits for the remaining treatment expense will be prorated over the appliance period. This procedure will be followed regardless of any schedule of payments arranged between the patient and the dentist.

   ***Note**: In the event of termination of coverage with reference to (4a), (4b) and (4c), covered expenses will include only services performed within 90 days of the incurred date as described. With reference to (4d), covered expenses will cease immediately.*

5. If a course of treatment is in progress on the effective date of dental benefits coverage:

   a. Benefits are not provided for treatment received prior to commencement of coverage.

   b. Claims for a course of treatment that was started prior to commencement of coverage but completed while coverage was in force will be investigated to determine the amount of the entire fee which should be allocated to the treatment received while covered.

   c. Only that portion of the total fee which can be allocated to treatment while covered will be included as a covered dental expense.

**Pretreatment Estimate**

A “treatment plan” must be submitted in advance using the regular claim forms necessary for orthodontic treatment, periodontic treatment, dentures and fixed bridgework. A treatment plan is a description of the dental problem, the work to be performed, the duration of treatment and the cost of the treatment. The treatment plan will advise you and your dentist in advance how much you may expect to receive for the described services. We recommend that you submit a treatment plan anytime you anticipate incurring substantial covered expenses.

**Expenses Not Covered**

Payment is not made for services, supplies and treatments:

1. Unless prescribed as necessary by a dentist;

2. For charges by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist;

3. Which are obtained from any governmental agency without cost by compliance with laws or regulations enacted by any governmental body, or incurred on account of war, declared or undeclared, including armed aggression;

4. From a medical or dental department of any employer, labor union or other association or similar group;

5. Furnished by or through any governmental agency;

6. Which are compensable under Workers’ Compensation or Employer’s Liability Law;

7. Due to loss or theft of dentures or bridgework or any prosthetic device;

8. For replacement or repair of orthodontic appliances;

9. For any duplicate prosthetic device or any other duplicate appliance;

10. For cosmetic purposes, including the alteration, extraction and replacement of sound teeth for the purpose of changing appearance, unless prescribed as necessary in a course of treatment;

11. For oral hygiene and dietary instruction;

12. For a plaque control program;

13. For any benefits which are paid under any other provision of the Plan;

14. The failure to keep a scheduled visit with the dentist;

15. For the completion of any insurance forms;

**Payment of Claims**

You can obtain the appropriate claim forms from your Employee Benefit Office or online at www.metlife.com/mybenefits. You should complete the employee section of the form before presenting it to your dentist. The claim procedure permits optional assignment of any benefits due you under the Plan for direct payment of such benefits to your dentist. If you elect to make this assignment, a check will be made payable and sent directly to the dentist, and you will receive a copy of the Explanation of Benefits calculation sheet. If your dentist does not file claim forms, the forms should be returned to your attention when completed by the dentist for submission directly to the insurance carrier at the address indicated on the claim form.

**Filing a Claim**

You should submit claims as soon as charges have been incurred, however, all claims should be submitted within 120 days after the end of the calendar year in which expenses are incurred for which payment is to be made and must be submitted no later than the end of the calendar year following the calendar year for which the covered expenses are payable. Claims received after these dates will not be honored by the insurance company.

**Steps to Take when Filing Claims for Dental Expense Reimbursement**

1. Obtain claim forms from the Employee Benefits Office where you are employed or online at www.metlife.com/mybenefits. You can also call MetLife at 1-800-942-0854.

2. A separate claim form must be filed for each person.

3. Complete the employee section of the claim form and give to your dentist for completion.

4. If the dentist does not file the claim for you, submit the claim form directly to the insurance carrier at the address stated on the claim form after the dentist completes the form.

## VISION CARE BENEFITS

This section describes the covered vision services available to you and your eligible dependents. Your vision care benefits are administered by EyeMed Vision Care.

**SCHEDULE OF VISION CARE BENEFITS**

| BENEFIT PROVISIONS | EyeMed Vision Care Select Plan | |
|---|---|---|
| | Network | Non-Network |
| **EXAM WITH DILATION AS NECESSARY** | $15 copay | Plan pays $35 |
| **FRAMES** | $75 allowance, 20% off balance over $75 | Plan pays $55 |
| **STANDARD PLASTIC LENSES** | | |
| Single Vision | $0 copay | Plan pays $25 (per lens) |
| Bifocal | $0 copay | Plan pays $30 (per lens) |
| Trifocal | $0 copay | Plan pays $35 (per lens) |
| Lenticular | $0 copay | Plan pays $40 (per lens) |
| Standard Progressive | $65 copay | Plan pays $35 (per lens) |
| **LENS OPTIONS** | | |
| UV Coating | $15 copay | N/A |
| Tint (Solid and Gradient) | $15 copay | N/A |
| Standard Scratch Resistant | $15 copay | N/A |
| Standard Polycarbonate | $40 copay | N/A |
| Standard Anti-Reflective | $45 copay | N/A |
| Other Add-Ons and Services | 20% off retail balance | N/A |
| **CONTACT LENSES** | | |
| Conventional | $80 allowance, 15% off balance over $80 | Plan pays $80 (per pair) |
| Disposable | $80 allowance, plus balance over $80 | Plan pays $80 (per pair) |
| Medically Necessary | $0 copay, paid in full | Plan pays $80 (per pair) |
| **BENEFIT PERIOD** | Exams and Lenses, every 12 months<br>Frames or Contacts, every 24 months | |

### Purpose of Benefits

The coverage is to help defray the cost of necessary vision care for you and your dependents. The plan allows you to use in-network or out-of-network providers.

### In-Network Benefits

If you use the in-network benefits, you will need to use a participating provider. To locate a participating provider, you can call EyeMed at 1-866-723-0514. You can also register online at www.eyemedvisioncare.com and look up providers. When you go to

the provider, present your ID card and the provider will file your claim for you with EyeMed Vision Care.

**Out-of-Network Benefits**

If you use an out-of-network provider, you will need to complete an out-of-network claim form and mail it along with your receipts to the address shown on the claim form. You can request claim forms from EyeMed by contacting them at 1-866-723-0514 or you can register online at www.eyemedvisioncare.com and download claim forms.

You will pay for all services up-front, complete the form and send it to EyeMed with your receipts. A separate claim form must be filed for each person who has incurred an expense for benefit payment.

EyeMed will reimburse you up to the out-of-network maximum allowable amount. Vision care benefits will be paid directly to you unless otherwise specified on the claim form.

