PIB-1000

Program of Insurance Benefits

For Employees of
United States Steel Corporation

Pursuant to Agreement with
United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union

Effective January 1, 2016

Amended to January 1, 2017

FOREWORD

This Plan Document describes the benefits and rights of eligible employees under the Program of Insurance Benefits ("Program") as in effect on January 1, 2016, as amended to January 1, 2017. The Program was established pursuant to the Insurance Agreement between United States Steel Corporation ("USS") whose headquarters are located at 600 Grant Street, Pittsburgh, Pennsylvania 15219-2800 and United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union ("Union") whose headquarters are located at 60 Boulevard of the Allies, Pittsburgh, Pennsylvania 15222 in effect on January 1, 2016 (the "Insurance Agreement"). The Insurance Agreement is attached to and incorporates this booklet.

This booklet is applicable to employees of United States Steel Corporation and subsidiaries in the Bargaining Units as shown in Exhibit A ("Company"). This booklet is also applicable to employees of the Company who are represented by (a) Bricklayers and Allied Craftworkers International Union, 1776 Eye Street N.W., Washington D.C. 20006; or (b) the Laborers' International Union of North America, 905 16th Street Northwest, Washington D.C. 20006 (collectively, the "Other Unions"), and who are in the Bargaining Units listed in Exhibit B. This booklet constitutes a part of the Insurance Agreement, which continues until February 1, 2019 and thereafter, subject to negotiations between the Company and the Union which are scheduled for 2018.

Details relating to the operation of this Program will be included in reasonable rules, regulations and arrangements with insurance carriers; provided, however, that such rules, regulations and arrangements shall not apply to the matters covered by paragraphs 8.7 through 8.16 and 8.23.

Life Insurance Benefits (including Basic Life Insurance, Optional Employee Life Insurance, Optional Spouse Life Insurance, Optional Child(ren) Life Insurance and Optional Accidental Death and Dismemberment Insurance) described in Section 1 are provided in accordance with a group insurance policy issued by Metropolitan Life Insurance Company ("MetLife"), 200 Park Avenue, New York, New York 10166. A certificate of your coverage under the MetLife group policy is available upon request to MetLife. Sickness and Accident Benefits described in Section 2 are administered through the United States Steel Claim Unit ("Claim Unit").

The PPO Medical Benefits described in Section 3 are provided in accordance with an administrative services agreement entered into by United States Steel and Carnegie Pension Fund on behalf of the Company with Highmark Blue Cross Blue Shield ("Highmark"), Fifth Avenue Place, Pittsburgh, Pennsylvania 15222. For Western Pennsylvania residents, the PPO Medical Benefits of this Program are provided in accordance with an administrative services agreement entered into by United States Steel and Carnegie Pension Fund on behalf of the Company with Aetna Life Insurance Company ("Aetna"), 151 Farmington Avenue, Hartford, Connecticut 06156. Highmark (and Aetna, where applicable) pays claims for PPO Medical Benefits and performs certain other administrative functions with respect to this Program but does not insure nor guarantee any benefits provided under this Program.

The Prescription Drug Benefits described in Section 4 are provided in accordance with an administrative services agreement entered into by United States Steel and Carnegie Pension Fund on behalf of the Company with Express Scripts, Inc. ("Express Scripts"), One Express Drive, St. Louis, Missouri 63121. Express Scripts administers the Prescription Drug Benefits under this Program and performs certain other administrative functions (such as claims payment) with respect to this Program but does not insure nor guarantee any benefits provided under this Program.

The Dental Care Benefits described in Section 5 are provided in accordance with an administrative services agreement entered into by United States Steel and Carnegie Pension Fund on behalf of the Company with United Concordia Companies, Inc., ("UCCI") 1800 Center Street, Camp Hill, Pennsylvania 17089-0089. UCCI pays claims for Dental Care Benefits under this Program and performs certain other administrative functions with respect to this Program but does not insure nor guarantee any benefits provided under this Program.

The Vision Care Benefits described in Section 6 are provided through an administrative services contract entered into by United States Steel and Carnegie Pension Fund on behalf of the Company with Davis Vision, Inc. ("Davis Vision"), 175 E. Houston Street, San Antonio, Texas 78205. Davis Vision pays claims for Vision Care Benefits under this Program and performs certain other administrative functions with respect to this Program but does not insure nor guarantee any benefits provided under this Program.

Flexible Spending Accounts described in Section 10 are administered in accordance with an agreement between the United States Steel and Carnegie Pension Fund on behalf of the Company with WageWorks, Inc. 1100 Park Place, 4th Floor, San Mateo, California 94493.

Other Optional Benefits (Critical Illness Coverage and Accident Coverage) described in Section 13 are provided in accordance with a group insurance policy issued by Metropolitan Life Insurance Company ("MetLife"), 200 Park Avenue, New York, New York 10166. A certificate of your coverage under the MetLife group policy is available upon request to MetLife.

The Insurance Agreement and the rules, regulations and arrangements referred to above form the basis on which the Program is administered, but if there is any inconsistency, the Insurance Agreement governs.

This Plan Document does not and cannot modify the Insurance Agreement, nor does it serve as an agreed-to interpretation of any provision of that Agreement. *Should there be any conflict or inconsistency between the explanations in this Plan Document and a provision of the Insurance Agreement, the Insurance Agreement provision will control and will define the benefit due under the Program.* ***Should there be any conflict or inconsistency between the explanations in this Plan Document or Insurance Agreement and a provision of the September 1, 2015 Settlement Agreement between the Company and the Union, the Settlement Agreement will control and will define the benefit due under the Program.***

Upon your written request, the Plan Administrator will advise you if a particular employer is a sponsor of the Plan, and if such employer is a sponsor of the Plan, the address of such employer. A copy of the applicable collective bargaining agreement may be obtained on written request and is available for examination.

The Plan

The name of the Plan under which the benefits outlined in the Program are provided is the United States Steel Corporation Plan for Active Employee Insurance Benefits (the "Plan"). The Plan is sponsored by United States Steel Corporation, and the employer identification number assigned by the IRS to the Plan Sponsor is 25-1897152. The Plan Number is 504. This Plan, which includes life, disability, medical, prescription drug, dental and vision care benefits, is a welfare benefit plan that is a group health benefit plan as defined by ERISA.

The benefits under the Plan are administered by United States Steel and Carnegie Pension Fund (a non-profit Pennsylvania membership corporation), 600 Grant Street, Room 1681, Pittsburgh, Pennsylvania 15219-2800, which is the Plan Administrator, Trustee and agent for service of legal process under the Plan. The telephone number for the Plan Administrator is (412) 433-5790 or 1-877-877-4586.

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IMPORTANT CONTACT INFORMATION

Plan Administrator	
Plan Administrator	United States Steel and Carnegie Pension Fund ("USS & CPF") 600 Grant Street Room 1681 Pittsburgh, Pennsylvania 15219-2800 USS Benefits Service Center (412) 433-5790 1-877-877-4586 BenefitsServiceCenter@uss.com

PPO Medical Benefits		
	Highmark	**Aetna**
If you live:	Outside of Western Pennsylvania	In Western Pennsylvania [1]
Benefits/Claims/ID Cards/Provider Questions/Non-English Interpreter	1-800-245-6642	1-800-308-8787
Precertification Inpatient Admission and Medical Necessity Mental Health/Substance Abuse	 1-800-452-8507 1-800-258-9808	 1-800-333-4432 1-800-333-4432
Claims Mailing Address	Highmark P. O. Box 3355 Pittsburgh, Pennsylvania 15230	Aetna P.O. Box 981106 El Paso, Texas 79998-1106
Care Management	Blues on Call 1-888-BLUE428	
Web Site	www.highmarkbcbs.com	www.aetna.com

Prescription Drug Benefits - Express Scripts	
Formulary/Copays/ID Cards/ Utilization Management/Lower Cost Alternatives	1-800-287-4508
Web Site	www.express-scripts.com
Accredo Specialty Pharmacy	
Accredo Specialty Pharmacy	1-800-803-2523
Web Site	www.accredo.com

Dental Care Benefits - United Concordia Companies, Inc.	
Dental Benefits/Claims/Network	1-800-332-0366
Web Site	www.ucci.com

[1] If you live in (or your zip code extends into) Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Washington, or Westmoreland counties in Pennsylvania

Vision Benefits - Davis Vision	
Network Providers	1-800-401-2581
Web Site	membershiphelp@davisvision.com

Metropolitan Life Insurance Company	
Life Insurance Claim Inquiries	1-800-638-6420
Web Site	www.metlife.com
Critical Illness and Accident Coverage Claim Inquiries	1-866-626-3705
Web Site	www.metlife.com/mybenefits

WageWorks, Inc.	
Questions regarding continuation of coverage through COBRA	1-877-502-6272
Flexible Spending Accounts	Phone: 1-877-924-3967 Fax: 1-877-353-9236
Web Site	www.wageworks.com

LifeMatters Employee Assistance and Work/Life Program (EAP)	
EAP Services	1-800-634-6433

Sickness and Accident Benefits	
Claims	1-866-760-1938

DEFINITIONS

As used herein,

(a) **Allowable Charge *(also called "Provider's Reasonable Charge")*** means for purposes of Section 3, the dollar amount that the Medical Claims Administrator used to determine payment for Covered Services, and is based on the type of provider who renders such services or as required by law. This is an important term to know if you go outside the Network for care. The Allowable Charge for in-Network providers is based on the contractual allowance agreed to by the provider and Medical Claims Administrator. The amount paid under Section 3 for Out-of-Network care is based on the Allowable Charge — not the provider's actual charge. The Allowable Charge for Out-of-Network care is determined by the Medical Claims Administrator based on the geographical area in which the service or supply is provided, negotiated charges, agreements and/or other factors.

For purposes of the Dental Care Benefits in Section 5, Allowable Charge means the dollar amount that UCCI (on behalf of the Plan Administrator) has determined will be payable to a provider for Covered Services provided under this Section. This is an important term to know if you go outside the network for care. The amount the Program pays for care from a provider that is not a Participating Provider is based on the Allowable Charge, not the provider's actual charge.

For purposes of the Vision Care Benefits in Section 6, the Allowance means the dollar amount that Davis Vision (on behalf of the Plan Administrator) has determined will be payable to a provider for Covered Services provided under this Section. This is an important term to know if you go outside the network for care. The amount the Program pays for care from a provider that is not a Participating Provider is based on the Allowance, not the provider's actual charge.

(b) **Approved Facility or Agency** means a Health Care Facility or Home Health Care Agency that has been approved by the Medical Claims Administrator based on the following criteria:

(1) it qualifies under Medicare or the Medical Claims Administrator determines that it meets the standards of Medicare certification, or

(2) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Medical Claims Administrator determines that it meets standards for such accreditation, or

(3) where applicable, it is a state licensed Birthing Center which meets the approval standards established by the Medical Claims Administrator (pending establishment of Medicare and Joint Commission on Accreditation standards), and

(4) where necessary, it has been approved by the applicable area-wide health care planning agency.

(c) **Authorized Representative** means a person granted authority by you and the Third Party Administrator to act on your behalf regarding a claim for benefit or an appeal of an adverse benefit determination. An assignment of benefits is not a grant of authority to act on your behalf in pursuing and appealing a benefit determination.

(d) **Charge** means the actual bill for services which would be payable by the participant in the absence of coverage under this Program and which may be calculated without regard to any discounts which the provider is obligated to extend to this Program by virtue of the contract between the provider and the Third Party Administrator.

(e) **Claim** means a request for precertification or prior approval of a Covered Service or for the payment or reimbursement of the charges or costs associated with a Covered Service. Claim includes:

(1) *Pre-Service Claim* — A request for precertification or prior approval of a Covered Service which under the terms of your coverage must be approved before you receive the Covered Service.

(2) *Urgent Care Claim* — A Pre-Service Claim which, if not decided within the time periods established for making non-Urgent Care Pre-Service Claim decisions, could seriously jeopardize your life, health, ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. The applicable Third Party Administrator is solely responsible for determining whether a Claim is an Urgent Care Claim. Note – this is not the same as a Claim for benefits from an Urgent Care provider.

(3) *Post-Service Claim* — A request for payment or reimbursement of the charges or costs associated with a Covered Service that you have received.

(f) **Coinsurance** means the percentage of the Allowable Charge paid under Section 3 or the percentage of Allowable Charge paid under Section 5; the remaining percentage is the percentage you pay.

(g) **Company** means United States Steel Corporation and its subsidiaries listed in Exhibit A.

(h) **Contribution** means the amount required from a participant for benefits elected under this Program.

(i) **Copayment or Copay** means a cost-sharing arrangement in which a participant pays for a specific charge, other than Deductible, or Coinsurance, under Section 3 such as the fixed up-front dollar amount you pay for certain covered expenses. Copayment amounts do not apply toward your Deductible or Coinsurance. This amount will be deducted from the Provider's Reasonable Charge before a determination of benefits payable is made under Section 3. The Copayment you are required to pay does not vary with the cost of the services. You are expected to pay the provider at the time of service. It also means a cost-sharing arrangement in which a participant pays for a specific charge for prescription drugs under Section 4.

(j) **Covered Services** means:

(1) For purposes of Section 3, the services, confinements, supplies, and/or treatments you receive from an Eligible Provider to the extent they are (A) determined to be Medically Necessary and Appropriate, and (B) specifically identified in Section 3, subject to modification by mutual agreement of the Company and the Union. However, such Covered Services are subject to the limitations, Deductibles, Coinsurance and Copayments outlined in Section 3.

(2) For purposes of the Dental Care Benefits in Section 5, Covered Services are the services you receive from a licensed dentist to the extent they are: (A) determined to be dentally necessary by UCCI, and (B) specifically identified in paragraph 5.20 or determined by UCCI to be a Covered Service, subject to modification by mutual agreement of the Company and the Union. However, Covered Services exclude: (A) services which UCCI determines are Experimental or Investigative in nature as outlined in paragraph 5.15, (B) services which UCCI determines do not meet accepted standards of dental practice as outlined in paragraph 5.16, (C) services which are excluded in paragraph 5.22, and (D) services which exceed the limitations of paragraph 5.23 or other limitations established under Section 5.

(3) For purposes of the Vision Care Benefits in Section 6, Covered Services are the services you receive from a Professional Provider to the extent they are specifically identified in paragraph 6.7 or determined by Davis Vision to be a Covered Service, subject to modification by mutual agreement of the Company and the Union. However, Covered Services exclude services listed in paragraph 6.11 and services that exceed the limitations of paragraph 6.9 or other limitations established under Section 6.

(k) **Custodial Care** means a level of service which meets personal but not medical needs and could be provided by persons without professional skills and training, such as: bathing, dressing, eating, taking medication and walking.

(l) **Deductible** under the PPO Medical Benefits of this Program means, for purposes of Section 3, the annual amount of Covered Services an individual or Family is required to pay (In-Network - $200 Individual/$400 Family[2], Out-of-Network - $500 Individual/$1,000 Family) before this Program begins to pay its share of benefits. Copayment amounts for in-network office visits (PCP, specialist or other), in-network urgent care facility, in-network emergency room visits, out-of-network emergency room visits in a true emergency, and prescription drug copayment amounts do not apply toward your PPO Medical Benefits Deductible. The PPO Medical Benefits deductible amount also does not include amounts in excess of the allowable charge for out-of-network or network-not-available services, and expenses covered under the Prescription Drug, Dental, or Vision benefits of this Program.

For purposes of the Dental Care Benefits in Section 5, Deductible means the annual amount you must pay each year for Covered Services before payment for benefits begins, as outlined in paragraph 5.17.

To assist participants with several covered Eligible Family Members, the Deductible you pay for the entire family, regardless of its size, is specified under "Family" Deductible. To reach this total, you can count the expenses

[2] Prior to April 1, 2016, there was no In-Network Deductible, and the Out-of-Network Deductible was $300 Individual/$600 Family. For the 2016 Plan Year only, effective April 1, 2016, the Deductibles are 75% of the annual amount (In-Network - $150 Individual/$300 Family, Out-of-Network - $375 Individual/$750 Family). Amounts applied to the Out-of-Network Deductible between January 1, 2016 and March 31, 2016 were carried forward to April 1, 2016.

incurred by two or more family members. However, the Deductible contributed toward the total by any one family member cannot be more than the amount of the Individual Deductible. If one family member meets the Individual Deductible and again needs to use benefits, payment for that person's Covered Services will begin even if the Family Deductible has not been met.

(m) **Dental Care Benefits** means benefits provided under Section 5, which is administered by United Concordia Companies, Inc.

(n) **Eligible Employee** means an employee in one of the Bargaining Units in Exhibit A or Exhibit B attached hereto, subject to the provisions of Section 8.0.

(o) **Eligible Family Member** means:

(1) Your spouse.

Note: Requests for enrollment of a common-law spouse will be investigated by the Plan Administrator or its designee to determine whether an alleged common-law spouse meets the definition of an Eligible Family Member in those states that recognize common-law marriages. In states which do not recognize common-law marriages, an alleged common-law spouse is not an Eligible Family Member.

(2) Your child under age 26 only if the child is:

(a) your natural son or daughter,
(b) your legally adopted child, including, from date of placement, a child placed for adoption and living with you, irrespective of whether the adoption is yet final, provided you have assumed, in anticipation of adoption, a legal obligation for total or partial support of such child, or
(c) your stepson or stepdaughter.

(3) Your unmarried child after attainment of age 26, if such child is:

(a) an Eligible Family Member is accordance with (2) above,
(b) incapable of self-support because of a continuously disabling illness or injury that commenced prior to age 26, and
(c) principally supported by you.

(4) Special rule –

(a) An Eligible Family Member also includes an unmarried child who is considered a dependent under Code Section 152[3] who is a child permanently residing in the household of which you are the head and actually being supported principally by you, provided:

(i) the child is your grandchild or you are the child's legal guardian, and
(ii) the child is under 21 years of age, a full-time student as described in paragraph (4)(b) below, or disabled as described in paragraph (4)(c) below.

(b) Children after attainment of age 21 but not beyond attainment of age 25, if, in addition to otherwise meeting the definition of Eligible Family Member children as contained in (4)(a), such Eligible Family Member 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 an Eligible Family Member under this provision, the child must have been eligible for coverage as an Eligible Family Member prior to attainment of age 21. Coverage for a child who would otherwise meet the criteria of this paragraph (4)(b) except for having to take a medically necessary leave of absence may not be terminated before the earlier of (A) the date that is one year after the first day of the medically necessary leave of absence, or (B) the date on which coverage would otherwise terminate under the terms of the Program. The medically necessary leave of absence must be certified using procedures established by the Plan Administrator. For purposes of this rule, a medically necessary leave of absence means, either: (A) the child's leave of absence from a post-secondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965 (20 USC §1001)), or (B) any other change in enrollment of the child at the institution, that: (a) begins while the child is suffering from a serious illness or injury; (b) is

[3] See Page 11 of IRS publication 501 for use in preparing 2013 tax returns for the definition of a "dependent" under Code Section 152. Go to www.irs.gov/pub/irs-pdf/p501.pdf to find the publication.

medically necessary; and (c) causes the child to lose student status for purposes of coverage, under the terms of the Program.

(c) Children after attainment of age 21 while incapable of self-support because of a disabling illness or injury that commenced prior to age 21 provided such child was eligible for coverage as an Eligible Family Member prior to attainment of age 21. Such children must otherwise meet the definition of Eligible Family Member as contained in (4)(a) and must be principally supported by you.

(5) To be eligible for coverage as an Eligible Family Member, proof may be required that the Eligible Family Member meets the requirements stated above; special certification will be required to qualify Eligible Family Members under (4).

(p) **Eligible for Medicare** means entitlement to benefits under Part A Hospital Insurance Benefits or Part B of Title XVIII of the Social Security Act--Health Insurance for the Aged and Disabled (Medicare).

(q) **Experimental/Investigative (Experimental or Investigative)** means the use of (A) any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is determined by the Medical Claims Administrator or its designated agent, on behalf of the Program, or (B) prescription drugs that Express Scripts or its designated agent, on behalf of the Program, determines not to be medically effective for the condition being treated. The Medical Claims Administrator and/or Express Scripts will consider an intervention to be Experimental/Investigative if:

- the intervention does not have Food and Drug Administration ("FDA") approval to be marketed for the specific relevant indication(s);
- available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes;
- the intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies;
- the intervention does not improve health outcomes; or
- the intervention is not proven to be applicable outside the research setting.

If an intervention, as defined above, is determined to be Experimental/Investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

For purposes of Section 3 of this Program, a panel of medical professionals works with a nationally recognized Medical Affairs Committee to review new technologies and new applications for existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all-encompassing, considering factors such as product efficiency, safety and effectiveness. If the technology passes the test, the Medical Affairs Committee recommends it be considered as acceptable medical practice and a covered benefit. Technology that does not merit this status is usually considered "Experimental/Investigative" and is not generally covered. However, it may be reevaluated in the future.

(r) **Family** means the participant and all Eligible Family Members.

(s) **Health Care Facility** ***(also called "Facility Provider")*** means, for purposes of Section 3, any of the following permanent facilities:

(1) *Hospital* — an acute care facility providing on a continuous inpatient basis diagnostic and therapeutic services for the surgical, medical and/or psychiatric diagnosis, treatment and care of ill or injured persons by or under the supervision of a professional staff of Licensed Physicians and surgeons, which provides 24-hours-a-day nursing service by registered graduate nurses, and which is not, other than incidentally, a place for domiciliary or convalescent care, rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

(2) *Substance Abuse Rehabilitative Facility* — a facility which is specifically engaged in providing inpatient and/or outpatient rehabilitation services, and detoxification, if necessary, to alcoholic and/or drug addicted patients.

(3) *Skilled Nursing Facility* — a facility which is primarily engaged in providing skilled nursing and related services on an inpatient basis to patients requiring 24-hour skilled nursing services but not requiring confinement in an acute care facility. Such care is rendered by or under the supervision of Licensed Physicians, and is not, other than incidentally, a place that provides minimal, custodial, ambulatory or part-time care or services or care for treatment of psychiatric illness, alcoholism, or drug addiction.

(4) *Ambulatory Surgical Facility* — a facility with an organized staff of Licensed Physicians which has permanent equipment for the primary purpose of performing surgical procedures on an outpatient basis and which provides treatment by or under the supervision of a physician and nursing services, and which does not provide inpatient accommodations.

(5) *Birthing Center* — a facility with inpatient beds which is primarily organized with the staff and equipment to provide prenatal, labor, delivery and post partum care for medically uncomplicated pregnancies.

(6) *Hospice Facility* — a permanent facility which provides a coordinated program of inpatient, outpatient and home care of a palliative and supportive nature for the terminally ill.

(7) *Free-Standing Kidney Dialysis, Radiation Therapy or Chemotherapy Facility* — a stand-alone facility which is specifically engaged in administering kidney dialysis, radiation therapy or chemotherapy.

(t) **Home Health Care Agency** means an organization with permanent administrative facilities which supplies or arranges for necessary medical services, including nursing services and other professional and technical services, to provide treatment for patients who have a variety of medical conditions, in their place of residence.

(u) **Licensed Physician** means any of the following licensed practitioners: medical doctor (M.D.), doctor of osteopathy (D.O.), doctor of dental medicine (D.M.D.), doctor of dental surgery (D.D.S.), doctor of chiropractic (D.C.), psychologist (Ph.D.), doctor of podiatric medicine (D.P.M.) and doctor of optometry (O.D.) when acting within the scope of that doctor's license.

(v) **Medical Claims Administrator** means, for purposes of Section 3, the organization responsible for paying claims for PPO Medical Benefits, for determining medical policy, performing certain other administrative functions and resolving claims and appeals on behalf of the Plan Administrator. It also means the organization responsible for the administration of the Precertification provisions contained in your PPO Medical Benefits including, but not limited to, the Precertification that must occur before a nonemergency admission to a Hospital, Alcohol and Drug Rehabilitative Facility, Skilled Nursing Facility or Hospice Facility, before arranging for inpatient psychiatric treatment or alcohol/drug treatments, before contracting for Hospice Facility services, the concurrent utilization review performed during inpatient stays and voluntary participation in the individual case management program.

(w) **Medical Emergency** means a medical condition with acute symptoms of severity or severe pain for which care is sought as soon as possible after the medical condition becomes evident and the absence of immediate medical attention could result in: placing health in serious jeopardy; serious impairment of bodily functions; serious dysfunction of any body part and/or other serious medical consequences.

(x) **Medically Necessary and Appropriate** means (1) the services or supplies provided by a health care provider that the Medical Claims Administrator, on behalf of the Program, or (2) prescription drugs that Express Scripts, on behalf of the Program, determines are the services, supplies or medications 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; and
- 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, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

The Medical Claims Administrator reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service or supply is Medically Necessary and Appropriate. The fact that your physician may prescribe, recommend or provide treatment (or a prescription drug) does not necessarily mean that the treatment (or prescription drug) is Medically Necessary and Appropriate as defined in this Program. No benefits will be provided unless the Medical Claims Administrator, on behalf of the Program, determines from time to time that the service or supply is Medically Necessary and Appropriate. Similarly, no benefits will be provided unless Express Scripts, for purposes of the Prescription Drug Benefits provisions, on behalf of the Program, determines that a covered medication is Medically Necessary and Appropriate through Pharmacy Management Strategies described in paragraph 4.3.

(y) **Out-of-Pocket Maximum** (also known as **Stop-Loss)** means, for purposes of under the PPO Medical Benefits in Section 3 of this Program, the highest dollar amount for which you are responsible each year before 100% (except for required Copayments) of all covered expenses are paid under this Section. To help participants with several covered Eligible Family Members, the out-of-pocket amount you pay for the entire family, regardless of its size, is specified under "Family" Out-of-Pocket Maximum in paragraph 3.3. To reach this total, you can count the expenses paid by two or more family members. However, the out-of-pocket expenses contributed toward the total by any one family member cannot be more than the amount of the Individual Out-of-Pocket Maximum. If one family member meets the Individual Out-of-Pocket Maximum and again needs to use benefits, payment would begin at 100% (except for required Copayments) for that person's Covered Services even if the Family Out-of-Pocket Maximum has not been met.

(1) Deductibles, Copayments and your Coinsurance accumulate toward the applicable Out-of-Pocket Maximum. The following items do not accumulate toward the Out-of-Pocket Maximum: services not covered under the PPO Medical Benefits of this Program (including services which are not Medically Necessary and Appropriate), physician fees in excess of the Allowable Charge, amounts in excess of the local Blue Cross Blue Shield Plan (or Aetna, if applicable) reimbursement to Non-Participating Facilities, excess private room charges, and your Coinsurance for prescription drugs do not apply toward the Out-of-Pocket Maximum.

(2) Although reimbursement increases to 100% for additional covered expenses incurred by that individual (or Family) during the remainder of that year when the applicable Out-of-Pocket Maximum is met, the following items are not covered at 100%: Copayments under Section 3, services not covered under the PPO Medical Benefits of this Program (including services which are not Medically Necessary and Appropriate), physician fees in excess of the Allowable Charge, amounts in excess of the local Blue Cross Blue Shield Plan (or Aetna, if applicable) reimbursement to Non-Participating Facilities, excess private room charges, and your Copayments for prescription drugs. Even if the applicable Out-of-Pocket Maximum is reached, private duty nursing will not be covered once the private duty nursing calendar year limit is exceeded.

(z) **Payroll Deduction Date** means the date in a given month that payroll deductions under this Program are taken. This date is the pay date for the first payroll period ending in the month. However, this date may be changed by the Plan Administrator on a reasonable and consistent basis.

(aa) **Plan Administrator** means United States Steel and Carnegie Pension Fund.

(bb) **Plan Year** means the calendar year.

(cc) **PPACA** means the Patient Protection and Affordable Care Act of 2010, as amended.

(dd) **PPO Medical Benefits** means benefits provided under Section 3 through the Highmark Blue Cross Blue Shield Preferred Provider Organization ("Highmark PPO") or the Aetna Choice POS II Network including hearing aids and excluding Prescription Drug Benefits.

(ee) **Precertification** means a process through which the Medical Claims Administrator determines whether certain services, confinements, supplies, and treatments are Medically Necessary and Appropriate.

(ff) **Preferred Provider Organization ("PPO")** means the provider network made up of physicians, specialists, hospitals and other health care facilities in the Aetna Choice POS II Network or Blue Cross Blue Shield BlueCard PPO Network, as applicable. This provider network helps assure that you receive maximum coverage under Section 3.

(gg) **Prescription Drug Benefits** means benefits provided under Section 4 through Express Scripts and includes:

- home delivery prescription drugs purchased through Express Scripts Home Delivery Pharmacy;
- Specialty Pharmacy Program provided by Accredo; and
- prescription drugs purchased at a retail network pharmacy through Express Scripts.

If you are covered by PPO Medical Benefits under this Program, you are also automatically covered by the Prescription Drug Benefits under this Program.

(hh) **Primary Benefits Coverage** means PPO Medical Benefits, Prescription Drug Benefits, Dental Care Benefits, Vision Care Benefits, Sickness and Accident Benefits, Basic Life Insurance and Other Optional Benefits (Critical Illness/Accident Coverage) under this Program.

(ii) **Program** means the benefits and provisions of the Program of Insurance Benefits (PIB-1000) that are described in this booklet.

(jj) **Psychiatric Condition** means a condition of psychological or physiological origin which is normally treated by a psychiatrist or psychologist or which is treated on an inpatient basis in a psychiatric Hospital or in the psychiatric unit of a general Hospital.

(kk) **TPA or Third-Party Administrator** means any organization which processes claims for benefits and includes Metropolitan Life Insurance Company, Highmark Blue Cross Blue Shield, Aetna, Express Scripts, United Concordia, Davis Vision and WageWorks, Inc. (WageWorks).

(ll) **Total Maximum Out-of-Pocket or TMOOP** – Under the PPACA, when Deductible, Coinsurance, Copayments for network covered medical expenses and any qualified prescription drug expenses exceed $6,850 for 2016 ($7,150 for 2017 and as adjusted for subsequent years) per covered individual, or $13,700 for 2016 ($14,300 for 2017 and as adjusted for subsequent years) for your Family (no individual can exceed $6,850 for 2016, $7,150 for 2017), 100% of all covered expenses will be covered under the PPO Medical Benefits and Prescription Drug Benefits of this Program. If you have reached the Total Maximum Out-of-Pocket, no additional Coinsurance, Copayments and Deductible will be incurred for network covered services under the PPO Medical Benefits and Prescription Drug Benefits of this Program during that Plan Year. The Total Maximum Out-of-Pocket does not include services not covered under the PPO Medical Benefits of this Program (including services which are not Medically Necessary and Appropriate), physician fees in excess of the Allowable Charge, amounts in excess of the local Blue Cross Blue Shield Plan (or Aetna, if applicable) reimbursement to Non-Participating Facilities, and excess private room charges. The Total Maximum Out-of-Pocket does not include non covered drugs that members pay out of pocket outside of the plan.

(mm) **United States** means all 50 states plus the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

(nn) **Vision Care Benefits** means benefits provided under Section 6 through Davis Vision.

SECTION 1. LIFE INSURANCE

General

1.0 In the event of your death, your life insurance will be payable to any person you designate as beneficiary. As of December 31, 2015, any designations previously made with the Company on paper are no longer valid, beneficiary designations must be made directly with the TPA online. You have the right to change the beneficiary at any time. Complete instructions about who you can designate and how to designate may be found on the TPA's web site. Go to the TPA's Web site to quickly and securely designate your Beneficiary(ies) online. If your beneficiary predeceases you, or effective January 1, 2016, if you do not have a valid life insurance beneficiary designation with the TPA, your Life Insurance will be payable in accordance with a preference beneficiary schedule contained in the group policy. The amount of your Basic Life Insurance is $50,000. See paragraphs 1.13 through 1.14 for life insurance after retirement.

Note: You may wish to consult your tax counsel before making such a beneficiary designation.

Optional Employee Life Insurance

1.1 You may elect employee-paid group term Optional Employee Life Insurance, which provides no cash, loan or paid-up values, in amounts equal to $25,000; $50,000; $75,000; $100,000; $125,000; $150,000; $175,000 and $200,000. The Optional Employee Life Insurance will be provided with a Guarantee Issue (meaning without evidence of good health) honored up to 30 days after your eligibility date. In the event you decide to enroll or increase coverage more than 30 days after your eligibility date, you will be required to submit, at your own expense, evidence of your good health satisfactory to the TPA.

You may elect to change your Optional Employee Life Insurance coverage only during annual enrollment or because of certain Qualified Life Events (see paragraph 7.2(a)(1)). In the event you decide to enroll or increase coverage during annual enrollment or within 60 days of certain Qualified Life Events (see paragraph 7.2(a)(1)), you will be required to submit, at your own expense, evidence of your good health satisfactory to the TPA. See paragraphs 1.13 - 1.14 for life insurance after retirement.

You may make separate beneficiary designations for your Optional Employee Life Insurance. See paragraph 1.0 for beneficiary designation provisions.

If you elect Optional Employee Life Insurance coverage upon initial eligibility, your coverage is effective on your eligibility date. Increases in coverage after your eligibility date are effective on the date such coverage is approved by the TPA.

1.2 If you are enrolled for Optional Employee Life Insurance, the full cost of such coverage is deducted from your earnings on an after-tax basis on the Payroll Deduction Date. If you do not have enough earnings to cover the full monthly deduction, then no deduction will be taken. (See paragraph 8.13.) Monthly Contributions for coverage may be changed annually to cover the entire cost of such insurance. The current age- and tobacco use-related monthly Contributions for Optional Employee Life Insurance, are:

	Amount of Coverage in Thousands – Non-Tobacco Rate							
Age	25	50	75	100	125	150	175	200
<25	$1.25	$2.50	$3.75	$5.00	$6.25	$7.50	$8.75	$10.00
25 - 29	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00
30 - 34	$2.00	$4.00	$6.00	$8.00	$10.00	$12.00	$14.00	$16.00
35 - 39	$2.25	$4.50	$6.75	$9.00	$11.25	$13.50	$15.75	$18.00
40 - 44	$2.63	$5.25	$7.88	$10.50	$13.13	$15.75	$18.38	$21.00
45 - 49	$4.13	$8.25	$12.38	$16.50	$20.63	$24.75	$28.88	$33.00
50 - 54	$6.75	$13.50	$20.25	$27.00	$33.75	$40.50	$47.25	$54.00
55 - 59	$10.75	$21.50	$32.25	$43.00	$53.75	$64.50	$75.25	$86.00
60 - 64	$18.50	$37.00	$55.50	$74.00	$92.50	$111.00	$129.50	$148.00
65 - 69	$31.75	$63.50	$95.25	$127.00	$158.75	$190.50	$222.25	$254.00
70 - 74	$51.50	$103.00	$154.50	$206.00	$257.50	$309.00	$360.50	$412.00
75+	$51.50	$103.00	$154.50	$206.00	$257.50	$309.00	$360.50	$412.00

	Amount of Coverage in Thousands – Tobacco Rate							
Age	25	50	75	100	125	150	175	200
<25	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00
25 - 29	$1.80	$3.60	$5.40	$7.20	$9.00	$10.80	$12.60	$14.40
30 - 34	$2.40	$4.80	$7.20	$9.60	$12.00	$14.40	$16.80	$19.20
35 - 39	$2.70	$5.40	$8.10	$10.80	$13.50	$16.20	$18.90	$21.60
40 - 44	$3.15	$6.30	$9.45	$12.60	$15.75	$18.90	$22.05	$25.20
45 - 49	$5.00	$10.00	$15.00	$20.00	$25.00	$30.00	$35.00	$40.00
50 - 54	$8.13	$16.25	$24.38	$32.50	$40.63	$48.75	$56.88	$65.00
55 - 59	$13.00	$26.00	$39.00	$52.00	$65.00	$78.00	$91.00	$104.00
60 - 64	$22.25	$44.50	$66.75	$89.00	$111.25	$133.50	$155.75	$178.00
65 - 69	$38.00	$76.00	$114.00	$152.00	$190.00	$228.00	$266.00	$304.00
70 - 74	$61.75	$123.50	$185.25	$247.00	$308.75	$370.50	$432.25	$494.00
75+	$61.75	$123.50	$185.25	$247.00	$308.75	$370.50	$432.25	$494.00

When you move to the next higher age bracket of the schedule, the increased monthly premium will become effective on the first day of the month of your birth.

In order to elect coverage at the lower, non-tobacco user rate, you must certify that you do not use tobacco and have not used tobacco for the past two years. The Company reserves the right to confirm this tobacco certification. Misrepresentation of this information will result in disciplinary action up to and including suspension subject to discharge. Your Optional Employee Life Insurance is subject to the terms of the group policy.

