

Covington USW Local Union 8-675 Year 2010 Healthcare Plan

(Proposed Rates and Benefits – Subject to Trustee Approval)

PREMIUM RATES	Employee Only	Employee + 1	Family
2010 Active Employees (Same Premiums as 2009, Dental Included)	\$179.24	\$367.46	\$464.75
2010 Pre-Medicare Retirees	\$384.24	\$622.46	\$714.75
CALENDAR YEAR DEDUCTIBLE PPO AND Non-PPO deductibles and out-of-pocket expenses accumulate separately	IN-NETWORK (PPO)		OUT-OF-NETWORK (Non-PPO)
PER INDIVIDUAL	\$500		\$1,000
PER FAMILY (at least 2 individuals)	\$1,000		\$2,000
OUT-OF-POCKET LIMIT (Only includes eligible expenses)	IN-NETWORK		OUT-OF-NETWORK
PER INDIVIDUAL	\$1,000		\$1,500
PER FAMILY (at least 2 individuals)	\$2,000		\$3,000
LIFETIME MAXIMUM BENEFITS			
Per Covered Person			
LIFETIME MAXIMUM FOR ALL BENEFITS (MEDICAL, DENTAL & PRESCRIPTION)			\$1,500,000

Any separate lifetime maximums are included in, and are not in addition to, the Lifetime Maximum Benefit for All Benefits, shown above. The total payments for all benefits under the Plan will not exceed that maximum, whether or not the covered person is continuously covered under the Plan.

CALENDAR YEAR MAXIMUM BENEFITS (Per Covered Person)	
CHIROPRACTIC CARE	\$500
PREVENTIVE CARE SERVICES (members age 7 and older)	\$350
SKILLED NURSING (or Extended Care) FACILITIES	100 days

Note: Plan year maximum benefits will accumulate toward any applicable lifetime maximum limits.

BENEFIT PROVISIONS	AT CLINIC (No Deductable)	IN-NETWORK (After Deductable)	OUT-OF-NETWORK (After Deductable)
Allergy Injections(s) When rendered without an office visit	Free	100%	60%
Diagnostic Laboratory and X-ray Imaging Does not include routine lab/x-ray. See Preventive Care Services	Free	100%	60%
Home Care Services		100%	60%
Inpatient Hospital Expenses ¹ All usual Hospital services and supplies, including semi-private room, intensive care, and coronary care units. Acute Care, Maternity, Physician Services and Rehabilitation.		100%	60%
Mental/Nervous Disorder & Substance Abuse Treatment - Inpatient & Partial Hospitalization Excludes coverage for organic disease.		100%	60%
Outpatient Services (including Maternity) ¹		100%	60%
Skilled Nursing Facility Calendar Year Maximum Benefit of 100 days		100%	60%
Transplant-Related Expenses (Organ & Tissue) No Travel Benefit Provided		100%	60%

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BENEFIT PROVISIONS continued	AT CLINIC (No Deductable)	IN-NETWORK (After Deductable)	OUT-OF-NETWORK (After Deductable)
Emergency/Urgent Care Accidental Injury & Emergency Care	Free	\$50 copay then 100%	60%
Preventive Care Office Visits for well care, Physical Exams, Well-Child check-ups, PAP Testing, PSA Testing, Related Preventive Services, Routine lab and x-ray services (i.e. routine stress test), Routine mammogram. Certain Preventive Care Services are limited to a Calendar Year Maximum Benefit of \$350 for members age 7 and older.	Free	80% (deductable waived)	60%
Ambulance Services		80%	
Chiropractic Services (including x-rays) Limited to a Calendar Year Maximum Benefit of \$500 per member for combined in/out of network		80%	60%
Durable Medical Equipment		80%	60%
Hospice Services		80%	60%
Hospital Services		80%	60%
Medical Supplies	Free	80%	60%
Outpatient Therapies Cardiac Rehab, Chemotherapy, Hemodialysis, IV Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehab, Radiation Therapy, Speech Therapy, Wound Therapy.		80%	60%
Physician Services Includes hospital & office visits, office surgery, diagnostic tests and other physician services	Free	80%	60%
Preventive Care Office Visits for well care, Physical Exams, Well-Child check-ups, PAP Testing, PSA Testing, Related Preventive Services, Routine lab and x-ray services (i.e. routine stress test), Routine mammogram. Certain Preventive Care Services are limited to a Calendar Year Maximum Benefit of \$350 for members age 7 and older.	Free	80% (deductable waived)	60%
Prosthetics		80%	60%
Additional Eligible Medical Expenses	Free	80%	60%
Emergency Room (non-emergent illness) Participants age 5 and older		Not Covered	Not Covered
Emergency Room (non-emergent illness) Children under age 5 - \$50 copay per visit		80%	Not Covered
Note 1- Anesthesiology, Radiology, Pathology and Lab Services rendered by out-of-network providers as part of a service rendered at an in-network facility are payable at the in-network benefit.			
Prescription Drug Card Program			
Retail – Generic drug	\$8 Copayment for up to 31-day supply - \$11 Copayment for up to 90-day supply		
Retail – Formulary Brand Name drug*	\$15 Copayment for up to 31-day supply - \$18 Copayment for up to 90-day supply		
Retail – Non-Formulary Brand Name drug*	\$30 Copayment for up to 31-day supply - \$33 Copayment for up to 90-day supply		
Mail Service – Generic drug	\$8 Copayment for up to 90-day supply		
Mail Service – Formulary Brand Name drug*	\$15 Copayment for up to 90-day supply		
Mail Service - Non-Formulary Brand Name drug*	\$30 Copayment for up to 90-day supply		