**Covered Expenses**

Expenses will be covered for the following services and supplies made or recommended by a licensed physician, optometrist, or optician:

1. Eye refractions (including those made in connection with the Employee Safety Glass Program) but not including charges for more than one such refraction performed with respect to the same person within 12 consecutive months;

2. Eyeglass lenses (excluding contact lenses, except as provided in 4. and 5. below) but not including charges for more than one pair of lenses with respect to the same person within 12 consecutive months;

3. Eyeglass frames but not including charges for more than one frame with respect to the same person within 24 consecutive months;

4. Contact lenses to be provided in lieu of any eyeglass lenses and/or frames to the same person within 24 consecutive months; or

5. Contact lenses when visual acuity cannot be corrected to 20/70 in the better eye except by their use. Contact lenses prescribed following a cataract operation may be covered under your health care plan.

The expense for purchases of optical materials will be deemed to have been incurred and covered on the date such order is placed with a qualified supplier, but reimbursement for such expenses will not be approved for payment until you have received such optical materials.

**Expenses Not Covered**

1. Services or supplies not prescribed as necessary by a licensed physician, optometrist or optician;

2. Replacement of lenses or frames which are lost, broken, or stolen except at the normal interval provided in paragraph, “Covered Expenses”;

3. Any services or materials which are covered by any Workers’ Compensation Laws or Employer’s Liability Acts, or services and materials which an employer is required by law to provide in whole or in part;

4. Services or supplies to which the insured person is entitled to under any other provision of the Benefits Plan or for which the employee incurred no expense; or

5. For the completion of any insurance forms.

**Coordination with Plant Safety Glass Program**

Industrial safety glasses for occupational uses will be furnished under the Safety Glass Program of each respective plant. Safety glasses for personal use will not be covered under the provisions of the Vision Benefits Plan.

## GENERAL PROVISIONS

### Non-duplication

The health care benefits provided under this Plan are subject to the following non-duplication provision:

1. The medical, prescription drug, dental and vision care benefits of the Plan 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 non-duplication provision, or

   b. Includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Plan.

2. In determining whether the Plan 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. When both plans cover the patient as a dependent child, the plan of the participant whose birthday falls first within the calendar year shall be the primary plan, or

   c. When the determination cannot be made in accordance with (1) or (2) above, the plan which has covered the patient for the longer period of time will be the primary plan.

3. As used herein, a '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.

4. A spouse of any participant in this Plan who is employed by an employer which offers health care coverage must enroll in that plan if the spouse's employer pays any part of the cost of such coverage. This requirement is not applicable for an employee's spouse who works less than 32 hours per week. In the event the spouse is required to pay more than 50% of the cost of the coverage, the company will reimburse the employee for any premium/cost paid by the spouse which is more than 50% of the cost of coverage for that employee. The employee will be reimbursed by the company for such excess on a quarterly basis upon proper application by the employee on a form provided by the company. To receive such

reimbursement, the employee must provide the following:

a. The monthly premium/cost of the spouse's employer's health plan;

b. The monthly amount the spouse will pay for their employer's health plan;

c. The employee will be responsible for notifying the company of any changes in the information;

d. Any other information as requested to make determination.

5. If it is determined that benefits under this Plan should have been reduced because of benefits provided under another group plan, Anthem 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 Plan have been provided under another group plan, Anthem may make reimbursement directly to the insurance company or other organization providing benefits under the other plan.

6. For the purpose of this provision, Anthem may, without consent of or notice to any person, release to or obtain from an insurance company or other organization or person any information which may be necessary regarding coverage, expenses and benefits.

7. Any person claiming benefits under this Plan must furnish Anthem such information as may be necessary for the purpose of administering this provision.

8. In the event of any payment on behalf of any Participant by this Plan, the Plan shall be subjugated to all rights of the Participant to recovery thereof against any person or organization. Participants under the Plan shall execute and deliver all instruments and papers necessary, and perform all acts necessary to secure the Plan's rights of subrogation, and shall do nothing after incurring any loss to prejudice those rights.

**Medicare - Age 65 and Over**

The Tax Equity and Fiscal Responsibility Act (TEFRA) gives active employees aged 65 and over and employees' spouses aged 65 and over a choice in deciding whether they want Medicare or the Company's Plan for primary medical benefits coverage. Should you elect the Company Plan as primary, claims would be submitted to the Company Plan for payment. You would not receive reimbursement for Medicare Part B. Should you elect Medicare, the Company Plan would be discontinued except for specified non-Medicare benefits plans (e.g., dental, vision care, etc.) and your cost for Medicare Part B would be reimbursed by AK Steel Corporation. If you wish to elect Medicare as primary coverage, contact your local benefits administrator.

If you or your spouse is age 65 or older with enough work credit under Social Security, you pay no premium for Medicare hospital insurance (Part A). No matter which option

you choose, you and your spouse should apply for Medicare Part A coverage at any Social Security office three months before you reach age 65. If you or your spouse choose coverage under the AK Steel Corporation medical plan, the Medicare Part A coverage will be supplementary at no charge to you.

Medicare supplementary medical insurance (Part B) is voluntary with a monthly premium. If you or your spouse enroll, Medicare Part B will be supplementary to any coverage either of you have under the Company Plan.

If you choose the Company Plan as primary while you are an active employee, upon retirement at age 65 or older, Medicare will become your primary plan.

The premium penalty for late Medicare Part B enrollment is waived while you are covered by the Company Plan as an active employee.

Re-enrollment for Medicare Part B is permitted without penalty within three months following the date of your retirement. If you do not enroll then, you can subsequently enroll during the month of January, February or March in any subsequent year with coverage effective on July 1 of that year. In this instance, you would then incur a penalty. This also means there could be a serious gap in your medical protection between the date you retire and the date your Medicare Part B coverage is effective. This gap exists because the company's retiree medical program provides that benefits payable under the retiree program will be reduced by benefits payable under Medicare, whether or not you are enrolled for Medicare coverage.

**Disabled Employees and Disabled Dependents of Active Employees**

For disabled active employees or disabled dependents of active employees, the Company Plan will be primary and Medicare secondary from the time the individual is eligible for Medicare coverage until age 65 or until the employee retires. If the employee is still active when the disabled dependent attains age 65, the disabled dependent will have an election between the Company Plan or Medicare as stated above. Medicare Part B will not be reimbursed while the Company Plan is primary.

The only exception is for end-stage renal disease patients where a separate provision under existing Social Security law requires the employer plan to be primary only for the first year.