Optional Spouse Life Insurance

1.3 The Program offers employee-paid group term Optional Spouse Life Insurance, which provides no cash, loan or paid-up values, at coverage levels of $20,000, $40,000, $60,000, $80,000 or $100,000 for your spouse. The Optional Spouse Life Insurance will be provided with a Guarantee Issue (meaning without evidence of good health) honored up to 30 days after your eligibility date (or up to 60 days after your marriage). You may enroll or change your coverage amount during annual enrollment or within 60 days of certain Qualified Life Events (see paragraph 7.2(a)(1)). If you request an increase to the amount of Optional Spouse Life Insurance during annual enrollment or due to certain Qualified Life Events (see paragraph 7.2(a)(1)), you will be required to submit, at your own expense, evidence of your spouse's good health satisfactory to the TPA. You also can decrease your Optional Spouse Life Insurance coverage during annual enrollment and within 60 days of certain Qualified Life Events (see paragraph 7.2(a)(1)). If you elect Optional Spouse Life Insurance coverage upon initial eligibility, your coverage is effective on your eligibility date. Increases in coverage after your eligibility date are effective on the date such coverage is approved by the TPA.

1.4 If you are enrolled in Optional Spouse Life Insurance, the cost of your Optional Spouse Life Insurance coverage will be deducted from your earnings on an after-tax basis on the Payroll Deduction Date. If you do not have enough earnings to cover the full monthly deduction, then no deduction will be taken. Monthly Contributions for coverage may be changed annually to cover the entire cost of such insurance. (See paragraph 8.13.) The current age-related monthly costs (based on age of the spouse), with tobacco and non-tobacco rates, are:

	Amount of Coverage in Thousands – Non-Tobacco Rate				
Age	20	40	60	80	100
<25	$0.78	$1.56	$2.34	$3.12	$3.90
25 - 29	$0.92	$1.84	$2.76	$3.68	$4.60
30 - 34	$1.24	$2.48	$3.72	$4.96	$6.20
35 - 39	$1.38	$2.76	$4.14	$5.52	$6.90
40 - 44	$1.62	$3.24	$4.86	$6.48	$8.10
45 - 49	$2.54	$5.08	$7.62	$10.16	$12.70
50 - 54	$4.20	$8.40	$12.60	$16.80	$21.00
55 - 59	$6.60	$13.20	$19.80	$26.40	$33.00
60 - 64	$11.40	$22.80	$34.20	$45.60	$57.00
65 - 69	$19.60	$39.20	$58.80	$78.40	$98.00
70 - 74	$31.80	$63.60	$95.40	$127.20	$159.00
75+	$31.80	$63.60	$95.40	$127.20	$159.00

	Amount of Coverage in Thousands – Tobacco Rate				
Age	20	40	60	80	100
<25	$0.94	$1.88	$2.82	$3.76	$4.70
25 - 29	$1.10	$2.20	$3.30	$4.40	$5.50
30 - 34	$1.48	$2.96	$4.44	$5.92	$7.40
35 - 39	$1.66	$3.32	$4.98	$6.64	$8.30
40 - 44	$1.94	$3.88	$5.82	$7.76	$9.70
45 - 49	$3.04	$6.08	$9.12	$12.16	$15.20
50 - 54	$5.00	$10.00	$15.00	$20.00	$25.00
55 - 59	$7.90	$15.80	$23.70	$31.60	$39.50
60 - 64	$13.60	$27.20	$40.80	$54.40	$68.00
65 - 69	$23.60	$47.20	$70.80	$94.40	$118.00
70 - 74	$38.20	$76.40	$114.60	$152.80	$191.00
75+	$38.20	$76.40	$114.60	$152.80	$191.00

When your spouse moves to the next higher age bracket of the schedule, the increased monthly premium will become effective on the first day of the month of your spouse's birth.
In order to elect coverage at the lower, non-tobacco user rate, you must certify that your spouse does not use tobacco and has not used tobacco for the past two years. The Company reserves the right to confirm this tobacco certification. Misrepresentation of this information will result in disciplinary action up to and including suspension subject to discharge.

1.5 Optional Spouse Life Insurance will terminate on the date your spouse ceases to be an Eligible Family Member under this Program or as referenced in paragraphs 1.13 and 1.14. The benefits will be paid to you if you survive your spouse in accordance with the group policy. Your Optional Spouse Life Insurance is subject to the terms of the group policy.

Optional Child(ren) Life Insurance

1.6 The Program offers employee-paid group term Optional Child(ren) Life Insurance, which provides no cash, loan or paid-up values, at coverage levels of $5,000 and $10,000 for your Eligible Family Member children, other than for a child who is your grandchild or for whom you are the legal guardian. Optional Child(ren) Life Insurance will be provided with a Guarantee Issue (meaning without evidence of good health). You may elect Optional Child(ren) Life Insurance coverage up to 30 days after your eligibility date. You may also enroll or change your coverage amount

during annual enrollment or within 60 days of certain Qualified Life Events (see paragraph 7.2(a)(1)). You also can decrease your Optional Child(ren) Life Insurance coverage during annual enrollment and within 60 days of certain Qualified Life Events (see paragraph 7.2(a)(1)).

1.7 If you are enrolled in Optional Child(ren) Life Insurance, the cost of your Optional Child(ren) Life Insurance coverage will be deducted from your earnings on an after-tax basis on the Payroll Deduction Date. If you do not have enough earnings to cover the full monthly deduction, then no deduction will be taken. (See paragraph 8.13.) Monthly Contributions for coverage may be changed annually to cover the entire cost of such insurance. The monthly costs are:

	$5,000	**$10,000**
Monthly Cost	$0.52	$1.03

1.8 Optional Child(ren) Life Insurance will terminate on the date your dependent ceases to be an Eligible Family Member under this Program or as referenced in paragraphs 1.13 and 1.14. The benefits will be paid to you if you survive the Eligible Family Member in accordance with the group policy. Your Optional Child(ren) Life Insurance is subject to the terms of the group policy.

Optional Accidental Death and Dismemberment Insurance

1.9 The Program offers Optional Accidental Death & Dismemberment Insurance ("AD&D"). AD&D coverage pays you benefits if you suffer an accident that results in death, paralysis or the loss of a limb, speech, hearing or sight, as well as other conditions. You may elect coverage levels of $50,000, $100,000, $150,000, $200,000 or $250,000 (1) for you, or (2) for both you and your spouse. If you elect to include your spouse, you both will be covered at the same coverage level. Employee-paid group term Accidental Death and Dismemberment Insurance provides no cash, loan or paid-up values. You can enroll within 30 days of your eligibility date, during annual enrollment or within 60 days of certain Qualified Life Events (see paragraph 7.2(a)(1)). You also can decrease your Optional Accidental Death and Dismemberment Insurance coverage during annual enrollment and within 60 days of certain Qualified Life Events (see paragraph 7.2(a)(1)). No evidence of insurability is required. You may make separate beneficiary designations for your Optional Accidental Death and Dismemberment Insurance. See paragraph 1.0 for beneficiary designation provisions. You are automatically the beneficiary for coverage elected for your spouse.

1.10 If you are enrolled in Optional Accidental Death and Dismemberment Insurance coverage, the cost of your Optional Accidental Death and Dismemberment Insurance coverage will be deducted from your earnings on a Pre-tax basis on the Payroll Deduction Date. If you do not have enough earnings to cover the full monthly deduction, then no deduction will be taken. (See paragraph 8.13.) Monthly Contributions for coverage may be changed annually to cover the entire cost of such insurance. The monthly costs are:

COVERAGE	EMPLOYEE ONLY	EMPLOYEE AND SPOUSE
$50,000	$1.05	$1.65
$100,000	2.10	3.30
$150,000	3.15	4.95
$200,000	4.20	6.60
$250,000	5.25	8.25

1.11 Optional Accidental Death and Dismemberment Insurance coverage for you will terminate as referenced in paragraphs 1.13 and 1.14. Optional Accidental Death and Dismemberment Insurance coverage for your spouse will terminate on the date your spouse ceases to be an Eligible Family Member under this Program or as referenced in paragraphs 1.13 and 1.14. Your Optional Accidental Death and Dismemberment Insurance is subject to the terms of the group policy.

Total Disability

1.12 If, while insured under the Program and before age 60, you become totally disabled for a period in excess of six months and thereafter submit satisfactory evidence of continuing total disability as required by the TPA, your Basic Life Insurance will be continued without Contributions from you and Optional Employee Life, Optional Spouse Life Insurance, Optional Child(ren) Life Insurance and Optional Accidental Death and Dismemberment, if any, will be continued with Contributions from you until the end of the month in which you attain age 62. Thereafter, any Optional Employee Life, Optional Spouse Life Insurance, Optional Child(ren) Life Insurance and Optional Accidental

Death and Dismemberment will terminate, and your Basic Life Insurance will be reduced to $10,000 at the end of the month in which you attain age 62.

Life Insurance After Retirement

1.13 You are eligible to continue your Basic, Optional Employee and Optional Spouse Life Insurance, if any, after you retire if:

(a) you are eligible for other than a deferred vested pension under the Company pension plan (or would be eligible for other than a deferred vested pension under such plan if you had been eligible for such plan instead of the Steelworkers Pension Trust and taking into account your continuous service with National Steel or with U. S. Steel Tubular Products, Inc. or its predecessors that was recognized under such plan),

(b) you retire with at least 10 years of continuous service, and

(c) you are not eligible for Retiree Health Care Account ("RHCA") contributions under the USS 401(k) Plan for USW-Represented Employees or the Transtar, LLC Savings Plan for Represented Employees (see paragraph 1.15).

Optional Child(ren) Life Insurance and Optional Accidental Death and Dismemberment Insurance terminate at retirement.

If you do not satisfy (a), (b) and (c) above, your Basic, Optional Employee and Optional Spouse Life Insurance will terminate on the date you retire.

1.14 Subject to the limitation in paragraph 1.13, provided your life insurance is not being continued in accordance with provisions relating to total disability described in paragraph 1.12:

(a) Your Basic Life Insurance will be continued until the end of the month in which you attain age 62 (or the end of the month in which you retire, if later). Your Basic Life Insurance will reduce to $10,000 at the end of the month in which you attain age 62 (or the end of the month in which you retire, if later), and

(b) Your Optional Employee Life and Optional Spouse Life Insurance will be continued until the end of the month in which you attain age 62 (or the end of the month in which you retire, if later) provided you make the full monthly Contribution. Optional Employee Life and Optional Spouse Life Insurance will terminate at the end of the month in which you attain age 62 (or the end of the month in which you retire, if later). Optional Child(ren) Life Insurance and Optional Accidental Death and Dismemberment Insurance terminate at retirement.

Effective as of 11:59:59 pm Eastern time on December 31, 2010, life insurance for participants who retire, which is summarized above, is provided under a separate program under the United States Steel Corporation Plan for Retiree Insurance Benefits, which is sponsored by United States Steel Corporation and is Plan Number 510.

1.15 You are not eligible to continue your Basic, Optional Employee and Optional Spouse Life Insurance, if any, after you retire if:

(a) your collective bargaining agreement with the Company provides for employing company contributions to be placed in the Retiree Health Care Account ("RHCA") under the USS 401(k) Plan for USW-Represented Employees or the Transtar, LLC Savings Plan for Represented Employees, and

(b) you are eligible for RHCA contributions because you were hired or rehired on or after January 1, 2016.

You are not eligible for RHCA contributions if:

- you were rehired on or after January 1, 2016, and
- either (a) you have already satisfied the requirements for retiree medical under the United States Steel Corporation Retiree Health Program for USW-Represented Employees and/or the requirements for retiree life insurance at the time of a prior termination of employment, or (b) your original date of hire occurred before January 1, 2016, you broke continuous service due to a layoff from the Company after January 1, 2016, and you are rehired within five years of the last day worked during a prior period of employment.

Conversion Privilege

1.16 When your life insurance (Basic, Optional Employee, Optional Spouse or Optional Child(ren)) is reduced or terminated as a result of layoff, leave of absence, disability, termination of employment, retirement or attainment of age 62, you will have the right to convert to an individual policy as explained in paragraphs 8.24 through 8.27.

How to File a Claim

1.17 Your designated beneficiary will be provided the necessary forms for claiming the life insurance proceeds by notifying the Benefits Service Center.

How to Appeal a Claim

1.18 If your designated beneficiary has any question concerning a denial in whole or in part of life insurance benefits, your beneficiary should write within 60 days from the date the claim was denied to the TPA's office which denied the claim, furnishing all pertinent data. Your beneficiary's appeal will be reviewed by that office and responded to within 60 days of the date the appeal is received. If your beneficiary is not satisfied with the decision rendered by that office, additional appeal procedures will be provided to your beneficiary by the TPA.

Accelerated Benefit Option

1.19 An Accelerated Benefit Option ("ABO") is available to you while you are an employee in active employment. In the event you are diagnosed as having a terminal illness with a life expectancy of 12 months or fewer, up to 80% (maximum of $40,000) of your Basic Life Insurance and up to 80% (maximum of $160,000) of your Optional Employee Life Insurance coverage in effect at the time of application may be received in a lump-sum payment if you meet specified criteria.

1.20 In the event your spouse who is covered under Optional Spouse Life Insurance while you are an employee in active employment is diagnosed as having a terminal illness with a life expectancy of 12 months or fewer, up to 80% (maximum of $80,000) of the Optional Spouse Life Insurance coverage applicable to your spouse in effect at the time of application may be received in a lump-sum payment if specified criteria are met.

1.21 The ABO is not available if the applicable insurance has been assigned to another party. It is not available on dependent children covered under Optional Child(ren) Life Insurance. It is also not available for Optional Accidental Death and Dismemberment Insurance.

1.22 Claiming an accelerated benefit will reduce the amount of Basic Life Insurance, Optional Employee Life Insurance or Optional Spouse Life Insurance in effect and will reduce any coverage eligible for conversion. Prior to applying for the ABO, consult with a qualified tax advisor and social services agencies to understand the effect, if any, that receipt of accelerated benefits may have on your personal tax situation and your eligibility, or that of your spouse or family, for public assistance programs.

1.23 The Plan Administrator determines the process for applying for an ABO claim. To begin the process of applying for the ABO, contact the Benefits Service Center to obtain a MetLife Accelerated Benefit Claim Form. Approval of an ABO claim is determined by the TPA and subject to an independent medical review by the TPA.

SECTION 2. SICKNESS AND ACCIDENT BENEFITS

Eligibility

2.0 If you become totally disabled as a result of sickness or accident so as to be prevented from performing the duties of your employment and a licensed physician certifies thereto, 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 (nor will they be payable for any period for which salary or sick leave salary continuance is paid). Sickness and Accident Benefits will not be payable for any period for which you work for another employer unless such work is permissible within the physical restrictions outlined by the physician.

Filing of Claims

2.1 The Company administers Sickness and Accident Benefits through its United States Steel Claim Unit ("Claim Unit"). In order for you to be eligible for benefits, the Claim Unit must receive written notice of your claim within 21 days after your disability commences (for salaried employees, within 21 days after the end of the period for which salary or sick leave salary continuance is paid or within 21 days after your disability commences if you are ineligible for salary or sick leave salary continuance by reason of continuous service), but this requirement will be waived upon showing of good and sufficient reason that you were unable to furnish such notice or have it furnished by someone else on your behalf. The following applies in the administration of this provision:

Normally it is anticipated that you will obtain or have someone on your behalf obtain a Sickness and Accident Benefits claim form from the employee benefits office at the plant or office where you work and complete your portion of the form and have your physician, a nurse practitioner or a physician assistant complete the attending physician's portion of the form and return it to United States Steel Claim Unit, P.O. Box 1308, Pittsburgh, Pennsylvania 15230-1308 within 21 days of commencement of your disability (for salaried employees who are eligible for salary or sick leave salary continuance, within 21 days after the end of the period for which salary or sick leave salary continuance is paid).

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

It is the intent of this provision to encourage prompt notice of your claim for Sickness and Accident Benefits so that the evaluation of the claim, including any necessary investigation of 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 your claim be denied for failure to comply with the notice requirement if such failure did not interfere with the ability of the Claim Unit to establish the medical and other factual aspects of the claim.

Duration of Benefits

2.2 Sickness and Accident Benefits are payable as set forth below commencing on the date specified in paragraph (a) below and continuing for the period outlined in (b) below, provided, however, that such Sickness and Accident Benefits terminate when you retire from the Company.

(a) In the case of disability due to accident, Sickness and Accident Benefits are payable beginning the first day of total disability (or, in the case of salaried employees who are eligible for salary or sick leave salary continuance, beginning with the first day of total disability for which no salary or sick leave salary continuance is paid or payable). In the case of disability due to sickness, Sickness and Accident Benefits are payable beginning with the earlier of (1) the eighth day of total disability, or (2) the first day of hospitalization or outpatient surgery (or, in the case of salaried employees who are eligible for salary or sick leave salary continuance, beginning with the first day of total disability for which no salary or sick leave salary continuance is paid or payable). However, if you are a salaried employee at the Fairfield Works and you become disabled subsequent to reporting on your first scheduled work day in any pay period, you will be eligible for Sickness and Accident Benefits (1) in the case of disability due to accident, during that pay period beginning with the first day of total disability resulting from an accident, and (2) in the case of disability due to sickness, beginning with the earlier of (i) the eighth day of total disability, or (ii) the first day of hospitalization or outpatient surgery; provided, however, if at the end of such pay period you are eligible for sick leave salary continuance, Sickness and Accident Benefits otherwise payable will be suspended until the first day following cessation of sick leave salary continuance.

(b) Sickness and Accident 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 reduced, in the case of salaried employees, by any period for which sick leave salary continuance is paid during such 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 reduced, in the case of salaried employees, by any period for which sick leave salary continuance is paid during such continuous period of disability; 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 reduced, in the case of salaried employees, by any period for which sick leave salary continuance is paid during such continuous period of disability; provided, however, that if (A) you have 15 or more years of continuous service as of your last day worked, and (B) you are not permanently disabled, as determined by Social Security (or the U. S. Steel Medical Department if you are age 62 or over), benefits will be continued for a period not to exceed 52 additional weeks.

2.3 In determining the maximum period for which Sickness and Accident Benefits are payable, successive periods of disability separated by a period of continuous active employment with the Company of less than 60 days will be considered to be one continuous period of disability, unless it is clear that they arise from unrelated causes; provided that if you complete (a) two years or (b) 15 years of continuous service after the start of one continuous period of disability and before the start of a succeeding period of disability which is considered to be part of such continuous period of disability under the foregoing provision, your benefits are payable for a period not to exceed 52 or 104 weeks, respectively, for such continuous period of disability (for salaried employees reduced by any period for which sick leave salary continuance is paid).

Note: If you are an eligible USW-represented employee of the Lone Star Plant and Star Tubular Plant of Lone Star Tubular Operations of U. S. Steel Tubular Products, Inc. covered by the January 14, 2013 Recognition Agreement, periods for which Salary Continuance and/or Short-Term Disability Benefits are received for disabilities that commenced prior to August 1, 2013, will be included in determining the maximum period for which Sickness and Accident Benefits are payable under this Program. Successive periods of disability shall also include such disabilities that commenced prior to August 1, 2013.

Amount of Benefits

2.4 The amount of weekly Sickness and Accident Benefits for which an employee is eligible will be equal to 70% of the weekly Base Rate of Pay for the employee's incumbent job with a minimum weekly benefit payment of $500. Any changes in the Base Rate of Pay while a participant is receiving a Sickness and Accident Benefit will not affect the amount of the Sickness and Accident Benefit payments.

Note: In the case of eligible USW-represented employees of the Lone Star Plant and Star Tubular Plant of Lone Star Tubular Operations of U. S. Steel Tubular Products, Inc. covered by the January 14, 2013 Recognition Agreement who became totally disabled prior to August 1, 2013, the amount of weekly Sickness and Accident Benefits for which an employee is eligible will be equal to the amount payable under paragraph 2.4; however, the weekly Base Rate of Pay for the job into which the employee has been slotted will be used, and the date the employee was placed on Salary Continuance and/or Short-Term Disability Benefits will be considered as the first date of disability.

2.5 In the event you become totally disabled due to sickness or accident arising out of or in the course of your employment with an Employing Company identified in Exhibit A or Exhibit B, the amount of weekly Sickness and Accident Benefits otherwise payable will be reduced by any weekly 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, any occupational disease or other similar applicable law. Payments under any such law for hospitalization or medical expense or specific allowances for 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.

2.6 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, occupational disease or other similar applicable law, Sickness and Accident Benefits will be paid in full if satisfactory arrangements are made to

assure that any overpayment of Sickness and Accident Benefits which may result by virtue of your success in pursuing such claim shall be reimbursed by you. Such arrangements shall include the execution by you of necessary documents authorizing the deduction of any such overpayment, less any applicable attorney's fees, 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, wages, salary and pension payments.

2.7 The amount of weekly Sickness and Accident Benefits otherwise payable will be reduced for each week of disability by the amount of any primary disability benefits or unreduced primary old-age benefits under the Social Security Act which you are entitled to receive or could become entitled to receive by making proper application, except that no reduction for such unreduced primary old-age benefits will be made for the first 26 weeks of Sickness and Accident Benefits during any one continuous period of disability (in the case of salaried employees, except that no reduction for such unreduced primary old-age benefits will be made from Sickness and Accident Benefits payable for any of the first 26 weeks of Sickness and Accident Benefits and sick leave salary continuance during any one continuous period of disability).

2.8 The Claim Unit will assume that you are receiving a disability 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 Claim Unit is furnished a copy of your Social Security disability award so that it may determine the exact amount of reduction. However, in the event that you are eligible for Sickness and Accident Benefits (and sick leave salary continuance for salaried employees) for a period in excess of 26 weeks and you still have not received your Social Security disability benefits, then your full Sickness and Accident Benefits (or salary continuance) will be continued if (i) you furnish to the Claim Unit written proof within the initial 15 weeks of disability that you have applied for such Social Security disability benefits, and (ii) you submit in writing to the Claim Unit written evidence that you continue to cooperate and fully pursue Social Security disability benefits. If these requirements are satisfied and you make arrangements with the Claim Unit for the repayment of weekly benefits as outlined below, your full Sickness and Accident Benefits (or salary continuance) will be continued until the earlier of:

(a) the date such Social Security disability benefits commence, or

(b) the date 34 weeks of such weekly benefits (Sickness and Accident Benefits and/or sick leave salary continuance) have been paid.

For any period of eligibility between 34 weeks and 52 weeks (before you receive a Social Security disability benefit award or denial), the amount of such benefits will be equal to 50% of the amount of the full weekly Sickness and Accident Benefits as described in paragraph 2.4, provided you satisfied the requirements in the preceding paragraph and submit written evidence to the Claim Unit that you continue to cooperate and fully pursue Social Security disability benefits. When you receive a Social Security disability benefit award or denial, your S&A benefit will be restored to 100% of the amount of the full weekly Sickness and Accident Benefits as described in paragraph 2.4, subject to the offset described in paragraph 2.7 if you are awarded a Social Security disability benefit.

To be eligible for this arrangement, you must make satisfactory arrangements with the Claim Unit to assure that any overpayment of weekly benefits which may result by reason of receipt of Social Security benefits will be repaid to the Claim Unit. You will be required to sign an agreement to reimburse the Claim Unit promptly upon receipt of 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, wages or salary and pension payments. You will also be required to sign an authorization for the Social Security Administration to release relevant information to the Claim Unit.

2.9 The Sickness and Accident Benefit otherwise available to you will not be subject to the offset for primary disability benefits as outlined in paragraph 2.7 or 2.8 if:

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

(b) you have not been disabled for a period sufficient to qualify for Social Security disability benefits, or

(c) you inform the Claim Unit that your application for Social Security disability benefits has been denied within two weeks (or as soon as practicable thereafter) of receiving notice of such denial; however, weekly Sickness and Accident Benefits will be paid beyond 34 weeks (in the case of salaried employees, 34 weeks of disability) only if

you sign an authorization for the Company (or its representative) to appeal such denial on your behalf at the Company's expense provided, however, that you may elect at any time to have such an appeal pursued by your own counsel or other representative.

Note: The Company (or its representative) has the sole discretion to determine whether or not to appeal a denial and to determine how far to pursue this appeal; provided, however, that the Company or its representative will notify you if it determines not to appeal the denial or if it determines to abandon such appeal at any point.

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

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

Note: You are not required to agree to pay your attorney more than the attorney's fee awarded by the Social Security Administration.

Transplant Benefits

2.12 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.

Disability During Suspension

2.13 If, during a suspension which is not converted into discharge, you satisfy all the eligibility conditions for receipt of Sickness and Accident Benefits and

(a) promptly notify the Claim Unit of your disability, and

(b) if requested to do so, report for examination to the medical department of the plant or office where you work, or to such other physician as may be designated by the Company (unless you are unable to do so for good and sufficient reason), Sickness and Accident Benefits will be payable in accordance with paragraph 2.2, except that days during the suspension period will not count toward any applicable waiting period nor will benefits be payable for any days during the period of suspension.

Administration of Benefits

2.14 The Claim Unit will be responsible for the administrative functions in connection with the handling of claims. In the typical case, handling will be routine and the claim will be paid within two weeks after receipt by the Claim Unit. In reaching its decision, the Claim Unit may take reasonable steps to investigate the medical and other factual aspects of the claim. Benefit checks will be issued by the Company.

2.15 When you have provided written notice or proof of disability to the Claim Unit and any difference shall arise between you and the Company whether you (a) have submitted sufficient evidence to demonstrate you are or continue to be totally disabled as a result of sickness or accident so as to be prevented from performing the duties of your employment or (b) are or continue to be totally disabled as a result of sickness or accident so as to be prevented from performing the duties of your employment, the dispute resolution process outlined in paragraphs 2.16 - 2.19 below will be utilized.

2.16 You shall be examined by a physician appointed for this purpose by the Company and by your attending physician. If they shall disagree concerning whether you are totally disabled within the meaning of Section 2.0, that question shall be submitted to a third physician selected by such two physicians. The medical opinion of the third physician, after examining you and consulting with the other two physicians and reviewing all medical records relating to the disputed claim, shall decide such question. Your Sickness and Accident Benefits will commence or continue to

be paid, as the case may be, during the dispute resolution process provided that you give any necessary authorization to permit deduction of any overpayment of Sickness and Accident Benefits from any amount payable to you by or on behalf of the Company. The amount of recovery will not exceed $50 per week.

2.17 (a) In the event the Company physician indicates that you may return to work and your physician disagrees, the issue will be submitted to a third physician selected by such two physicians under the procedures outlined in paragraph 2.16.

(b) In the event your physician indicates that you may return to work and the Company physician disagrees, the Sickness and Accident Benefits will continue to be paid in accordance with paragraph 2.2 as long as the Company physician indicates that you are unable to perform the duties of your employment.

(c) In the event your physician or the Company physician indicates that you may return to work with restrictions, but the Company does not have a position available for you with such work restrictions, the Sickness and Accident Benefits will continue to be paid in accordance with paragraph 2.2 as long as the Company does not have a position for you with such work restrictions.

(d) In the event that your physician and the Company physician cannot agree on the restrictions placed on you, the issue may be submitted to a third physician selected by such two physicians under the procedures outlined in paragraph 2.16.

(e) In the event the Company physician indicates that you may not return to work and your physician disagrees, the issue will be submitted to a review group comprised of the USS Medical Director, the USS Safety Director, and a Representative from the USW International.

2.18 The fees and expenses of the third physician shall be shared equally by the Company and the Union.

How to Appeal the Denial of a Claim

2.19 Refer to the Insurance Grievance Procedure in Section 9 for the appropriate procedures to follow to file a grievance if your Claim is not subject to resolution pursuant to paragraphs 2.15 - 2.18 above.

SECTION 3. PPO MEDICAL BENEFITS
(FOR YOU AND YOUR ELIGIBLE FAMILY MEMBERS)

Introduction

3.0 You and your Eligible Family Members are covered by the PPO Medical Benefits detailed in this Section 3, unless you waive coverage.

3.1 PPO Medical Benefits under this Program are administered by Highmark Blue Cross Blue Shield ("Highmark") utilizing a Preferred Provider Organization ("PPO"). If you live in (or your zip code extends into) Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Washington, or Westmoreland counties in Pennsylvania, PPO Medical Benefits are administered by Aetna. The PPO Medical Benefits of this Program are designed to cover all Medically Necessary and Appropriate, as determined by the Medical Claims Administrator, confinements, services, supplies or treatments required to treat a definite condition of illness or injury that are not Experimental or Investigative. Certain preventive services are also covered.

Participating Providers

3.2 Under the PPO Medical Benefits of this Program, you have complete freedom of choice to utilize whichever medical services provider you choose. However, there are significant benefits to utilizing in-network participating providers. Such providers are called PPO or Network providers.

- Benefits for the services of PPO providers are generally payable at 90% to 100% of the Allowable Charge (as opposed to generally 70% of the Allowable Charge if you use an Out-of-Network provider).
- PPO providers will accept the Medical Claims Administrator's determination of the Allowable Charge based on its policies and will not bill you for more than the Deductible, Copayment and Coinsurance required by this Program. They may bill you for any non-covered item and for amounts over your maximum benefit). Out-of-Network providers may balance bill you for the difference between their charge and the amount paid by the Medical Claims Administrator.
- PPO providers will receive reimbursement for services directly from the Medical Claims Administrator and will bill you only for your Deductible, Copayment and Coinsurance. They may bill you for any non-covered item and for amounts over your maximum benefit). Out-of-Network providers may bill you for their entire fee with the result that you will have to file a claim form to obtain reimbursement for the portion of the Allowable Charge payable under this Section.
- You can call the Medical Claims Administrator for information on the nearest PPO participating providers or to determine if a particular provider is in the Network. You can find a list of PPO providers on the Medical Claims Administrator's Web site (see Important Contact Information).

Note: When you receive care from an Out-of-Network provider, coverage is almost always paid at the lower level — even if you are directed to an Out-of-Network provider by a Network provider. It is critical — in all cases — that you check to see that your provider is in the Network before you receive care.

Summary of Medical Benefits

3.3 This Summary of PPO Medical Benefits provides an overview of the PPO Medical Benefits available to you. Please refer to the subsequent pages for a more detailed description of Covered Services, limitations and exclusions. Items listed in the Summary as covered at 100% after the Out-of-Pocket Maximum is met are only covered at 100% if exclusions in Definitions (y) do not apply.

SUMMARY OF PPO MEDICAL BENEFITS (Effective as of April 1, 2016)		
Benefits	**In-Network**	**Out-of-Network**
	Note: Refers to the percentage of Allowable Charge	
Deductible[4] Individual Family	 $200 $400	 $500 $1,000
Payment Level/Coinsurance	90% after Deductible until Out-of-Pocket Maximum is met, then 100%	70% after Deductible until Out-of-Pocket Maximum is met, then 100%
Out-of-Pocket Maximum Individual Family	 $1,000 $2,000	 $2,000 $4,000
Primary Care Physician Office Visit (Including Pediatricians and OB/GYNs)[5]	100% after $20 Copay	70% after Deductible
Specialist Office Visit[6]	100% after $25 Copay	70% after Deductible
Preventive Care ***Adult*** Routine physical exams Routine GYN exams including a PAP Test Mammograms as required ***Pediatric*** Routine physical exams Pediatric immunizations	 100% 100% 100% 100% 100%	 70% after Deductible 70% 70% after Deductible 70% after Deductible 70%
Emergency Room Physician Services	100%	70% after Deductible
Emergency Room Facility Charges[7]	100% after $75 Copay (waived if you are admitted)	
Urgent Care[8]	100% after $30 Copay	70% after Deductible
Retail Clinic (e.g. CVS Minute Clinic, Walgreens Healthcare Clinic)[5]	100% after $20 Copay	70% after Deductible
Ambulance Service[9]	100%	

[4] Prior to April 1, 2016, there was no In-Network Deductible, and the Out-of-Network Deductible was $300 Individual/$600 Family. For the 2016 Plan Year only, effective April 1, 2016, the Out-of-Network Deductibles are 75% of the annual amount (In-Network - $150 Individual/$300 Family, Out-of-Network - $375 Individual/$750 Family). Amounts applied to the Out-of-Network Deductible between January 1, 2016 and March 31, 2016 were carried forward to April 1, 2016.

[5] Prior to April 1, 2016, In Network physician office visit copayments were $15.

[6] Prior to April 1, 2016, In Network copayments for specialist office visits, spinal manipulations, physical therapy, occupational therapy, speech therapy, outpatient mental health visits and the initial visit for outpatient substance abuse were $15.

[7] Prior to April 1, 2016, the emergency room facility charge copayment was $40 (waived if admitted).

[8] Prior to April 1, 2016, a $15 copayment applied to urgent care visits.

[9] Ambulance services are paid at 100% of Provider's Reasonable Charge.

SUMMARY OF PPO MEDICAL BENEFITS
(Effective as of April 1, 2016)

Benefits	In-Network	Out-of-Network
	Note: Refers to the percentage of Allowable Charge	
Hospital Services Inpatient Outpatient	90% after Deductible 90% after Deductible	70% after Deductible 70% after Deductible
Hearing Aids/Exams	100% Limit: $1,500 per ear per 36 month period	
Maternity	90% after Deductible	70% after Deductible
Infertility counseling, testing and treatment	90% after Deductible	70% after Deductible
Assisted Fertilization Procedures	Excludes all assisted fertilization procedures	
Medical/Surgical Services (except office visits)	90% after Deductible	70% after Deductible
Spinal Manipulations[6]	100% after $25 Copay	70% after Deductible
	Combined Limit: 18 visits per calendar year	
Simple Diagnostic Services (Lab, X-ray, Standard Imaging, and other tests)	100%	
Advanced Imaging (CT Scan, CTA, MRI, MRA, PET Scan, PET/CT Scan	90% after Deductible	70% after Deductible
Physical Therapy[6]	100% after $25 Copay	70% after Deductible
	Combined Limit: 60 visits per calendar year combined with Occupational Therapy	
Occupational Therapy[6]	100% after $25 Copay	70% after Deductible
	Combined Limit: 60 visits per calendar year combined with Physical Therapy	
Speech Therapy[6]	100% after $25 Copay	70% after Deductible
	Combined Limit: 20 visits per calendar year	
Durable Medical Equipment, Orthotics and Prosthetics	90% after Deductible	70% after Deductible
Skilled Nursing Facility Services	90% after Deductible	70% after Deductible
	Combined Limit: 100 days per calendar year	
Private Duty Nursing	90% after Deductible $10,000 per calendar year	
Home Health Care	90% after Deductible	70% after Deductible Limit: 30 visits per calendar year
Hospice	100%	
Transplant Services	90% after Deductible	70% after Deductible
Mental Health[6] *Inpatient*	90% after Deductible	70% after Deductible
Outpatient	100% after $20 Copay	70% after Deductible
Substance Abuse[6] *Inpatient*	90% after Deductible	70% after Deductible
Outpatient	100% after $20 Copay per initial visit; 100% thereafter	70% after Deductible
Other Covered Services	90% after Deductible	70% after Deductible

SUMMARY OF PPO MEDICAL BENEFITS (Effective as of April 1, 2016)		
Benefits	**In-Network**	**Out-of-Network**
	Note: Refers to the percentage of Allowable Charge	
Precertification Requirements	Performed by Member (See paragraphs 3.12 - 3.16)	

Copayments for Office Visits

3.4 Coverage for office visits will vary based on provider type, facility type, and whether the provider is an in-network or out-of-network provider. As noted below, you will either pay a Copayment (also referred to as "Copay") or Deductible and Coinsurance:

(a) Primary Care Physician Office Visit: Services are performed by a primary care physician ("PCP"), nurse practitioner and/or a physician's assistant in his or her office and billed through that office. PCP is defined as a physician who limits his or her practice to family practice, general practice, internal medicine or pediatrics and who may supervise, coordinate and provide specific basic medical services and maintain continuity of patient care. The Program requires you to pay a $20 Copayment for an in-network office visit to a PCP, nurse practitioner and/or a physician's assistant.

(b) Specialist Office Visit: Services are performed by a physician, other than a primary care physician, who limits his or her practice to a particular branch of medicine or surgery. The Program requires you to pay a $25 Copayment for an in-network office visit to a specialist. Copayments for Occupational Therapy, Physical Therapy and Speech Therapy are subject to a $25 Copayment.

(c) Office visits to an in-network mental health provider and/or the initial office visit to an in-network substance abuse provider are subject to a $20 Copayment.

Deductibles

3.5 A Deductible is money you must spend on your own for covered expenses before the Program pays benefits. There are separate individual and family Deductibles, depending on whether you use in-network or out-of-network providers (or network-not-available) as shown in the chart in paragraph 3.3. No Deductible is necessary for Routine Preventive/Wellness Care (received from in-network or network-not-available providers).

The medical Deductible does not include:

a) Copayment amounts for in-network office visits (PCP, specialist or other), in-network urgent care facility, in-network emergency room visits, and out-of-network emergency room visits in a true emergency,
b) Amounts in excess of the allowable charge for out-of-network or network-not-available services, and
c) Expenses covered under the Prescription Drug, Dental, or Vision benefits of this Program.

Out-of-Pocket Maximum

3.6 The "Out-of-Pocket Maximum" limits the amount you pay each year for covered medical expenses. When your share of eligible expenses (including your medical copayments, deductible and coinsurance amounts) reaches the out-of-pocket maximum, the PPO Medical Benefits pay 100% of your eligible expenses for the rest of the calendar year. There are separate individual and family out-of-pocket maximums, as shown in paragraph 3.3. See Definitions (y) for a detailed explanation of the Out-of-Pocket Maximum applicable to the PPO Medical Benefits. You also are protected by the "Total Maximum Out-of-Pocket" or TMOOP which includes qualified prescription drug expenses (See also Definitions (ll)).

Blue Cross Blue Shield Identification

3.7 When you elect PPO Medical Benefits under this Section 3 for the first time, you will be issued a new ID card. It is recommended that you carry your ID card with you at all times and destroy any previously issued cards.

3.8 When you or one of your Eligible Family Members receives health care services, show your ID card to the hospital, physician, or other professional health care providers and ask the provider to file a Claim for you.

Protect Your Card

3.9 If your card is lost or stolen, please contact the Medical Claims Administrator immediately. Your card is only to be used by persons who are covered under the PPO Medical Benefits Section of this Program.

3.10 To request additional ID cards, contact the Medical Claims Administrator.

Medically Necessary and Appropriate

3.11 For benefits to be paid under this Section, at either the In-Network or Out-of-Network level, services and supplies must be considered Medically Necessary and Appropriate as determined by the Medical Claims Administrator (or its designee).

Precertification (Required for Inpatient Admissions)

3.12 Prior to a non-emergency admission to a Facility Provider (hospital, alcohol or drug rehabilitation facility, skilled nursing facility or hospice), you must obtain certification from the Medical Claims Administrator to determine whether your confinement is Medically Necessary and Appropriate for purposes of reimbursement. Accordingly, you should contact the Medical Claims Administrator using the contact information in the Important Contact Information section of this Program. For an emergency or maternity admission, you must contact the Medical Claims Administrator within 48 hours following admission, or as soon as is reasonably possible.

3.13 If you are to be admitted to an In-Network facility, the provider is responsible for notifying or insuring that the Medical Claims Administrator is notified of your admission. If you are to be admitted to an Out-of-Network facility, you, not the provider, are responsible for notifying or insuring that the Medical Claims Administrator is notified of your admission.

3.14 A nurse reviewer will review your inpatient admission to ensure it is:

- appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury;
- provided for your diagnosis or the direct care and treatment of your condition, illness, disease or injury;
- not primarily for the convenience of you, your physician, hospital or health care provider;
- in accordance with standards of good medical practice;
- being delivered in the appropriate setting; and
- the most appropriate service that can safely be provided.

3.15 If the nurse reviewer is unable to authorize your admission, your case will be referred immediately to a Medical Claims Administrator physician for a determination. The physician may authorize your admission. Alternatively, the physician may determine that one or more days of the proposed hospital admission are unnecessary and that the same services can be provided in an outpatient setting, such as outpatient testing, outpatient surgery or observation. If the physician does not authorize your inpatient admission, you and your physician will be notified by letter, and if necessary, by telephone. You and your physician can then decide to appeal the denial of your hospital admission or to proceed and obtain services in an alternate setting.

3.16 If you do not obtain certification for your admission to a Facility Provider, the Medical Claims Administrator will review your care after services are received to determine if it was Medically Necessary and Appropriate. *If the admission is determined not to be Medically Necessary and Appropriate, you will be responsible for costs not covered.*

Discharge Planning

3.17 Discharge planning is a review of the case to identify your discharge needs. The process begins prior to admission and extends throughout your stay in a facility. Discharge planning ensures continuous, quality care and is coordinated with input from your physician.

3.18 To plan effectively, the Medical Claims Administrator Care Manager assesses your:

- level of function pre- and post-admission;
- ability to perform self-care;
- primary caregiver and support system;
- living arrangements pre- and post-admission;
- special equipment, medication and dietary needs;
- obstacles to care;

- need for referral to Case Management or Disease Management; and
- availability of benefits or need for benefit adjustments.

3.19 Once continued confinement is determined to be no longer necessary, the Medical Claims Administrator and your physician will discuss plans for discharge or for a continued course of treatment in an alternate setting, provided that an alternate setting for less acute care is immediately available. If a less acute care setting is not available within a reasonable distance, full benefits will be provided for your continued confinement until such care is available. The Medical Claims Administrator will notify you, your physician and the hospital by telephone if a determination is made that your confinement is no longer necessary or that an alternate setting is available. *If you continue to stay in the facility beyond the date specified by the Medical Claims Administrator, you will be responsible for all inpatient facility charges subsequent to such date.*

Individual Case Management Services

3.20 Individual Case Management, which concentrates on those cases where the early identification of catastrophic and chronic illnesses or injuries can enhance the quality of care and recovery, is available. A catastrophic case typically involves the following types of illnesses or injuries.

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

3.21 Individual Case Management can help:

- coordinate a treatment plan to enable you to reach optimum recovery in a timely manner;
- identify alternatives to an acute care setting such as rehabilitative therapies or specialized home care services when appropriate;
- provide benefits for confinements, services, supplies, equipment and treatments which would not otherwise be covered under the Program provided that, in the sole judgment of the Medical Claims Administrator acting on behalf of the Program, the provision of benefits not otherwise required under the Program represent a less costly means (from the standpoint of the Program) of providing the care required by the patient; and
- work with you to obtain the maximum level of health care coverage.

Eligible Providers

3.22 To be covered under this Section, services must be obtained from one or more of the following types of providers ("Eligible Providers"). Below is a sample of the types of Eligible Providers. Please contact the Medical Claims Administrator to verify if your provider is eligible.

(a) Facility Providers

- Hospitals
- Psychiatric Hospitals
- Rehabilitation Hospitals
- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/Night psychiatric facility
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home Health Care Agency
- Home infusion therapy provider
- Hospice
- Outpatient substance abuse treatment facility
- Outpatient physical rehabilitation facility

- Outpatient psychiatric facility
- Pharmacy provider
- Skilled nursing facility
- Substance abuse treatment facility

(b) Professional Providers [10]

- Audiologist
- Certified registered nurse
- Chiropractor
- Clinical laboratory
- Dentist
- For Skilled Nursing Care, Registered nurses(RN) and Licensed Practical nurses(LPN)
- Licensed certified social workers
- Nurse-midwife
- Nurse practitioner
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Physician assistant
- Podiatrist
- Psychologist
- Respiratory therapist
- Speech-language pathologist / speech therapist
- Teacher of hearing impaired

Covered Services

3.23 This Program provides benefits for the following confinements, services, supplies and treatments you receive from an Eligible Provider when such services are determined to be Medically Necessary and Appropriate. All Deductibles, Copayment amounts, Coinsurance levels, Out-of-Pocket Maximum and frequency limitations are described in the Summary of PPO Medical Benefits outlined in paragraph 3.3. Covered Services include the services, confinements, supplies, and treatments provided in paragraphs 3.24 - 3.86.

REMEMBER: In-Network care is covered at a higher level of benefits than Out-of-Network care.

Routine and Preventive Care

3.24 Benefits payable under the Program for Routine and Preventive Care services are offered in accordance with a predefined schedule based on age, sex and certain risk factors. The schedule of covered services is periodically revised based on the requirements of the Patient Protection and Affordable Care Act of 2010 ("PPACA") and recommendations from organizations such as the American Academy of Pediatrics, the U.S. Preventive Services Task Force, the American Cancer Society, the Medical Claims Administrator and medical consultants. Therefore, the frequency and eligibility of services are subject to change.

3.25 All Routine and Preventive Care services must be listed on the Medical Claims Administrator's Preventive Schedule, which includes the services required under PPACA, in order to be covered under the Program. Any Routine and Preventive Care service that is not required by PPACA is at the discretion of the Medical Claims Administrator and any changes in such Routine and Preventive Care services are automatically incorporated into this Section. For a current schedule of covered Routine and Preventive Care services, visit the Medical Claims Administrator's Web site or call the Member Service telephone number on your ID card.

[10] Participants are urged to verify with the Medical Claims Administrator that a particular specialist is eligible. Changes in the list of authorized Professional Providers in the PPO are automatically incorporated into this Section 3.

3.26 The following are examples of the Routine and Preventive Care services (contact your Medical Claims Administrator for a current list):

- ***Adult Care*** — Routine physical examinations.
- ***Adult Immunizations*** — Benefits are provided for adult immunizations, including the immunizing agent, when required for the prevention of disease.
- ***Medical Screenings and Procedures*** — Benefits are provided for certain routine screening tests and procedures.
- ***Routine Gynecological Examination and Pap Test*** — All females, regardless of age, are covered for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year.
- ***Mammographic Screening*** — Benefits are provided for the following:
  - An annual routine mammographic screening for all female members 40 years of age or older.
  - Mammographic examinations for all females regardless of age when such services are prescribed by a physician. Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified.
- ***Pediatric Immunizations*** — Benefits are provided to individuals under 21 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control and U.S. Department of Health and Human Services.
- ***Well-Baby Care/Pediatric Care*** — Routine and Preventive services include wellness examinations as shown in the table below.

Schedule of Wellness Examinations*	
Birth	12 months
1 month	15 months
2 months	18 months
4 months	24 months
6 months	30 months
9 months	Every year from age 3 - 18

*This includes, at appropriate ages, height, weight and Body Mass Index (BMI) measurement, developmental and behavioral assessment, including autism screening. Coverage is based on a calendar year.

- ***Colorectal Cancer Screenings*** — Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:
  - Diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
  - Diagnostic x-ray screening services such as barium enema
  - Surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
  - Such other diagnostic pathology and laboratory, diagnostic x-ray, surgical screening tests and diagnostic screening services consistent with approved medical standards and practices for the detection of colon cancer

Benefits are provided for members 50 years of age or older as follows, or more frequently and regardless of age when prescribed by a physician:

- An annual fecal-occult blood test or fecal immunochemical test
- A sigmoidoscopy every five years
- A screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every five years
- A colonoscopy every 10 years

Note: If you are determined to be at high or increased risk, regardless of age, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician and in accordance with the American Cancer Society guidelines on screening for colorectal cancer. Colorectal cancer screening services which are otherwise not described herein and are

prescribed by a physician for a symptomatic member are not considered preventive care services. The payment for these services will be consistent with similar Medically Necessary and Appropriate covered services.

Care of Illnesses and Injuries

Physician Visits

3.27 The following services are covered:

- outpatient medical care rendered that is not related to surgery, pregnancy or mental illness, except as specifically provided herein; and
- medical care visits and consultations to examine, diagnose and treat an injury or illness.

Emergency Care Services

3.28 Emergency Accident Care – Services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident.

3.29 Emergency Medical Care – Services and supplies, including drugs and medicines, for the outpatient emergency treatment of a Medical Emergency as defined in Definitions (w).

3.30 This Program covers services in an emergency department of a hospital:

- without the need for any prior authorization determination;
- without regard to whether the emergency care provider is a participating provider in the network;
- in a manner such that if the emergency services are provided out-of-network, any limits on coverage or cost-sharing limits are not more restrictive than those applied to in-network services; and
- without regard to any other term or condition of the coverage (other than the exclusion of or coordination of benefits, an affiliation or waiting period, or applicable cost-sharing).

3.31 REMEMBER: Emergency Care Services will be subject to the Out-of-Network Deductible and Coinsurance provisions of this Section if the reason for your visit is determined not to be a Medical Emergency and you receive care at an Out-of-Network hospital.

3.32 Out-of-network providers may balance bill patients for the difference between the providers' charges and the amount collected from this Program.

Facility Services

3.33 The Program covers the services outlined below that you receive in a hospital or other Facility Provider.

Bed, Board and General Nursing Services

3.34

- In a semi private room.
- In a private room with the allowance limited to the amount negotiated between the Facility Provider and the Medical Claims Administrator.
- In a bed in a Special Care Unit which gives intensive care to the critically ill.

Other Services

3.35

- Operating, delivery and treatment rooms and equipment.
- Drugs and medicines provided to you while you are an inpatient in a hospital or other Facility Provider.
- Whole blood, administration of blood, blood processing, and blood derivatives.
- Anesthesia, anesthesia supplies and services rendered in a hospital or other Facility Provider by an employee of the hospital or other Facility Provider.
- Administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic services.
- Therapy services.

Surgery

3.36 Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, and anesthesia supplies and services furnished by an employee of the hospital or other Facility Provider, other than the surgeon or assistant at surgery are covered.

Pre-Admission Testing

3.37 Coverage is provided for outpatient tests and studies required for your scheduled admission as an inpatient.

Medical/Surgical Services

3.38 The Program covers the services outlined below that you receive from a Professional Provider.

Surgical Services

3.39 Surgery performed by a Professional Provider is a Covered Service. Payment includes visits before and after surgery.

(a) Sterilization procedures such as tubal ligation and vasectomy are covered, regardless of whether Medically Necessary and Appropriate. Tubal ligation and the non-surgical Essure contraceptive implant are covered at 100% (with no Copayment, Deductible or Coinsurance).

(b) Elective abortions are covered where permitted by law.

(c) Lap band surgery is covered if determined Medically Necessary and Appropriate.

(d) Oral surgery benefits are provided for the following limited oral surgical procedures in an outpatient setting when preauthorized by the Medical Claims Administrator (acting on behalf of the Program) or in an inpatient setting if determined to be Medically Necessary and Appropriate:

- extraction of teeth in preparation for radiation therapy;
- mandibular staple implant when not done to prepare the mouth for dentures;
- Facility Provider and anesthesia services rendered in conjunction with non-covered dental procedures when determined by the Medical Claims Administrator (acting on behalf of the Program) to be Medically Necessary and Appropriate due to your age and/or medical condition;
- accidental injury to the jaw or structures contiguous to the jaw;
- the correction of a non-dental physiological condition which has resulted in a severe functional impairment;
- treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth;
- orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

(e) A mastectomy performed on an inpatient or outpatient basis, as well as surgery to re-establish symmetry or alleviate functional impairment is covered, including but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy. Physical complications of all stages of mastectomy are also covered, including lymphedemas. Also covered are the use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof and one home health care visit within 48 hours after discharge, as determined by your physician, if discharge occurred within 48 hours after admission for a mastectomy.

Assistant at Surgery

3.40 Services of a physician who actively assists the operating surgeon in performing covered surgery if a house staff member, intern or resident is not available are covered.

Anesthesia

3.41 Administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or the assistant at surgery is covered. Benefits will also be provided for the administration of anesthesia for oral surgical procedures covered under this Section and performed in an outpatient setting when ordered and administered by the attending Professional Provider.

Second Surgical Opinion

3.42 A second physician's opinion and related diagnostic services to help determine the need for elective covered surgery recommended by your first physician are covered.

Keep in mind that:

- your second opinion must be from someone other than your first physician who recommended the elective surgery;
- elective surgery means non-emergency surgery or surgery that may be deferred; and
- a third opinion is covered if the first and second opinions conflict.

3.43 If the consulting opinion is against elective covered surgery and you decide to have the elective surgery, the surgery is a Covered Service.

Inpatient Medical Services

3.44 The following services you receive from a Professional Provider are covered when you are an inpatient for a condition not related to surgery, pregnancy or mental illness:

(a) Inpatient Medical Care Visits

(b) Intensive Medical Care
- Constant attendance and treatment by a Professional Provider when your condition requires it for a prolonged time.

(c) Concurrent Care
- Care for a medical condition by a Professional Provider who is not your surgeon while you are in the hospital for surgery.
- Care by two or more Professional Providers during one hospital stay when the nature or severity of your condition requires the skills of separate physicians.

(d) Consultation
- Consultation by another Professional Provider when requested by the attending Professional Provider. Staff consultations required by hospital rules are excluded.

(e) Newborn Care
- Professional Provider visits to examine the newborn infant while the mother is an inpatient.

Ambulance Service

3.45 The Program provides coverage for Medically Necessary and Appropriate local transportation by a specially designed and equipped vehicle used only to transport the sick and injured:

- from your home, the scene of an accident or Medical Emergency to a hospital;
- between hospitals;
- between a hospital and a skilled nursing facility;
- transport to dialysis;
- from a hospital to your home; or
- from a skilled nursing facility to your home.

The Program also covers air ambulance service by a specially designed and equipped vehicle used only to transport the sick and injured if: (i) the patient's medical condition requires immediate and rapid transportation that cannot be provided by land ambulance because either the point of pick-up is inaccessible or great distances or obstacles (for example, heavy traffic) are involved in transporting the patient to the nearest appropriate hospital, and (ii) the patient's medical condition is such that the time needed to transport the patient by land, or the instability of transportation by land, poses a threat to the patient's survival or seriously endangers the patient's health.

3.46 Trips must be to the closest local facility that can provide Covered Services appropriate for your condition. If there is no facility in the local area that can provide Covered Services appropriate for your condition, you are covered for trips to the closest such facility outside your local area that can provide the necessary service. Local professional ambulance services used in non-emergency situations for transport to or from a provider for required treatment are covered provided the attending physician certifies, and the Medical Claims Administrator agrees, that such transportation is required.

Maternity Care

3.47 If you think that you are pregnant, the PPO Medical Benefits Section of this Program covers your contact with your physician and visit to an obstetrician or nurse midwife. When your pregnancy is confirmed, you are covered for follow up care which includes prenatal visits, sonograms, delivery, and postpartum and newborn care.

Maternity Home Health Care Visit

3.48 You are covered for one maternity home health care visit provided at your home within 48 hours of discharge when the discharge from a Facility Provider occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery or (b) 96 hours of inpatient care following a cesarean delivery. This visit is covered if made by a Network provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at your sole discretion, occur at the office of your Network provider. The visit is subject to all the terms of this Section and is exempt from any Copayment, Coinsurance or Deductible amounts.

Diagnostic Services

3.49 Covered Services include the following when ordered by an eligible Professional Provider:

- diagnostic x-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
- diagnostic pathology consisting of laboratory and pathology tests;
- diagnostic medical procedures consisting of electrocardiogram, electroencephalogram, and other electronic diagnostic medical procedures and physiological medical testing approved by the Medical Claims Administrator; and
- allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Therapy Services

3.50 The following services you receive from an eligible Professional Provider are covered. See the Summary of Benefits in paragraph 3.3 for any benefit limitations.

- radiation therapy;
- chemotherapy;
- dialysis treatment;
- physical therapy;
- respiration therapy;
- occupational therapy;
- speech therapy;
- infusion therapy; and
- cardiac rehabilitation.

Spinal Manipulations

3.51 Coverage is provided for spinal manipulations for the detection and correction, by manual or mechanical means, of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

See the Summary of Benefits in paragraph 3.3 for any benefit limitations.

Home Infusion Therapy Services

3.52 Services provided by a home infusion therapy provider in a home setting are covered, including pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with home infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with home infusion therapy.

Private Duty Nursing Services

3.53 Coverage is provided for private duty nursing services when ordered by a physician, provided the nurse does not ordinarily reside in your home or is not a member of your immediate family and:

- If you are an inpatient in a hospital or other Facility Provider, only when the Medical Claims Administrator, on behalf of the Plan Administrator, determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.
- If you are at home, only when the Medical Claims Administrator, on behalf of the Plan Administrator, determines that the nursing services require the skills of a medical professional.

3.54 There is an annual limit for private duty nursing services. See the Summary of Benefits in paragraph 3.3.

Skilled Nursing Facility Services

3.55 The Program covers services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital.

See the Summary of Benefits in paragraph 3.3 for any benefit limitations.

3.56 No benefits are payable under this Section for Skilled Nursing Facility Services:

- after you reach the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care;
- when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or
- for treatment of substance abuse or mental illness.

Home Health Care/Hospice Care Services

3.57 The Program covers the following services you receive from a Home Health Care Agency, hospice or a hospital program for home health care and/or hospice care. See the Summary of Benefits in paragraph 3.3 for any benefit limitations.

(a) skilled nursing services, excluding private duty nursing services;

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

(c) medical and surgical supplies provided by the Home Health Care Agency or hospital program for home health care or hospice care;

(d) oxygen and its administration;

(e) medical social service consultations;

(f) health aide services when you are also receiving covered nursing or therapy services; and

(g) family counseling related to your terminal condition.

3.58 No Home Health Care/Hospice Care Benefits will be provided under this Section for:

- dietician services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;
- Custodial Care; or
- food or home delivered meals.

Dental Services Related to Accidental Injury

3.59 Dental services rendered by a physician or dentist which are required as a result of accidental injury to the jaws, sound natural teeth, mouth or face are covered. Injury caused by chewing or biting will not be considered accidental.

Durable Medical Equipment

3.60 Coverage is provided for the rental or, at the option of the Medical Claims Administrator (acting on behalf of the Plan Administrator), the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a Professional Provider. Rental costs cannot exceed the total cost of purchase.

Prosthetic Appliances

3.61 The Program covers the purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies that:

- replace all or part of a missing body organ and its adjoining tissues; or
- replace all or part of the function of a permanently inoperative or malfunctioning body organ.

3.62 Dental appliances are not covered.

Orthotic Devices

3.63 The purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part is covered.

Transplant Services

3.64 The Program provides benefits for Covered Services furnished by a hospital which are directly and specifically related to the transplantation of organs, bones or tissue.

3.65 If a human organ, bone or tissue transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are covered by this Program, each is entitled to the benefits of this Program;
- when only the recipient is covered by this Program, both the donor and the recipient are entitled to the benefits of this Program subject to the following additional limitations: (1) the donor benefits are limited to only those not provided or available to the donor from any other source, including but not limited to, other insurance coverage, other Blue Cross or Blue Shield coverage or any government program, and (2) benefits provided to the donor will be charged against the recipient's coverage under this Program;
- when only the donor is covered by this Program, the donor is entitled to benefits, subject to the following additional limitations: (1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Program, and (2) no benefits will be provided to the non-covered transplant recipient; and
- if any organ or tissue is sold rather than donated to the covered recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the covered recipient's Program limit.

Enteral Formulae

3.66 Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. Benefits for such enteral formulae are exempt from any applicable Deductible requirements.

3.67 Enteral formulae is a liquid source of nutrition administered under the direction of a physician which may contain some or all the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

3.68 Additional coverage for enteral formulae is provided when administered on an outpatient basis, when Medically Necessary and Appropriate for your medical condition, when considered to be the sole source of nutrition and:

(a) when provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or

(b) when provided orally and identified as one of the following types of defined formula:

- with hydrolyzed (pre-digested) protein or amino acids; or
- with specialized content for special metabolic needs; or
- with modular components; or
- with standardized nutrients.

These additional benefits are subject to the Program Deductible and maximum amounts, if applicable. Once it is determined that you meet the above criteria, coverage for enteral formulae will continue as long as it represents at least 50% of your daily caloric requirement.

3.69 Coverage for Enteral Formulae excludes the following:

- blenderized food, baby food, or regular shelf food when used with an enteral system;
- milk or soy-based infant formulae with intact proteins;
- any formulae, when used for the convenience of you or your family members;
- nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance;
- the following formulae when provided orally; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and
- normal food products.

Diabetes Treatment

3.70 The Program provides coverage for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

(a) Equipment and supplies: Blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices; and

(b) Outpatient Diabetes Education: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through an Outpatient Diabetes Education Program:

- visits determined to be Medically Necessary and Appropriate upon the diagnosis of diabetes; and
- subsequent visits under circumstances whereby your physician: (a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in self-management, or (b) identifies, as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.
- The Outpatient Diabetes Education Program is a program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to the Medical Claims Administrator criteria acting on behalf of the Program. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).

Care Management

3.71 The Medical Claims Administrator identifies those individuals at risk for certain health problems and provides specific courses of care. You may receive assistance in self-management of health problems like diabetes, congestive heart failure or chronic obstructive pulmonary disease. Such services may include:

- an evaluation of your physical and psychosocial status;
- development of an individualized treatment plan by a nurse in conjunction with your physician;
- education and training such as symptom monitoring, medication dosages and compliance, appropriate diet and nutrition, smoking cessation and exercise; and
- ongoing monitoring and treatment modifications.

Mental Health Services

3.72 The Program covers the services identified below that you receive from an Eligible Provider to treat mental illness.

Inpatient Facility Services

3.73 Coverage is provided for inpatient hospital services provided by a hospital or other Facility Provider.

Inpatient Medical Services

3.74 The following inpatient medical services provided by a Professional Provider are covered:

- individual psychotherapy;
- group psychotherapy;
- psychological testing;
- counseling with family members to assist in your diagnosis and treatment; and
- electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same Professional Provider.

Partial Hospitalization for Mental Health Services

3.75 Partial hospitalization for mental health care services provided by a partial hospitalization program which has been approved by the Medical Claims Administrator is covered. Such programs are subject to periodic review.

Outpatient Mental Health Services

3.76 Inpatient hospital and medical services (except room and board) provided by a hospital, or other Facility Provider or Professional Provider when you are an outpatient are covered.

Substance Abuse Services

3.77 The Program covers inpatient detoxification and inpatient non-hospital residential and rehabilitation therapy that you receive in a hospital or other Facility Provider.

Outpatient Rehabilitation

3.78 Covered Services also include individual and group counseling and psychotherapy, psychiatric and psychological testing, and family counseling for the treatment of substance abuse.

Infertility Counseling, Testing and Treatment

3.79 The Program covers infertility, counseling and treatment. Treatment includes coverage only for the correction of a physical or medical problem associated with infertility, diagnostic services and counseling. Assisted fertilization procedures are not covered.

Autistic Disease of Childhood and Attention Deficit Disorders

3.80 The Program provides coverage for the procedures and services required to manage the medical conditions of autistic disease of childhood and attention deficit disorders (ADD/ADHD). These services include, but are not limited to, the diagnostic testing, counseling and ongoing monitoring of medication usage. Covered expenses include Applied Behavior Analysis when prescribed by a licensed physician or licensed psychologist as part of a written treatment plan that has been reviewed and approved by the claims administrator. The treatment must be provided by a Behavioral Health Provider/Practitioner licensed or certified by the state in which the services are provided and based on the treatment plan. The treatment plan must be updated and submitted for review at least every six months or more often if required by the claims administrator. A Behavioral Health Provider/Practitioner is a licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

3.81 Inpatient confinement for environmental change is not covered.

Hearing Aid Benefits

3.82 Hearing aids and the examination and fitting or repair of hearing aids are a covered expense with a benefit maximum of $1,500 per ear per a 36-month period.

3.83 Replacement hearing aid(s) will be covered if at least three years have passed since the hearing aid(s) being replaced were purchased and the previous hearing aid(s) are unserviceable.

What Is Not Covered by PPO Medical Benefits

3.84 Benefits are not provided for services, supplies or charges:

(a) which are not Medically Necessary and Appropriate as determined by the Medical Claims Administrator acting on behalf of the Plan Administrator;

(b) which are not prescribed by, performed by or upon the direction of a Professional Provider;

(c) rendered by other than hospitals, other Facility Providers, Professional Providers or suppliers as defined in paragraph 3.22 above;

(d) which are Experimental/Investigative in nature, as defined in Definitions (q);

(e) rendered prior to your effective date of coverage;

(f) incurred after the date of termination of your coverage except as provided herein;

(g) for any illness or injury suffered after your effective date as a result of any act of war;

(h) for which you would have no legal obligation to pay;

(i) received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

(j) for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation;

(k) to the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury unless you have a legal obligation to pay;

(l) for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;

(m) for prescription drugs which were paid or are payable under a freestanding prescription drug program;

(n) for methadone hydrochloride treatment for which no additional functional progress is expected to occur;

(o) which are submitted by a certified registered nurse and another Professional Provider for the same services performed on the same date for the same patient;

(p) rendered by a provider who is a member of your immediate family;

(q) for operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. Other exceptions to this exclusion are: (1) surgery to correct a condition resulting from an accident; and (2) surgery to correct functional impairment which results from a covered disease, injury or congenital birth defect;

(r) for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a Claim form;

(s) for personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a Professional Provider;

(t) for inpatient admissions primarily for physical therapy;

(u) for inpatient admissions primarily for diagnostic studies;

(v) for Custodial Care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;

(w) for respite care;

(x) directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to,

apicoectomy (dental root resection), root canal treatments, soft tissue impactions, bony impactions, frenectomy, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided herein;

(y) for oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face;

(z) for treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;

(aa) for palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes;

(bb) for any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;

(cc) for treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;

(dd) for reversal of sterilization;

(ee) for eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury);

(ff) for the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants and LASIX;

(gg) for nutritional counseling, except as provided herein;

(hh) for weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary and Appropriate;

(ii) for preventive care services, wellness services or programs, except as provided herein or as mandated by federal law;

(jj) for routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not Medically Necessary and Appropriate, except as provided herein or as mandated by federal law;

(kk) for treatment of sexual dysfunction not related to organic disease or injury;

(ll) for any care, treatment or service which has been disallowed under the provisions of the Medical Claims Administrator acting on behalf of the Plan Administrator;

(mm) for any care for conditions (a) related to hyperkinetic syndromes, learning disabilities, behavioral problems, and mental retardation, or (b) for inpatient confinement for environmental change, except that traditional treatment for medical conditions are not excluded;

(nn) for immunizations required for foreign travel or employment;

(oo) for ambulance services, except as provided herein;

(pp) for allergy testing, except as provided herein or as mandated by federal law;

(qq) for well-baby care visits, except for Routine and Preventive Care services (see paragraphs 3.25 and 3.26);

(rr) for any other medical or dental service or treatment, except as provided herein or as mandated by federal law; and

(ss) for nicotine cessation support programs and/or classes.

Nationwide Coverage

Nationwide Coverage

3.85 The Program provides nationwide coverage. Under the PPO Medical Benefits of this Program, you have complete freedom of choice to utilize whichever medical services provider you choose. However, there are significant benefits to utilizing in-network participating providers.

Services Provided for a Student While Away at School

3.86 For an Eligible Family Member child who is away at school:

- care provided by the school's medical center is usually included in the tuition, and therefore, not normally filed under the parent's health insurance plan;
- for emergency care to be reimbursed at the higher In-Network level, the condition must be a Medical Emergency situation; and
- if other medical care is needed and is not provided by the school's medical center, the student Eligible Family Member is required to use Network providers to receive the higher level of benefits.

Care Outside of the United States

3.87 The Program provides assistance with medical problems you may incur while traveling outside of the United States. Services include: making referrals and appointments for you with nearby physicians and hospitals; verbal translation from a multilingual service representative; providing assistance if special help is needed; making arrangements for medical evacuation services; processing inpatient hospitalization Claims; and for outpatient or professional services received abroad, you should pay the provider, then contact the Medical Claims Administrator for details on submitting a claim.

Claims Processing

3.88 The Medical Claims Administrator will process in-network claims using its procedures. The amount you pay for Covered Services is calculated on the lower of:

- the billed charges for Covered Services; or
- the discounted prices negotiated by the Medical Claims Administrator.

Benefits After Termination of Coverage

3.89 If you are an inpatient on the day your coverage under this Program terminates, inpatient benefits will be continued until whichever of the following occurs first:

(a) the maximum amount of benefits has been paid; or

(b) the inpatient stay ends; or

(c) you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program.

3.90 If you are pregnant on the date coverage terminates, no additional coverage will be provided, except as provided in paragraph 3.89.

How to File a Claim

Member Inquiries

3.91 General inquiries regarding your eligibility for coverage and benefits are not Claims. These general inquiries should be made by directly contacting the Member Service Department using the telephone number on your ID card.

Authorized Representatives

3.92 You have the right to designate an authorized representative to file a Claim or appeal a denied Claim on your behalf. The Medical Claims Administrator on behalf of the Plan Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by the Medical Claims Administrator will, in the case of an Urgent Care Claim, permit a physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative. In the case of a minor, an authorized representative shall include parent(s) entitled or authorized to act on the minor's behalf.

Types of Claims

3.93 Claims (see Definitions (e)) include:

(a) Urgent Care Claim (note – this is not the same as a Claim for benefits from an Urgent Care provider)

(b) Pre-Service Claim (see paragraph 3.12)

(c) Post-Service Claim

Urgent Care Claims

3.94 (a) To file an Urgent Care Claim you must contact Member Service at the telephone number on your ID card. The Medical Claims Administrator will make a decision on your Urgent Care Claim as soon as possible, following its receipt taking into account the medical exigencies involved. You will receive notice of the decision made on your Urgent Care Claim no later than 72 hours following its receipt.

(b) If you do not provide sufficient information with your Urgent Care Claim for the Medical Claims Administrator to determine whether or to what extent benefits are provided under this Section, you will be notified within 24 hours following the Medical Claims Administrator's receipt of the Claim of the specific information needed to complete your Claim. You will be given at least 48 hours from the receipt of the notice to provide the specific information. The Medical Claims Administrator will notify you of its determination on your Claim as soon as possible but not later than 48 hours after the earlier of (1) the Medical Claims Administrator's receipt of the additional specific information, or (2) the date the Medical Claims Administrator informed you it must receive the additional specific information.

(c) In addition, the 72 hour time frame may be shortened in those cases where your Urgent Care Claim seeks to extend a previously approved course of treatment and it is made at least 24 hours prior to the expiration of the previously approved course of treatment. In that situation, the Medical Claims Administrator will notify you of its decision concerning your Urgent Care Claim to extend that course of treatment not later than 24 hours following its receipt.

Filing and Determination on Non-Urgent Care Pre-Service Claims

3.95 The procedures for filing a Pre-Service Claim with the Medical Claims Administrator are described in paragraph 3.12.

3.96 If your Pre-Service Claim is denied, in whole or in part, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal. For a description of your right to file an appeal concerning an adverse benefit determination of a Pre-Service Claim, see paragraph 3.104.

3.97 You will receive written notice of any decision on a Pre-Service Claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date the Medical Claims Administrator receives the Claim.

Filing a Post-Service Claim

3.98 If you receive services from a Network provider, you will not have to file a Post-Service Claim. If you receive services from an Out-of-Network provider, you may be required to file the Post-Service Claim yourself, taking the following steps:

(a) Know Your Benefits

Review this Section to see if the services you received are Covered Services.

(b) Get an Itemized Bill

Itemized bills must include:

- the name and address of the service provider;
- the patient's full name;
- the date of service or supply;
- a description of the service/supply;
- the amount charged;
- the diagnosis or nature of illness;
- for durable medical equipment, the doctor's certification;
- for private duty nursing, the nurse's license number, charge per day and shift worked;
- for ambulance services, the total mileage.

Note: If you've already made payment for the services you received, you must also submit proof of payment (receipt from doctor) with your Claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

(c) Copy Itemized Bills

You must submit originals, so you will want to make copies for your records. Once your Claim is received, itemized bills cannot be returned.

(d) Complete a Claim Form

Make sure all information is completed properly, and then sign and date the form. Claim forms are available from your employee benefits department or Member Service at the Medical Claims Administrator.

(e) Attach Itemized Bills to the Claim Form and Mail

Attach all itemized bills to the Claim form and mail everything to the address on the form.

REMEMBER: Multiple services for the same patient can be filed with one Claim form. However, a separate Claim form must be completed for each patient.

Your Explanation of Benefits Statement

3.99 Once a Claim is processed, you will receive an Explanation of Benefits ("EOB") statement. This EOB statement lists: the provider's charge; allowable amount; the Copayment, Deductible and Coinsurance amounts, if any, you are required to pay; total benefits payable; and the total amount you owe.

3.100 If you believe that the Copayment, Coinsurance or Deductible amount identified in your EOB statement is not correct or that any portion of these amounts is covered under this Section, you may file a Post-Service Claim with the Medical Claims Administrator. For instructions on how to file such Claims, you should contact Member Services using the telephone number on your ID card.

When Post-Service Claims Must Be Filed

3.101 To be eligible for benefits, you must submit all Post-Service Claims by the end of the calendar year following the calendar year containing the date of service.

Determinations on Post-Service Claims

3.102 The Medical Claims Administrator will notify you in writing of its determination on your Post-Service Claim within a reasonable period of time following the Medical Claims Administrator's receipt of your Claim. That period of time will not exceed 30 days from the date your Claim was received.

3.103 If your Post-Service Claim is denied, in whole or in part, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

Appeal Procedure

3.104 ***General***

(a) The appeal process for Urgent Care Claims involves the following steps:

Highmark

(1) Initial Review by Highmark
(2) External Review under paragraph 3.109
(3) Insurance Grievance Procedure under Section 9

Note: After the Initial Review by Highmark, you may choose to proceed directly to the Insurance Grievance Procedure.

Aetna

(1) Initial Review by Aetna
(2) Second Level Review by Aetna
(3) External Review under paragraph 3.109
(4) Insurance Grievance Procedure under Section 9

Note: After the Initial Review by Aetna, you may choose to proceed directly to the Insurance Grievance Procedure.

(b) The appeal process for all other Claims involves the following steps:

Highmark

(1) Initial Review by Highmark
(2) Second Level Review by Highmark (voluntary for Pre-Service Claims)
(3) External Review under paragraph 3.109
(4) Insurance Grievance Procedure under Section 9

Aetna

(1) Initial Review by Aetna
(2) Second Level Review by Aetna
(3) External Review under paragraph 3.109
(4) Insurance Grievance Procedure under Section 9

(c) Your decision to appeal a Claim is completely voluntary. In other words, you are not required to pursue an appeal before using the Insurance Grievance Procedure. You will not be penalized for voluntarily seeking (or not seeking) an appeal.

(d) Except as provided in (a) above, at any point during the appeal process, including before the Initial Review by the Medical Claims Administrator, you may choose to proceed directly to the Insurance Grievance Procedure.

(e) You can request copies of information relevant to your claim, free of charge, including documents and records; reasons for the adverse benefit determination; copies of information relied upon; the diagnosis and treatment codes and their corresponding meanings.