1. For the second year of end-stage renal disease, Medicare will be primary and the Company Plan will be secondary. Medicare Part B premium will be reimbursed by the company except where the Part B charge for a dependent is deducted from Social Security or Railroad Retirement benefits.

2. Payment under the Plan shall be the benefit which would otherwise be payable for Covered Medical Expenses under the Plan reduced by the amount of benefits which you or your dependent receives, or would upon application receive under Medicare

Part A or Medicare Part B.

**How to Appeal a Claim for Life, A D & D, and Dependent Life Insurance**

If you or your designated beneficiary has any question concerning a denial in whole or in part of life insurance benefits, accidental death and dismemberment insurance benefits and/or dependent life insurance benefits, you or your beneficiary should write within 60 days from the date the claim was denied to the office of the insurance company which denied the claim, furnishing all pertinent claim data. You or your beneficiary's appeal will be reviewed by that office and reply made within 60 days of the date the appeal is received. If you or your beneficiary are not satisfied with the decision rendered by that office, you or your beneficiary may further appeal the claim by writing within 60 days from the date of the reply to the initial appeal to the Assistant Vice President, Group Benefits Department, CIGNA, 1600 West Carson Street, Suite 300, Pittsburgh, Pennsylvania 15219. You or your beneficiary will be advised by that office of the final decision within 60 days.

**How to Appeal a Medical Claim**

If you apply for medical benefits and your believe that the Plan provisions have not been applied correctly or have any other claim regarding the Plan, you should submit your written claim to National Appeals, Anthem Blue Cross & Blue Shield, P O Box 7094, Indianapolis, IN 46207-7094.

Within 90 days you will receive written notice of the decision on your claim. In special circumstances, this period may be extended for an additional 90 days by written notice.

If the claim is wholly or partially denied, the written notice denying your claim will set forth an explanation of the specific findings and conclusions on which the denial is based. If you disagree with the denial, you may file a written request for review of the denial with Anthem Appeals Committee, Anthem Blue Cross & Blue Shield, P O Box 7094, Indianapolis, IN 46207-7094.

This appeal must be delivered within 60 days after you receive notice of the denial of your claim, must state the basis on which you disagree with the determination, and must include any additional information which you wish to be considered.

The Committee will fully and fairly review the matter, make a final determination with 60 days of the receipt of your request for review of the disputed claim, and send you a written reply. In special circumstances, this period may be extended for an additional 60 days. If the Committee denies your claim, its reply will clearly explain the reasons for its denial.

If you are a member of a bargaining unit and you have applied for and have been denied benefits under the Plan, you should submit a written claim for benefits to Anthem. If you are not satisfied with the decision, then your appeal may be processed

as a grievance under the provisions of the applicable collective bargaining agreement. If no collective bargaining agreement controls the resolution of your claim, you should process your claim by an appeal in the manner described above.

**How to Appeal a Claim for Sickness and Accident, Medical, Dental or Vision Benefits**

If you apply for benefits under this Plan and you believe that the Plan provisions have not been applied correctly, you should submit a claim for benefits to the Employee Benefits office where you work.

Within 90 days you will receive written notice of the decision on your claim. In special circumstances, this period may be extended for an additional 90 days by written notice.

If the claim is wholly or partially denied, the written notice will set forth an explanation of the specific findings and conclusions on which the denial is based. If you still believe that the Plan has not been applied correctly in your case, you may file a written request with the AK Steel Corporation Benefit Plans Administrative Committee, 9227 Centre Pointe Drive, West Chester, Ohio 45069. This appeal must be made within 60 days after you receive notice of the denial of your claim and it should state the basis on which you disagree with the determination of your benefits and any additional information which you wish the AK Steel Corporation Benefit Plans Committee to consider.

The AK Steel Corporation Benefit Plans Committee will fully and fairly review the matter, make a final determination within 60 days of the receipt of your request for review of the disputed claim, and send you a written reply. In special circumstances, this period may be extended for an additional 60 days. If the Committee denies your claim, its reply will clearly explain the reasons for its denial.

If you are a member of a bargaining unit and you have applied for benefits under this Plan and you believe that the Plan provisions have not been applied correctly, you should submit such claim for benefits to the Employee Benefits office where you work. If such difference is not resolved by discussion with the Employee Benefits office, then such differences may be processed as a grievance under the provisions of the application collective bargaining agreement.

# GENERAL INFORMATION

## Eligibility

You will be eligible to participate in the Plan if you are in the regular, full-time service of the company in a group of employees designated by the company as covered by the Plan. For the purposes of Plan eligibility, regular, full-time service requires a normal work schedule of at least twenty hours a week and three days a week and requires that you initially attain 520 hours of actual work (three months of uninterrupted employment) with the company.

No enrollments will be made on a partial basis; participation in the Plan is for the full amounts of all coverages to which you are entitled.

## Dependents

The term 'dependents' includes your spouse and unmarried children between 14 days and 21 years of age except for hospital and physicians' services for which children under 14 days of age are included.

For all coverages, the term 'children' includes:

1. A blood descendent of the first degree,

2. A legally adopted child (including a child living with the adopted parents during the period of probation),

3. A stepchild residing in your household, or

4. A child related to you by blood or marriage or for whom you hold legal custody, permanently residing in your household of which you are the head and actually being supported by you.

Coverages for children terminate at the end of the month in which age 21 is attained; however, children are included after attainment of age 21 but not beyond attainment of age 25, if, in addition to otherwise meeting the definition of dependent children as stated above, 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 after attainment of age 21 under this provision, the child must have been eligible for coverage as a dependent prior to attainment of age 21.

Children are also included after attainment of age 21 while incapable of self-support because of a disabling sickness or injury that commenced prior to age 21 provided such child was eligible for coverage as a dependent prior to attainment of age 21. Such

children must otherwise meet the definition of dependent children as stated above, must legally reside with you and must be principally supported by you.

To be eligible for dependent coverage, proof will be required that the child(ren) or spouse meets the definition of dependent.

Any person eligible to participate in this or any other group insurance program as an employee of the company may not be included in the term 'dependents' with respect to dependent life insurance, medical, dental or vision care benefits.

**Enrollment**

You are to be enrolled for all coverages at the time of your employment and after having worked at least 520 hours or at the time you first become eligible as a member of a designated group of employees. Your coverage will become effective after meeting the eligibility requirements and after you sign the proper forms for premium deductions by enrolling in the Plan.

To enroll for coverage, all applicable enrollment forms and certifications required by the Plan Sponsor must be submitted by the date established by the Plan Sponsor. If an eligible individual does not enroll during an initial enrollment period or an open enrollment period, an eligible individual may be eligible to enroll for coverage under special enrollment situations.