(f) At any time during the appeal process at the Medical Claims Administrator, you may contact the Member Service Department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

(g) Medical Claims Administrator address for appeals:

Highmark - Member Grievance and Appeals Department, P.O. Box 535095, Pittsburgh, Pennsylvania 15253-5095, Attention: Review Committee

Aetna - Appeals Resolution Team, Appeals Resolution Team, PO Box 14463, Lexington, Kentucky 40512

(h) Notwithstanding anything to the contrary, all disputes over whether an item is an Allowable Charge, whether an item is Experimental/Investigative, and/or whether services and supplies are Medically Necessary and Appropriate are subject to review by the Medical Claims Administrator, external review (paragraphs 3.104-3.109 under the PPO Medical Benefits of the Program) and the grievance and arbitration process (under Section 9).

3.105 Initial Review by the Medical Claims Administrator

(a) If you receive notification that a Claim has been denied by the Medical Claims Administrator, in whole or in part, you may appeal the decision. Your appeal must be submitted not later than 180 days from the date you received notice from the Medical Claims Administrator of the adverse benefit determination.

(b) Upon request to the Medical Claims Administrator, you may review all documents, records and other information relevant to the Claim which is the subject of your appeal and you shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

(c) A representative from the Medical Claims Administrator's Appeal Review Department will review the initial appeal. The representative will be a person who was not involved in any previous adverse benefit determination regarding the Claim and will not be the subordinate of any individual that was involved in any previous adverse benefit determination regarding the Claim.

(d) The Medical Claims Administrator's Appeal Review Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by the Medical Claims Administrator. The Medical Claims Administrator's Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the Claim that is the subject of your appeal.

(e) If a decision on an appeal is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is Medically Necessary and Appropriate or Experimental/Investigative, the Medical Claims Administrator's Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination regarding the Claim and will not be the subordinate of any person involved in a previous adverse benefit determination regarding the Claim.

(f) Your appeal will be promptly investigated and the Medical Claims Administrator will provide you with written notification of its decision within the following time frames:

Highmark

(1) Pre-Service Claims
   (A) When the appeal involves an Urgent Care Claim, as soon as possible taking into account the medical exigencies involved but not later than 72 hours following receipt of the appeal by Highmark;
   (B) When the appeal involves a non-Urgent Care Pre-Service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 30 days following receipt of the appeal by Highmark; or

(2) When the appeal involves a Post-Service Claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal by Highmark.

Aetna

(1) Pre-Service Claims
   (A) When the appeal involves an Urgent Care Claim, as soon as possible taking into account the medical exigencies involved but not later than 36 hours following receipt of the appeal by the Aetna;
   (B) When the appeal involves a non-Urgent Care Pre-Service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 15 days following receipt of the appeal by Aetna; or

(2) When the appeal involves a Post-Service Claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal by Aetna.

(g) In the event the Medical Claims Administrator renders an adverse benefit determination on appeal, you have the right to further appeal this decision to a Second Level Review at the Medical Claims Administrator (Highmark does not require a Second Level Review for an Urgent Care Claim and allows a voluntary Second Level Review for Pre-Service Claims), an External Review under paragraph 3.109, and then to use the Insurance Grievance Procedure, or you may proceed directly to the Insurance Grievance Procedure. The notification of the adverse benefit determination will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file a further appeal.

(h) Your decision to proceed with a Second Level Review of a Pre-Service Claim with Highmark (other than an Urgent Care Claim, which involves one level of review) is completely voluntary. In other words, you are not required to pursue the Second Level Review of a Pre-Service Claim with Highmark before pursuing a claim for benefits in court or using the Insurance Grievance Procedure. Should you elect to pursue the second level review before filing a claim for benefits in court, the Program will not later assert in a court action that you failed to exhaust administrative remedies (i.e., that you failed to proceed with a Second Level Review) prior to the filing of the lawsuit; agrees that any statute of limitations applicable to the claim for benefits will not commence (i.e., run) during the Second Level Review; and will not impose any additional fee or cost in connection with the Second Level Review.

(i) If you have further questions regarding a Second Level Review of Claims, you should contact Member Service using the telephone number on your ID card.

3.106 Second Level Review by the Medical Claims Administrator

(a) Highmark

If you are dissatisfied with the decision following the initial review of your appeal (other than the review of an Urgent Care Claim), you may request to have the decision reviewed by Highmark. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 45 days from the date of your receipt of an adverse benefit determination.

Aetna

If you are dissatisfied with the decision following the initial review of your appeal, you may request to have the decision reviewed by Aetna. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 60 days from the date of your receipt of an adverse benefit determination.

(b) Upon request to the Medical Claims Administrator, you may review all documents, records and other information relevant to the Claim which is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

(c) A representative from the Medical Claims Administrator Appeal Review Department will review your Second Level appeal. The representative will be an individual who was not involved in any previous adverse benefit determination on your Claim and will not be the subordinate of any individual that was involved in any previous adverse benefit determination on your Claim.

(d) The Medical Claims Administrator Appeal Review Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by the Medical Claims Administrator. The Medical Claims Administrator Appeal Review Department will also afford no deference to any previous adverse benefit determination regarding the matter under review.

(e) If a decision on a Second Level appeal is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is Medically Necessary and Appropriate or Experimental/Investigative, the Medical Claims Administrator Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be a person who was not involved in any previous adverse benefit determination on your Claim and will not be the subordinate of any person involved in a previous adverse benefit determination on your Claim.

(f) Your Second Level appeal will be promptly investigated and the Medical Claims Administrator will provide you with written notification of its decision with the following time frames:

Highmark

(1) When the appeal involves a non-Urgent Care Pre-Service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 15 days following receipt of the appeal by Highmark; or

(2) When the appeal involves a Post-Service Claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal by Highmark.

Aetna

(1) Pre-Service Claims

(A) When the appeal involves an Urgent Care Claim, as soon as possible taking into account the medical exigencies involved but not later than 36 hours following receipt of the appeal by the Aetna;

(B) When the appeal involves a non-Urgent Care Pre-Service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed 15 days following receipt of the appeal by Aetna; or

(2) When the appeal involves a Post-Service Claim, within a reasonable period of time not to exceed 30 days following receipt of the appeal by the Medical Claims Administrator.

(g) In the event the Medical Claims Administrator renders an adverse benefit determination on your Second Level appeal, this is a final determination unless you seek an External Review under paragraph 3.109 or you may choose to proceed directly to the Insurance Grievance Procedure in Section 9. The notification of the adverse benefit determination will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to appeal this determination.

3.107 The Insurance Grievance Procedure in Section 9 is the final level of appeal under the Program. As indicated above, you may proceed directly to the Insurance Grievance Procedure before exhausting other levels of appeal available under the Program; however, you many not request any further review of your claim after the Insurance Grievance Procedure.

Additional Internal Review Requirements

3.108 The claims and appeals provisions above shall include the following requirements, which shall be applicable **only** to PPO Medical Benefits claims:

(a) A rescission of coverage, other than the termination of coverage for non-payment of premiums, is considered as an adverse benefit determination.

(b) The Medical Claims Administrator shall defer to the attending provider with respect to the determination of whether a claim constitutes an Urgent Care Claim as defined in Definitions (e).

(c) To ensure a full and fair review, (1) the claimant must be allowed to review the claim file and present evidence and testimony during the claims and appeals process; and (2) the plan must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim and with any new or additional rationale on which an adverse benefit determination on appeal is based; such evidence or rationale must be provided as soon as possible and sufficiently in advance of the date the benefit determination is due in order to provide the claimant with a reasonable opportunity to respond prior to that date.

(d) The plan must ensure that all claims and appeals are adjudicated in a manner to ensure the independence and impartiality of the persons involved in making the decision.

(e) If the plan fails to adhere to all the requirements of the internal claims and appeals process, the internal claims and appeals process will be deemed to be exhausted and the claimant may proceed to the external claims review or may pursue any available remedies under section 502(a) of ERISA. Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. However, the exception described in the previous sentence is not available, and the internal claims and appeals process will be deemed exhausted, if the violation is part of a pattern or practice of violations by the plan. The claimant may request a

written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects a claimant's request for immediate review on the basis that the plan met the de minimis standard described in this paragraph, the claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the plan shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon the claimant's receipt of such notice.

(f) Any notice of adverse benefit determination must include the reasons for the adverse benefit determination, including information sufficient to identify the claim involved (including the date of the service, the health care provider, and the claim amount), a description of internal and external appeals and review processes, contact information for further assistance, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. The notice must also include the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim and, a discussion of the decision.

(g) Notices must be provided in a culturally and linguistically appropriate manner. The plan must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language; the plan must provide, upon request, a notice in any applicable non-English language; and the plan must include in the English versions of all notices, a statement prominently displayed in any applicable non- English language clearly indicating how to access the language services provided by the plan. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

External Review Requirements

3.109 With respect to PPO Medical Benefits claims, the claims and appeals procedures will include an external review process, which will comply with the standards set forth in Technical Release 2010-01 and any subsequent guidance.

(a) In general, a claimant must file a request for an external review within four (4) months after the date of receipt of a notice of: (a) an adverse benefit determination (including a final internal adverse benefit determination) by a plan that involves medical judgment (including, but not limited to, those based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). Note that for Pre-Service Claims to Highmark, the four month period after an adverse benefit determination begins to run from the date you received Highmark's first-level adverse benefit determination.

(b) You are entitled to the same procedural rights to an external review as described above on an expedited basis if you receive

- an adverse benefit determination if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal; or
- a final internal adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility rendering the emergency services;

Immediately upon receipt of the request for expedited external review, the Medical Claims Administrator will determine whether the request meets the reviewability requirements set forth above for standard external review. The Medical Claims Administrator must immediately send you a notice if its eligibility determination.

(c) An external review decision is binding on the plan, as well as the claimant, except to the extent other remedies are available under state or federal law **or under Section 9**, and except that the requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such

payment or benefits. For this purpose, the plan must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. An External Review is a final determination unless you decide to further appeal such claim for benefits by filing a grievance in accordance with the Insurance Grievance Procedure outlined in Section 9.

SECTION 4. PRESCRIPTION DRUG BENEFITS
(FOR YOU AND YOUR ELIGIBLE FAMILY MEMBERS)

Introduction

4.0 You and your Eligible Family Members are automatically covered by the Prescription Drug Benefits outlined in this Section 4, unless you waive coverage. The Prescription Drug Benefits under the Program are administered by Express Scripts, Inc. ("Express Scripts").

Who is Eligible?

4.1 This drug benefit has been designed for individuals who reside in the United States or Puerto Rico. Employees enrolled in the PPO Medical Benefits Section of this Program are covered. Eligible Family Members of such employees are also eligible unless they have prescription drug coverage under another group plan which is the primary plan pursuant to the coordination of benefits provision of this Program.

How Does the Program Work?

4.2 Whenever you or an Eligible Family Member requires a prescription drug, you have the following options for getting your prescription filled:

- **Retail Pharmacy**
  - You can purchase up to a 30-day supply of your prescription medications from any retail pharmacy of your choice. However, there are certain advantages if you obtain your medication from a participating retail pharmacy.
  - See "Home Delivery" below for an explanation of the requirement to use Home Delivery for any long-term/maintenance medication you may be taking.
- **Home Delivery (through Express Scripts Home Delivery Pharmacy)**
  - You can order up to a 90-day supply of medications prescribed for treatment of chronic or long-term illness (such as arthritis, diabetes, high blood pressure) through the mail from Express Scripts.
  - Effective April 1, 2016, you will be required to use Home Delivery for any long-term/maintenance medication you may be taking. You can get your initial fill and first refill of a long-term/maintenance medication at a retail pharmacy. If you use a retail pharmacy for any subsequent refills, you will be required to pay 100% of the negotiated discount price.
- **Specialty Pharmacy Program (provided by Accredo)**
  - You may receive a 30-day supply of specialty injectable and oral prescription medications for treatment of hemophilia, hepatitis, oncology, multiple sclerosis, rheumatoid arthritis, and other illnesses that require personalized care and ongoing patient support.

Pharmacy Management Strategies

4.3 The Program uses pharmacy management strategies to control costs and utilization:

- Prior Authorization Programs – Prior Authorization programs are designed to reduce potential abuse or misuse of medications that have a high potential for abuse/misuse by ensuring that the medication provided under the Prescription Drug Benefits of this Program is prescribed per the FDA approved indications. The Prior Authorization programs make sure the medications are being used for an appropriate medical condition and are not being used for non-medical purposes.
- Generic Substitution Provision[11] – The Program covers both brand-name and generic equivalent drugs. However, generic equivalents will be substituted where permissible by law. If your physician prescribes a brand-name drug

[11] From January 1, 2016 to March 31, 2016, the Generic Substitution Provision above was not applicable. Instead, the Generic Substitution Provision was as follows: A mandatory generics provision that identifies claims for Single and Multi-Source Brand medications within the same therapy class that the physician is indicating to dispense the Brand medication only on the prescription form. Members, who are receiving this medication for the first time within a year, will be able to receive their prescription for the applicable Brand name copayment and will receive a letter stating their plan has a mandatory generic provision and their second fill must be a generic medication or they will

that can legally be filled with the generic equivalent and indicates that generic substitution is not permitted or you request the brand, you will be charged the generic Copay plus the difference in cost between the brand and generic. If your physician determines that a generic equivalent will not be acceptable for your specific need and if you wish to continue using this Program to purchase this particular drug, your physician must complete and return to Express Scripts the appropriate form providing the medical reasons a brand-name drug is required. Any subsequent refills and prescriptions authorized by your physician will be filled by Express Scripts only if Express Scripts determines, on the basis of the physician's explanation, that use of the brand-name drug is required in accordance with accepted standards of medical practice.

- Therapeutic Interchange (Step Therapy) - Within specific classes of medications, multiple drugs are available to treat the same condition. Therapeutic Interchange manages drug costs by ensuring that you try frontline (first step), clinically effective, lower-cost medications before you can "step up" to a higher-cost medication.
- Drug Quantity Management - Quantity Limits – The Drug Quantity Management Program manages drug costs by aligning the dispensed quantity of prescription medication with Food and Drug Administration ("FDA")-approved dosage guidelines. In addition, consolidation of dosing ensures that the most cost-effective product strength is dispensed. Online edits to drugs on the quantity limit list allow coverage up to a predefined amount per dispensing or days supply. For medications used to treat chronic conditions, the defined amount is determined using a 30-day regimen based on FDA-approved dosing guidelines and medical literature.
- Concurrent Drug Utilization Review – Concurrent Drug Utilization Review identifies the most important drug and patient-specific pharmaceutical care concerns at the point of service. Express Scripts claims processing system reviews each electronically transmitted claim to identify pertinent clinical or utilization concerns and, when applicable, provide a safety alert to the pharmacist.
- Specialty Pharmacy Program – Accredo, a specialty pharmacy and subsidiary of Express Scripts Inc., provides drug therapies for complex and potentially life threatening illnesses to a wide range of patients to treat rheumatoid arthritis, hemophilia, hepatitis, multiple sclerosis and other illnesses that require personalized care and ongoing patient support. This high-touch, patient-focused care model has achieved some of the best clinical outcomes in the industry. Dispensing a 30-day supply of medication ensures that each patient remains in contact with a professional caregiver on a regular basis.

Note: Renewals of prescriptions written before April 1, 2016 are excluded from the expanded Express Scripts Pharmacy Management Programs.

Any new prescription management programs will be implemented after review with and approval of the USW.

What Is My Cost?

4.4 Your prescription Drug Benefits are provided through an integrated network of national chain and local pharmacies, and via home delivery from the Express Scripts Home Delivery Pharmacy, and via Accredo. Your cost per prescription is displayed below.

SUMMARY OF PRESCRIPTION DRUG BENEFIT COPAYMENTS		
	Participating Pharmacy	**Non-Participating Pharmacy**
Home Delivery Prescription Copayments (per Rx)		
Preferred Generic	$20.00	Not Covered
Preferred Brand-Name	$40.00	Not Covered
Non-Preferred Generic or Brand-Name	$60.00	Not Covered

need a prior authorization to continue on the Brand name medication. This program will exclude medications included within the Anti-Depressant therapeutic category.

SUMMARY OF PRESCRIPTION DRUG BENEFIT COPAYMENTS		
	Participating Pharmacy	**Non-Participating Pharmacy**
Excluded Drugs	Not Covered	Not Covered
Home Delivery, Maximum Supply	Up to 90-days	Not Covered
Specialty Prescription Copayments (per Rx)		
Generic	$ 0.00	Not Covered
Brand-Name	$20.00	Not Covered
Excluded Drugs	Not Covered	Not Covered
Specialty Drugs, Maximum Supply	Up to 30-days	
Retail Prescription Copayments (per Rx)		
Preferred Generic	$10.00	50% copayment (via reimbursement)
Preferred Brand-Name	$20.00	50% copayment (via reimbursement)
Non-Preferred Generic or Brand-Name	$30.00	50% copayment (via reimbursement)
Excluded Drugs	Not Covered	Not Covered
Retail, Maximum Supply	Up to 30-days	Up to 30-days

The discounted price is the ingredient price of the participating pharmacy plus the dispensing fee.

4.5 The copayment for smoking cessation drugs (such as Zyban, Wellbutrin and certain nasal sprays) that are not covered under paragraph 4.8 and are purchased at a local retail pharmacy shall be equal to the generic copayment. These medications are not available through Express Scripts Home Delivery Pharmacy. See paragraph 4.8 for special provisions applicable to smoking cessation drugs.

What Quantity Can Be Dispensed?

4.6 (a) Other than Controlled Substances

- When using the Express Scripts Home Delivery Pharmacy: up to a 90-day supply with refills not exceeding one year[12].
- When using Accredo: a 30-day supply with refills not exceeding one year.
- When using a Retail Pharmacy: up to a 30-day supply with refills not exceeding one year.

(b) Controlled Substances: up to a 30-day supply *with up to five refills. However, Schedule II drugs (such as Percodan and Demerol) cannot be refilled* (each order requires a new prescription). If you are not sure the prescription drug you are taking is a controlled substance, ask your doctor or call Express Scripts toll-free at 1-800-287-4508.

Covered Prescriptions

4.7 The Program covers prescriptions written by licensed prescribers (i.e., physicians, dentists, nurse practitioners, physician's assistants and others as legally allowed) for medications which *require* a prescription pursuant to federal or state law, including insulin, disposable insulin syringes (when dispensed with insulin), blood glucose testing agents and strips. Each prescription for a "controlled substance" (including Schedule II drugs) must be written by a licensed physician on a separate prescription blank.

- [12] Prior to April 1, 2016, the initial home delivery prescription is limited to a 30-day supply, and your copayment will be 1/3 of the applicable home delivery copayment as follows: Formulary Generic $7, Formulary Brand-Name $13 and Non-Formulary (Generic or Brand Name) $20.

Preventive Prescription Drug Services

4.8 The Program covers certain preventive services. The schedule of covered preventive prescription drug services in paragraph (a), (b) and (c) below is periodically revised based on the requirements of the Patient Protection and Affordable Care Act. Therefore, the frequency and eligibility of services are subject to change.

(a) Over the Counter Drugs and Medicines

As required under the preventive care services benefit provisions of the PPACA, the Program also covers the following over-the-counter (OTC) drugs and medicines prescribed by your physician at 100% (with no Copayment, Deductible or Coinsurance):

- aspirin to prevent cardiovascular disease for men age 45 to 79 and women age 55 to 79;
- aspirin to prevent preeclampsia for women under age 55;
- oral fluoride supplementation for children from six months through age 5;
- iron supplementation for children from six to 12 months of age who are at an increased risk for iron deficiency anemia;
- folic acid supplementation for women of child-bearing age 18 to 45; and
- immunizations - recommended ages per CDC Vaccination Schedule.

(b) Contraceptives

(1) In addition, the Program covers FDA-approved contraceptive methods as prescribed by a health care provider. Contraceptive methods that are generally available over-the-counter (OTC), such as contraceptive sponges and spermicides are covered if the method is both FDA-approved and prescribed for a woman by her health care provider (notwithstanding paragraph 4.11).

(2) Generic and OTC contraceptives are covered at 100% (with no copayment, deductible or co-insurance). A brand name or Non-Formulary brand name contraceptive will be covered at 100% (with no copayment, deductible or co-insurance), in the event a generic contraceptive is not available or a generic contraceptive (or a brand name formulary contraceptive) would be medically inappropriate. Brand name Formulary and Non-Formulary contraceptives are covered at Program Copayment/Coinsurance as outlined in paragraph 4.4.

(3) The Program covers the following forms of contraception:

- Implantable Rod (generic only)
- IUD – Copper (ParaGard)
- IUD – Progestin (generic only)
- Injection (generic only)
- Oral contraceptives – combined (generic only)
- Oral Contraceptives – progestin only (generic only)
- Oral Contraceptives – extended/continuous use (generic only)
- Patch (generic only)
- Vaginal Ring (NuvaRing)
- Diaphragm with Spermicide (Milex Omniflex)
- Sponge with Spermicide (Today Sponge)
- Cervical Cap with Spermicide (FemCap)
- Female Condom (generic only)
- Spermicide alone (generic only)
- Emergency Contraception-Progestin (generic only)
- Emergency Contraception- Ulipristal Acetate (ella)

(c) Smoking Cessation Drugs

The Program covers FDA-approved smoking cessation drugs (such as but not limited to Nicorette, Nicorette Lozenge, NicoDerm CQ, Nicorette QuickMist spray, Wellbutrin, Zyban and Chantix) without prior authorization.

(1) Generic smoking cessation drugs (OTC and prescription) are covered at 100% (with no Copayment, Deductible or Coinsurance) for individuals 18 and over, up to two 90-day treatment regimens per rolling 365 days;
(2) Chantix is covered at 100% (without prior authorization and with no Copayment, Deductible or Coinsurance) for individuals 18 and over, up to two 90-day treatment regimens per rolling 365 days.
(3) Brand name Preferred and Non-Preferred smoking cessation drugs are covered at Program Copayment/Coinsurance, as outlined in paragraphs 4.4 and 4.5, for individuals 18 and over, up to 90 days of therapy per rolling 365 days.

What Is a Formulary?

4.9 This Program follows a select drug list or formulary. The formulary is an extensive list of Food and Drug Administration ("FDA") approved generic and brand-name prescription drugs selected for their quality, safety and effectiveness. Effective April 1, 2016, the formulary is the Express Scripts, Inc. ("ESI") National Preferred Formulary Drug list, (prior to April 1, 2016, the Express Scripts, Inc. ("ESI") Basic Formulary list), or the equivalent from another Pharmacy Benefit Manager should there be a change in vendors during the term of the Basic Labor Agreement. It includes products in every major therapeutic category and is maintained by Express Scripts. The medications on the formulary have been selected by an independent group of doctors and pharmacists for safety and efficacy, and only FDA approved medications are included. Express Scripts, on behalf of the Plan Administrator, may remind your doctor when a formulary medication is available for a medication that is not on your formulary. This may result in a change in your prescription. However, your doctor will always make the final decision on your medication, subject to Pharmacy Management Strategies under this Program.

4.10 The benefits under this Section include coverage for both formulary and non-formulary drugs. It does not include coverage for drugs that are considered excluded drugs under the formulary. To receive a copy of the formulary, call the Patient Care Contact Center at the number on the back of your Express Scripts ID card. You can also access the formulary online at *www.express-scripts.com*.

What Prescriptions Are Not Covered?

4.11 Except for insulin and certain over-the-counter drugs or medicines listed in paragraphs 4.7 and 4.8, this Program does not cover any drugs or medicines that can be purchased over-the-counter without a prescription, nor does it cover:

- drugs not medically necessary to treat a condition of illness or injury (such as drugs prescribed for cosmetic purposes);
- experimental drugs;
- drugs prescribed for weight loss, unless Medically Necessary and Appropriate;
- growth promoting agents;
- drugs prescribed for treatment of infertility;
- allergy serums;
- vaccines, toxoids and serums;
- diabetic supplies, excluding syringes, blood test strips, urine test strips and lancets (please see paragraph 3.70 for the Diabetes Treatment provisions under PPO Medical Benefits in Section 3);
- durable medical equipment;
- Prescription Homeopathic medications;
- certain compound drugs;
- refills of any prescription older than one year;
- drugs that are excluded drugs on the National Preferred Formulary Drug list, and
- home infusion therapy drugs.

Smoking cessation drugs are covered only to the extent that they are described in paragraphs 4.5 or 4.8.

In addition, the following are not available through home delivery pharmacy:

- drugs for acute, short-term illnesses as determined by Express Scripts even though prescribed for 30 days or more; and
- drugs which may not be legally provided through home delivery.

Using the Home Delivery Option

Home Delivery Pharmacy for Maintenance Prescriptions

4.12 Effective April 1, 2016, if you need a maintenance prescription drug, which is a medication for a long-term condition, you may fill your initial prescription and one refill at a retail pharmacy. Beginning with your third fill, you must have your prescription filled using the Express Scripts Home Delivery Pharmacy. If you order more than two fills (original fill plus one refill) of a maintenance drug at a network retail pharmacy instead of ordering it through the Express Scripts Home Delivery Pharmacy, you will pay 100% of the discount negotiated cost. Express Scripts will notify you if your prescription is a maintenance prescription drug subject to the mandatory use of the Express Scripts Home Delivery Pharmacy.

Initial and Refill Prescriptions

4.13 When using the home delivery option through the Express Scripts Home Delivery Pharmacy, it is recommended that you ask your physician to write a prescription for up to a 90-day supply of all needed maintenance drugs, plus the appropriate number of refills. If you or your Eligible Family Members previously used the Express Scripts Home Delivery Pharmacy, and you have a new prescription, follow the instructions outlined on the order form. If no one in your Family previously ordered prescription drugs through the home delivery option, complete the New Patient Home Delivery Order form, which you can obtain by calling Express Scripts toll-free at 1-800-287-4508 or by visiting the Express Scripts Web site at *www.express-scripts.com*. Answer all questions, making sure you enter your member identification number in the space provided. *This form is completed only with your first order*; however, if you become aware of an allergy or health condition after completing the New Patient Home Delivery Order form, be sure to notify Express Scripts. Place your original prescription(s), completed order form, check or money order payable to "Express Scripts" (where applicable), and New Patient Home Delivery Order form in the pre-addressed envelope also provided by Express Scripts, and mail to Express Scripts.

IMPORTANT: Write your name, address, date of birth and member identification number on the back of *each* prescription you enclose.

If the label indicates that the prescription may be refilled and the prescription is not for a Schedule II drug [see paragraph 4.6(b)], follow one of these refill options:

- **Telephone**
  Call the Patient Care Advocate Call Center toll-free at 1-800-287-4508. Have your member identification number, the prescription number, and your card information ready.
- **Mail**
  Use the refill and order form provided with your medication shipment and mail them in the postage-paid envelope along with your copayment.
- **Web Site**
  Visit the Express Scripts Web site at *www.express-scripts.com*. Have your member identification number, the prescription number, and your card information ready. You will need to register first before you can refill a prescription.

What If I Want to Order by Home Delivery But Need Medication Immediately?

4.14 If you need medication for an acute short-term illness or injury, and the prescribed medication is FDA approved only for short-term use, it cannot be obtained through the Express Scripts Home Delivery Pharmacy. You must obtain medication prescribed for less than a 30-day period from a retail pharmacy under the Retail Pharmacy option (preferably a participating Express Scripts network pharmacy).

4.15 If you need medication immediately for a chronic or long-term condition, have your doctor write two prescriptions: one for a 30-day supply that you can have filled at a retail pharmacy, and one for up to a 90-day supply that you can send to Express Scripts Home Delivery Pharmacy.

How Soon Will I Receive My Home Delivery Prescription?

4.16 Orders are usually processed and mailed within 48 hours of receipt via First Class U.S. Mail or United Parcel Service. However, you should allow 10 to 14 days from the date you mailed your prescription for normal mail delivery.

Who Do I Contact for Express Scripts Home Delivery and Pharmaceutical Information?

4.17 If you have any questions or problems concerning a prescription ordered via Express Scripts Home Delivery Pharmacy, call the Patient Care Contact Center toll-free at 1-800-287-4508 or visit the Express Scripts Web site at *www.express-scripts.com*. If you do not receive your medication in 14 days, call Express Scripts and a replacement order will be sent to you at no additional charge if your first order cannot be traced. The above toll-free telephone number is also available for any questions about an order, including physician inquiries, and for you to phone in refills.

Using the Specialty Pharmacy Program

4.18 The Specialty Pharmacy Program provides drug therapies for complex and potentially life threatening illnesses to a wide range of patient populations including those with hemophilia, hepatitis, oncology, multiple sclerosis, rheumatoid arthritis, and other illnesses that require personalized care and ongoing patient support through Accredo. Because treatments for these diseases now rely upon biopharmaceutical injectables, many retail pharmacies are unable to supply these medications due to their high cost, special handling and storage needs. The Specialty Pharmacy Program is designed to provide patients with convenient access to an experienced clinical care management team who can assist with coordinating medication delivery, monitoring your progress, communicating with your physician and other healthcare providers as needed and assisting you with your medication questions and needs. Accredo also provides ancillary supplies needed for medication administration, at no additional cost. Specialty drugs include injectable and non-injectable drugs and are defined as drugs that have one or more of several key characteristics, including: (1) requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; (2) need for intensive patient training and compliance assistance to facilitate therapeutic goals; (3) limited or exclusive product availability and distribution; and (4) specialized product handling and/or administration requirements. Effective January 1, 2017, if a prescription drug manufacturer offers financial assistance for certain specialty medications and the specialty pharmacy administrator is able to participate, your Copayment may be adjusted to reflect any available assistance, but in no case will your Copayment be greater than the Program's specialty Copayment. Only your Copayment, not the financial assistance, will be applied to the Total Maximum Out-of-Pocket.

Initial Prescriptions

4.19 You may order original specialty prescriptions by:

- Calling toll-free 1-800-803-2523 to start your service with Accredo. An Accredo representative will verify benefit coverage, assist with letters of medical necessity, and coordinate delivery of your medications.
- Asking your physician to call 1-800-803-2523.

Refill Prescriptions

4.20 Your Patient Care Coordinators will call you before you run out of your prescription to coordinate the delivery of your next refill or you may:

- **Telephone**
  Call Accredo's toll free number at 1-800-803-2523. Have your member identification number, the prescription number, and your card information ready.
- **Mail**
  Mail prescriptions in the postage-paid envelope along with your copayment.

How Soon Will I Receive Prescription?

4.21 Your Patient Care Coordinators will work with you to schedule delivery of your medication based upon your specific needs to ensure appropriate continuation of your medication therapy.

Who Do I Contact for the Specialty Pharmacy Program and Pharmaceutical Information?

4.22 If you have any questions or problems concerning a prescription ordered through the Specialty Pharmacy Program via Accredo, call toll-free 1-800-803-2523 or visit the Accredo Web site at *www.accredo.com*. The above toll-free telephone number is also available for any questions about an order, including physician inquiries, and for you to phone in refills.

Using the Retail Pharmacy Option

4.23 When using the Retail Pharmacy option, it is recommended that you ask your physician to write the prescription for up to a 30-day supply and to prescribe the drug in generic form or agree to generic substitution. On average, a brand-name drug costs twice as much as its generic equivalent.

Participating Pharmacies

4.24 (a) At a participating retail pharmacy, show your Express Scripts ID card and pay the applicable Copayment.

(b) Currently, participating pharmacies include selected national chains as well as selected local drugstores. Because the list of participating pharmacies is subject to change, you are encouraged to find a participating retail pharmacy nearest you by calling the Patient Care Contact Center toll-free at 1-800-287-4508 or visiting the Express Scripts Web site at *www.express-scripts.com*.

(c) There are several advantages to using a Participating Retail Pharmacy. All participating retail pharmacies maintain computerized files on all medications you and member of your Family obtain, thereby reducing your risk of an adverse drug reaction if you are taking more than one prescription or have special medical conditions. You obtain your medication by presenting your Express Scripts ID card and paying your share of the discounted price. No claim forms are required when you use a participating retail pharmacy. However, if you obtain medication from a pharmacy that is not a participating retail pharmacy, you must pay the pharmacy its charge, complete a claim form (you and the pharmacist), attach your receipts, and send the claim to Express Scripts (within one year of purchase) for reimbursement.

Non-Participating Retail Pharmacies

4.25 At a non-participating retail pharmacy, pay the pharmacy its charge for the medication. Then complete your portion of the Member Direct Submission Form, which may be obtained by visiting the Express Scripts Web site at *www.express-scripts.com* or by calling Express Scripts toll-free at 1-800-287-4508, have the pharmacist complete the pharmacy portion of the Form (including the NDC number), attach a receipt for each prescription and send to Express Scripts at the address shown on the Form ***within one year*** from the purchase date. Claims submitted without all required information will be returned for proper completion, which will delay your reimbursement. Claims filed later than one year after purchase are not eligible for reimbursement. A separate Form must be completed for each member of your Family and each pharmacy. You will be reimbursed 50% of the pharmacy's charge for each properly completed claim filed on a timely basis. A new Member Direct Submission Form will be sent to you with your reimbursement check.

Before Leaving the Doctor's Office

4.26 It is recommended that before you leave the doctor's office, you examine the prescription to make sure that generic substitution is permitted. Also make sure that the prescription includes the date, patient's name and doctor's name and signature.

What Are the Quality Standards?

4.27 All prescriptions dispensed (a) by Express Scripts Home Delivery Pharmacy, (b) Accredo, and (c) at a participating retail pharmacy meet the highest pharmaceutical standards of quality, safety and effectiveness. Each prescription will be filled by qualified licensed pharmacists and checked to assure that the quantity, quality and potency are accurate. Also, under the drug utilization review program, prescriptions filled are examined for potential drug interactions based on your personal medication profile. A drug interaction occurs when certain drugs acting together result in an adverse effect on the body. The drug utilization review is especially important if you or your covered Eligible Family Members take many different medications or see more than one doctor. If there is a question about your prescription, your pharmacist may contact your doctor before dispensing the medication.

Deadlines for Initial Determinations

4.28 Post-Service Claims

A Post-Service Claim is any claim for a benefit that is made after the prescription is received. You will receive notice of the decision that has been made on your Post-Service Claim within 30 days of Express Scripts' receipt of the claim. A 15-day extension is available. To be eligible for benefits under the Program, your claim must be submitted to Express Scripts within one year from the prescription purchase date.

Authorized Representatives

4.29 You have the right to designate an authorized representative to file a Claim or appeal a denied Claim on your behalf. Express Scripts on behalf of the Plan Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by Express Scripts will, in the case of an Urgent Care Claim, permit a physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative. In the case of a minor, an authorized representative shall include parent(s) entitled or authorized to act on the minor's behalf.

How Do I Appeal a Claim for a Prescription Purchased at a Retail Pharmacy or Through Home Delivery?

4.30 If you want to appeal the denial of a prescription claim under this Section you may do so by using the following procedures.

(a) For Post-service Claims, the appeal procedure involves the following steps subject to paragraph (c) below:
   (1) Initial Review by Express Scripts
   (2) Review by the Plan Administrator
   (3) External Review under paragraph 4.35
   (4) Insurance Grievance Procedure under Section 9.

(b) For Pre-service and Urgent Care Claims, the appeal procedure involves the following steps:
   (1) Initial Review by Express Scripts
   (2) Voluntary Second Review by Express Scripts
   (3) External Review under paragraph 4.35
   (4) Insurance Grievance Procedure under Section 9.

(c) At any point in the appeals process, including before the Initial Review by Express Scripts, you may choose to proceed directly to the Insurance Grievance Procedure in Section 9. You can request copies of information relevant to your claim, free of charge, including documents and records; reasons for the adverse benefit determination; and copies of information relied upon.

4.31 Initial Review by Express Scripts

(a) If you receive notification that a claim has been denied by Express Scripts, in whole or in part, you may appeal the decision to Express Scripts, Inc., Attention: Pharmacy Appeals-TTS, 6625 West 78th Street, Mail Route #BL0390, Bloomington, Minnesota 55439. Your appeal will be reviewed and decided by Express Scripts. Your appeal must be in writing and must be submitted not later than 180 days from the date you received notice from Express Scripts of the adverse benefit determination.

(b) Upon request to Express Scripts, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and you shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

(c) Express Scripts will provide written notification of its decision within a reasonable period of time not to exceed (1) 30 days for Post-service claims, (2) 30 days for Pre-service claims or (3) 24 hours for Urgent Claims, following receipt of the appeal by Express Scripts.

(d) A notification of an adverse benefit determination on your appeal will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file a further appeal as outlined in paragraph 4.32. The following additional information will be included in the notification, if applicable:
   (1) Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination will be set forth;

(2) An explanation of any scientific or clinical judgment forming the basis for the conclusion that a prescription was not covered.

(e) The decision of Express Scripts on appeal is final unless you seek External Review under paragraph 4.35, if requested. An External Review is a final determination unless you file a grievance as described in the Insurance Grievance Procedure or appeal to the Plan Administrator.

(f) At any point during the Initial Review by Express Scripts, you may proceed directly to the Insurance Grievance Procedure outlined in Section 9.

4.32 Second Review

(a) For Pre-service Claims, you may further appeal the claim (a voluntary Second Review) within 60 days of your receipt of an adverse determination from Express Scripts by writing to MCMC llc, ERISA Appeal Team, U. S. Steel - Express Scripts Appeal Program, 88 Black Falcon Avenue, Suite 353, Boston, Massachusetts 02210. For Post-service Claims, you may further appeal the claim within 60 days of your receipt of an adverse determination from Express Scripts by writing to the Plan Administrator. Once again, you should supply any information necessary to support your position. You will be advised of the final decision within 30 days of the date that your appeal is received.

(b) Notification of an adverse benefit determination by the Plan Administrator/Express Scripts will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file a further appeal as outlined below.

(c) The decision of the Plan Administrator/Express Scripts is final unless you seek External Review under paragraph 4.35 or you may choose to proceed directly to the Insurance Grievance Procedure outlined in Section 9.

4.33 The Insurance Grievance Procedure in Section 9 is the final level of appeal under the Program. As indicated above, you may proceed directly to the Insurance Grievance Procedure before exhausting other levels of appeal available under the Program; however, you many not request any further review of your claim after the Insurance Grievance Procedure.

Additional Internal Review Requirements

4.34 The claims and appeals provisions above shall include the following requirements, which shall be applicable **only** to Prescription Drug Benefits claims:

(a) A rescission of coverage, other than the termination of coverage for non-payment of premiums, is considered as an adverse benefit determination.

(b) Express Scripts shall defer to the attending provider with respect to the determination of whether a claim constitutes an Urgent Care Claim as defined in Definitions (e).

(c) To ensure a full and fair review, (1) the claimant must be allowed to review the claim file and present evidence and testimony during the claims and appeals process; and (2) the plan must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim and with any new or additional rationale on which an adverse benefit determination on appeal is based; such evidence or rationale must be provided as soon as possible and sufficiently in advance of the date the benefit determination is due in order to provide the claimant with a reasonable opportunity to respond prior to that date.

(d) The plan must ensure that all claims and appeals are adjudicated in a manner to ensure the independence and impartiality of the persons involved in making the decision.

(e) If the plan fails to adhere to all the requirements of the internal claims and appeals process, the internal claims and appeals process will be deemed to be exhausted and the claimant may proceed to the external claims review or may pursue any available remedies under section 502(a) of ERISA. Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. However, the exception described in the previous sentence is not available, and the internal claims and appeals process will be deemed exhausted, if the violation is part of a pattern or practice of violations by the plan. The claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects a claimant's request for immediate review on the basis that the plan met the de minimis standard described in this paragraph, the claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable

time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the plan shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon the claimant's receipt of such notice.

(f) Any notice of adverse benefit determination must include the reasons for the adverse benefit determination, including information sufficient to identify the claim involved (including the date of the service, the health care provider, and the claim amount), a description of internal and external appeals and review processes, contact information for further assistance, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning). The notice must also include the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim and, a discussion of the decision.

(g) Notices must be provided in a culturally and linguistically appropriate manner. The plan must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language; the plan must provide, upon request, a notice in any applicable non-English language; and the plan must include in the English versions of all notices, a statement prominently displayed in any applicable non- English language clearly indicating how to access the language services provided by the plan. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

External Review Requirements

4.35 With respect to Prescription Drug Benefits claims, the claims and appeals procedures will include an external review process, which will comply with the standards set forth in Technical Release 2010-01 and any subsequent guidance. In general, a claimant must file a request for an external review within four (4) months after the date of receipt of a notice of: (a) an adverse benefit determination (including a final internal adverse benefit determination) by a plan that involves medical judgment (including, but not limited to, those based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). An external review decision is binding on the plan, as well as the claimant, except to the extent other remedies are available under state or federal law **or under Section 9**, and except that the requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the plan must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. An External Review is a final determination unless you decide to further appeal such claim for benefits by filing a grievance in accordance with the Insurance Grievance Procedure outlined in Section 9.

SECTION 5. DENTAL CARE BENEFITS
(FOR YOU AND YOUR ELIGIBLE FAMILY MEMBERS)

Introduction

5.0 You and your Eligible Family Members are covered by the Dental Care Benefits outlined in this Section 5 (the "Dental Care Benefits"). Dental Care Benefits are administered by United Concordia Companies, Inc. ("UCCI").

Participating Providers

5.1 Under this Section, you are not required to use a provider who participates with UCCI to receive benefits. However, there are significant benefits to utilizing providers who do participate with UCCI. Such providers are called Participating Providers. Providers who do not participate with UCCI are called Non-Participating Providers.

5.2 When using Participating Providers:

- The providers will accept the UCCI determination of the Allowable Charge.
- Benefits under this Section are generally payable at 80% to 100% of the Allowable Charge (or, in the case of certain services, 60% of the Allowable Charge).
- Your responsibility for payments to the provider will be limited to the portion, if any, of the Allowable Charge that is not payable under this Section (unless you do not pay on a timely basis).
- You will be responsible for paying for dental services, supplies and treatments that UCCI (on behalf of the Plan Administrator) determines not to be dentally necessary.
- The providers will receive payment for their services directly from UCCI.

Non-Participating Providers

5.3 Should you receive Covered Services from a dental provider who does not participate with UCCI, you may be subject to more out-of-pocket costs. Unlike providers who do participate with UCCI:

- The providers may not accept the UCCI determination of the Allowable Charge.
- You will be responsible for paying, via balance billing from the provider, the provider's normal charge (not the Allowable Charge) to the extent that it exceeds the amount payable under this Section.
- The providers may bill you direct for their entire fee with the result that you will have to file a claim form to obtain reimbursement for the portion of the Allowable Charge payable under this Section.
- The providers may bill you for services that are determined by UCCI (on behalf of the Plan Administrator) to be not dentally necessary.
- The providers will be reimbursed at the 99th percentile for Covered Services as determined by UCCI.

How to Find a Participating Provider

5.4 You can call the toll-free telephone number on the back of your UCCI ID Card to determine if a particular provider is a Participating Provider or to request information on the nearest Participating Provider. You can find a list of Participating Providers on the UCCI Web site at *www.ucci.com*. The Participating Provider network is called the Alliance network.

Summary of Dental Care Benefits

5.5 This Summary of Benefits provides an overview of the Dental Care Benefits available to you. Please refer to the subsequent pages for a more detailed description of Covered Services, limitations and exclusions.

SUMMARY OF DENTAL CARE BENEFITS (Effective as of January 1, 2016)	
Benefit Provision	**What the Program Covers**
Annual Deductible (does not apply to Diagnostic or Preventive Services) INDIVIDUAL: $25 FAMILY: $50	

SUMMARY OF DENTAL CARE BENEFITS
(Effective as of January 1, 2016)

Benefit Provision	What the Program Covers
Diagnostic Services ➢ Routine oral examinations ➢ Dental X-rays - Full mouth X-rays - Bitewing X-rays ➢ Palliative Treatment	**100%** of the Allowable Charge
Preventive Services ➢ Routine cleanings ➢ Topical fluoride application for Eligible Family Members who are children under age 19 ➢ Space maintainers (not made of precious metals) that replace prematurely lost teeth for Eligible Family Members who are children under 19 years of age ➢ Basic Restorative (Fillings)	**100%** of the Allowable Charge
General and Restorative Services ➢ Simple extractions ➢ Endodontics, including pulpotomy and root canal treatment ➢ Sealants when provided to children. Coverage is limited to one sealant per tooth in any three-year period ➢ Inpatient consultations ➢ Repairs of crowns, inlays, onlays, bridges and dentures	**80%** of the Allowable Charge after Deductible
Periodontal Services ➢ Diagnosis and treatment planning including periodontal examination ➢ Non-surgical periodontal therapy including periodontal scaling and root planing ➢ Surgical periodontal therapy ➢ Maintenance – post treatment preventive periodontal procedures (periodontal cleanings)	**80%** of the Allowable Charge after Deductible
Oral Surgery ➢ Surgical removal of teeth and certain other procedures listed in paragraph 5.20(e)	**80%** of the Allowable Charge after Deductible
Prosthetics ➢ Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays) ➢ Initial insertion of partial or full dentures (including any adjustments during the six-month period following insertion) ➢ Replacement of an existing partial or full denture or bridge by a new denture or bridge	**60%** of the Allowable Charge after Deductible
Crown, Inlay and Onlay Restorations ➢ Single unconnected crowns, inlays and onlays ➢ Replacement of crowns, inlays and onlays, but only if satisfactory evidence is presented that at least 5 years have elapsed since the date of insertion of the existing crown, inlay or onlay, and only if the existing crown, inlay or onlay is unserviceable and cannot be made serviceable	**60%** of the Allowable Charge after Deductible
Orthodontics (Not subject to Annual Maximum, limited to Eligible Family Members who are children under age 19) ➢ Diagnosis, including radiographs ➢ Active treatment, including necessary appliances ➢ Retention treatment following active treatment ➢ Lifetime Maximum $2,250	**60%** of the Allowable Charge
Annual Maximum / Person	**$2,250**

5.6 Except as otherwise indicated in the rest of this Section, benefits are payable without regard to the setting in which the applicable services, treatment and/or supplied are performed or rendered.

Date Expenses are Incurred

5.7 Benefits are provided only for Covered Services incurred on or after the date when coverage under this Section is in effect. Except as provided in paragraphs 5.8 and 5.9 below, Covered Services are considered to have been incurred on the date when the applicable dental services, supplies or treatments are received.

5.8 The Program does not pay benefits for any services started prior to the effective date of coverage for you or your Eligible Family Members. Multi-visit procedures are considered "started" when the teeth are irrevocable altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. Procedures started prior to the effective date are your liability or that of a prior insurance carrier.

5.9 If your coverage or coverage for your Eligible Family Members is terminated, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for a period of ninety (90) days after termination date in order for the procedure to be finished. The procedure must be started prior to the termination date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. For orthodontic treatment, if covered under this Section, coverage will be extended through the end of the month of the termination date.

Payment of Benefits

5.10 You or your provider may submit a claim for benefits to the address listed on the back of your Dental Care ID card. Claim forms are available from UCCI or the Company.

5.11 Payment for Covered Services performed by a Participating Provider will be made by UCCI directly to the Provider. As long as you pay your share of the Allowable Charge as well as any Coinsurance, Deductible, or amounts exceeding the maximum within 60 days of the date UCCI advises you of the payment due from you, the Participating Provider will accept the UCCI payment plus your payment, if any, as payment in full. If, however, you do not pay any monies that you owe within 60 days of notification from UCCI, the Participating Provider is free to bill you for the difference between his normal charge and the Allowable Charge as well as for the monies UCCI has determined are owed by you.

Pretreatment Estimate

5.12 A Pretreatment Estimate is used by UCCI to determine eligibility of the patient and to review the treatment plan to determine the extent of coverage. This assures both the patient and the dentist that the particular service to be performed is a Covered Service. However, approval by UCCI of the treatment plan during the Pretreatment Estimate process does not necessarily constitute acceptance by UCCI of liability for the services involved in the treatment plan. For example, if the patient's coverage is terminated before the planned treatment is completed, UCCI will not be liable for any services provided after the date of such termination. Pretreatment Estimates are encouraged for the following types of services: Prosthetics, Crowns, Inlay and Onlay Restorations, Periodontal Services and Orthodontics.

Alternate Treatment

5.13 Frequently your dentist can choose from several alternate methods of treating a particular dental problem. For example, a tooth can be restored with either a crown or a filling, and missing teeth can be replaced with either a fixed bridge or a partial denture. In cases where alternate methods of treatment are possible and professionally acceptable, UCCI will make payment based on its Allowable Charge for the less expensive procedure *provided that the less expensive procedure meets the accepted standards of dental treatment.* Whenever this alternate treatment is applied, a Dental Advisor reviews the claim.

5.14 UCCI's decision on the Allowable Charge it will pay does not commit you to the less expensive procedure. You may decide to have the more costly treatment and be responsible for the additional charges beyond those for the treatment paid by UCCI.

Experimental Treatment

5.15 This Section does not cover services that UCCI, on behalf of the Plan Administrator, determines are experimental or investigative in nature. Experimental and investigative services are those that the general dental community (dental consultants, dental journals and/or governmental regulations) determine are not acceptable standard dental treatments

of the condition for which care is being provided. However, situations may occur when a patient and his or her provider agree to pursue an experimental treatment. If your provider performs an experimental procedure, you are responsible for the charges. You or your provider may contact UCCI to determine whether a service is considered experimental or investigative.

Services That Do Not Meet Accepted Standards of Dental Practice

5.16 The Program does not pay for services that are considered unusual procedures or techniques or for which supplies or other services are used that do not meet the accepted standards of dental practice. A Participating Provider accepts the decision of UCCI on behalf of the Plan Administrator and will not bill you for these services without your consent. A Non-Participating Provider, however, is not obligated to accept this determination and may bill you for such services. You are responsible for these charges when performed by a Non-Participating Provider. You can avoid these charges simply by choosing a Participating Provider for your care.

Annual Deductible

5.17 Payment of benefits for all services, supplies and treatments (other than diagnostic and preventive services, supplies and treatments) covered under this Section is subject to a Deductible of $25 per individual or $50 per Family (you and all of your Eligible Family Members) for each calendar year. Expenses incurred in the last three months of the prior calendar year will be applied to meet the Deductible in the next calendar year unless the applicable Deductible for the prior calendar year was satisfied.

Annual and Lifetime Maximums

5.18 Payment is limited to a maximum of $2,250 per *year* per individual, except for Orthodontics, which specifies a $2,250 *Lifetime Maximum* per individual.

5.19 In determining the Lifetime Maximum for Orthodontics, amounts paid under the 2003 PIB and 2008 PIB are considered.

Covered Services

5.20 The following services provided by a licensed dentist are covered benefits under this Program, provided they are deemed dentally necessary by UCCI (on behalf of the Plan Administrator):

(a) DIAGNOSTIC SERVICES

The Program pays 100% of the Allowable Charge for the following services:

(1) Routine oral examinations (including cleaning, scaling and polishing of teeth), but not more than once in any period of six consecutive months.
(2) Dental X-rays
- Full mouth X-rays, but not more than once every 36 consecutive months.
- Two sets of Bitewing X-rays, but not more than once in any period of six consecutive months.
- Periapical X-rays as required.

(3) Palliative emergency treatment of an acute condition requiring immediate care.

(b) PREVENTIVE SERVICES

The Program pays 100% of the Allowable Charge for the following services:

(1) Routine prophylaxis (cleaning) but not more than once in any period of six consecutive months.
(2) Fluoride application for Eligible Family Members who are children under 19 years of age, but not more than once in any period of six consecutive months.
(3) Space Maintainers for Eligible Family Members who are children under 19 years of age when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not developed.

(c) MINOR RESTORATIONS

After satisfaction of the Annual Deductible, the Program pays 100% of the Allowable Charge for the following services:

(1) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth.

(2) Composite restorations on posterior teeth will be limited to the allowance for amalgam restoration. The balance of the cost is the participant's responsibility.

(d) GENERAL SERVICES

After satisfaction of the Annual Deductible, the Program pays 80% of the Allowable Charge for the following services:

(1) Repair of broken partial or full removable dentures;
(2) Simple extractions;
(3) Endodontics, including pulpotomy and root canal treatment;
(4) Inpatient consultations if the condition requires it and the dentist in charge of the case requests the consultation. You are limited to one consultation per consultant during any one inpatient stay;
(5) Pulpal therapy;
(6) Repairs of broken crowns, inlays, onlays and bridges – repair, recementation, re-lining, re-basing and adjustment;
(7) Sealants for Eligible Family Members who are children through age 10 on permanent first molars (tooth numbers 3, 14, 19, 30) and through age 15 on permanent second molars (tooth numbers 2, 15, 18, 31), only if teeth to be sealed are free of proximal caries and there are no previous restorations on the surface to be sealed. One sealant per tooth in any period of 3 years; and
(8) Crown lengthening.

(e) ORAL SURGERY

After satisfaction of the Annual Deductible, the Program pays 80% of the Allowable Charge for the following services:

(1) Alveolus;
(2) Apicoectomy (surgical removal of the end of a root);
(3) Aveolectomy/alveoplasty, per quadrant;
(4) Excision pericoronal gingiva (operculectomy);
(5) Frenulectomy;
(6) Maxillary or mandibular frenectomy;
(7) Procedures performed for the preparation of the mouth for dentures;
(8) Removal of cyst or tumor;
(9) Removal of exostosis;
(10) Removal of impacted teeth;
(11) Surgical removal of erupted tooth;
(12) Removal of tori;
(13) Root recovery (surgical removal of residual tooth root) – completely covered by bone;
(14) Surgical exposure of impacted or unerupted tooth;
(15) Surgical reduction of tuberosity;
(16) Surgical removal of maxillary or mandibular intrabony cysts;
(17) Surgical removal of tooth;
(18) Tooth reimplantation;
(19) Transseptal fiberotomy;
(20) Vestibuloplasty; and
(21) Services of a dentist who actively assists the operating surgeon in the performance of covered surgery when the condition of the patient or the type of surgery performed requires assistance. Surgical assistance is not covered when performed by a dentist who himself performs and bills for another surgical procedure during the same operative session.
(22) Administration of nitrous oxide, general anesthesia and IV sedation.

(f) PERIODONTAL SERVICES

After satisfaction of the Annual Deductible, the Program pays 80% of the Allowable Charge for the following services:

(1) Diagnosis and treatment planning including periodontal examinations.
(2) Nonsurgical periodontal therapy including periodontal scaling and root planing.
(3) Surgical periodontal therapy (one per 24 months per area of the mouth).
(4) Maintenance – post-treatment preventive periodontal procedures (periodontal prophylaxis).

(g) PROSTHETICS, CROWNS, INLAY AND ONLAY RESTORATIONS

After satisfaction of the Annual Deductible, the Program pays 60% of the Allowable Charge for the following services. Coverage for prosthetics, crowns, inlays and onlays may be limited to the least expensive but adequate treatment plan, consistent with established dental standards. A more expensive treatment plan than that covered under this Section may be selected with the understanding that you will be responsible for paying the difference in cost between the treatment received and UCCI's allowance.

(1) Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays).
(2) Initial insertion of partial or full dentures (including any adjustments during the six-month period following insertion).
(3) Replacement of an existing partial or full denture or bridge by a new denture or by a new bridge, but only if satisfactory evidence is presented that:
- the existing denture or bridge was inserted at least five years prior to replacement; and
- the existing denture or bridge is not serviceable and cannot be made serviceable. If the existing denture or bridge can be made serviceable, payment will be made toward the cost of the services which are necessary to render such appliance serviceable;

(4) Single unconnected crown, inlays and onlays (none of which is part of a bridge or are splinted together);
(5) Replacement of crowns, inlays and onlays, but only if satisfactory evidence is presented that at least five years have elapsed since the date of the insertion of the existing crown, inlay or onlay and that the appliance is not serviceable and cannot be made serviceable;
(6) Addition of teeth to an existing partial denture or to a bridge, but only if satisfactory evidence is presented that the addition of teeth is required to replace one or more teeth extracted after the existing denture or bridge was inserted;
(7) Relining or rebasing of dentures more than six months after the insertion of an initial or replacement denture, if provided by the same dentist, but not more than one relining or rebasing in any period of 36 consecutive months;

(h) ORTHODONTICS

The Program pays 60% of the Allowable Charge for the following orthodontic services prescribed by a treatment plan approved by UCCI consisting of:

(1) Diagnosis, including radiographs
(2) Active treatment, including necessary appliances
(3) Retention treatment following active treatment.

(i) ADDITIONAL SERVICES

The Program may also cover additional services under UCCI's **Smile for Health**℠ program. Contact UCCI for details.

5.21 Notwithstanding any other provision in this Section, UCCI shall make payment in accordance with the Coinsurance percentage specified. The amount of UCCI's liability shall be payable over a period not to exceed the length of the approved treatment plan.

Exclusions

5.22 Except as specifically provided in this Section, you are *not* covered for the following services, supplies or charges:

(a) not specifically listed as a covered benefit;

(b) which in the opinion of the dentist are not dentally necessary for the patient's health;

(c) which are necessitated by lack of patient cooperation or failure to follow a professionally prescribed treatment plan;

(d) started by any dentist prior to the patient's eligibility under this Program, including, but not limited to: endodontics, crowns, bridges, inlays, onlays and dentures, except as provided in paragraph 5.8 above;

(e) incurred prior to the patient's effective date or after the termination date of coverage under the Program, except those services as provided for in paragraph 5.9;

(f) that do not meet accepted standards of dental treatment, which are experimental or investigative in nature or are considered enhancements to standard dental treatment as determined by UCCI;

(g) for hospitalization costs;

(h) determined by UCCI (on behalf of the Plan Administrator) to be the responsibility of Worker's Compensation or Employer's Liability, services for which benefits are covered under any federal government or state program, excluding Medical Assistance, or for services for treatment of any automobile related injury in which the patient is entitled to payment under an automobile insurance policy. Benefits under this Program would be in excess to the third party benefits and therefore, UCCI would have the right to recovery for any benefits paid in excess;

(i) for prescription drugs;

(j) which are cosmetic in nature as determined by UCCI (on behalf of the Plan Administrator) , including, but not limited to bleaching, veneers, personalization or characterization of crowns, bridges and/or dentures;

(k) elective procedures including but not limited to the prophylactic extraction of third molars;

(l) for the following that are not included as orthodontic benefits: retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect, or repair of an orthodontic appliance;

(m) for any dental or medical services performed by a physician and/or services for which benefits are otherwise provided under a Medical-Surgical plan of the patient;

(n) for congenital mouth malformations or skeletal imbalances, including, but not limited to: treatment related to cleft lip or cleft palate treatment related to disharmony of facial bone, treatment related to or required as the result of orthographic surgery including orthodontic treatment, dental implant services including placement and restoration of implants, and oral and maxillofacial and temporomandibular joint services including but not limited to associated hospital, facility, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth, all treatment of temporomandibular disorders (TMD, TMJ, CMD, MFPD, etc.), both surgical and nonsurgical treatment, arthroscopy of the joint and orthognathic surgery, and treatment of any malocclusion involving joints or muscles by orthodontic repositioning of the teeth. This exclusion shall not apply to newly born children of participants;

(o) for dental treatment of fractures and dislocations of the jaw;

(p) for treatment of malignancies or neoplasms;

(q) procedures requiring appliances or restorations (except when involving full or partial dentures or correction of a dental condition as a result of accidental injury) that are necessary for adult or pediatric full mouth rehabilitation, including precision attachments or stress breakers, restoration of occlusion, to alter vertical dimension of occlusion, restorative equilibration and kinesiology;

(r) for the cost to replace lost, stolen or damaged prosthetic or orthodontic appliances;

(s) deemed by UCCI (on behalf of the Plan Administrator) to be of questionable efficacy;

(t) for broken appointments;

(u) which are not dentally necessary as determined by UCCI (on behalf of the Plan Administrator) ;

(v) arising from any intentionally self-inflicted injury or contusion, or as a consequence of the patient's commission of or attempt to commit a felony or engagement in an illegal occupation or of the patient's being intoxicated or under the influence of illicit narcotics;

(w) for house calls for dental services;

(x) for any services for which the patient failed to follow the guidelines of this Section.

Limitations

5.23 The following services will be subject to the limitations as set forth below:

(a) full mouth X-rays – one every 36 months;

(b) two sets of bitewing X-rays but not more than once in any period of six consecutive months;

(c) periodic oral evaluation – one per six consecutive months;

(d) prophylaxis – one per six consecutive months;

(e) fluoride applications – one per six consecutive months through age 18;

(f) space maintainers – only provided through age 18 when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not develop;

(g) replacement restorations – limited to one per 12 months;

(h) contiguous surface posterior restorations not involving the occlusal surface will be payable as one surface restoration;

(i) posts are covered only as part of a post buildup;

(j) prefabricated stainless steel crowns – one per tooth per lifetime for age 14 years and younger;

(k) periodontal maintenance following active periodontal therapy – four in any 12 consecutive months per patient reduced by the number of routine prophylaxis received during that 12-month period so that total prophylaxes for the period does not exceed four;

(l) periodontal scaling and root planing – one per 24 months per area of the mouth;

(m) placement or replacement of single crowns, inlays, onlays, single and abutment buildups and post and cores, bridges, full and partial dentures – one within five years of their placement;

(n) denture relining or rebasing or adjustments – are included in the denture charge (and are not covered as a separate service) if provided within six months of the date the denture was inserted;

(o) subsequent denture relining or rebasing – limited to one every three years thereafter;

(p) surgical periodontal procedures – one per 24-month period per area of the mouth;

(q) sealants – one per tooth per three years through age 10 on permanent first molars (tooth numbers 3, 14, 19, 30) and through age 15 on permanent second molars (tooth numbers 2, 15, 18, 31);

(r) root canal therapy – limited to one per tooth per lifetime;

(s) inlays, onlays, crowns, dentures and bridges shall be considered completed on the date they are finally inserted;

(t) if for any reason orthodontic services are terminated before completion of approved treatment, the liability of the plan will cease with payment through the month of termination;

(u) payment for orthodontic services shall cease at the end of the month after termination by the Company;

(v) functional/myofunctional therapy is covered only when provided by a dentist in conjunction with appliance therapy;

(w) limited oral evaluation (problem focused) limited to one per dentist per 12 months;

(x) recementations by the same dentist who initially inserted the crown or bridge during the first 12 months are included in the crown or bridge benefits, then one per 12 months thereafter; one per 12 months for other than the dentist who initially inserted the crown or bridge; and

(y) crown lengthening limited to one per tooth per lifetime.

Proof of Claim

5.24 UCCI reserves the right at its discretion to accept, or to require verification, of any alleged fact or assertion pertaining to any claim for Dental Care Benefits under this Section. As part of the basis for determining benefits payable, UCCI may require submission of X-rays and other appropriate diagnostic and evaluative materials. When these materials are unavailable, and to the extent that verification of the covered expenses cannot reasonably be made by UCCI based on the information available, benefits for the course of treatment may cover a lesser amount than that which otherwise would have been payable.

How to File a Claim for Services From a Non-Participating Provider

5.25 You may obtain a claim form at the employee benefits office at the plant or location where you are employed. In addition, you may obtain a claim form by calling UCCI at 1-800-332-0366 and requesting one. Once you obtain the claim form, you should complete and mail it along with the required proof of purchase to UCCI at United Concordia Claims, P.O. Box 69420, Harrisburg, Pennsylvania 17106. UCCI will process the claim in 30 days after receipt of all requested information by UCCI. To be eligible for benefits under the Program, your claim must be submitted to UCCI within one year from the date of service.

How to Appeal If You Disagree With a Claim Decision

5.26 If a claim for benefits is denied either in whole or in part, you will receive written notice explaining the reason or reasons for the denial of benefits. If the information received with the claim was incomplete, the notice will tell you what additional facts or materials are needed and why.

5.27 If you want to appeal the denial of a dental claim under this Section, you may do so using the following procedures.

The appeal procedure involves the following steps:

(a) Initial Review by UCCI

(b) Review by Plan Administrator

(c) Insurance Grievance Procedure, including arbitration.

5.28 As described below, you are not required to pursue either the Initial Review by UCCI or the Plan Administrator before proceeding to the Insurance Grievance Procedure outlined in Section 9.

5.29 Initial Review by UCCI

(a) You or your Authorized Representative may file an appeal with UCCI within 180 days of the receipt of an adverse benefit determination. An adverse benefit determination is a denial, reduction, or termination of or failure to make payment (in whole or in part) based on the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigative or not Dentally Necessary or Appropriate. To file an appeal, send a letter to UCCI at United Concordia Claims, P.O. Box 69420, Harrisburg, Pennsylvania 17106, stating why you think your claim should not have been denied, along with any additional information, documents, data or comments bearing on your claim. UCCI will review your appeal and notify you of its decision within 30 days of UCCI's receipt of your appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination. In preparing your appeal, you or your Authorized Representative will have the right to examine documents pertinent to your appeal. However, medical and/or dental information cannot be released to you unless your physician or dentist authorizes its release in writing.

(b) Notice of the appeal decision, in written or electronic form, will include the specific reason for the appeal decision, reference to specific provisions of this Section on which the decision was based and a statement that you are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all Relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts. A document, record, or other information will be considered Relevant to a given claim if it was relied on in making the benefit determination, if it was submitted, considered, or generated in the course of making the benefit determination (even if UCCI did not rely on it); if it demonstrated that, in making the determination, UCCI followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency; or if it is a statement of UCCI's policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

(c) The decision of UCCI on appeal is final unless you file a grievance as described in the Insurance Grievance Procedure or appeal to the Plan Administrator.

(d) At any point during the Initial Review by UCCI, you may choose to proceed directly to the Insurance Grievance Procedure outlined in Section 9.

5.30 Review by the Plan Administrator

(a) You may further appeal the claim within 60 days of your receipt of an adverse determination by UCCI by writing to the Plan Administrator, United States Steel and Carnegie Pension Fund, Room 1681, 600 Grant Street, Pittsburgh, Pennsylvania 15219-2800. Once again, you should supply any information necessary to support your position. You will be advised of the final decision within 30 days of the date that the second appeal is received by the Plan Administrator.

(b) Notification of an adverse benefit determination by the Plan Administrator will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file a further appeal as outlined below.

(c) The decision of the Plan Administrator is final unless you decide to further appeal such claim for benefits by filing a grievance as described in the Insurance Grievance Procedure outlined in Section 9.

(d) At any point during the review by the Plan Administrator, you may choose to proceed directly to the Insurance Grievance Procedure outlined in Section 9.

SECTION 6. VISION CARE BENEFITS
(FOR YOU AND YOUR ELIGIBLE FAMILY MEMBERS)

Introduction

6.0 You and your Eligible Family Members are covered by the Vision Care Benefits outlined in this Section 6. Vision Care Benefits under the Program are administered by Davis Vision. This Program provides you with flat dollar payment and designated copayments for vision care services and supplies. To obtain the highest level of coverage, you should make sure you receive services from a full-service Davis Vision provider who performs exams, dispenses glasses and contacts and carries the Davis Vision Exclusive Frame Collection.

Summary of Vision Care Benefits

6.1 This Summary of Benefits provides an overview of the vision care benefits available to you under this Section. Please refer to the subsequent pages for a more detailed description of Covered Services, limitations and exclusions. Please note that when utilizing Out-of-Network providers, you will have to pay the provider's charge and then file a claim for reimbursement equal to the amount of the Allowance.

SUMMARY OF VISION CARE BENEFITS (Effective as of January 1, 2016)			
Service/ Product	**In-Network, You Pay:**	**Out-of-Network, You Pay:**	**Frequency**
Eye Examination	$0	Provider's charge and file claim to be reimbursed for $48 Allowance	Once per 12 months
Single Vision Lenses (standard)	$0	Provider's charge and file claim to be reimbursed for $36 Allowance	Once per 12 months
Bifocal Lenses (standard)	$0	Provider's charge and file claim to be reimbursed for $54 Allowance	Once per 12 months
Trifocal Lenses (standard)	$0	Provider's charge and file claim to be reimbursed for $69 Allowance	Once per 12 months
Aphakic/ Lenticular Lenses	$0	Provider's charge and file claim to be reimbursed for $108 Allowance	Once per 12 months
Non-Standard Lenses (e.g., photochromatic, polycarbonate)	Provider's charge	Provider's charge	Once per 12 months
Progressive Lenses	$50 - for standard ($90 - for premium or $140 – for Ultra)	Provider's charge and file claim to be reimbursed for $62 Allowance	Once per 12 months
Frames	$0 (if frames cost $60 or less and are purchased at retail) If frames cost more than $60 retail, you pay the difference between $60 and provider's charge	Provider's charge and file claim to be reimbursed for $36 Allowance	Once per 12 months
Contact Lens Fitting and Evaluation	$0	Provider's charge and file claim to be reimbursed for $30 Allowance – for daily wear contacts ($45 Allowance – for extended wear contacts)	Once per 12 months
Standard Contact Lenses (see paragraph 6.4(b))	$0	Provider's charge and file claim to be reimbursed for $72 Allowance	Once per 12 months

Specialty Contact Lenses (see paragraph 6.4(b))	$0 (if contacts cost $75 or less) If contacts cost more than $75, you pay the difference between $75 and provider's charge	Provider's charge and file claim to be reimbursed for $72 Allowance	Once per 12 months
Disposable Contact Lenses Unlimited	$0 (if contacts cost $113 or less) If contacts cost more than $113, you pay the difference between $113 and provider's charge	Provider's charge and file claim to be reimbursed for $113 Allowance	Once per 12 months
Lens Options	$12 – UV coating $35 – standard anti-reflective coating (ARC) $48 – premium ARC $60 - Ultra ARC $55 – Hi-Index Lenses $65 – Plastic photosensitive lenses $20/$40 – single/multi vision scratch protection plan	Provider's charge	Once per 12 months

Eligible Providers of Service

6.2 The following providers are eligible to render services under this Program:

(a) A Professional Provider, who is a licensed doctor of medicine or osteopathy, including a specialist in ophthalmology (ophthalmologist), or a licensed doctor of optometry (optometrist), is eligible to provide professional services and post-refractive services.

(b) A supplier, which is an entity engaged in dispensing ophthalmic lenses (e.g., contact lenses, eyeglass lenses) in accordance with a prescription written by a Professional Provider, is eligible to provide post-refractive services. Suppliers include opticians and retail optical dispensing firms.

Payment for Professional Services

6.3 Participating Providers will accept the amounts set forth in the Summary of Vision Care Benefits in paragraph 6.1 as payment in full for services. If you use a Participating Provider for professional services, you will have no copayment and you will not have to file a claim. However, if you use a Non-Participating Provider, you will have to pay the provider's charge and then file a claim for the amount of the Allowance to be paid directly to you. You will not receive any payment for the difference between the Allowance and the amount of the Non-Participating Provider's charge.

Payment for Post-Refractive Services and Supplies

6.4 (a) Eyeglasses

- Frames: Contracting suppliers and Participating Providers agree to accept the lower of the Allowance or the amount charged as payment-in-full for frames that have a charge of $60 or less. If you choose frames with a charge over $60, you are responsible at the point of purchase for the difference between $60 and the charge.
- Lenses: Contracting suppliers and Participating Providers agree to accept the lower of the Allowance or the amount charged as payment-in-full for standard lenses. If you choose non-standard lenses, you are responsible for a flat fee as determined by the TPA. This payment must be made at the point of purchase. Contracting suppliers and Participating Providers agree to accept these payments as payment-in-full for non-standard lenses. Non-standard lenses are those that have, as a part of their manufacturing process, been

provided with features that enhance their desirability to consumers. Such lenses include, but are not limited to, polycarbonate lenses and progressive "no-line" bifocals. Other enhancements (such as lens options and tinting) are subject to a flat fee as determined by the TPA.

(b) Contact Lenses

- Contracting suppliers and Participating Providers agree to accept the lower of the Allowance or the amount charged as payment-in-full for standard contact lenses. If you choose specialty contact lenses, the contracting supplier or Participating Provider agrees to accept the Allowance as payment-in-full for lenses that have a charge of $75 or less. You are responsible at the point of purchase for the difference between $75 and the charge for the specialty lenses. Specialty contact lenses include, but are not limited to, hard or soft bifocal, hard or soft toric, soft extended wear, gas permeable and disposable.

6.5 Participating Providers and contracting suppliers will accept the Allowances described in the Summary of Vision Care Benefits as payment for their services and supplies and charge you only the copayments described in the Summary of Vision Care Benefits. If you use a Participating Provider or contracting supplier for eyeglasses and contact lenses, you will not have to file a claim. However, if you use a Non-Participating Provider, you will have to pay the provider's charge and then file a claim for the amount of the Allowance to be paid directly to you. You will not receive any payment for the difference between the Allowance and the amount of the Non-Participating Provider's charge.

Provider/Supplier Sale Items

6.6 You may not obtain eyeglasses and contact lenses at the prices set forth above and also take advantage of special sale pricing. You have the choice of paying the sale price and not using the above pricing arrangements or using the above pricing arrangements. You may choose the best deal for you. In all circumstances, however, you will be credited with the Allowances set forth in the Summary of Vision Care Benefits against whatever pricing arrangement you utilize.

Professional Services

6.7 (a) Eye Examination and Refractive Services

Such services shall include, but are not necessarily limited to, the following:

(1) Case history;
(2) Visual acuity, near and far;
(3) External examination, including biomicroscopy or other magnified evaluation of the anterior chamber;
(4) Objective, subjective and ophthalmoscopic examinations;
(5) Binocular measure; and
(6) Summary, findings and recommendations.

(b) Contact Lens Prescription and Fitting Services

Such services shall include, but are not necessarily limited to, the following:

(1) Keratometry, or "K" reading, through the use of a keratometer to determine measurements of the eyes, curvature and base curve;
(2) Proper fitting of appropriate contact lenses, including the application of trial contact lenses to the patient's corneas; and
(3) Post-dispensing contact lens follow-up care, including the correction of any ill-fitting or unsuitable lenses.

Contact lens prescription and fitting services must be preceded by eye examination and refraction services as described in paragraph (a) above.