If a husband and wife are both hourly employees, and eligible for enrollment under the Plan, they may enroll for coverage under one plan, with one spouse being the dependent of the other spouse. If there are dependent children, one employee may carry family coverage with spouse and children as dependents. Should a change in marital status occur, it is the responsibility of both parties to notify the company. Written notice of the change must be made to the Employee Benefits Office within 30 days.

**Special Enrollment**

An eligible person or dependent who was previously eligible for coverage, but did not enroll during an initial enrollment period, and who meets the following conditions will be allowed to enroll during a special enrollment period if:

1. An eligible Person or Dependent declined this coverage initially due to other health coverage, and;

2. The other health coverage was:

    a. COBRA continuation which exhausted, or

    b. Terminated as a result of loss of eligibility for that coverage (due to legal separation, divorce, death, termination of employment or reduction in the number

of hours of employment); or terminated as a result of employer contributions towards such coverage ceasing; or

c. The person becomes a dependent of a Participant through marriage, birth, adoption or placement for adoption,

Enrollment must be requested no later than 30 days after the date the coverage described above terminated or the date the person becomes a dependent of the Participant. If enrollment is not requested ***within 30 days***, then the person(s) will be eligible for re-enrollment only upon the next open-enrollment period.

**Effective Date of Coverage**

The effective date of all coverages begins on the day you attain 520 hours of actual work (approximately 3 months of uninterrupted employment) with the company.

If you are enrolled for personal coverage only and thereafter marry or otherwise acquire a dependent, coverage on the dependent will become effective on the date you acquire the dependent, subject to the above. You must give written notice ***within 30 days*** on the prescribed form of any change in your family status, such as marriage, birth or adoption of a child, the marriage or death of any of your dependent children, the death of your spouse, or divorce.

If, on the date coverage for any of your dependents would otherwise become effective, a dependent is confined in a hospital for any reason other than his/her birth therein, coverage for that dependent will not become effective until he/she is discharged from the hospital by a physician on the basis that further hospitalization was not required at time of discharge.

**Payment of Premiums**

In order to attain coverage, an authorization for payroll to deduct medical premiums must be signed and submitted with enrollment material. Should you cease work due to disability, you will be responsible for your premium payments. Contact your local benefits administrator for more information.

If you are absent without pay, it is your responsibility to submit health care premiums to the Employee Benefits department as long as you continue to be eligible for health care benefits.

If you resume receiving pay and you have an arrearage, payroll will deduct such arrearage from your regular pay. Should the arrearage exceed six weeks for any reason, the participant may submit a request to Payroll to have arrearages deducted in three equal payments.

## Provisions Applicable If You Cease Active Work

Non-Occupational Sickness or Accident

If you are absent from work because of a non-occupational disability, all coverage under the Plan will be continued up to the end of the month of the period for which you are eligible to receive Sickness and Accident weekly benefits. If you are disabled beyond this period and your life insurance is not being continued under the provisions relating to total and permanent disability, your life insurance and medical coverage will be continued at company expense for an additional period of up to eighteen months, but not beyond two years from the end of the month in which you last worked, unless Long-Term Disability or retirement eligibility on other than a Deferred Vested Pension, has been attained.

Occupational Sickness or Accident

If you are absent from work because of occupational disability, coverage under this Plan will be continued during absence due to such disability, but not beyond one month following the end of the month for which statutory compensation payments terminate, except that Sickness and Accident benefits coverage will terminate:

1. At the end of six months following the month in which you last worked if you had less than two years of continuous service on the date you ceased work; or

2. At the end of 12 months following the month in which you last worked if you had two or more years of continuous service on the date you ceased work; or

3. At the end of the last month during which you are eligible for Sickness and Accident benefits, if you had 20 or more years of continuous service on the date you ceased work.

Layoff

If you cease work because of a layoff, all coverages are continued to the end of the month in which you last worked, except that Sickness and Accident and Long Term Disability benefit coverages are terminated on the date you cease work; thereafter, the following provisions will apply:

1. First six full months of layoff:

    a. If you have less than two years of continuous service at the date of layoff, your life insurance will be continued without cost to you for six months. All other coverages will be terminated at the end of the month in which your layoff occurred;

b. If you have two or more years of continuous service at the date of layoff, all coverage except Sickness and Accident and Long Term Disability benefits will be continued for up to six months.

2. Next 18 months of layoff:

   a. If layoff continues beyond six months, and you have two or more but less than 10 years of continuous service on the date you cease work, all coverages other than life insurance will be terminated at the end of six months following the month in which you were laid off. Life insurance coverage terminates after 12 months;

   b. If you have 10 but less than 20 years of continuous service on the date you cease work, all coverages will be continued during such layoff up to a maximum of 12 months from the end of the month in which you last worked;

   c. If you have 20 or more years of continuous service on the date you cease work, all coverage will be continued during such layoff up to the later of (i) 12 months from the end of the month in which you last worked or (ii) the number of weeks from your date last worked equal to the number of your credit units under the Supplemental Unemployment Benefit (SUB) Plan as of the date you ceased work; provided however, that if your remaining coverage will terminate pursuant to (b) above on a date other than the last day of the month, such remaining coverage will be continued through the end of that month. Notwithstanding the above, if you become disqualified from receiving weekly benefits from the Supplementary Unemployment Benefit Plan, your remaining coverage will terminate as of the later of (i) 12 months from the end of the month in which you last worked or (ii) the date you first become so disqualified. In addition, if you receive a weekly benefit as a result of an additional SUB credit unit granted to you, your remaining coverage will be continued during a week for which such weekly benefit is paid;

   d. If you have 20 or more years of continuous service on the date you cease work due to layoff and do not return to work due to disability, the provisions set forth in the case of an employee who ceases work due to layoff will continue to apply to you.

See **Continuation of Coverage (COBRA)** section for provisions under which you may continue health coverage under the Plan.

You may elect to continue your group life insurance only for an additional period ending twenty-four months after the month in which layoff occurred. In order to keep this insurance in effect, you must make the required contribution of 60 cents per month per $1,000 of insurance. Failure to make these payments by the first day of the month will terminate this coverage at the end of the last month for which payment was made.

Leave of Absence

The company reserves the right to decide the terms and conditions under which benefits coverage may be continued during each individual leave of absence. You will be informed as to your benefits continuation at the time you are granted a leave of absence. In all cases, however, Sickness and Accident benefits and Long Term Disability benefits will be terminated on the last day worked.