Post-Refractive Services

6.8 Post-refractive services consist of:

(a) ordering lenses and frames (facial measurements, lenticular formula, any other specifications);

(b) cost of the materials;

(c) verification of the completed prescription;

(d) adjustment of the completed glasses; and

(e) subsequent servicing (refitting, realigning, readjusting, tightening) for a period not to exceed 90 days.

Limitations

6.9 Payment for Covered Services and supplies will be limited in the following manner:

(a) Payment for an eye examination and refraction is limited to once every 12 months.

(b) Payment for contact lens prescription and fitting is limited to once every 12 months.

(c) Regardless of the age of the covered individual, payment is limited to one set of frames in any 12-month period. Eligibility will be determined from the date of the last previous refraction.

(d) Payment for lenses or contact lenses is limited to once every 12 months. Eligibility will be determined from the date of the last previous refraction.

(e) Payment will not be made for both contact lenses and frames within the same 12-month period.

(f) Payment for frames, lenses and/or contact lenses not supplied by a Professional Provider, will be made only if prescribed by a Professional Provider.

Additional Savings

6.10 In circumstances where the services or products are covered, but exceed the frequency limitations outlined in paragraph 6.9, contracting suppliers and Participating Providers may offer a discount on services.

Exclusions

6.11 Except as specifically provided in this Section, you are not covered for services, supplies or charges:

(a) for examinations and materials that are not listed herein as a Covered Service or item of supply;

(b) for the cost of any insurance premiums indemnifying you against losses for lenses or frames;

(c) for industrial safety glasses and safety goggles;

(d) for procedures determined by Davis Vision (on behalf of the Plan Administrator) to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids and tonography;

(e) for medical or surgical treatment of the eye;

(f) for diagnostic services such as diagnostic X-rays, cardiographic, encephalographic examinations and pathological or laboratory tests;

(g) for drugs or any other medications;

(h) for eye examinations or materials necessitated by the participant's employment or furnished as a condition of employment;

(i) for any illness or bodily injury that occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation;

(j) to the extent benefits are provided by any governmental unit, unless payment is required by law;

(k) for which you would have no legal obligation to pay in the absence of this or any similar coverage;

(l) received from a medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

(m) performed prior to the effective date of coverage under this Section;

(n) incurred after the date of termination of coverage except for lenses and frames prescribed prior to such termination and delivered within 31 days from such date;

(o) for telephone consultations, charges for failure to keep a scheduled visit or charges for completion of a claim form;

(p) for temporary devices, appliances and services;

(q) for which you incur no charge;

(r) the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim except where prohibited by law;

(s) in a facility performed by a professional provider or supplier who in any case is compensated by the facility for similar Covered Services performed for patients;

(t) to the extent payment has been made under Medicare when Medicare is primary or would have been made if you had applied for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the Company is obligated by law to offer you all the benefits of this Program and you so elect this coverage as primary;

(u) treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law.

How to File a Claim for Services from a Non-Participating Provider or Non-Contracting Supplier

6.12 (a) Authorized Representatives

You have the right to designate an Authorized Representative to file or pursue a Claim on your behalf. If you wish to do so, you must notify Davis Vision in writing of your choice of an Authorized Representative. Your notice must include the representative's name, address, telephone number and a statement indicating the extent to which the individual is authorized to pursue the Claim or appeal on your behalf. A consent form that you may use for this purpose will be provided to you by Davis Vision upon request.

For purposes of this Section, a Claim is a request for payment or reimbursement of the charges or costs associated with Covered Services or supplies.

(b) You may obtain a claim form at the employee benefits office at the plant or location where you are employed. In addition, you may obtain a claim form by calling Davis Vision at 1-800-401-2581 or visiting the Davis Vision Web site at *www.davisvision.com* and requesting one. Once you obtain the claim form, you should complete and mail it, along with the required proof of purchase, to Davis Vision Care Processing Unit, P.O. Box 1525, Latham, New York 12110. To be eligible for payment or reimbursement under the Program, your Claim must be submitted to Davis Vision no later than one year from the date of service.

(c) Davis Vision will notify you in writing of its determination on your Claim within a reasonable period of time following receipt of your Claim. That period of time will not exceed 30 days from the date your Claim is received by Davis Vision. However, this 30-day period of time may be extended one time by Davis Vision for an additional 15 days, provided that Davis Vision determines the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30-day determination period. If an extension of time is necessary because you failed to submit information necessary for Davis Vision to make a decision on your Claim, the notice of extension sent to you will specifically describe the information you must submit. In this event, you will have at least 45 days from the date such notice is received to submit the information before a decision is made on your Claim.

(d) If your Claim is denied in whole or in part, you will receive written notification that will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

How to Appeal If You Disagree with a Claim Decision

6.13 If you want to appeal the denial of a vision claim under this Section, you may do so using the following procedures:

The appeal procedure involves the following steps:

(a) Initial Review by Davis Vision

(b) Review by the Plan Administrator

(c) Insurance Grievance Procedure under Section 9.

Note: At any point during the appeal process, including before the initial review by Davis Vision, you may choose to proceed directly to the Insurance Grievance Procedure.

6.14 *Initial Review by Davis Vision*

(a) You may call (1-800-401-2581) to determine if your Claim can be resolved. If it cannot be resolved by telephone, send a letter to Davis Vision, 159 Express Street, Plainview, New York 11803, Attention: Quality Assurance/Patient Advocate Department, stating why your Claim should not have been denied, along with any additional information, documents, data or comments bearing on your Claim. Your appeal must be made within 180 days after you have been notified by Davis Vision of the denial of benefits.

(b) Your appeal will be reviewed by the Member Appeal Committee and will not involve any individual or the subordinate of any individual that participated in any prior decision concerning the Claim that is the subject of your appeal. If a decision on your appeal is based in whole or in part on medical judgment, the Member Appeal Committee will consult with a licensed physician in the same or similar specialty that typically manages or consults on the vision care service involved prior to making a decision on your appeal. The vision care professional providing the consultation will not have participated in, or be the subordinate of, any individual that participated in any prior decision to deny the Claim that is the subject of your appeal.

(c) You may, upon request, review all documents, records and other information that may be relevant to your appeal. Upon request, copies of all such materials will be made available to you free of charge. In addition, the identity of any physician or medical expert whose advice was obtained in connection with the initial determination to deny your Claim, whether or not that advice was relied upon, will be made available to you upon request and free of charge. You also have the right to submit any written data, comments, documents, records and other information that you wish to have the Member Appeal Committee consider prior to rendering a decision on your appeal.

(d) Your appeal will be promptly investigated and decided. The Member Appeal Committee will consider all of the comments, documents, records, reports and other information that have been made available and will not afford deference to any prior decision that has been made to deny your Claim. Written notification of the decision will be provided within a reasonable period of time appropriate to the circumstances, not to exceed 30 days following receipt of your appeal.

(e) The notification will include, among other items, the reasons for the decision and your right to pursue further appeal, if you are not satisfied with the results of the review.

(f) At any time during the appeal process at Davis Vision, you may contact the Member Service Department at the toll-free telephone number listed on your ID card to inquire about the filing or status of your appeal.

6.15 *Review by the Plan Administrator*

(a) You may further appeal the Claim within 60 days of your receipt of an adverse determination by Davis Vision by writing to the Plan Administrator, United States Steel and Carnegie Pension Fund, Room 1681, 600 Grant Street, Pittsburgh, Pennsylvania 15219-2800. Once again, you should supply any information necessary to support your position. You will be advised of the final decision within 30 days of the date that the second appeal is received by the Plan Administrator.

(b) Notification of an adverse benefit determination by the Plan Administrator will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file a further appeal as outlined below.

(c) The decision of the Plan Administrator is final unless you decide to further appeal such Claim for benefits by filing a grievance as described in the Insurance Grievance Procedure outlined in Section 9.

SECTION 7. GENERAL PROVISIONS RELATING TO HEALTH CARE BENEFITS

Coordination of Benefits

7.0 The health care benefits (PPO Medical, Prescription Drug, Dental Care, and Vision Care) otherwise provided under the terms outlined in this Program are subject to the following coordination of benefits provision:

(a) The health care benefits of the Program will be coordinated with the benefits under any other group plan so that no more than 100% of the provider's reasonable charge for Covered Services will be paid for between the other group plan and this Program with this Program making a supplemental payment after payment by the other plan in each case where the other plan does not include a coordination of benefits or non-duplication provision or does include a coordination of benefits or non-duplication provision and is the primary plan compared to this Program.

(b) If a working spouse by reason of employment with an employer other than the Company, is eligible to participate in another group plan which is paid for in whole or in part by the employer but has not enrolled thereunder, or in the absence of coverage under this Program is eligible to participate in another group plan which is paid for in whole or in part by that employer but is not enrolled thereunder for any reason, the health care benefits payable under this Program will be reduced as though enrollment in the other plan had occurred.

(1) A working spouse must enroll in the other employer's plan ("other plan") if the other plan is offered on a partially contributory or non-contributory basis, except that a spouse who works part-time (less than 32 hours per week) and is required to pay for health coverage shall be excluded from the application of this provision.

(2) The Program will continue to provide primary coverage to the Eligible Family Members until the earliest date the spouse is permitted to enroll in the other plan. Such earliest enrollment date must be certified in writing to the Plan Administrator.

(3) If the other plan contains a medical pre-existing condition limitation clause, the Program will continue to be primary for that medical condition until liability is accepted by the other plan.

(4) If the other plan requires that each Eligible Family Member provide acceptable evidence of insurability before coverage is effective and if any such person is rejected for coverage because of such requirement, the Program will continue to provide coverage but the Program will contact the employer to investigate the reasons for rejection for coverage by the other plan. Said rejected persons will provide the Program with the necessary releases to conduct the investigation and the Program will keep such information confidential.

(5) Investigation for other coverage will occur upon receipt of a claim by the Plan Administrator. The employee will be required to complete and return the questionnaire to the Plan Administrator in order to receive benefits.

(6) For those employees with working spouses (i) who knowingly fail or refuse to provide the Plan Administrator with the required information or (ii) refuse to elect available coverage, claims will be paid on a secondary basis.

(7) An employee's spouse who is required to pay premiums for coverage under his/her employer's plan in excess of $50 per month will be reimbursed by the Company for such excess up to a maximum benefit of $350.00 per month on a quarterly basis for coverage effective on or after January 1, 2009, upon proper application by the employee on a form provided by the Company. To receive such reimbursement, the employee must provide evidence to the Company on a form provided by the Company of the premiums paid by such spouse after the end of any current year but no later than 6 months after the end of that current year.

(8) The Company will provide the employee an annual reminder notice regarding these working spouse provisions.

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

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

(2) Where both plans cover the patient as an Eligible Family Member child, the plan of the parent whose birthday falls earlier in the calendar year will be primary; however, if both parents have the same birthday, the plan of the parent who has been covered for the longer period of time will be primary. The birthday rule described in the preceding sentence shall not apply in the event Contributions are required under the spouse's plan, except where the Eligible Family Member child is enrolled under the spouse's plan. In any event, if the parents are separated or divorced, benefit determination will be as follows:

(i) if there is a court decree which establishes financial responsibility for the health care expenses of such child, the benefits of a plan which covers the child as an Eligible Family Member of the parent with such financial responsibility will be determined before the benefits of any other plan which covers the child as a dependent;

(ii) if there is no court decree and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as an Eligible Family Member of the parent with custody will be

determined before the benefits of a plan which covers the child as an Eligible Family Member of the parent without custody;

(iii) if there is no court decree and the parent with custody of the child has remarried, the benefits of a plan which covers the child as an Eligible Family Member of the parent with custody will be determined before the benefits of a plan which covers that child as an Eligible Family Member of the stepparent, but the benefits of a plan which covers that child as an Eligible Family Member of the stepparent will be determined before the benefits of a plan which covers that child as an Eligible Family Member of the parent without custody.

(3) Where the order of benefit determination is not clearly established in accordance with (1) or (2) above (i.e., each plan's order of benefit determination provides that the other plan is primary), and both plans include a provision regarding determination of benefits for laid off or retired employees, the plan which covers the patient as an employee in active employment or as an Eligible Family Member of an employee in active employment will be primary.

(4) Where the order of benefit determination is not clearly established in accordance with (1), (2) or (3) above (i.e., each plan's order of benefit determination provides that the other plan is primary), the plan which has covered the patient for the longer period of time will be the primary plan.

(d) As used herein "group plan" means (1) any plan covering individuals as members of a group and providing health care benefits or services through group insurance or a group prepayment arrangement, or (2) any plan covering individuals as employees of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

(e) If it is determined that benefits under the Program should have been reduced because of benefits provided under another group plan, Highmark, Express Scripts, UCCI, Davis Vision and/or any other Company-sponsored health care provider will have the right to recover any payment already made which is in excess of its liability. Similarly, whenever benefits which are payable under the Program have been provided under another group plan, Highmark, Express Scripts, UCCI, Davis Vision and/or other Company-sponsored health care provider may make reimbursement direct to the insurance company or other organization providing benefits under the other plan.

(f) For the purpose of this provision, Highmark, Express Scripts, UCCI, Davis Vision and/or any other Company-sponsored health care provider may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expenses and benefits. Notwithstanding anything contained herein to the contrary, no disclosure, dissemination or use of such information shall be made or required if prohibited by law or regulation, including without limitation the Health Insurance Portability and Accountability Act ("HIPAA") or applicable state law preempting HIPAA.

(g) Any person claiming benefits under the Program must furnish Highmark, Express Scripts, UCCI, Davis Vision and/or other Company-sponsored health care provider such information as may be necessary for the purpose of administering this provision.

Waiver of Medical and Prescription Drug Coverage

7.1 An employee who waives coverage will have the ability to re-enroll in the coverage annually or in the event of a qualified Family Status Change as described in paragraph 7.2. An employee who waives coverage and certifies that he/she has health coverage under a spouse's or previous employer's plan, excluding a plan to which the Company contributes, will receive a monthly payment of $300. An employee is permitted to waive coverage and to certify that he/she has other qualifying coverage in order to receive the opt-out allowance only during an annual open enrollment period or as a result of a qualified Family Status Change. An employee who waives coverage and does not certify that he/she has coverage under a spouse's or previous employer's plan is not eligible to receive the $300 monthly payment. Employees who have waived coverage are not eligible to receive a Working Spouse Reimbursement as described in 7.0(b)(7). In order to receive the $300 monthly payment, an employee must apply, and must recertify on a quarterly basis, using the forms and procedures established by the Plan Administrator.

Qualified Benefit Election Changes (including Changes in Family Status)

7.2 Qualified Benefits, for purposes of this paragraph, means PPO Medical Benefits of this Program, Health Care and Dependent Care Flexible Spending Accounts and Optional Accidental Death and Dismemberment Insurance. If you wish to revise your Qualified Benefit elections as a result of (i) a change in your Family status, or (ii) a significant cost or coverage change(s), or (iii) entitlement to Medicare, you must make your election within 60 days following such change. If you have not met the 60 day deadline to revise your existing Dependent Care Flexible Spending Account

election as a result of a significant cost or coverage change, you may revise your Dependent Care Reimbursement Account election as a result of a significant cost or coverage change on a prospective basis by completing and returning your enrollment/election form. The federal income tax laws and regulations governing cafeteria plans contain special provisions relating to permitted election changes under Flexible Spending Accounts. You may revise your Qualified Benefit elections as follows:

(a) Changes in Family Status

(1) You may *change any/all* of your Qualified Benefits (PPO Medical Benefits, Health Care and/or Dependent Care Flexible Spending Accounts and Optional Accidental Death and Dismemberment Insurance) if your Family status change is by reason of:

- your or an Eligible Family Member's ceasing work because of, or returning to work following layoff, leave of absence or disability, provided absence is 30 or more days;
- marriage, divorce or legal separation of any member of your immediate family;
- birth, placement for adoption or final adoption of a child or acquisition of a stepchild who will reside in your household;
- a covered Eligible Family Member's ceasing to be an Eligible Family Member (such as death of any Eligible Family Member or a child attaining age 26);
- your or your spouse's being called into military service or returning to work following active military service;
- a covered Eligible Family Member's becoming employed, terminating employment, or obtaining or losing coverage through another employer group plan; or
- loss of your or your spouse's former employer's group coverage.

Any change in your elections under (a)(1) above must be on account of and correspond with a Family status change that affects eligibility for coverage under an employer plan.

(2) You may *change only* your Dependent Care Flexible Spending Account if your Family status change is by reason of:

- a change in your or a covered Eligible Family Member's place of residence or worksite.

Any change in your elections under (a)(2) above must be on account of and correspond with a Family status change that affects eligibility for coverage under an employer plan.

(b) Significant Cost or Coverage Changes

(1) You may *change only* your PPO Medical Benefits if the change is the result of:

- a significant change in the cost or level of coverage of your or a covered Eligible Family Member's health care coverage.

(2) You may *change only* your Dependent Care Flexible Spending Account if the change is the result of:

- a significant change in the cost or level of dependent care coverage.

If you have a change in coverage fact pattern that reduces or eliminates the need for a Dependent Care Flexible Spending Account in mid-year (such as a child going to school), an election change is permitted. If you anticipate the need for a Dependent Care Flexible Spending Account in mid-year (for the summer when school is out), you should make an appropriate annual election during open enrollment to cover the partial year period; otherwise, you will not be able to make a mid-year election change.

(c) Entitlement to Medicare

(1) You may *change only* your PPO Medical Benefits if the change is the result of:

- Your or a covered Eligible Family Member's becoming entitled to coverage under Medicare.

The effective date of any change in your elections will be the date the change in your Family status, significant cost or coverage change(s) or entitlement to Medicare occurs if you complete a revised enrollment/election form within 60 days of such occurrence. If you do not make your election within 60 days of a permitted change, you may not change your Qualified Benefits elections until the earlier of another permitted change or the next annual enrollment period. Any change in your Dependent Care Flexible Spending Account election associated with a significant cost or coverage change that you report more than 60 days after the date of the significant cost or coverage change will be effective the first day of the month following the month in which you report the change.

Note: If your change in Family status results from layoff, leave of absence or disability, the effective date of any change in your elections is the last day worked provided you make your election within 60 days following the date last worked.

Adding or Deleting Eligible Family Members

7.3 (a) If you want to make a change in your medical (PPO Medical Benefits, Prescription Drug Benefits, Dental Care Benefits and Vision Care Benefits) which affects the amount of your Pre-tax deduction (i.e., add or delete spouse and/or child coverage), the effective date of any change in dependent coverage will be the earlier of (i) the date of a change in your Family status, significant cost or coverage change(s) or entitlement to Medicare provided you make your election within 60 days thereafter or (ii) January 1 next following the annual enrollment period during which you elect such change.

(b) If you want to make a change in your medical (PPO Medical Benefits, Prescription Drug Benefits, Dental Care Benefits and Vision Care Benefits) which does not affect the amount of your pre-tax deduction (i.e., add or delete a child where the same pre-tax deduction will be continued for other Covered Eligible Family Members who are children), the effective date of the change will be the date of change in your Family status, significant cost or coverage change(s) or entitlement to Medicare. Although you are not required to complete a new enrollment/election form *within 60 days*, you should do so promptly so as to (i) avoid having future claims denied for a newly-acquired Eligible Family Member who is not included in the TPAs' eligibility files or (ii) comply with paragraph 8.19 with respect to a deleted Eligible Family Member.

Note 1: You will be required to provide evidence to establish the eligibility and date of birth of new Eligible Family Members (e.g., marriage certificate, birth certificate or adoption papers). If the document presented clearly establishes that the person is an Eligible Family Member as defined in Definitions (o), coverage will be effective as indicated above.

Note 2: If you request coverage for a common-law spouse, an investigation will be conducted to substantiate eligibility inasmuch as all states do not recognize common-law marriage and among those that do, criteria for determining the validity of such a marriage vary. Your Employee Benefits Office will be advised by the Plan Administrator whenever a determination has been made as to whether or not your common-law spouse is an Eligible Family Member under this Program. If approved as an Eligible Family Member, coverage for your common-law spouse will become effective on the date a completed enrollment/election form is received by your Employee Benefits Office.

(c) Your coverage may be retroactively cancelled or discontinued in the event of fraud or intentional misrepresentation of a material fact or in the event of failure to timely pay required premiums or contributions towards the cost of coverage.

Eligibility for Medicare by Reason of Permanent Kidney Failure (End Stage Renal Disease)

7.4 If you or your Eligible Family Member become Eligible for Medicare (under Title XVIII of the Social Security Act--Health Insurance for the Aged and Disabled) solely because of End Stage Renal Disease, Medical Benefits under this Program will continue to be payable on the same basis as prior thereto for the 30-month period following the date you or your Eligible Family Member became Eligible for Medicare. At the end of such continuation coverage period, Medicare will become the primary payer and the following apply:

(a) Payment under this Program shall be the benefit which would otherwise be payable under this Program reduced by the amount of benefits you or your Eligible Family Member receive, or would upon application receive, under Part A (Hospital Insurance Benefits) or Part B (Supplementary Medical Insurance Benefits) of Medicare.

Note: In calculating benefits in Section 3, Covered Services will be reduced by Medicare benefits before applying the Deductible, if any, imposed by this Program.

(b) For any month for which you or an Eligible Family Member of yours is covered under Section 3 of this Program, the Company will reimburse you for the Medicare Part B premium, except where the Part B charge for an Eligible Family Member is deducted from Social Security or Railroad Retirement benefits.

Eligibility for Medicare by Reason of Attaining Age 65 or Eligibility for Social Security Disability Benefits

7.5 If you or an Eligible Family Member of yours becomes Eligible for Medicare by reason of attaining age 65 or eligibility for Social Security disability benefits, the Medicare-eligible person should enroll for Medicare Part A on a timely basis (within three months of eligibility for a person attaining age 65) if such coverage is provided without cost and such person must then elect one of the following options:

(a) Continue in the Program and enroll for Medicare Part B coverage. If the Medicare-eligible person elects this option, that person's coverage under the Program will continue without change as long as you continue working. However, that person will have to pay a monthly premium for Medicare B coverage and will be eligible for only limited Medicare benefits since such benefits would be reduced by Program benefits. The Company will not reimburse you for the Medicare Part B premium.

(b) Discontinue coverage under Sections 3 and 4 of the Program and elect Medicare coverage. If this option is elected, you must notify the Company in writing that the Medicare-eligible person has enrolled for coverage under Medicare and is canceling coverage under Sections 3 and 4 of the Program. In this case, coverage under the Program will be limited to Sections 1, 2, 5 and 6 and the Company will reimburse you for the Medicare Part B premium.

(c) Continue in the Program and decline Medicare Part B coverage. If the Medicare-eligible person elects this option, coverage under the Program will continue without change as long as you continue working. However, in any case where a Medicare-eligible person does not enroll for Medicare B on a timely basis (i.e., not later than the end of the third month following the month in which that person attains age 65 or within the seven-calendar-month period following your retirement, if later), that person can subsequently enroll for Medicare B coverage only during the months of January, February and March of any year with Part B coverage becoming effective the following July 1. It is most important therefore for a Medicare-eligible person to enroll for Medicare B immediately upon retirement since any delay in the effective date of Medicare B coverage will result in a serious gap in health care coverage because the Company's retiree medical plan provides that benefits payable under that Program will be reduced by benefits payable under Medicare whether or not the person is enrolled for Medicare coverage.

(d) Notwithstanding the above, if you are absent from work for more than two years by reason of occupational disability but still retain active employee status for seniority and benefit purposes, and if you become Eligible for Medicare by reason of attaining age 65 or eligibility for Social Security disability benefits (and the Company gives you written notice of your obligation to enroll for Medicare Parts A and B), you should enroll for Medicare Part A on a timely basis (within three months of eligibility for a person attaining age 65) and should also enroll for Medicare Part B. Payment under the Program shall be the benefit which would otherwise be payable under the Program reduced by the amount of benefits which you receive, or would upon application receive, under Medicare A or Medicare B. (In calculating Medical Benefits under the Program, the reduction is applied to Covered Services.) For any month in which you are covered by the Medical Benefits of this Program, the Company will pay the charge for Medicare Part B coverage for you.

(e) If you (1) are Eligible for Medicare while retaining active employee status for seniority and benefit purposes, (2) opt out of Medicare Part B, and (3) want to enroll in coverage under the United States Steel Corporation Retiree Health Program for USW-Represented Employees upon retirement, you should enroll in Medicare Part B prior to retirement to avoid any gaps in coverage.

Subrogation

7.6 In the event any health care benefits are provided under the Program to you or to one of your Eligible Family Members, then Highmark, Express Scripts, UCCI, Davis Vision and/or any other Company-sponsored health care provider shall be subrogated and succeed to your rights of recovery therefor against any person or organization except against insurers on policies of insurance issued to you as an individual. You or your Eligible Family Member will be required to execute and deliver such instruments and papers and do whatever else is necessary to secure such rights.

Frequency Limits

7.7 In applying those provisions of the Program which limit the frequency at which certain services, supplies and treatments may be obtained or which limit the number of confinements, services, supplies or treatments which an individual may receive in a calendar year or in his lifetime, the Program will take into account the dates at which such services, supplies and treatments were last rendered under this Program, and the Program will reduce the confinements, services, supplies and treatments which an individual may receive during a year or his lifetime by confinements, services, supplies and treatments received while covered under this Program.

SECTION 8. GENERAL PROVISIONS

Eligibility

8.0 You will be covered by the Program if you are actively at work on or after the date the Program becomes effective, in the regular service of the Company in a group of employees designated by the Company as covered by the Program. If you are enrolled in the Program more than once because you are in more than one of such groups, you will be deemed to have only that coverage which provides you the highest benefits.

Part-Time Employees

8.1 If you are a part-time employee (an employee who for the mutual convenience of the employee and the Company is regularly scheduled to work fewer hours than the straight-time schedule of full-time employees), the following applies to you:

(a) The amount of your life insurance and the amount of your Sickness and Accident Benefit, as determined in paragraph 2.4, will be reduced to amounts equitably related to the hours worked by you in comparison to hours worked by full-time employees.

(b) Your Eligible Family Members will not be eligible for the PPO Medical, Prescription Drug, Dental Care and Vision Care Benefits of the Program.

(c) In applying the provisions of paragraph 7.0 concerning coordination of benefits, any other group plan providing you benefits will be deemed to be the primary plan as compared to the Program.

If at any time you become a full-time employee, the provisions applicable to full-time employees will apply to you.

Sickness and Accident Benefits for Part-Time Employees

8.2 The determination as to the amount of your Sickness and Accident Benefit will be made when you first become covered under the Program.

Enrollment and Effective Date of Coverage

8.3 If you are a new employee, you will be enrolled in the Program at the time of your employment with coverage becoming effective as of the dates specified below.

Note: If you are a re-employed pensioner, you will be enrolled in the Program at the time of your re-employment with coverage becoming effective as of the date you start work. Any coverage applicable to you as a retiree will terminate on the day immediately preceding the effective date of your coverage under this Program.

8.4 If you have Eligible Family Members, you and your Eligible Family Members will be enrolled for coverage, except that if both you and your spouse are eligible for enrollment under the Program, each will be enrolled for personal coverage only unless there are Eligible Family Members who are children, in which case, Eligible Family Member children may only be covered by one parent, not both, based on your election. In the event that the coverage of either you or your spouse is terminated for any reason, that individual and that individual's Eligible Family Members, if otherwise eligible, will automatically be enrolled as Eligible Family Members of the other covered employee.

See paragraphs 8.40 - 8.43 for the provisions pertaining to Eligible Family Members who are students.

8.5 If you were hired by the Company on or after August 1, 1999, all of your coverage under the Program will become effective 60 calendar days from your date of hire. If you are a student hired on or after May 1 for summer employment, however, you will not be covered for the Dental Care Benefits of the Program unless such employment extends beyond September 30, in which case you will then be covered for Dental Care Benefits as described in Section 5. Eligible Family Member coverage becomes effective on the same date as your coverage.

8.6 The addition of or increase in Optional Employee Life Insurance will become effective when approved by the Life Insurance Claims Administrator provided you are then actively at work as determined by the Life Insurance Claims Administrator; otherwise, the addition of or increase in Optional Employee Life Insurance will become effective on the date you return to work. The addition of or increase in Optional Spouse Life Insurance will become effective on the date the Company receives satisfactory evidence of good health provided you are then actively at work as determined by the Life Insurance Claims Administrator; otherwise, the addition of or increase in Optional Spouse Life Insurance will become effective on the date you return to work.

Provisions Applicable to Primary Benefits Coverage If You Cease Active Work Because of Certain Specified Reasons

8.7 If you cease work because of nonoccupational disability, the following provisions will be applicable to all your Primary Benefits coverage (as defined in Definitions (hh)) under the Program.

(a) If you have two or more years of continuous service on the date you cease work, all your Primary Benefits coverage under the Program will be continued during absence due to such disability up to a maximum of 12 months from the end of the month in which you last worked, subject to the provisions relating to total disability as described in paragraph 1.12; provided that if you have 15 or more years of continuous service on the date you cease work, all Primary Benefits coverage under the Program will be continued until the end of the last month during which you are eligible for Sickness and Accident Benefits.

(b) If you have less than two years of continuous service on the date you cease work, all your Primary Benefits coverage under the Program will be continued during absence due to such disability up to a maximum of six months from the end of the month in which you last worked. If you continue to be disabled beyond such period and your life insurance is not being continued in accordance with the provisions relating to total disability as described in paragraph 1.12, your basic life insurance will continue in effect for an additional period not to exceed six months.

8.8 If you cease work because of occupational disability, all your Primary Benefits coverage under the Program will be continued during absence due to such disability, but not beyond one month following the end of the month for which statutory compensation payments terminate, except that Sickness and Accident coverage will terminate (a) at the end of the last month during which you are eligible for Sickness and Accident Benefits pursuant to paragraph 2.2, if you have 20 or more years of continuous service on the date you cease work; (b) at the end of 12 months following the month in which you last worked, if you have two but less than 20 years of continuous service on the date you cease work; or (c) at the end of six months following the month in which you last worked, if you have less than two years of continuous service on the date you cease work.

8.9 If you cease work because of layoff, the following provisions will be applicable to all your Primary Benefits coverage under the Program:

(a) Your Sickness and Accident coverage will terminate on the date you cease work.

(b) If you have 20 or more years of continuous service on the date you cease work, your remaining Primary Benefits coverage will be continued during such layoff up to the maximum of 24 months from the end of the month in which you last worked.

(c) If you have 10 or more but less than 20 years of continuous service on the date you cease work, your remaining Primary Benefits coverage will be continued during such layoff up to a maximum of 12 months from the end of the month in which you last worked. If your layoff continues beyond that period, you may elect, on or before the 20th day of the 13th month of layoff, to continue your basic life insurance for not more than the next 12 months of layoff provided you make payments of 60¢ per month per $1,000 of basic life insurance. Failure to make your life insurance payments on or before the 20th day) of any month will terminate such insurance at the end of the last month for which payment has been made.

(d) If you have two but less than 10 years of continuous service on the date you cease work, your remaining Primary Benefits coverage will be continued during such layoff up to a maximum of six months from the end of the month in which you last worked. If your layoff continues beyond that period, you may elect, on or before the 20th day of the seventh month of layoff, to continue your basic life insurance for not more than the next 18 months of layoff, provided you make payments in the same manner and amount as outlined in (c) above.

(e) If you have less than two years of continuous service on the date you cease work, your basic life insurance will be continued on the same basis as in (d) above, but your health care benefits coverage will terminate at the end of the month in which you last worked.

This paragraph 8.9 is modified, as necessary, if otherwise provided by your bargaining agreement.

8.10 If you cease work because of suspension, the provisions set forth in paragraph 8.9 are applicable except that sickness and accident coverage will be continued during a period of suspension which is not converted into discharge.

8.11 If you cease work for one of the reasons specified in paragraphs 8.7 through 8.10 and you do not return to active work because of another one of such reasons, all your Primary Benefits coverage under the Program will be continued

for the unexpired portion, if any, of the period which would have been applicable if the reason for not returning to active work had been the original reason for cessation of work. However, in no event will any coverage which has terminated for any reason during your absence be reinstated until you return to work. Notwithstanding the above, if you have 20 or more years of continuous service on the date you cease work due to layoff and do not return to work due to disability, the provisions set forth in the case of an employee who ceases work due to layoff will continue to apply to you.

8.12 If you cease work because of a leave of absence, all your Primary Benefits coverage under the Program, will cease at the end of the month in which you last worked. Your basic life insurance will continue in effect during such leave of absence for a further period not to exceed six months. If earlier termination of coverage is required by federal or state election laws, Program coverage will terminate earlier. If cessation of work is due to authorized military duty, however, your Primary Benefits coverage under the Program will terminate as of the 31st day after you cease work. If cessation of work is due to authorized leave under the Family and Medical Leave Act ("FMLA"), however, your health care benefits will terminate upon expiration of the authorized leave except as you return to work at that time.

Optional Life Insurance and Optional Spouse and Child(ren) Life Insurance and Optional Accidental Death and Dismemberment Insurance During Absence From Work

8.13 If you cease work because of disability, layoff or leave of absence, you may elect to continue your optional life insurance and/or Optional Spouse and Child(ren) Life Insurance and Optional Accidental Death and Dismemberment Insurance for the respective periods referred to in paragraphs 8.7 through 8.12 for continuation of basic life insurance, provided you make the regular monthly payments required for such optional life insurance. Failure to make such payments on or before the 20th day of any month will terminate such insurance at the end of the last month for which payment has been made. If you fail to make a payment when due, you will be deemed to have voluntarily terminated your optional life insurance and/or Optional Spouse and Child(ren) Life Insurance and Optional Accidental Death and Dismemberment Insurance and such insurance will not be reinstated upon your return to work.

Flexible Spending Account Contributions During Absence From Work

8.14 If you elected a monthly deduction for one or both of the Flexible Spending Accounts, such deductions will continue as long as you have sufficient earnings from which the deduction can be taken; if earnings are insufficient to permit the full amount to be deducted, then no deduction will be made. Your Flexible Spending Account will be terminated at the end of the month in which the last deduction was taken. However, if you are off work on an approved leave of absence pursuant to the Family and Medical Leave Act, your Health Care Flexible Spending Account will be terminated as of the due date for a missed contribution if you fail to make such contribution by the end of the grace period.

Termination of Insurance Coverage

8.15 If your employment is terminated by other than retirement, all your coverage under the Program will end on the date of such termination. In addition, for the purpose of this paragraph only, you will be considered to have terminated your employment if you are absent from work for a period of five or more calendar days for reasons other than disability, layoff, leave of absence, suspension, vacation, jury duty, witness duty or any other specifically authorized absence and all your coverage under the Program will terminate at the end of the fifth day of such absence.

Notwithstanding anything contained in this paragraph 8.15 to the contrary, if your employment is terminated as the result of payment of Severance Allowance, all your coverage under the Program will terminate:

(a) at the end of the month in which your employment terminated (the payment date for Severance Allowance) if you are eligible for an immediate pension (either under the Company pension plan or from the Steelworkers Pension Trust); or

(b) on the date your employment terminates (the payment date for Severance Allowance) if you are not eligible for an immediate pension.

8.16 Eligible Family Member coverage under the Program terminates on the earlier of:

(a) the date your coverage terminates, except that Eligible Family Member coverage will be continued until the end of the month in which you die; or

(b) the end of the day immediately preceding the date any individual ceases to be an Eligible Family Member, except that coverage for any Eligible Family Member who dies will terminate as of the date of death and coverage for an Eligible Family Member child will be continued until:

- for an Eligible Family Member described in Definitions (o)(4), the end of the month in which such person (i) attains age 21 if not a full-time student nor disabled, (ii) ceases to be a full-time student subject to medically necessary leave of absence provisions in Definitions (o)(4) (or attains age 25, if earlier), or (iii) ceases to meet the disabled dependent criteria, or
- for an Eligible Family Member described in Definitions (o)(4), August 31 in the event you fail to recertify the student by the last business day of August, or effective December 31 in the event you fail to recertify the student by December 31, or
- in all other situations, the end of the month in which such person (i) attains age 26, or (ii) ceases to meet the disabled dependent criteria.

Continuation of Health Care or Medical Coverage Pursuant to Consolidated Omnibus Budget Reconciliation Act (COBRA)

8.17 If your health care coverage under this Program terminates for a reason other than gross misconduct, you and each covered Eligible Family Member may elect to continue group health care coverage (PPO Medical/Prescription Drug/Dental Care/Vision Care) under the Program without evidence of insurability for up to 18 months; provided, however, if you or a covered Eligible Family Member becomes disabled within 60 days of the date you cease work, coverage may be continued for the disabled person (as well as other members of your family) for an additional 11 months beyond the initial 18 months. To obtain an additional 11 months of coverage on the basis of disability, you must within the original 18 months of COBRA coverage submit evidence that you (or your Eligible Family Member) have been found to be disabled by the Social Security Administration. This evidence must be submitted within 60 days of the date of the Social Security Administration's determination of disability. If your contributions to a Health Care Flexible Spending Account under this Program terminate under paragraph 10.9 (or paragraph 8.14) for a reason other than gross misconduct, you may elect to continue making contributions for no longer than the period described in paragraph 10.10. The maximum continuation period will be reduced by any period that health care coverage is continued at Company cost during absence from work pursuant to paragraphs 8.7 - 8.12. You or your Eligible Family Members will be required to pay the full cost of the coverage(s) elected; the cost of coverage continued beyond 18 months due to the disability rule will be increased by 50%. For the purpose of paragraphs 8.17 through 8.19 your Eligible Family Members who are children include any child born to you, or adopted by you, during the period in which your coverage is being continued in accordance with this Program.

Note 1: You, and your Eligible Family Members may make the above election if your coverage terminates because of your entry into the armed forces for a period to exceed 30 days even though you, your spouse and your children may be eligible for CHAMPUS coverage.

8.18 In addition to being eligible to continue coverage as set forth in paragraph 8.17, each covered Eligible Family Member may elect to continue health care or medical coverage under this Program for up to 36 months in the event of your divorce, legal separation or death. Additionally, each of your children may elect to continue health care or medical coverage under this Program for up to 36 months upon ceasing to be an Eligible Family Member. The 36-month period will be reduced by any period health care coverage was continued immediately prior thereto pursuant to paragraph 8.17. You or your Eligible Family Members will be required to pay the full cost of the coverage(s) elected.

8.19 In order to elect continuation of health care or medical coverage under the Program, you and/or your Eligible Family Members must notify the employee benefits office at the plant or office where you work of your divorce or legal separation or a child's loss of status as an Eligible Family Member within 60 days of the date coverage terminated under the Program. Upon such notification, or if coverage terminated because of one of the reasons specified in paragraphs 8.7 - 8.16 of this booklet, WageWorks, Inc. (WageWorks) (the designated agent of the Plan Administrator) will notify you, your spouse and/or Eligible Family Member children as to eligibility for continuation of health care or medical coverage under the Program and the applicable cost of each. If you, your spouse and/or your children wish to continue health care or medical coverage and/or contributions to a Health Care Flexible Spending Account, an election to do so must be received by WageWorks within 60 days from the later of (a) the date coverage under the Program terminated or (b) the date of notification by WageWorks of eligibility for continuation of coverage. The first premium payment must be received by the later of the due date shown on the initial bill or within 45 days after the election form is signed. Premiums are payable monthly in advance and subsequent premiums are due 30 days after the due date shown on each monthly bill.

8.20 The 18-, 29- or 36-month period referred to in paragraphs 8.17 and 8.18 may be shortened for any of the following reasons:

(a) The Company no longer provides health care coverage to any group of employees;

(b) Failure to pay the premium within the prescribed time limits for continuing health care or medical coverage; or

(c) The person who is continuing health care or medical coverage under the Program and/or continuing contributions to a Health Care Flexible Spending Account (i) becomes entitled to Medicare benefits or becomes covered under any other group health plan (if the group health plan does not contain any preexisting condition exclusion or limitation [other than those that do not apply to, or are satisfied by, the person by reason of the provisions in Internal Revenue Code Section 9801]); or (ii) requests cancellation in writing.

8.21 When coverage under the COBRA provisions of this Program terminates, the Blue Cross Blue Shield conversion provisions in paragraphs 8.28 and 8.29 apply. This paragraph does not apply to continuation of contributions to a Health Care Flexible Spending Account.

8.22 Any questions concerning the continuation coverage or the cost thereof are to be directed to WageWorks (See Important Contact Information).

Retirement

8.23 Upon your retirement, your life insurance (Basic, Optional Employee Life and Optional Spouse Life Insurance) will be continued if you are eligible as set forth in paragraphs 1.13 through 1.14. See paragraphs 8.32 through 8.34 with respect to hospital and medical coverage following retirement. See paragraph 10.9 with respect to Health Care Flexible Spending Account coverage following retirement. Any other coverage then in effect under the Program terminates at the end of the month in which employment terminates due to such retirement.

Life Insurance Conversion Privilege

8.24 Upon application to Metropolitan Life Insurance Company within 31 days after your life insurance coverage terminates as provided in paragraphs 8.7 through 8.14, you may arrange to continue your life insurance protection under an individual policy, for an amount not greater than the amount of life insurance you have under the Program at the time of such termination, without medical examination. Such individual policy may be on any one of the forms of policy then customarily issued by Metropolitan Life 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. Conversion is not available for Optional Accidental Death and Dismemberment Insurance. Optional Spouse Life Insurance can be converted if you are no longer in an eligible class, your employment ends, the group policy ends and the spouse has been insured for five consecutive years, or the group policy is amended to no longer provide dependent coverage and the spouse has been insured for five consecutive years. The spouse will have the right to convert if your spouse ceases to be an Eligible Family Member as defined by the Program (i.e., due to a divorce), or you die. Optional Child(ren) Life Insurance can be converted if you are no longer in an eligible class, your employment ends, the group policy ends and your Eligible Family Member child has been insured for five continuous years, or the group policy is amended to no longer provide dependent coverage and the Eligible Family Member child has been insured for five continuous years. The Eligible Family Member child will have the right to convert for the following reasons: the Eligible Family Member child ceases to be an Eligible Family Member as defined by the Program (i.e. the child reaches the limiting age), or you die.

8.25 If your life insurance coverage terminates under the Program as a result of your transfer to other employment which makes you eligible for life insurance under another group insurance plan toward the cost of which the Company or one of its subsidiaries contributes, the amount of life insurance which you may continue under an individual policy as referred to in paragraph 8.24 shall in no event exceed the amount of life insurance terminated under the Program less the amount of life insurance for which you become eligible under such other plan.

8.26 Furthermore, whenever your life insurance under the Program is reduced, you may apply for an individual policy, in accordance with paragraph 8.24, 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.

8.27 Any such individual life insurance policy referred to in paragraphs 8.24, 8.25 or 8.26 will become effective at the end of the 31-day conversion period. If you should die during such period, whether or not you have applied for such a policy, an amount equal to the amount of life insurance in force under the Program immediately prior to termination or

reduction, less any amount of life insurance for which you became insured under any other group insurance plan as referred to in paragraph 8.25, will be payable to your beneficiary. If any such amount is payable, no life insurance will be payable under paragraph 8.23. In the case of Optional Spouse Life Insurance, if your spouse should die during such period, whether or not an application had been made for an individual policy, an amount equal to the maximum amount of life insurance for which an individual policy could have been issued will be payable (1) to you, or (2) if you are not living at the date of death of the Eligible Family Member, in accordance with a preference beneficiary schedule contained in the group policy. In the case of Optional Child(ren) Life Insurance, if your covered child should die during such period, whether or not an application had been made for an individual policy, an amount equal to the maximum amount of life insurance for which an individual policy could have been issued will be payable (1) to you, or (2) if you are not living at the date of death of the Eligible Family Member, in accordance with a preference beneficiary schedule contained in the group policy.

Blue Cross Blue Shield Conversion

8.28 If your coverage under the Medical Benefits Section of this Program is terminated as provided in paragraph 8.7 through 8.12, except as specified below, you may convert to a direct payment program. Also, conversion is available to anyone who has elected continued coverage through COBRA as provided in paragraphs 8.17 through 8.22 and the term of that coverage has expired. This same conversion opportunity is also available to each of your Eligible Family Members whose coverage under the Medical Benefits Section of this Program is terminated.

8.29 The conversion opportunity is not available if either of the following applies:

- You are eligible for another group health care benefits program through your place of employment.
- The Medical Benefits Section of this Program is terminated and replaced by another health care benefits program.

Certificates of Creditable Coverage

8.30 The Plan Administrator is required to issue a certificate to you if you change jobs or lose your health care coverage. This Certificate of Creditable Coverage provides evidence of your prior coverage.

8.31 Certificates will be mailed automatically to everyone who changes or loses their health care coverage. You can also request a certificate from your previous employer or insurance company.

Medical Coverage for Retirees and Surviving Spouses

8.32 You and your Eligible Family Members may be eligible for medical coverage under the United States Steel Corporation Retiree Health Program for USW-Represented Employees (the "RHP") in accordance with the terms of such Program.

8.33 See the applicable provisions of the RHP for a more detailed explanation of the eligibility and participation requirements. You are ineligible for the RHP if you were hired or rehired on or after January 1, 2016 (and who are not entitled to regain eligibility to become a participant under the Retiree's and Surviving Spouses' Health Insurance Agreement if such rehire is within 5 years of the last day worked during a prior period of employment). You are also ineligible for the RHP if your original date of hire occurred before January 2016, you broke pension continuous service due to a layoff from the Company after January 1, 2016 and are rehired more than five years after the last day worked during a prior period of employment.

8.34 Upon your death, your surviving spouse may also be eligible for the RHP coverage. See the applicable provisions of the RHP for a more detailed explanation of the eligibility and participation requirements.

Reinstatement or Reemployment

8.35 If you return to work following an absence on account of layoff, leave of absence or disability during which some or all of your coverage under the Program shall have terminated and prior to a break in continuous service, all your coverage under the Program, other than optional life insurance, Optional Spouse and Optional Child Life Insurance, and Flexible Spending Accounts will be reinstated on the day you return to work.

8.36 If you return to work after a break in continuous service, you will be enrolled in the Program as a new employee and, except as otherwise specified below, you will not be covered by the Program until 60 calendar days following your reemployment. However, (a) if you sustained a break in continuous service and at such time you were eligible for an immediate or deferred vested pension under the Company pension plan applicable to you, (b) if your break in

continuous service was removed at the time of your reemployment, or (c) if you sustained your break in continuous service prior to completing 60 calendar days because of lack of work and you are rehired at the same plant within one year from the date of termination and given credit for prior hours worked for purposes of completing your probationary period, the calendar days completed by you prior to your break in service will be counted towards the 60 calendar days which you must complete under paragraph 8.5 prior to becoming covered under the Program.

Continuous Service

8.37 Wherever the term "continuous service" is used in this booklet, it means your continuous service as it would be determined for pension eligibility purposes under the Company pension plan, regardless of whether you are a participant in such pension plan. In addition:

(a) For purposes of this paragraph, continuous service under the National Steel pension agreement, including service earned before May 20, 2003 but not credited after the termination of National Steel's pension plans, will be treated as continuous service.

(b) In the case of Union-represented employees who were hired by the Company effective November 1, 2003 in connection with the Gary Plate/ISG Pickle Line exchange, for purposes of this paragraph, continuous service includes service with ISG (as determined for eligibility purposes under the Steelworkers Pension Trust).

(c) In the case of Union-represented employees of the Texas Operations Division and the Star Tubular Services Division of U. S. Steel Tubular Products, Inc., effective January 1, 2009, for purposes of this paragraph, continuous service includes service with U. S. Steel Tubular Products, Inc. and its subsidiaries and service with Lone Star Technologies, Inc. and its subsidiaries, including service prior to June 14, 2007.

Laws Affecting Program Benefits

8.38 The Program has been modified, as described in this booklet, because of the provisions of federal law concerning Medicare. If such law shall be amended, or if any other state or federal legislation shall be enacted to provide benefits similar to those described in this booklet, appropriate adjustments will be made in the provisions of the Program. If, under any such state or federal law (including state laws regarding disability benefits), any benefits are now or in the future provided which are in excess of the Program's benefits, any contribution required for such excess benefits shall be paid entirely by the employees covered for such benefits.

8.39 The benefits otherwise payable under the Program will be offset by similar benefits payable for wage loss or medical expenses or which would be payable upon timely and proper submission of claim (unless good and sufficient reason is shown for your inability to submit such claim or to have such claim submitted by someone else on your behalf), under any insurance policy, bond, fund, or other arrangement required by any motor vehicle insurance law requiring the provision of benefits for personal injury without regard to fault. The benefits of the Program will not be offset if the provisions of such law require that other insurance benefits be utilized before benefits are available pursuant to such law or you have obtained no-fault insurance at a lower cost because of your coverage under the Program. The offset referred to above shall be made on a dollar-for-dollar basis, matching the first dollar of benefits payable under the Program against the first dollar of benefits payable under the insurance policy, bond, fund or other arrangement.

Full-Time Students

8.40 In order for an Eligible Family Member described in Definitions (o)(4) to be eligible for the health care benefits of the Program as a full-time student after attainment of age 21, the child:

(a) must be under 25 years of age and otherwise meet the Program's definition of an Eligible Family Member child under 21 years of age;

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

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

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

(e) must be enrolled full-time in a recognized course of study or training and in active, full-time attendance at an institution such as a

(1) high school or vocational school supported or operated by state or local governments, or by the federal Government;
(2) state university or college or community college;
(3) licensed private school, college or university; or a

(4) licensed technical school, nurses' training school, beautician school, automotive school, or similar training school.

(f) must have been under age 21 when you were last enrolled in the Program and must have been eligible for coverage as an Eligible Family Member immediately prior to attainment of age 21.

8.41 (a) General Rule — United States Steel and Carnegie Pension Fund (the "Plan Administrator") is the single point of contact for student dependent certifications under this Program. The Employee Portal is the primary means of student dependent certifications (with manual certifications available when necessary). You are responsible for both the accuracy of the information provided in the certification and for notifying the Plan Administrator of any changes in the full-time student's status.

(b) Initial Certification — If your Eligible Family Member who is described in Definitions (o)(4) will be reaching the maximum age for a covered Eligible Family Member who is described in Definitions (o)(4) (who is neither a full-time student nor disabled as defined in Definitions (o)), Family Member you must certify your full-time student Eligible Family Member by the end of the month in which they reach the age limit for a covered Eligible Family Member child. If you do not certify your full-time student Eligible Family Member within this period, coverage for your Eligible Family Member child will be cancelled effective on the first day of the month following the month in which they reached the age limit for a covered Eligible Family Member child (who is neither a full-time student nor disabled) as defined in this Program.

(c) Re-Certification — You must re-certify that an Eligible Family Member continues to satisfy the requirements for eligible full-time students twice each year; in July (for the period from September 1 – December 31) and during open enrollment (for the period from January 1 – August 31). If you do not re-certify your full-time student Eligible Family Member by the last business day of August (or the last date of open enrollment, in the case of a certification that should have been made during open enrollment), coverage for your Eligible Family Member who is described in Definitions (o)(4) will be cancelled effective August 31 (or December 31, in the case of a certification that should have been made during open enrollment). You will not receive another notification when the applicable re-certification period has expired.

(d) Retroactive Certifications/Re-certifications

(1) Initial Certifications - If you fail to file an initial student certification on a timely basis but subsequently file a valid initial student certification, coverage for the student Eligible Family Member will be retroactive to the student's attainment of the maximum age for a covered Eligible Family Member child as defined in this Program (or if later, the date the Eligible Family Member child became an eligible student).

(2) Re-Certifications - If you fail to file an initial student certification on a timely basis but subsequently file a valid student re-certification, coverage for the student Eligible Family Member will be retroactive to September 1 (or January 1, in the case of a certification that should have been made during open enrollment).

8.42 The eligibility of an Eligible Family Member who qualifies as a full-time student will continue during:

(a) A regularly scheduled vacation period or between-term period as established by the institution. Work limited to such period is not considered employment on a regular full-time basis.

(b) A period of absence from class due to disability for up to four months following the end of the month in which such disability occurred provided that the student continues to be enrolled in the institution, as modified by the medically necessary leave of absence provisions in Definitions (o)(4).

8.43 The student's eligibility will terminate at the end of the month in which full-time student status ends either by (a) graduation or completion of the course or (b) other termination of full-time attendance at the institution, at the end of the month in which the student attains age 25, or when the student ceases to be a dependent under Code Section 152.[13]

Disabled Children

[13] See Page 11 of IRS publication 501 for definition of who qualifies as a dependent under Code Section 152. Go to *www.irs.gov/pub/irs-pdf/p501.pdf* to find the version of IRS publication 501 in effect when this document was printed.

8.44 In order for a dependent child to be eligible as a disabled child for coverage under the Program after attainment of age 26, the child must:

(a) otherwise meet the Program's definition of an Eligible Family Member child under 26 years of age;

(b) be incapable of self-support because of a continuously disabling illness or injury which commenced prior to age 26; and

(c) be principally supported by you.

8.45 A disabled child greater than age 26 and not otherwise covered under the Program, may be considered an Eligible Family Member and enrolled in the Program if the participant follows necessary steps in paragraph 8.46 to certify such Eligible Family Member is a disabled child.

8.46 If you believe that an Eligible Family Member of yours meets the disability criteria above, you should secure from the employee benefits office at the plant or office where you work the Disabled Dependent Certification form which must be completed by you and the attending physician and returned to Highmark within 90 days of the date such Eligible Family Member attains the limiting age for dependent eligibility (age 26 if you are enrolled under this Program). That form will be reviewed by Highmark to determine the eligibility of such an Eligible Family Member for benefits under this Program. You may be required to submit additional information in connection with such eligibility determination. You will be notified by Highmark as to whether or not the Eligible Family Member is eligible for benefits of this Program as a disabled child. If such eligibility is approved, you will be further required, usually not more frequently than once a year, to furnish satisfactory evidence to substantiate the continued eligibility of such an Eligible Family Member.

SECTION 9. INSURANCE GRIEVANCES

9.0 If your claim for benefits under Section 2, 3, 4, 5, 6, or 10 of the Program, has been denied in whole or part and you believe such claim should have been granted, you may appeal the denial in accordance with paragraphs 2.19, 3.104, 4.30, 5.27, 6.13, 10.14 or 10.29. Whether or not you appeal such denial to the insurance carrier, you have the right to file a grievance appealing a denial of a claim under these paragraphs of the Program as well as to file a grievance protesting the denial of a claim under Sections 7 and 8 of the Program. If at any time you elect to bypass the insurance carrier and proceed directly to file a grievance, you will not be permitted to subsequently appeal to the insurance carrier or request External Review, if applicable. Within 60 days after written notification of the denial of the appeal of your claim, you may appeal to:

(1) if you are represented by the United Steelworkers, the Board of Arbitration established under the provisions of the Basic Labor Agreement between United States Steel Corporation and the United Steelworkers (P&M) (see Article Five, Section I) applicable to insurance grievances, or
(2) if you are represented by a union other than the United Steelworkers, the arbitrator designated under the basic labor agreement between the Company and the applicable union,

Such provisions do not apply to a beneficiary's claim for life insurance (See paragraph 1.17) and to any claim for benefits under Section 12.

9.1 The decision of the arbitrator shall be final and binding on the Company, the Plan Administrator, the applicable union, and you and your Eligible Family Members.

Grievance and Arbitration

9.2 During the time in which a discharge is being pursued through the Grievance and Arbitration process, all coverage under the Program, other than Sickness and Accident Benefits will be continued. In the event that the Company prevails in Arbitration, coverage will be terminated as of the date of the Arbitration decisions, at which time COBRA coverage will be offered.

SECTION 10. FLEXIBLE SPENDING ACCOUNTS
(FOR YOU AND YOUR ELIGIBLE DEPENDENTS)

Health Care Flexible Spending Account

Enrollment

10.0 You may elect to establish a Health Care Flexible Spending Account ("FSA") to pay for Covered Expenses incurred by you and/or your Eligible Family Members for which reimbursement is not provided through any other plan or policy. To establish a Health Care FSA, you must authorize a monthly deduction (taken on the Payroll Deduction Date) from your earnings on a pre-tax basis - based on an annual amount (minimum of $120 up to a maximum of the amount in Internal Revenue Code ("IRC") Section 125(i) as indexed for inflation for the Plan Year) for allocation to your Health Care FSA. The maximum Contribution amount is subject to change each year. Refer to your annual enrollment materials you receive to verify the most current maximum amount for allocation to the Health Care FSA. Health Care FSA Contributions may not be made from Supplemental Unemployment Benefit Program payments. You may elect each year during the annual enrollment period to establish a Health Care FSA. If you are a new employee, you must enroll prior to the date you become eligible for coverage under this Program.

10.1 Monthly deductions will begin as soon as possible following the effective date of your election. If your earnings during any month are insufficient to deduct the full amount of your designated Contribution, then no deduction will be made. Also, remember that reducing your earnings below the Social Security taxable wage base ($118,500 for 2016, $127,200 for 2017) can result in a small reduction in the amount of your Social Security benefit at retirement. To find the Social Security taxable wage base amount for a year, go to *www.ssa.gov*.

Eligible Family Members

10.2 For the purposes of the Health Care FSA, eligible Family Members include Eligible Family Members as defined in Definition (o), as well as any person who could qualify as a dependent on your federal income tax return. However, since certain exceptions may apply with respect to children of separated/divorced parents, you should obtain Publication 504 from, and/or consult, the IRS.

Covered Expenses — General Rules

10.3 "Covered Expenses" are expenses related to health care, which are defined as medical care under Code Section 213(d), provided such expenses:

(a) are incurred by you and/or your Eligible Family Members within the Applicable Claim Period. The applicable Claim Period (i) runs from January 1 to December 31 of the Plan Year for the 2016 Plan Year only and (ii) is the 14-1/2 month period commencing on January 1 of the Plan Year and ending on March 15 of the following calendar year beginning with the 2017 Plan Year.

Note: Covered Expenses are considered to have been incurred on the date the applicable medical services, supplies or treatments are received, except orthodontia expenses will be deemed to have been incurred on the date the initial procedure is performed if the orthodontist requires full payment upon commencement of treatments.

(b) are incurred after commencement of your participation in such Health Care FSA;

(c) are not reimbursable under the Medical Benefits described in Sections 3 and 4, the Dental Care Benefits described in Section 5, the Vision Care Benefits described in Section 6 or under any other plan or policy;

(d) are not claimed as a deduction or tax credit on your federal income tax return;

(e) are properly substantiated; and

(f) are not over-the-counter medications, except (a) when obtained with a prescription or (b) for insulin.

10.4 Covered Expenses fall into the following categories:

(a) Your share of expenses under the PPO Medical and Prescription Drug Benefits described in Sections 3 and 4, such as Program Deductibles, Coinsurance or Copayments, and amounts in excess of Program limits, including physicians' fees that exceed the Allowable Charge;

(b) Expenses that are not covered under the PPO Medical and Prescription Drug Benefits described in Sections 3 and 4;

(c) Expenses that are not reimbursed under the Dental Care Benefits described in Section 6; and

(d) Medical, prescription drug, dental, hearing and vision care expenses that you pay for persons who are Eligible Family Members under this Health Care FSA, but who are not covered under the PPO Medical Benefits described in Section 3, Prescription Drug benefits described in Section 4, Vision Care Benefits described in Section 5, and/or the Dental Care Benefits described in Section 6.

Non-Covered Expenses

10.5 Please refer to the TPA's Web site for a list of covered expenses.[14]

How Does the Health Care FSA Work?

10.6 When you elect a Health Care FSA, your account is funded with the full amount you have chosen during annual enrollment. There are three convenient payment options available:

(a) WageWorks Health Care Card. Use it instead of cash at health care providers and wherever accepted for health-related services and health expenses. You may not use your Card for Over-the-Counter (OTC) drugs at the pharmacy counter unless you provide a valid prescription for the OTC drugs at the times of purchase. You are able to use your Card for non-drug OTC items and devices, such as bandages and contact lens solutions, as long as you show the Card at merchants that have an industry standard (IIAS) inventory system that can verify the eligibility of items at checkout. An updated list of IIAS merchants is maintained at *www.sig-is.org*. Always remember to save receipts when using the Card. The IRS requires you keep them for your tax records, and you will also need them if WageWorks requests documentation for verification.

(b) Pay My Provider. An automatic bill pay system that requires appropriate documentation of the expense, such as a detailed invoice or Explanation of Benefits that contains the patient's name, service start and end date, the name of the service provider, description of service rendered and the amount paid or owed.

(c) Pay Me Back. Paper-based claims forms that provide rapid turnaround, real-time online visibility. File a claim online, by fax or mail for reimbursement.

Maximum Amount of Reimbursement

10.7 The full annual Health Care FSA election amount is available to you on the first day of the Plan Year. The total amount of reimbursements of Covered Expenses from Contributions made to your Health Care FSA with respect to a Plan Year cannot exceed the total Contributions authorized by you for allocation to your Health Care FSA during such Plan Year. If your employment is terminated (or your Health Care FSA coverage is terminated under paragraph 8.14), and if you do not elect COBRA continuation coverage under paragraph 10.10, the full annual Health Care FSA election amount is available for reimbursement; however, reimbursements will be limited to claims incurred prior to your date of termination.

Forfeiture of Unused Contributions

10.8 Covered Expenses incurred by you and/or your Eligible Family Members must be filed for reimbursement no later than (a) for the 2016 Plan Year only, April 15 immediately following the end of the Applicable Claim Period, and (b) beginning with the 2017 Plan Year only, June 15 immediately following the end of the Applicable Claim Period. At the end of this period of time, all remaining Contributions in your Health Care FSA for that Plan Year are forfeited. Such forfeitures will be reallocated equally among participants in the Health Care Flexible Spending Account in the future in such manner as the Plan Administrator deems to be consistent with IRS regulations.

Cessation After Termination of Employment (or Termination of Coverage under Paragraph 8.14)

10.9 Unless you make a COBRA election under paragraph 10.10 below, Contributions to your Health Care FSA will cease if your employment with the Company is terminated (or your Health Care FSA coverage is terminated in the event of disability, layoff, suspension or leave of absence under paragraph 8.14). Covered Expenses incurred by you and/or your Eligible Family Members prior to termination of your employment (or coverage) will be reimbursed. Covered Expenses incurred by you and/or your Eligible Family Members following your termination of employment (or termination of coverage) will not be reimbursed unless you make a COBRA election to continue your coverage. Claims are to be filed in accordance with paragraphs 10.12 and 10.13 below.

[14] Since special rules and/or exceptions may apply, you should obtain Publication 502 from, and/or consult, the IRS.

Continuation of Coverage (After Termination of Employment or Coverage)

10.10 If your employment with the Company is terminated or your Health Care FSA coverage is terminated under paragraph 8.14, you may be able to elect COBRA continuation coverage for your Health Care FSA. In such case, you may elect COBRA continuation coverage for your Health Care FSA if (a) is greater than (b) below:

(a) the net of:

(i) the sum of your elected monthly Contributions to your Health Care FSA for the entire 12-month Plan Year, minus

(ii) the amount of reimbursable claims submitted for that Plan Year as of the qualifying event date;

(b) the sum of your elected monthly Contributions to your Health Care FSA for the portion of the entire 12-month Plan Year that occurs subsequent to the qualifying event date, times 102%.

The term "qualifying event date" means the date your employment with the Company is terminated or the date your Health Care FSA coverage is terminated under paragraph 8.14. However, for employees who do not return to work at the end of FMLA leave, "qualifying event date" means the last day of FMLA leave. If COBRA continuation coverage is elected, the maximum period of such coverage extends from the qualifying event date to the end of the Plan Year.

See paragraphs 8.17 - 8.22 for additional details regarding COBRA.

Payment in the Event of Your Death

10.11 In the event of your death, payment of Covered Expenses for which a claim for reimbursement if timely filed will be made at the discretion of the claims administrator to either:

(a) one or more persons in the group consisting of your descendants, parents or heirs-at-law; or

(b) your estate.

When to File a Claim

10.12 You may file a claim for reimbursement of Covered Expenses incurred by you and/or your Eligible Family Members at any time. Reimbursements for Covered Expenses which are not filed during the Applicable Claim Period should be filed as soon thereafter as possible, but, in any event, not later than (a) for the 2016 Plan Year only, April 15 immediately following the end of the Applicable Claim Period, and (b) beginning with the 2017 Plan Year only, June 15 immediately following the end of the Applicable Claim Period. For example, claims for Covered Expenses incurred between January 1, 2016 and December 31, 2016 must be filed not later than April 15, 2017, and claims for Covered Expenses incurred between January 1, 2017 and March 15, 2018 must be filed not later than June 15, 2018.

How to File a Claim

10.13 You can file a claim in one of three ways, using the WageWorks Health Care Card, the TPA's Pay My Provider service or by reimbursement. For each item of expense for which reimbursement is requested on your form, you must attach required supporting documentation. In the case of reimbursement, send the completed claim form and accompanying documentation of expenses to the TPA at the address indicated on the claim form. Payment for Covered Expenses will be sent directly to you (by check) or to your checking or savings account if you have enrolled in the TPA's Direct Deposit Program.

How to Appeal a Claim

10.14 If you have any question concerning a denial in whole or in part of your claim, you should write within 180 days from the date of such denial to: WageWorks Claims Appeal Board, P.O. Box 991, Mequon, WI 53092-0991, furnishing all information supporting your position. If you are not satisfied with the decision rendered by that office, you may further appeal by writing within 60 days from the date of the reply to the Vice President - Administration, United States Steel and Carnegie Pension Fund, Room 1681, 600 Grant Street, Pittsburgh, Pennsylvania 15219-2800, furnishing additional information supporting your position.

Special Rule for Employees on FMLA Leave

10.15 If you are on an approved FMLA leave of absence, there is no reimbursement for Covered Expenses that are incurred after the date that your Health Care FSA coverage is terminated due to failure to make contributions. Upon your return to work after an approved FMLA leave, you may increase your monthly contributions to the amount that will allow you, during the remainder of the calendar year, to make up the amount of your unpaid contributions during your FMLA leave.

Penalties for Misuse

10.16 This benefit is governed by federal law, which is enforced by the Internal Revenue Service and other tax authorities. In addition to other legal remedies, your refusal to follow the terms of any applicable Agreement with the TPA or provision of false or fraudulent statements regarding the items or services you have purchased may result in deactivation of your Health Care Card, termination of participation in the Health Care FSA or other consequences. The tax authorities may also initiate tax collections against you.

Dependent Care FSA

Enrollment

10.17 You may elect to establish a Dependent Care FSA to pay for Covered Expenses incurred by reason of your employment. If you are married, your spouse must be employed, disabled or a full-time student in order to qualify for reimbursement of dependent care expenses. To establish a Dependent Care FSA, you must authorize a monthly deduction (taken on the Payroll Deduction Date) from your earnings (on a pre-tax basis) of a minimum of $120 per year to the amounts in Internal Revenue Code ("IRC") Section 129(a)(2)(A) for the Plan Year (i.e. for 2016, the yearly maximum amounts are a maximum of $5,000 per year if you have one or more qualifying persons, or $2,500 per year maximum if you are married and do not file a joint federal income tax return), for allocation to your Dependent Care FSA[15]. Because special rules and/or exceptions may also apply, you should obtain Publication 503 from, and/or consult, the IRS. Dependent Care FSA Contributions may not be made from Supplemental Unemployment Benefit Program payments. You may elect each year during the annual enrollment period to establish a Dependent Care FSA. If you are a new employee, you must enroll prior to the date you become eligible for coverage under this Program.

10.18 Monthly deductions will begin as soon as possible following the effective date of your election. If your earnings during any month are insufficient to deduct the full amount of your designated Contribution, then no deduction will be made. Also, remember that reducing your earnings below the Social Security taxable wage base ($118,500 for 2016) can result in a small reduction in the amount of your Social Security benefit at retirement. To find the Social Security taxable wage base amount for a year, go to *www.ssa.gov*.

Qualifying Persons

10.19 A qualifying person is:

(a) any person whom you claim or who could be claimed as your dependent under federal income tax regulations (obtain Publication 503 from, and/or consult, the IRS for special rules and/or exceptions) who is (1) under the age of 13, or (2) age 13 or over and physically or mentally incapable of self-care, and

(b) your spouse if that spouse is physically or mentally incapable of self-care.

However, because certain exceptions may apply regarding children of separated/divorced parents and with respect to income of disabled dependents, you should obtain Publications 503 and 504 from, and/or consult, the IRS.

Covered Expenses

10.20 "Covered Expenses" are expenses which are incurred primarily for the care of a qualifying person in order for you to be employed or to actively seek employment, provided such expenses comply with federal income tax regulations. If the care is provided outside your household, such care may be eligible for a qualifying person only if such person spends at least eight hours a day in your household. Covered Expenses include but are not limited to the following:

(a) Charges for baby-sitters or companions;

(b) Charges for a day care center which meets local regulations, provides care for more than six non-resident individuals, and charges a fee for service, whether or not for profit;

(c) Schooling costs for children before entry into kindergarten; and

(d) Charges for before- or after-school care; and

(e) Charges for ancillary household services performed by an individual who is primarily providing care for a qualifying person.

[15] The maximum amounts include any Company contributions if authorized by your bargaining agreement.

Please refer to the TPA's Web site for a list of covered expenses.

Note: Expenses reimbursed under the Dependent Care FSA cannot be claimed as a deduction or tax credit on your federal income tax return. In addition, dependent care expenses eligible for federal income tax credits must be offset by contributions to the Dependent Care FSA. See paragraphs 10.31 through 10.32 to help you determine whether a Dependent Care FSA or a federal income tax credit is best for you.

Non-Covered Expenses

10.21 Non-covered expenses include, but are not limited to, the following:

(a) Charges for services provided by an individual related to you or your spouse who could be claimed under a personal exemption for dependents under federal income tax regulations;

(b) Charges for services provided by your non-dependent child who is under age 19 at the end of the Plan Year;

(c) Food and clothing expenses related to the qualifying person;

(d) Educational expenses in or beyond kindergarten for a qualifying child who is not incapacitated; and

(e) Overnight camp expenses.

Please refer to the TPA's Web site for a list of covered expenses.

How Does the Dependent Care FSA Work?

10.22 When you elect a Dependent Care FSA, you can use these convenient payment options:

(a) Pay My Provider. An automatic bill pay system that requires appropriate documentation of the expense, such as a detailed invoice, the name of the dependent under care, service start and end date, the name of the service provider, description of service rendered and the amount paid or owed.

(b) Pay Me Back. Paper-based claims forms that provide rapid turnaround, real-time online visibility. File a claim online, by fax or mail for reimbursement.

Maximum Amount of Reimbursement

10.23 The maximum amount of expenses reimbursable from this Dependent Care FSA for a Plan Year during which you have made Contributions to your Dependent Care FSA[16] shall be equal to the least of the following:

(a) for the 2016 Plan Year - $5,000 if you have one or more qualifying persons, or $2,500 if you are married and do not file a joint federal income tax return (because special rules and/or exceptions may apply, you should obtain Publication 503 from, and/or consult, the IRS);

(b) the amount allocated to your Dependent Care FSA;

(c) your annual compensation if you are not married at the close of the Plan Year; or

(d) the lesser of your annual compensation or the earned income of your spouse, if you are married at the close of the Plan Year.

Note: In the event that your spouse is a student or is mentally or physically incapable of self-care, then such spouse will be deemed to have earned income of not less than $250 per month if you claim one qualifying person or $500 per month if you claim two or more qualifying persons for each month during which either situation exists.

In the event you submit a claim for Covered Expenses which exceed the balance in your Dependent Care FSA, you will be reimbursed up to the amount of Contributions credited to your Dependent Care FSA. The excess expense will be pended and automatically reimbursed as additional Contributions accrued to your Dependent Care FSA during the Plan Year in which the expenses were incurred.

Forfeiture of Unused Contributions

10.24 Covered Expenses incurred by you and/or your Eligible Family Members must be filed for reimbursement no later than April 15 immediately following the end of the Applicable Claim Period. At the end of this period of time, all remaining Contributions in your Dependent Care FSA for that Plan Year are forfeited. Forfeitures of employee contributions will be reallocated equally among participants in the Dependent Care Flexible Spending Account in the future in such manner as the Plan Administrator deems to be consistent with IRS regulations.

[16] The maximum amounts include any Company contributions if authorized by your bargaining agreement.

Continuation After Termination of Employment

10.25 If your employment with the Company is terminated, Contributions to your Dependent Care FSA will cease. However, Covered Expenses incurred during the remainder of the Plan Year will be reimbursed to the extent you have accrued contributions in your Dependent Care FSA. Claims are to be filed in accordance with paragraphs 10.27 and 10.28 below.

Payment in the Event of Your Death

10.26 In the event of your death, payment of Covered Expenses for which a claim for reimbursement is timely filed will be made at the discretion of the claims administrator to either:

(a) one or more persons in the group consisting of your descendants, parents or heirs-at-law; or

(b) your estate.

When to File a Claim

10.27 You may file a claim for reimbursement of Covered Expenses at any time. Covered Expenses which are not filed during the Plan Year in which they were incurred should be filed as soon thereafter as possible. In any event, all Covered Expenses must be filed not later than April 15 of the year following the Plan Year in which they were incurred.

How to File a Claim

10.28 You can file a claim in one of two ways, the TPA's Pay My Provider service or reimbursement. You must attach required supporting documentation in the case of reimbursement, send the completed claim form and accompanying documentation of expenses to the TPA at the address indicated on the claim form. Payment for Covered Expenses will be sent directly to you or your checking or savings account if you have enrolled in the TPA's Direct Deposit Program.

How to Appeal a Claim

10.29 If you have any question concerning a denial in whole or in part of your claim, you should write within 180 days from the date of such denial to WageWorks Claims Appeal Board, P.O. Box 991, Mequon, WI 53092-0991, furnishing all information supporting your position. If you are not satisfied with the decision rendered by that office, you may further appeal by writing within 60 days from the date of the reply to the Vice President - Administration, United States Steel and Carnegie Pension Fund, Room 1681, 600 Grant Street, Pittsburgh, Pennsylvania 15219-2800, furnishing additional information supporting your position.