Termination of Employment

If your employment is terminated, all your coverage under the Plan will end on the date of such termination. Your life insurance protection, however, continues for 31 days after the termination of the coverage in accordance with the provisions and limitations of the policy.

In the event of your death as an active employee:

1. If you had attained at least 15 years of continuous service prior to the date of death, benefits provided under the medical plan will be continued, as long as premiums are paid, for your spouse and your eligible dependents until your spouse remarries;

2. If you had less than 15 years of continuous service upon the date of death, benefits provided under the medical plan will be continued for your spouse and your eligible dependents for a period of six months following the month of death, as long as the premiums are paid.

If there is no spouse upon the date of your death, or upon the spouse's death or remarriage following such an occurrence, the benefits will terminate as of the end of the month for any surviving dependents.

See the **Continuation of Coverage (COBRA)** section for provisions under which you may continue health coverage under the Plan.

Retirement and/or Long Term Disability (LTD) Benefits

If you become a Long Term Disability (LTD) Benefits Plan recipient or retire prior to age 62, on other that a Deferred Vested pension, the full amount of life insurance you had under the Plan immediately prior to retirement or disability will be continued until the end of the month in which you attain age 62; the amount of your life insurance will then be reduced to $11,000. Dependent life insurance for your spouse will be continued at a reduced rate. Dependent life insurance on your child(ren) will terminate at the end of the month in which you retire or become a LTD Benefits Plan recipient.

If you become a LTD Benefits Plan recipient or retire under the company pension plan applicable to you on other than a Deferred Vested pension, you and your eligible dependents may be enrolled for retiree medical benefits.

In the event of your death:

1. If you had qualified for continued coverage as a retiree, or a retiree-LTD Benefit recipient, coverage under the medical plan, as long as premiums are paid, may be continued for your spouse and your eligible dependents until your spouse remarries;

2. If you had attained less than 13 years of continuous service prior to becoming disabled, medical benefits may be continued for your spouse and your eligible dependents for a period of six months following the month of death, as long as the premiums are paid.

If there is no spouse upon the death, or upon the spouse's death or remarriage following such occurrence, the benefits will terminate as of the end of the month for any surviving dependents.

Life Insurance Conversion Privilege

If your life insurance is terminated because of termination of your employment by the company, you may arrange, upon application to CIGNA within 31 days after your life insurance coverage terminates, to continue your life insurance at your own cost under an individual policy, for an amount not greater than the amount of life insurance you have under the Plan at the time of such termination, without medical examination.

Furthermore, whenever your life insurance under the Plan is reduced because of retirement or attainment of age 65, you may apply for an individual policy, in accordance with the foregoing provisions governing such application, in an amount not greater than the amount of the reduction. Such application must be made within the 31-day period, commencing with the effective date of the reduction.

Such individual policy may be on any one of the forms of policy then customarily issued by the insurance company other than a policy of term insurance or one which provides disability benefits or special benefits in the event of accidental death, and will be issued at the rate applicable to your age and class of risk at that time.

Any such individual life insurance policy will become effective at the end of the 31-day conversion period referred to, and if you should die during such period, whether or not you have applied for such a policy, an amount equal to the amount of life insurance in force under the Plan immediately prior to termination or reduction will be payable to your beneficiary. If any such amount is payable, no life insurance will be payable under the Retirement provision herein. If the beneficiary named to receive the death benefit under such an individual policy or in the application therefore is different from the beneficiary named under the group policy, any amount payable under the group policy will be payable to the beneficiary under the individual policy.

Anthem Conversion Privilege

If your Anthem coverage under the Plan is terminated, you may arrange, by contacting your nearest Anthem office within 90 days after your coverage terminates, to convert the coverage at your own cost for yourself and your dependents under the provisions of the Anthem Plans serving the area in which you live.

Certain Anthem Plans provide maternity and obstetrical coverage only if you elect a Subscription Agreement providing family coverage. Therefore, if you desire such coverage, you must enroll for the type of Subscription Agreement which provides maternity and obstetrical benefits.

**Reinstatement or Re-Employment**

If you return to work following a break in your continuous service, you will be enrolled in the Plan as a new employee, and except as noted below, your coverage will not become effective until you complete 520 hours of actual work following your re-employment.

If you 1) have a break in continuous service and at that time you were eligible for an immediate or deferred vested pension under the company pension plan applicable to you, or 2) your break in continuous service was removed when you were re-employed, or 3) you have a break in continuous service before completing 520 hours of actual work because of lack of work and you were rehired within one year from your termination date and credited for prior hours worked for purposes of completing your probationary period, those hours credited to you before your break in continuous service will be credited toward the 520 hours of actual work which you must complete prior to becoming eligible for coverage under the Plan.

**Benefits Provided Under Law**

If any benefits are provided by any state or federal legislation similar to those described in this booklet, appropriate adjustments will be made in the provisions of the Plan to increase or reduce the Plan benefits by the amount of any such benefits provided under law.

**Former Announcements**

The foregoing is an outline of certain policy procedures and benefits for your general guidance. All previous announcements from any and all sources, whether written or oral, made concerning this Insurance Benefits Plan are superseded and canceled by this statement.

**Beneficiary**

Any part of the life and accidental death and dismemberment insurance for which there is no designated beneficiary living at your death, will be payable in a single sum to the first surviving class of the following classes of successive preference beneficiaries:

1. Your widow or widower;

2. Surviving children;

3. Surviving parents;

4. Surviving brothers and sisters;

5. Executors or administrators.

In the absence of the appointment of a legal guardian, any minor's share may be paid at a rate not exceeding $50 a month to such adult or adults as have, in CIGNA's opinion, assumed the custody and principal support of such minor.

**Full-Time Students**

In order for a dependent child to be eligible for the benefits of the Insurance Benefits Plan as a full-time student after attainment of age 21, the child:

1. Must be under 25 years of age and otherwise meet the Plan's definition of a dependent child under 21 years of age;

2. Must not be employed on a regular full-time basis;

3. Must not be paid by another employer while in school at the request of that employer;

4. Must not be covered under any other employer group insurance or prepayment plan;

5. Must be enrolled full-time in a recognized course of study or training and in active full-time attendance at an institution such as a:

    a. High school or vocational school supported or operated by state or local governments, or by the Federal government,

    b. State university or college or community college,

    c. Licensed private school, college or university,

d. Licensed technical school, nurses' training school, beautician school, automotive school, or similar training school, and

6. Must have been under age 21 when you were last enrolled in the Plan and must have been eligible for coverage as a dependent immediately prior to attainment of age 21.

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 in the Plan. If your dependent qualifies under the criteria listed above as a full-time student, you need not continue any Anthem coverage that the student may have (or may be eligible to obtain) under an individual contract, direct payment basis. You are required to contact your Employee Benefits Office to obtain a Full Time Student Certification form. This form will need to be completed and returned to the Benefits Office. A determination will then be made on whether your dependent qualifies as an eligible Full Time Student.

The eligibility of a dependent who qualifies as a full-time student for benefits of the Plan will continue during:

1. 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); or

2. 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 enrolled in the institution.

The student's eligibility will terminate at the end of the month in which the full-time status ends;

1. Either by graduation or completion of the course,

2. By other termination of full-time attendance at the institution, or

3. Upon attainment of age 25.

It is the employee's responsibility to notify the Employee Benefits Office of a student's eligibility or ineligibility for coverage.

**Disabled Children**

In order for a dependent child to be eligible for benefits of the Insurance Benefits Plan as a disabled child after attainment of age 21, the child:

1. Must otherwise meet the Plan definition of a dependent child under 21 years of age;

2. Must be incapable of self-support because of a continuously disabling sickness or injury which commenced prior to age 21;

3. Must legally reside with the employee;

4. Must be principally supported by you; and

5. Must have been under age 21 when you were last enrolled in the Plan and must have been eligible for coverage as a dependent immediately prior to attainment of age 21.

If you believe that you have a dependent who meets the disability criteria above, you should secure from the Employee Benefits Office the Disabled Dependent Certification form which must be completed by you and the attending physician and returned to that office within 90 days of the attainment of age 21 of such a dependent. That form will be reviewed to determine eligibility for benefits under the Plan and you may be required to submit additional information in connection with such eligibility determination. You will be notified if your dependent is eligible for benefits under the Plan as a disabled child. If such eligibility is approved, you will be further required, usually not more frequently than once a year, to furnish satisfactory evidence the Employee Benefits Office to substantiate the continued eligibility of such a dependent for benefits under the Plan. If eligibility is approved, a disabled child will also be eligible for any other benefits provided by the Insurance Benefits Plan as applicable to your present employment status.

**Sterilization Procedures**

Regardless of medical necessity, sterilization procedures will be covered under the hospital benefits and physicians' services benefits of the Plan.

**Elective Abortions**

The maternity and obstetrical benefits of the Plan are provided for elective abortions where permitted by law, subject to any requires waiting period.

**Organ Transplants**

When hospital and physicians' services are required for any type of human organ or tissue transplant requiring surgical removal of the donated part from a living donor to a transplant recipient, (a) the donor, if he/she is covered under the Plan, shall not be denied sickness and accident benefits on the basis that his/her disability did not result from a sickness or accident and (b) the medical expenses of the Plan are payable as follows:

1. When the transplant recipient and donor are both covered under the Plan, payment for covered services will be provided for both;

2. When the transplant recipient is covered under the Plan but the donor is not, payment for covered services will be provided for both the recipient and the donor to the extent that charges for such services are not payable under any other insurance (benefits payable on behalf of the donor are charged to the recipient's claims); or

3. When the transplant donor is covered under the Plan but the recipient is not, payment for covered services attributable to the donor will be provided to the extent that charges for such services are not payable under any other insurance. Payment will not be provided for services attributable to the recipient.

**Discontinuance and Amendment**

The company reserves the right at any time to amend, suspend or terminate the Plan and to suspend or terminate its contributions and premium payments on behalf of employees, in whole or in part for any reason and without the consent of any employee, beneficiary or any other person.

No benefit is payable under the Plan unless the Benefits Administrator is provided with a completed enrollment form and application for benefits and all other information which he/she requests on forms approved by him. All forms are available from the Employee Benefits office.

*Note: All participants should carefully review the booklet for other circumstances which may result in disqualification, ineligibility, denial, reduction, loss or suspension of benefits for them or their dependents.*

# LEGISLATION

## Continuation of Coverage (COBRA)

Under a federal law commonly known as COBRA, you, your spouse and dependent children may elect to temporarily continue your current health care benefits coverage under the Company medical, dental, and vision plans and the health care spending account as the result of a "qualifying event" when coverage otherwise would end. Individuals that may be entitled to COBRA continuation (qualified beneficiaries) are you, your spouse and your dependent children who are covered at the time of a qualifying event. A child who is born to you, adopted, or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary.

Qualifying Events

If your employment terminates with the Company for any reason other than your gross misconduct or if your hours worked are reduced so that your Plan coverage is reduced or terminated, you, your covered spouse and dependent children may continue your current health care benefits coverage under the Plan for up to 18 months.

If you as an employee of the Company should die, become divorced or become entitled to Medicare, your covered dependents whose health coverage under the Plan would be reduced or terminated may continue current health care benefits coverage under the Plan for up to 36 months. Also, your covered children may continue their current health care benefits coverage election for up to 36 months after they no longer qualify as covered dependents under the terms of the Plan.

Any period of coverage provided by the Company after a qualifying event as stated in this section may run concurrently with continuation coverage eligibility. For example, if the Company provides coverage for 12 months after a qualifying event, the Company may apply those 12 months to your 18-month period of COBRA eligibility.

COBRA continuation for the health care flexible spending account is only available if the benefit available at the time of the qualifying event exceeds the COBRA premium for the remainder of the plan year.

In no case, other than for a covered retiree and the retiree's covered family members during the Company's bankruptcy proceedings, may the total amount of continued coverage be more than 36 months.

Certain events may extend an 18-month COBRA continuation period:

- If your dependent(s) experience a second qualifying event such as death, divorce or change in dependent status, within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event). If you as an employee

cancel coverage on a spouse in anticipation of a divorce, upon receiving notice of the divorce, the Company is required to make COBRA continuation available, effective on the date of the divorce, but not for any period before the date of divorce.

- In the case of a qualified beneficiary who is born to, or placed for adoption with a covered employee during a period of COBRA continuation, the duration of COBRA coverage is measured from the date of the covered employee's qualifying event. If a second qualifying event occurs before the actual birth or adoption placement, the duration of coverage will be for 36 months from the date of the original qualifying event.

- If you as an employee of the Company became entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (such as your termination of employment or reduction in hours of work) happens within 18 months, your dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.