Penalties for Misuse

10.30 This benefit is governed by federal law, which is enforced by the Internal Revenue Service and other tax authorities. In addition to other legal remedies, your refusal to follow the terms of any applicable Agreement with the TPA or provision of false or fraudulent statements regarding the items or services you have purchased may result in termination of participation in the Dependent Care FSA or other consequences. The tax authorities may also initiate tax collections against you.

FSA vs. Federal Income Tax Credit

10.31 You have a choice between two methods to save taxes on your eligible dependent care expenses: (a) the Dependent Care FSA, or (b) a tax credit on your federal income tax return for your dependent care expenses based on the number of your dependents and your adjusted household gross income.

10.32 You are encouraged to carefully consider which method will save you the most in taxes. Because there is no established rule about who may benefit from one method or another it is difficult to advise employees whether to continue Dependent Care FSA contributions or to use the tax credit (due to variables such as income level, availability of other deductions and credits such as the child credit and the earned income tax credit, the effect of tax legislation, and the effect of the alternative minimum tax). Your own situation can be determined only by a close look at your records. Personal tax situations vary. You should carefully consider the impact a Dependent Care FSA will have on your tax status. You are encouraged to consult your tax advisor to help understand how your circumstances, and the rules for federal income tax credits, will affect your decision.

SECTION 11. UNITED STATES STEEL CORPORATION FLEXIBLE BENEFITS PLAN (UNION)

Background

11.0 This Program is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, ("Code") and is to be interpreted in a manner consistent with the requirements of Code Section 125.

Definitions

11.1 (a) As used herein:

(1) **Cash** shall be defined to have the meaning outlined in paragraphs 11.6 and 11.7.

(2) **Key Employee** means any person who is a key employee as defined in Section 416(i) of the Code.

(3) **Qualified Benefits** shall have the meaning outlined in paragraph 11.5.

(b) **Gender and Number -** A pronoun or adjective in the masculine gender includes the feminine gender and the singular includes the plural, unless the context clearly indicates otherwise.

General Provisions

11.2 The General Provisions applicable to this Program regarding enrollment, costs of the benefits, periods of coverage, annual enrollment periods, changes in Family status, and other relevant provisions are outlined in Sections 7 and 8.

Option for Cash or Qualified Benefits

11.3 Subject to the limitations outlined in the General Provisions of Section 8, an employee may choose under this Program to receive his full compensation for any Plan Year in Cash (including the opt-out payment described in paragraph 7.1) or have a portion of his compensation applied by the Company toward the cost of one or more Qualified Benefits. The portion of compensation applied to the cost of Qualified Benefits shall be treated as non-taxable benefits under the Program to the extent permitted under the Code.

Maximum Amount of Elective Contributions

11.4 In the case of an employee who participates under the Program continuously for an entire Plan Year, the maximum amount per year of compensation that can be applied to the cost of Qualified Benefits is equal to the sum of:

(a) an amount equal to the highest monthly contributory cost of full Family coverage for Medical Benefits under this Program as outlined in Section 3 and Prescription Drug Benefits under this Program as outlined in Section 4;

(b) an amount equal to the maximum annual amount in Internal Revenue Code ("IRC") Section 125(i) as indexed for inflation for the Plan Year of compensation that can be applied to the Health Care FSA, as outlined in Section 10;

(c) an amount equal to the maximum amount in Internal Revenue Code ("IRC") Section 129(a)(1)(A) for the Plan Year;

(d) an amount equal to the maximum amount per month of compensation that can be applied to Dental Care Benefits, as outlined in Section 5;

(e) an amount equal to the maximum amount per month of compensation that can be applied to Vision Care Benefits, as outlined in Section 6; and

(f) an amount equal to the maximum amount per month of compensation that can be applied to Optional Accidental Death and Dismemberment Insurance, as outlined in Section 1.

Qualified Benefits Available Under the Program

11.5 In accordance with paragraphs 11.3 and 11.4, an employee may elect under this Program to apply a portion of his compensation to his share of the cost of one or more of the following optional Qualified Benefits.

(a) ***Health Care FSA (Section 10)***
The employee may allocate up to the maximum amount specified in paragraph 10.0 each month to this benefit.

(b) ***Dependent Care FSA (Section 10)***
The employee may allocate up to the maximum amount specified in paragraph 10.17 each month to this benefit.

(c) ***Optional Accidental Death and Dismemberment Insurance (Section 1)***
The employee may allocate up to the maximum amount specified in paragraph 1.10 each month to this benefit.

If an employee elects to receive a Qualified Benefit, the employee's cash compensation will be reduced and an amount equal to the reduction will be contributed by the Company under the applicable Qualified Benefit to cover the employee's share of the cost of such benefit as determined by the Company. The balance of the cost of each such benefit shall be paid by the Company under this Program with non-elective Company contributions.

Cash Benefits Available Under the Program

11.6 In accordance with the procedures and limitations outlined in Section 8, an employee who fails to return a completed election form to the Company on or before the specified due date for the election has effectively elected to claim his full compensation as a Cash Benefit. In addition, to the extent an employee elects not to allocate his compensation to the cost of a Qualified Benefit, the compensation shall be allocated to the employee as a Cash Benefit at the same time such compensation accrues.

11.7 An employee may elect under this Program to contribute all or a portion of his net after-tax Cash Benefit to the employee's share of the cost of one or more of the following optional benefits.

(a) Optional Life Insurance
Subject to the limitations and provisions outlined in Section 1, the employee may enroll for an amount of optional life insurance equal to $25,000; $50,000; $75,000; $100,000; or $125,000 $150,000; $175,000; or $200,000 and apply the Cash Benefit or other taxable compensation to make the required contribution for the purchase of this optional life insurance.

(b) Optional Spouse Life Insurance
Subject to the limitations and provisions outlined in Section 1, the employee may enroll for an amount of spouse life insurance equal to $20,000; $40,000; $60,000; $80,000; or $100,000 and apply the Cash Benefit or other taxable compensation to make the required contribution for the purchase of this life insurance.

(c) Optional Child(ren) Life Insurance
Subject to the limitations and provisions outlined in Section 1, the employee may enroll for an amount of optional child(ren) life insurance for each of his Eligible Dependent children (as defined in the Program for purposes of this benefit) equal to $5,000; or $10,000 and apply the Cash Benefit or other taxable compensation to make the required contribution for the purchase of this life insurance.

(d) Optional Critical Illness Coverage
Subject to the limitations and provisions outlined in Section 12, the employee may enroll for an amount of optional Critical Illness Coverage equal to $15,000 or $30,000 and apply the Cash Benefit or other taxable compensation to make the required contribution for the purchase of this insurance.

(e) Optional Accident Coverage
Subject to the limitations and provisions outlined in Section 12, the employee may enroll for optional Accident Coverage and apply the Cash Benefit or other taxable compensation to make the required contribution for the purchase of this insurance.

Notification of Employees

11.8 The Plan Administrator shall communicate in writing to all eligible employees the terms and conditions of the Program.

Contributions and Financing

11.9 All payments from this cafeteria plan, other than Contributions from Cash Benefits, will be financed by Company contributions. Any expense incurred by the Company relative to the administration of the cafeteria plan shall be paid by the Company.

Adoption of Applicable Claim Period for Health Care FSAs

11.10 Effective with the 2017 Plan Year, the Applicable Claim Period is defined as the 14-1/2 month period commencing on January 1 of the Plan Year and ending on March 15 of the following calendar year under the Health Care Flexible Spending Account provisions of Section 10, as authorized by IRS Notice 2005-42. For the 2016 Plan Year, the Applicable Claim Period is the calendar year.

SECTION 12. Other Optional Benefits
(For You and Your Eligible Family Members)

Critical Illness

Eligibility/Enrollment

12.0 You are eligible to elect optional Critical Illness coverage (or increase your coverage amount or level at annual enrollment or due to a Qualified Life Event) if you are a full-time active Employee. You may keep Critical Illness coverage if you are not actively at work and remain eligible for continuation of PPO Medical Benefits. You may elect Critical Illness coverage to pay for certain conditions incurred by you and/or your Eligible Family Members. If you are a new Employee, you must enroll within 30 days of your eligibility. You may elect coverage levels of $15,000 or $30,000. Your benefit amount is determined based on the coverage level elected. Coverage is guaranteed provided you are actively at work (and the spouse and/or Eligible Family Member child is/are not subject to medical restriction as set forth in the Certificate). Your Critical Illness coverage is subject to the terms of the group policy, which is incorporated herein by reference. In the event of any conflicts between the provisions below and the group policy, the group policy will control.

12.1 Contributions will be deducted from your earnings on an After-tax basis on the Payroll Deduction Date. If you do not have enough earnings to cover the full monthly deduction, then no deduction will be taken. (You will be billed for such amounts if your pay is insufficient to cover the Contribution.) Your monthly Contribution amount may change from year to year. Refer to the annual enrollment materials you receive each year for the most current monthly Contribution amount required. Monthly Contributions will automatically increase upon attainment of an age included in the next age band. Monthly Contributions are as follows:

Monthly Contribution for					
	Amount of Coverage				
	$15,000			**$30,000**	
Age	**Employee Only**	**Family**		**Employee Only**	**Family**
<25	$5.10	$12.55		$10.20	$25.11
25–29	$7.05	$16.45		$14.10	$32.90
30–34	$9.60	$19.97		$19.20	$39.94
35–39	$11.70	$22.56		$23.40	$45.13
40–44	$14.85	$27.19		$29.70	$54.38
45–49	$16.95	$30.39		$33.90	$60.79
50–54	$25.80	$44.07		$51.60	$88.14
55–59	$29.25	$48.79		$58.50	$97.57
60–64	$37.50	$61.10		$75.00	$122.20
65–69	$77.55	$124.28		$155.10	$248.55
70+	$108.45	$177.10		$216.90	$354.19

Eligible Family Members

12.2 Eligible Family Members are defined in Definitions (o).

How Does Critical Illness Coverage Work?

12.3 Critical Illness coverage complements (does not replace) your existing medical and disability income coverage, and provides coverage for certain Covered Conditions such as certain cancer-related conditions, certain heart-related conditions, and certain other specified conditions. Once enrolled, if you are diagnosed with certain specified Covered Conditions for the first time after your effective date under the policy, you will receive an "Initial Benefit", which is a lump-sum benefit payment that can be used as you see fit. A Recurrence Benefit is available if an Initial Benefit has been paid for the following covered conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer and Partial Benefit Cancer. A Benefit Suspension Period between Recurrences applies.

Covered Conditions

12.4 "Covered Conditions" are certain specified diseases or certain specified surgeries that you and/or your Eligible Family Members have been diagnosed with or have incurred for the first time after Critical Illness coverage is effective, and while coverage is in effect. MetLife Critical Illness Insurance will pay 100% of the Initial Benefit Amount when a covered person is first diagnosed with one of the Covered Conditions (other than Partial Benefit Cancer and each of the 22 Listed Conditions, which are payable at 25% of the Initial Benefit Amount).

12.5 Covered Conditions fall into the following categories: Alzheimer's Disease; Coronary Artery Bypass Graft; Full Benefit Cancer; Heart Attack; Kidney Failure; Major Organ Transplant Partial Benefit Cancer; Stroke; 22 Listed Conditions (see below).

Listed Conditions

12.6 MetLife Critical Illness Insurance will pay 25% of the Initial Benefit Amount when a covered person is first diagnosed with one of the 22 Listed Conditions. A Covered Person may only receive one payment for each Listed Condition in his/her lifetime. **Listed Conditions** means any of the following diseases: Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

Maximum Amount of Reimbursement

12.7 In the event that you suffer more than one Covered Condition, the Total Benefit Amount payable per Covered Person per lifetime is three times the coverage elected ($45,000 or $90,000, respectively).

Critical Illness coverage is subject to certain benefit amounts, limitations and exclusions as set forth in the group policy.

When does Coverage End?

12.8 Your coverage will end on the earliest of:

- the date the Group Policy ends;
- the date you die;
- the date coverage ends for your class;
- the end of the month for which the last full premium has been paid for you;
- the date you cease to be in an eligible class; or
- the end of the month your employment ends for any reason.

Your Eligible Family Member's coverage will end on the earliest of:

- the date your coverage under the Certificate ends;
- the date Eligible Family Member's coverage ends under the Group Policy for all employees or for your class;
- the end of the month the person ceases to be an Eligible Family Member;
- the date the Total Benefit Amount has been paid for that Eligible Family Member;
- the date you cease to be in a class that is eligible for Eligible Family Member coverage;
- the end of the month you retire in accordance with the Group Policyholder's retirement plan; or
- the end of the month for which the last full premium has been paid for the Eligible Family Member.

Portability (After Coverage Ends)

12.9 If your employment with the Company is terminated you will be able to continue your Critical Illness coverage by paying premiums directly to the TPA.

Payment of Benefits

12.10 Payment for Covered Conditions will be sent directly to you (by check). In the event that you are determined to be not legally competent to claim or receive benefits, payment of up to $10,000 may be paid to anyone related to you by blood or marriage (upon discretion of the TPA), with the remainder paid to your legal representative.

Payment in the Event of Your Death

12.11 In the event of your death, payment of Covered Conditions for which a claim is timely filed will be made to any person you designate as beneficiary. You have the right to change the beneficiary at any time by completing an on-line beneficiary designation with the TPA. If there is no beneficiary designated or no surviving beneficiary at your death, the TPA will determine the beneficiary to be one or more of the following who survive you, in the order listed below:

(a) your spouse;
(b) your child(ren);
(c) your parent(s);
(d) your sibling(s); or
(e) your estate.

Instead of making payment in the order above, the TPA may pay your estate. Any payment made in good faith will discharge the TPA's liability to the extent of such payment. If a beneficiary or payee is a minor or incompetent to receive payment, that person's guardian will be paid.

When to File a Claim

12.12 Claims for Covered Conditions should be filed as soon as possible, but, in any event, not later than the deadline established by the TPA (within one year of the date of loss, or if you are legally incapacitated, until you are able to file a claim).

How to File a Claim

12.13 You can obtain a claim form at www.metlife.com/mybenefits. For each Covered Condition for which payment is requested on your form, you must attach required supporting documentation. Send the completed claim form and accompanying documentation to the TPA at the address indicated on the claim form.

How to Appeal a Claim

12.14 If you have any questions concerning a denial in whole or in part of your claim, you must write within 60 days from the date you receive such denial to MetLife at the address indicated on the claim form, furnishing the reason(s) you believe the claim was improperly denied, and all information supporting your position (additional comments, documents, records or other information relating to your claim that you deem appropriate to enable the TPA to give your appeal proper consideration). The TPA will carefully evaluate all the information and will advise you of its decision within 60 days. Claims and appeals will be processed by the TPA in accordance with the Department of Labor's claims regulations.

Accident Coverage

Eligibility/Enrollment

12.15 You are eligible to elect optional Accident Coverage (or increase your coverage level at annual enrollment or due to a Qualified Life Event) if you are a full-time active Employee. You may keep Accident coverage if you are not actively at work and remain eligible for continuation of PPO Medical Benefits. You may elect Accident Coverage for you or for you and your Eligible Family Members. If you are a new Employee, you must enroll within 30 days of your eligibility. Coverage is guaranteed provided you are actively at work (and the spouse and/or Eligible Family Member child is/are not subject to medical restriction as set forth in the Certificate). Your Accident Coverage is subject to the terms of the group policy, which is incorporated herein by reference. In the event of any conflicts between the provisions below and the group policy, the group policy will control.

12.16 Contributions will be deducted from your earnings on an After-tax basis on the Payroll Deduction Date. If you do not have enough earnings to cover the full monthly deduction, then no deduction will be taken. (You will be billed for such amounts if your pay is insufficient to cover the Contribution.) Your monthly Contribution amount may change from year to year. Refer to the annual enrollment materials you receive each year for the most current monthly Contribution amount required. Monthly Contributions are as follows:

Coverage Level	Monthly Rate
Employee	$9.77
Employee + Family	$30.11

Eligible Family Members

12.17 Eligible Family Members are defined in Definitions (o).

Covered Accident

12.18 "Covered Accidents" means accidents that you and/or your Eligible Family Members occurring for the first time after Accident Coverage is effective, and while coverage is in effect. Accident Coverage provides you with a payment if you undergo testing, receive medical services, treatment or care resulting from the accident, for any one of more than 150 covered events as defined in your group coverage certificate, and includes hospitalization resulting from an accident and accidental death and dismemberment.

How Does Accident Coverage Work?

12.19 Accident Coverage provides coverage if you experience a covered event, but only while off the job. There is no waiting period for coverage to begin. Once enrolled, if you if you experience a covered event after your effective date under the policy, you will receive a lump-sum benefit payment that can be used as you see fit, and is paid in addition to any other insurance you may have.

Maximum Amount of Reimbursement

12.20 Accident Coverage provides you with a lump-sum payment that is determined according to a schedule of benefits as set forth in the group policy. Accident Coverage is subject to certain benefit amounts, limitations and exclusions as set forth in the group policy.

12.21 "Covered Events" include but are not limited to:

- Fractures;
- Dislocations;
- Second and third degree burns
- Skin Grafts
- Torn knee cartilage
- Ruptured Disc
- Concussions
- Cuts/lacerations

- Eye injuries
- Coma
- Broken Teeth

Covered Medical Services/Treatments

12.22 "Covered Medical Services/Treatments" means any of the following medical services/treatments:

- Ambulance
- Emergency care
- Inpatient surgery
- Outpatient surgery
- Medical Testing Benefits (x-rays, MRIs, CT scans);
- Physician follow-up visits
- Transportation
- Home modifications
- Therapy services (including physical and occupational therapy)

When does Coverage End?

12.23 Contributions will cease if your employment with the Company is terminated.

Your coverage will end on the earliest of:

- the date the Group Policy ends;
- the date you die;
- the date coverage ends for your class;
- the end of the month for which the last full premium has been paid for you;
- the date you cease to be in an eligible class; or
- the end of the month your employment ends for any reason.

Your Eligible Family Member's coverage will end on the earliest of:

- the date your coverage under the Certificate ends;
- the date Eligible Family Member's coverage ends under the Group Policy for all employees or for your class;
- the end of the month the person ceases to be a Eligible Family Member;
- the date you cease to be in a class that is eligible for Eligible Family Member coverage;
- the end of the month you retire in accordance with the Group Policyholder's retirement plan; or
- the end of the month for which the last full premium has been paid for the Eligible Family Member.

Portability (After Coverage Ends)

12.24 If your employment with the Company is terminated you will be able to continue your Accident Coverage by paying premiums directly to the TPA.

Payment of Benefits

12.25 Payment for Covered Accidents will be sent directly to you (by check). In the event that you are determined to be not legally competent to claim or receive benefits, payment of up to $10,000 may be paid to anyone related to you by blood or marriage (upon discretion of the TPA), with the remainder paid to your legal representative.

Payment in the Event of Your Death

12.26 In the event of your death, payment of Covered Accidents for which a claim is timely filed will be made to any person you designate as beneficiary. You have the right to change the beneficiary at any time by completing an on-line beneficiary designation with the TPA. If there is no beneficiary designated or no surviving beneficiary at your death, the TPA will determine the beneficiary to be one or more of the following who survive you, in the order listed below:

(a) your spouse;
(b) your child(ren);
(c) your parent(s);
(d) your sibling(s); or
(e) your estate.

Instead of making payment in the order above, the TPA may pay your estate. Any payment made in good faith will discharge the TPA's liability to the extent of such payment. If a beneficiary or payee is a minor or incompetent to receive payment, that person's guardian will be paid.

When to File a Claim

12.27 Claims for Covered Accidents/Events incurred by you and/or your Eligible Family Members should be filed as soon as possible, but, in any event, not later than the deadline established by the TPA (within one year of the date of loss, or if you are legally incapacitated, until you are able to file a claim).

How to File a Claim

12.28 You can obtain a claim form at www.metlife.com/mybenefits. For each Covered Accident for which payment is requested on your claim form, you must attach required supporting documentation. Send the completed claim form and accompanying documentation to the TPA at the address indicated on the claim form. Claims are generally processed within 10 business days.

How to Appeal a Claim

12.29 If you have any questions concerning a denial in whole or in part of your claim, you must write within 60 days from the date you receive such denial to MetLife at the address provided on the claim form, furnishing the reason(s) you believe the claim was improperly denied, and all information supporting your position (additional comments, documents, records or other information relating to your claim that you deem appropriate to enable the TPA to give your appeal proper consideration). The TPA will carefully evaluate all the information and will advise you of its decision within 60 days. Claims and appeals will be processed by the TPA in accordance with the Department of Labor's claims regulations.

INSURANCE AGREEMENT

Between

United States Steel Corporation

and the

United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union

Effective January 1, 2016

Pittsburgh, Pennsylvania

INSURANCE AGREEMENT

AGREEMENT effective January 1, 2016 between United States Steel Corporation and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (the "Union").

Definition

1. Wherever used herein
   (a) "Employee" means an employee in one of the Bargaining Units in Exhibit A attached hereto;
   (b) "Program" means the Program of Insurance Benefits effective January 1, 2016, established by this Agreement and described in the booklets adopted by the parties, such booklets constituting a part of this Agreement as though incorporated herein;
   (c) "Prior Program" means for those Bargaining Units with an effective date under this Insurance Agreement of January 1, 2016, the Program of Insurance Benefits in effect as of December 31, 2015;
   (d) "Company" means United States Steel Corporation and its participating subsidiaries.

Program of Insurance Benefits

2. The Program shall be applicable to Employees while this Agreement is in effect (the period starting January 1, 2016), in accordance with the provisions of this Agreement, subject to the following provisions:
   (a) Any coverage which as of January 1, 2016 is being continued in accordance with the provisions of the Prior Program during an Employee's absence because of layoff, leave of absence or disability shall be continued after December 31, 2015 for the maximum period provided by the Program, reduced by the period such coverage was continued prior to January 1, 2016. Any such coverage which was terminated under the Prior Program prior to January 1, 2016 shall be reinstated under the Program as of the date the Employee returns to active work.
   (b) The benefits of the Prior Program shall be applicable to any occurrence prior to January 1, 2016, subject to all of the provisions of the Prior Program, except that to the extent medical, prescription drug, dental and vision care benefits related to such occurrence are payable for a period extending beyond December 31, 2015, the benefits otherwise payable shall be conformed to the benefits provided under the Program, and will be payable for the period provided under the Program reduced by the amount of or the period for which benefits were paid prior to January 1, 2016.
   (c) Benefit provisions of the Program not contained in the Prior Program shall not be applicable to any period prior to January 1, 2016.

Cost of Benefits

3. The cost of the benefits under the Program shall be paid by the Company, except as provided below in this paragraph 3 and in paragraph 6 hereof:
   (a) Any Employee on layoff who elects to continue basic life insurance after the last month of layoff for which such life insurance is continued without Employee contribution will be required to pay 60¢ per month per $1,000 of basic life insurance for each month as to which he or she is eligible in order to continue such insurance.
   (b) The amounts required to be paid for benefits provided under law in excess of Program benefits shall be paid entirely by the Employees.
   (c) In the event of a strike resulting from failure of the parties to reach an agreement following proper notice given by either party under the provisions of any collective bargaining agreement, the Program, with the exception of Sickness and Accident coverage, will be continued for 30 days. The Company will advance the premiums for coverage during such 30 days, which premiums will be repaid by the Employees. During such 30 days, the parties will discuss procedures and arrangements with respect to further continuation of insurance coverage and the repayment of premiums advanced.

Participation by Employees

4. Each Employee shall be a participant in the Program and the amount, if any, which the Employee shall be required to contribute to the cost thereof shall be deducted by the Company from his or her pay. Each Employee shall furnish to the Company any such written authorization or assignment (in a form agreed to by

the Company and the Union) as shall be necessary to authorize the deduction from his or her pay of the amount of any contributions.

Requirements of Law

5. It is intended that the provisions for the insurance benefits which shall be included in the Program shall comply with and be in substitution for the provisions for similar benefits which are or shall be made by any applicable law or laws. Where, by agreement, certain basic benefits under the Program are provided under law rather than under the Program, the Company will pay the amount required to be paid therefor, including any Employee contribution required by law on account of such benefits. The Company shall, after consultation with the Union, reduce the benefits of the Program to the extent that benefits provided under any law would otherwise duplicate any of the Program benefits.

Additional and Alternate Benefits

6. (a) The Program shall be in substitution for any and all insurance benefits or payments to or on behalf of Employees for death, sickness or accident, medical (PPO), dental, prescription drug or vision care service or health care or dependent care reimbursement accounts provided by the Company in whole or in part, except as the Company and the Union have agreed or may agree in writing.

   (b) The Union and the Company may agree that benefits may be provided in addition to those which are to be financed by the arrangements set forth in paragraph 3, provided that the full cost of such additional benefits shall be paid by the Employees covered for such additional benefits and provision may be made by agreement between the Company and the Union to deduct the cost of such additional benefits from the pay of such Employees.

Administration of the Program

7. The Program shall be administered by the Company or through arrangements provided by it. Except as may otherwise be provided in this Agreement, the Company will arrange to have the PPO Medical, Dental Care and Vision Care Benefits under the Program provided through contracts with carriers mutually agreed to by the Company and the Union. Sickness and Accident Benefits, Life Insurance, Prescription Drug Benefits and Health Care and Dependent Care Flexible Spending Accounts shall be provided by such method and through such carriers, if any, as the Company in its sole discretion shall determine. Any contracts entered into by the Company with respect to the benefits of the Program shall be consistent with this Agreement and shall provide benefits and conditions conforming to those set forth in the booklet. The administrative arrangements with Highmark Blue Cross Blue Shield, Aetna, United Concordia Companies and Davis Vision concerning the provision of benefits required by the Program shall not be changed or modified except by mutual agreement of the Company and the Union, which agreement neither party shall unreasonably withhold.

Life Insurance After Retirement

8. Any Employee who shall have retired and who shall have become entitled to basic life insurance after retirement pursuant to the provisions of the insurance agreement and booklet applicable to such Employee at the time of retirement shall not have such basic life insurance terminated or reduced (except as provided in such booklet) so long as he or she remains retired from the Company, notwithstanding the expiration of such agreement or booklet or of this Agreement, except as the Company and the Union may agree otherwise.

Extent of Company Obligation

9. The failure of any carrier to provide for benefits under the Program shall not result in any liability to the Company, nor shall such failure be considered a breach by the Company of any of the obligations which it has undertaken by this or any other agreement with the Union. In the event of any such failure, the Company and the Union shall immediately take action to provide substitute coverage in accordance with the provisions of this Agreement. Notwithstanding the foregoing, any decision reached with respect to a grievance processed under the provisions of the basic labor agreement applicable to insurance grievances shall be binding on the Company, and, to the extent such decision requires the provision of benefits which the carrier fails to pay, the Company will provide such benefits.

Insurance Reports

10. The Union shall be furnished annually a report regarding the Program. From time to time during the term of this Agreement, the Union shall be furnished such additional information as shall be reasonably required for the

purpose of enabling it to be properly informed concerning the operation of the Program. Any accounting under the Program shall make no distinction between the experience with respect to Employees and other employees who may be covered, except that experience of employees who participate in the Program on a different basis or are entitled to different benefits from those provided for Employees represented by the Union shall be included in such accounting only to the extent that the Company and the Union agree to such inclusion. The Company will keep insurance records of individual employees and a major portion of the investigation and payment of claims. The cost to the Company of performing such work will not, for any accounting under the Program, be deemed to be a cost of the Program.

Separate Benefits

11. The Parties agree that Medical (including Prescription Drug), Dental Care and Vision Care will be considered separate benefits.

Term of Agreement

12. This Agreement shall become effective as of January 1, 2016, and shall remain in effect until February 1, 2019 and thereafter subject to the right of either party on 60 days' written notice served on or after December 3, 2018 to terminate this Insurance Agreement.

UNITED STATES STEEL CORPORATION

J. MICHAEL WILLIAMS
General Manager – Employee Benefits

Confirmed:

UNITED STEELWORKERS

THOMAS M. CONWAY
International Vice President - Administration

EXHIBIT A. USW BARGAINING UNITS COVERED BY INSURANCE AGREEMENT

Following are the groups of employees, and their locations, in bargaining units to which the Insurance Agreement is applicable:

United Steelworkers
USS Steel Operations – Hourly P&M

	Effective Date	Location
USS Clairton*	1/1/16	Clairton, PA
USS East Chicago Tin*	1/1/16	East Chicago, IN
USS Edgar Thomson*	1/1/16	Braddock, PA
USS Fairfield Steel*	1/1/16	Fairfield, AL
USS Fairfield Flat Roll*	1/1/16	Fairfield, AL
USS Fairfield Pipe*	1/1/16	Fairfield, AL
Fairfield Seamless Tubular Operations**	3/6/16	Fairfield, AL
USS Fairless*	1/1/16	Fairless Hills, PA
USS Gary Sheet and Tin*	1/1/16	Gary, IN
USS Gary Steel*	1/1/16	Gary, IN
USS Granite City*	1/1/16	Granite City, IL
USS Great Lakes*	1/1/16	Ecorse, MI
USS Irvin*	1/1/16	West Mifflin, PA
USS Lorain Tubular*	1/1/16	Lorain, OH
Seamless Tubular Operations – Lorain**	3/13/16	Lorain, OH
USS Midwest*	1/1/16	Portage, IN

USS Steel Operations – Salaried O&T

USS Clairton*	1/1/16	Clairton, PA
USS East Chicago Tin*	1/1/16	East Chicago, IN
USS Edgar Thomson*	1/1/16	Braddock, PA
USS Fairfield*	1/1/16	Fairfield, AL
Fairfield Seamless Tubular Operations**	3/6/16	Fairfield, AL
USS Fairless*	1/1/16	Fairless Hills, PA
USS Gary Sheet and Tin*	1/1/16	Gary, IN
USS Gary Steel*	1/1/16	Gary, IN
USS Granite City*	1/1/16	Granite City, IL
USS Great Lakes	1/1/16	Ecorse, MI
USS Irvin*	1/1/16	West Mifflin, PA
USS Lorain Tubular*	1/1/16	Lorain, OH
Seamless Tubular Operations – Lorain**	3/13/16	Lorain, OH
USS Midwest*	1/1/16	Portage, IN

USS Steel Operations – Salaried Plant Protection

USS Clairton*	1/1/16	Clairton, PA
USS East Chicago Tin*	1/1/16	East Chicago, IN
USS Edgar Thomson*	1/1/16	Braddock, PA
USS Fairfield*	1/1/16	Fairfield, AL
Fairfield Seamless Tubular Operations**	3/6/16	Fairfield, AL
USS Gary Sheet and Tin*	1/1/16	Gary, IN
USS Gary Steel*	1/1/16	Gary, IN
USS Granite City*	1/1/16	Granite City, IL
USS Great Lakes*	1/1/16	Ecorse, MI
USS Irvin*	1/1/16	West Mifflin, PA
USS Midwest*	1/1/16	Portage, IN

USS Minnesota Ore Operations – Hourly P&M

United Steelworkers

Minntac*	1/1/16	Mt. Iron, MN
Keetac*	1/1/16	Keewatin, MN

USS Minnesota Ore Operations –	Effective Date	Location
Salaried O&T*	1/1/16	Mt. Iron, MN

EMPLOYEES OF
FAIRFIELD SOUTHERN COMPANY

United Steelworkers

Fairfield Southern Company	1/1/16	Various

EMPLOYEES OF
U. S. STEEL TUBULAR PRODUCTS, INC. ("USSTP")

United Steelworkers

USSTP Lone Star Tubular Operations –
Hourly P&M

Lone Star Plant	1/1/16	Lone Star, TX
Star Tubular Plant	1/1/16	Lone Star, TX

Employing Company
**** UNITED STATES STEEL CORPORATION ("USS")***
***** U. S. STEEL SEAMLESS TUBULAR OPERATIONS, LLC***

This Agreement is also applicable to employees who are members of bargaining units not listed above, but included in Exhibit A of the January 1, 2013 Insurance Agreement between the Company and the Union, whose health care coverage is in effect on January 1, 2016 pursuant to the provisions of the Prior Program.

(Other bargaining units of employees represented by the Union may be added to this Exhibit A from time to time by written agreement of the parties.)

EXHIBIT B. NON-USW BARGAINING UNITS COVERED BY THE PROGRAM

Following are the groups of employees, and their locations, in bargaining units to which the Insurance Agreement is applicable:

EMPLOYEES OF
UNITED STATES STEEL CORPORATION ("USS")

	Effective Date	Location
Laborers' International Union of North America –		
Local #397		
USS Steel Operations		
Granite City	1/1/16	Granite City, IL
Bricklayers and Allied Craftworkers International Union –		
Local #8 IL		
USS Steel Operations		
Granite City	1/1/16	Granite City, IL

(Temporary employees are excluded. Other bargaining units of employees represented by the unions listed above may be added to this Exhibit B from time to time.)

EXHIBIT C. LETTER OF UNDERSTANDING

January 1, 2016

Mr. Thomas M. Conway
International Vice President - Administration
United Steelworkers
Five Gateway Center
Pittsburgh, Pennsylvania 15222

Dear Mr. Conway:

As a condition of the Insurance Agreement effective January 1, 2016, it is understood that:

1. Pursuant to paragraph 7 of the Insurance Agreement, the Medical, Vision and Dental Benefits of the Program set forth in the booklets adopted by the parties pursuant to said Agreement will, during the term of the Program, be provided by contracts with Highmark Blue Cross Blue Shield, Davis Vision, Inc., and United Concordia Companies, Inc., respectively, unless otherwise agreed upon by the parties.

2. The arrangement contained in the Program with respect to Medicare has been developed by the parties in the light of the specific provisions of the Medicare Program, and shall not be regarded as any precedent with respect to the adjustment of the Program required by the Insurance Agreement because of benefits provided by law.

3. The arrangement contained in the Program with respect to no-fault insurance has been developed by the parties in the light of the specific provisions of the no-fault insurance laws and shall not be regarded as any precedent with respect to the adjustment of the Program required by the Insurance Agreement because of benefits provided by law.

4. In the case of an employee who while actively at work receives benefits under a workers' compensation or occupational disease law or other similar applicable law because of a partial disability and who subsequently suffers a temporary total disability resulting from the same or a related cause, the payments received under such law for the period of temporary total disability shall not reduce the total benefits for partial disability the employee would receive if he or she had continued actively at work without recurrence of total disability.

5. An employee's rights and the Company's right to discharge him or her shall not be enlarged or affected by reason of any provision of this Agreement.

Very truly yours,

/s/ J. Michael Williams

J. MICHAEL WILLIAMS
General Manager – Employee Benefits
United States Steel Corporation

Confirmed:

/s/ Thomas M. Conway

THOMAS M. CONWAY
International Vice President - Administration
United Steelworkers

EXHIBIT D. LETTER OF UNDERSTANDING

September 1, 2015

Mr. Thomas M. Conway
Vice President and Chairman
Union Negotiating Committee
United Steelworkers
Five Gateway Center
Pittsburgh, PA. 15222

Re: Expanded Drug Utilization Management Programs

Dear Mr. Conway:

The following confirms our commitment to ensure the inclusion of additional drugs within the prescription drug care management programs for active employees effective April 1, 2016 with minimal disruption or inconvenience to our participants.

If in the future, while we believe it is unlikely and unanticipated, the Union identifies that there are participant issues with availability or significant difficulties getting approvals for certain drugs, the Company and Union will work with Express Scripts to address those issues.

Furthermore, if the parties determine that the issues with any specific drug or drugs which are added to this enhanced list are so significant that we cannot reasonably address and resolve the issues, U. S. Steel will eliminate such drugs form the care management program.

Very truly yours,

/s/ J. Michael Williams

J. MICHAEL WILLIAMS
General Manager – Employee Benefits
United States Steel Corporation

Confirmed:

/s/ Thomas M. Conway

THOMAS M. CONWAY
International Vice President - Administration
United Steelworkers

EXHIBIT E. LETTER OF UNDERSTANDING (UNPUBLISHED)

October 26, 2017

Mr. Thomas M. Conway
Vice President and Chairman
Union Negotiating Committee
United Steelworkers
Five Gateway Center
Pittsburgh, PA. 15222

Re: Allowable Charges for Out-of-Network Services

Dear Mr. Conway:

This is to confirm that with respect to medical out-of-network claims, effective for claims incurred on or after January 1, 2017:

Highmark BCBS will calculate its reimbursement for claims from non-contracted providers in Pennsylvania, Delaware and West Virginia based on the applicable Highmark in-network allowance for participating providers. For medical claims from non-contracted providers outside of Pennsylvania, Delaware and West Virginia, Highmark will attempt to negotiate resolution of the claim, in which case there will be no balance billing to the participant. If efforts to negotiate the reimbursement of billed charges are unsuccessful, reimbursement will be made based on the Data iSight claims database (subject to exclusions and applicable effective dates determined by the medical claims administrator).

Aetna will process out-of-network claims for providers who do not accept its negotiated or contractual charge in accordance with the FAIR Health charge data at the 90th percentile (or equivalent, if unavailable), updated periodically and based on the geographic area where the patient receives the service or supply.

Very truly yours,

/s/ J. Michael Williams

J. MICHAEL WILLIAMS
General Manager – Employee Benefits
United States Steel Corporation

Confirmed:

/s/ Thomas M. Conway

THOMAS M. CONWAY
International Vice President - Administration
United Steelworkers