- If you or your dependent is disabled (as determined by the Social Security Administration) on the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months). In the case of a qualified beneficiary who is born to, or placed for adoption with a covered employee during a period of COBRA continuation, the 60-day period is measured from the date of the child's birth or placement for adoption. To qualify for this disability extension, your Benefits Administrator must be notified of the person's disability status both within 60 days after the Social Security disability determination is issued *and* before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify your Benefits Administrator within 30 days after this determination.

***Important Note:*** *If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary (whether or not disabled) may further extend COBRA coverage for 7 more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.*

<u>Giving Notice That A COBRA Event Has Occurred</u>

To qualify for COBRA continuation upon divorce or loss of a child's dependent status under the company health plan, you are required to notify the Plan Administrator of the divorce or loss of dependent status within 60 days after the later of the event or the date the individual would lose coverage under the Plan. Your covered dependent will then be contacted with instructions for continuing your current benefits coverage. Individuals already on COBRA must notify the Plan Administrator within these deadlines if a divorce

or loss of child's dependent status occurs that would extend the period of COBRA coverage for your spouse or covered dependents.

For other qualifying events (if your employment ends, your hours are reduced, or you become entitled to Medicare), you will be contacted with instructions for continuing your medical coverage. In the event of your death, the Company will notify your covered dependents how to continue medical coverage.

Should you be on a Family Medical Leave of Absence and elect not to return to work, your qualifying event occurs on the last day of your FMLA leave.

Electing and Paying for COBRA Continuation Coverage

You and/or your covered dependents must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered dependents would lose coverage as a result of the qualifying event, or

- The date the Company notifies you and/or your covered dependents of your right to choose to continue coverage as a result of the qualifying event.

A qualified beneficiary is entitled to the coverage made available to similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not occurred.

In computing deductible credits and other plan limits for family and family units receiving COBRA coverage, the plan is required to take into account only expenses incurred before the qualifying event by family members who elect COBRA.

If you are denied coverage by another party which is in violation of applicable law, (including HIPAA) you will be considered a qualified beneficiary if a qualifying event has occurred.

If you are incapacitated, a legal representative may elect COBRA coverage on your behalf or other dependent qualified beneficiaries.

If you elect continuation coverage, you or someone on your behalf must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date.

The cost of COBRA coverage is 102% of the full cost of Plan coverage. The cost of coverage for the 19$^{th}$ through 29$^{th}$ months of coverage under the disability extension is 1) 150% of the full cost of coverage for all family members participating in the same coverage option as the disabled individual, and 2) 102% for any family members

participating in a different coverage option than the disabled individual, except as provided below.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual subsequently becomes disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, the 19th through 29th month), then the rates are 1) 150% for all family members participating in the same coverage option as the disabled individual, and 2) 102% for any family members in a different coverage option than the disabled individual.

If you elect COBRA continuation but then fail to pay, or the responsible party fails to pay the premiums due within the initial 45-day grace period, or you or the responsible party fails to pay any subsequent premium by the due date, your coverage will be terminated. Your coverage can be reinstated if payment is made by the end of the 30-day grace period. The premium is considered paid on the date it is sent to the Company based on the postmark.

If you make a timely but incorrect payment to the Company in an amount that is not significantly less than the cost of your continuation coverage, you will be notified by the Company of the amount of the deficiency. You will have 30 days from the date of the notice from the Company to pay the full amount.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The Company reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Coverage during the Continuation Period

If coverage under the company medical, dental and vision plans is changed for active employees (non-COBRA beneficiaries), the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods or if a change in status occurs, or at other times under the Plan to the same extent that active employees (non-COBRA beneficiaries) may do so.

When COBRA Continuation Coverage Ends

The COBRA coverage under the company medical, dental and vision plans will end for any person when the first of the following occurs:

- The applicable continuation period ends.

- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected or any subsequent premium is not paid within 30 days after it is due.

- You become covered under another health plan, and any preexisting conditions, exclusions or limitations of that plan do not apply or are satisfied by you. *This provision applies individually to each individual with COBRA coverage.* In some cases, a plan's preexisting conditions exclusion period may be reduced by each month that you and your family had continuous coverage (including COBRA continuation coverage) with no break in coverage greater than 63 days.

- After the date COBRA is elected, the qualified beneficiary becomes entitled to Medicare. *This does not apply to other qualified beneficiaries who are not entitled to Medicare.*

- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.

- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends unless a second qualifying event has occurred.

- The Company terminates health coverage for all employees.

Special Note Regarding Medicare

If you (the employee) become entitled to Medicare (that is, you become enrolled, not just eligible) before you elect COBRA, your Medicare enrollment has no effect on the maximum COBRA continuation period available to you. However, if you elect COBRA continuation *first* and then enroll in Medicare, your Medicare enrollment will terminate your COBRA coverage immediately. You are required to notify your Employee Benefits Office if this occurs.

Conversion

If you do not wish to purchase COBRA continuation coverage as described above, you may convert your medical insurance to a policy offered by the insurance carrier to individual subscribers within 90 days. If you purchase COBRA continuation coverage, the conversion privilege is available to you when your COBRA continuation coverage ends.

Coverage levels will be different from what is available under the company Plan. You have to pay your premiums directly to the insurance carrier.

Dependent children who no longer qualify for the Company Plan may also convert their coverage to an individual policy if they do not wish to purchase COBRA continuation coverage or after their COBRA continuation coverage has ended. Again, the coverage will be different from the Company Plan and required plan premiums will be paid directly to the insurance carrier.

Contact the Plan Administrator for further details. Also, if you or your spouse changes your address, please notify the Plan Administrator.

**Health Insurance Portability and Accountability Act**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rules with these limits as follows:

1. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you because of HIPAA's restrictions on pre-existing condition clauses, the Company may terminate your COBRA coverage.

2. You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Company reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

**Protected Health Information (PHI)**

HIPAA requires that health plans must protect the confidentiality of your private health information. A complete description of your rights under HIPAA will be found in the Plan's privacy notice, which will be distributed to you upon enrollment and will be available from the benefits manager.

This Plan and the Plan Sponsor will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan will require all of its business associates to observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S.

Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact your local Benefit Plan Administrator. The Company's Privacy Official will be your contact if you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA.

**Family and Medical Leave Act**

Subject to the requirements of the Family and Medical Leave Act of 1993 (FMLA) as amended, any participant entitled to FMLA may continue his/her coverage and any dependent coverage under this Plan as if continually employed during the FMLA leave period. You may be entitled to FMLA for the following reasons:

- Birth of a child or placement of a child with you for adoption or foster care,
- To care for a seriously ill spouse, child or parent,
- To care for a covered service member if you are the spouse, child, parent or next of kin of the covered service member, or
- You are unable to perform your job functions due to a serious health condition.

The Company is responsible for determination of your eligibility, rights, or the length of leave period for FMLA, and shall notify the Plan for purposes of continuing your coverage under this Plan.

**"Qualified Medical Child Support Orders"**

The Plan will comply with any Qualified Medical Child Support Order (as such term is defined in ERISA § 609) by providing group coverage under the health care plan to the named child or children (alternate recipient) based upon conditions specified by a Qualified Medical Child Support Order.

**Newborns' and Mothers' Health Protection Act**

In accordance with the "Newborns' and Mothers' Health Protection Act," the Plan may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under

Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Women's Health and Cancer Rights Act**

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

**Special Enrollment Rights**

If you have declined coverage under an AK Steel Corporation group health plan for yourself or your dependents because you (or your dependents) are covered under another health insurance arrangement, you may be able to subsequently elect coverage under an AK Steel Corporation group health plan if such other coverage is lost for any of the following reasons: exhaustion of COBRA or state law continuation rights, loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in hours, or the cessation of employer contributions for non-COBRA continuation coverage. To enroll yourself or your dependents, you must contact the Employee Benefits Office and request enrollment within 30 days after your other coverage ends. The Employee Benefits Office will determine whether you are eligible to elect coverage.

Additionally, if you acquire a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to elect coverage under an AK Steel Corporation group health plan for yourself, your spouse or the new dependent. To elect such coverage, you must contact the Employee Benefits Office within 30 days after the marriage, birth, adoption, or placement for adoption. The Employee Benefits Office will determine whether you are eligible to elect coverage.

**Qualified Change in Family Status**

Under IRS regulations, elections for health care coverage and flexible spending accounts may not be changed after the annual open enrollment period. However, if any of the following changes in family status occur, you may change an election that is consistent with the change in family status:

- Marriage,

- Divorce, annulment or legal separation,
- Death of spouse,
- Birth, death or adoption of child or placement for adoption,
- Significant cost or coverage change,
- Employee or spouse switching from full-time to part-time or part-time to full-time,
- Employee or spouse taking or returning from an unpaid leave of absence,
- Significant change in health coverage of the employee or spouse attributable to the spouse's employment,
- Separation from service,
- Cessation of required contributions,
- Commencement or termination of spouse's or dependent's employment,
- Reduction in hours by employee, spouse or dependent including full-time or part-time,
- Dependent satisfies or ceases to satisfy requirement for unmarried dependent, or
- Change in place of residence or work of employee, spouse or dependent

Changes in health care elections must be consistent with the qualified change in family status. For instance, if you get married, you may change from single to family coverage. Changes in family status must be reported in writing to your Benefits Administrator within 30 days following the change.

**ERISA Statement of Rights**

As a participant in the AK Steel Corporation Welfare Benefit Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

<u>Receive Information about Your Plan and Benefits</u>

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor

and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

If you have creditable coverage under another plan, it may reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan 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 Plan review and reconsider your claim. 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 $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

# ADMINISTRATIVE INFORMATION

## Plan Administrator and Agent for Service of Legal Process

The AK Steel Corporation Benefit Plans Administrative Committee (BPAC) is the Plan Administrator and agent for service of legal process. BPAC has the sole discretion and authority to interpret all plan provisions in administration of the Plan and to determine all factual and legal questions under the Plan. The insurance carrier is your primary source of information regarding this plan. However, if the insurance carrier cannot satisfactorily respond to your question or request for information within a reasonable time, you should contact your Benefits Administrator. If the local administrator cannot satisfactorily respond to your question or request for information within a reasonable time, you may write or contact BPAC at this address:

AK Steel Corporation
Benefit Plans Administrative Committee
9227 Centre Pointe Drive
West Chester, OH 45069

The Plan Administrator exercises it power solely in the interest of plan members and their dependents.

## Rights of the Plan Administrator

The Benefit Plans Administrative Committee is the Plan Administrator and shall have the power and authority in its sole, absolute and uncontrolled discretion to control and manage the operation and administration of the Plan and shall have all powers necessary to accomplish these purposes. The responsibilities and authority of the Plan Administrator shall include, but not be limited to, the following:

- Determining all questions regarding the eligibility of employees to participate,

- Determining the amount and kind of benefits payable to any participant, spouse or beneficiary,

- Establishing, reducing to writing and distributing to any participant or beneficiary a claims procedure and administering that procedure, including the processing and determination of all appeals hereunder, and

- Interpreting the provisions of the Plan, including the publication of rules for the regulation of the Plan, as it in its sole, absolute and uncontrolled discretion are deemed necessary or advisable and which are not inconsistent with the express terms thereof or ERISA.

If you have any questions about the Plan, you should contact your Employee Benefits Office.

**Employer**

AK Steel Corporation
9227 Centre Pointe Drive
West Chester, OH 45069

**Plan Administrator**

AK Steel Corporation
Benefit Plans Administrative Committee
9227 Centre Pointe Drive
West Chester, OH 45069

**Insurers**

Anthem Blue Cross and Blue Shield
6740 N High Street
Worthington, OH 43085

CIGNA
1600 West Carson Street, Suite 300
Pittsburgh, PA 15219

Medco Health Solutions, Inc.
100 Parsons Pond Drive
Franklin Lakes, NJ 07417

MetLife
P O Box 14587
Lexington, KY 40512

EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040

# SCHEDULE OF LABOR GRADES

## THE AK STEEL CORPORATION
## PROGRAM OF INSURANCE BENEFITS

## MIDDLETOWN WORKS

| LABOR GRADE | JOB CLASSIFICATION |
|---|---|
| 1 | Utility Person |
| 2 | Utility Technician |
| 3 | Operating Technician I |
| 4 | Operating Technician II<br>Maintenance Technician |
| 5 | Senior Operating Technician<br>Senior Maintenance Technician |

| IMPORTANT PLAN INFORMATION | |
|---|---|
| **Plan Sponsor** | AK Steel Corporation |
| **Plan Administrator** | Benefit Plans Administrative Committee |
| **Name of Plan** | AK Steel Insurance Benefits Program |
| **Plan Type** | Welfare Benefit Plan |
| **Plan Year** | January 1 through December 31 |
| | |
| **Employer Identification Number** | 31-1267098 |
| **Plan Identification Number** | 501 |

**NOTES:**