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

Summary Plan Description (SPD)
Effective
January 1, 2016

Amended to January 1, 2018

PIB-1000
January 2018

Summary Plan Description (SPD) Booklet

This document describes the benefits and rights provided to eligible employees under the Program of Insurance Benefits for Employees of United States Steel Corporation (referred to as the Program) in effect on January 1, 2016, as amended to January 1, 2018.

This Program was established in accordance with agreements that are part of overall collective bargaining agreements between United States Steel Corporation ("USS") (and certain subsidiaries) and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers Industrial Union (headquarters - 60 Boulevard of the Allies, Pittsburgh, Pennsylvania 15222) (referred to as the "United Steelworkers" or "Union"). The Program also applies to certain employees of the Company who are represented by the Bricklayers and Allied Craftworkers International Union (headquarters - 1776 Eye Street N.W., Washington D.C. 20006); and the Laborers' International Union of North America (headquarters - 905 16th Street Northwest, Washington D.C. 20006) (collectively referred to as the "Other Unions").

The Program may be amended or terminated in accordance with the terms of the applicable insurance agreement.

This SPD is not the official plan document, and only the official plan document governs the operation of the Program. If there are any differences between this SPD and the official plan document, the terms of the official plan document and any related administrative rules govern. The official plan document cannot be modified by this SPD, other unofficial communications (such as e-mails), or oral statements made by anyone.

Want a copy of the plan document or an insurance agreement for this Program? Send an e-mail (or letter) to the plan administrator at the Benefits Service Center. You can access this SPD, the plan document and other benefits information from the Health & Welfare website (see below).

Have a question on how this Program is administered? Call the Benefits Service Center.

Benefits Service Center
600 Grant Street
Room 1681
Pittsburgh, PA 15219-2800

Phone: **412-433-5790 or toll free 877-877-4586**
Fax: **412-433-4886**
E-mail: **BenefitsServiceCenter@uss.com**

Hours of Operation: 8 a.m. - 5 p.m. Eastern Time on non-holiday weekdays

How to Use Your SPD Booklet

This SPD gives you general, easy-to-understand explanations of Program features such as:

- if, and when, you are eligible to participate;
- how you enroll;
- your available options;
- how you pay your share of the costs;
- covered services (and what's limited or not covered);
- how you file a claim; and
- your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

In addition to using this booklet, you can find information on Company-sponsored benefits through an online benefits website 24/7, and by contacting a service center staffed by benefit representatives:

Health and Welfare website – Go to the Company's intranet from work or home (https://employee.uss.com). After you log in, navigate to the Employee Resources tab and click on the Health & Welfare link under the Benefits Center heading to connect to the website and access an online version of this SPD and other benefits information and forms. It's also a handy resource for learning how a personal or work-related change may affect your benefits and what you need to do.

Benefits Service Center – For all benefit-related questions, call the Benefits Service Center from 8 a.m. - 5 p.m. Eastern Time on non-holiday weekdays or send an e-mail.

Benefits Service Center	Phone:	Toll free 877-877-4586 or 412-433-5790
600 Grant Street	Fax:	412-433-4886
Room 1681	E-mail:	BenefitsServiceCenter@uss.com
Pittsburgh, PA 15219-2800		

Who to Call

If you have a question, claim or need information on network providers, contact the following claims administrators / insurance companies directly, using the following contact information. You can also find this information on your ID cards.

Not sure who to call? Check with the Benefits Service Center first at 877-877-4586.

Access this information online using *the Benefit Claims Administrators – Contact List* in the *Library* on the Health & Welfare website.

Medical		
Highmark Blue Cross/Blue Shield • Precertification • Mental health/substance abuse	800-245-6642 800-452-8507 800-258-9808	www.highmarkbcbs.com
Aetna • Precertification • Mental health/substance abuse	800-308-8787 800-333-4432 800-333-4432	www.aetna.com
Prescription Drugs		
Express Scripts Accredo (Specialty Pharmacy)	800-287-4508 800-803-2523	www.express-scripts.com www.accredo.com
Dental		
United Concordia	800-332-0366	www.ucci.com
Vision		
Davis Vision	800-401-2581	www.davisvision.com
Life Insurance (Basic, Optional, AD&D)		
MetLife • Claims & Statement of Health • Beneficiary Information • Coverage Information (contact the Benefits Service Center)	800-638-6420 855-877-3500 877-877-4586	www.metlife.com/mybenefits
Sickness & Accident		
Integrated Disability Management	866-760-1938	
Flexible Spending Accounts		
PayFlex (2018 Plan Year)	844-729-3539	www.payflex.com
WageWorks (2016 and 2017 Plan Years)	877-924-3967 FAX: 877-353-9236	www.wageworks.com
COBRA		
bswift, LLC (2018 Plan Year)	866-365-2413	www.bswift.com
WageWorks (2016 and 2017 Plan Years)	877-502-6272	www.wageworks.com
Optional Benefits – Accident/Critical Illness		
Aetna (2018 Plan Year)	888-772-9682	www.aetnavoluntaryforms.com
MetLife • Coverage Information • Claims	800-438-6388 866-626-3705	www.metlife.com/mybenefits

Table of Contents

BENEFIT BASICS

Program Overview

To help you achieve and maintain good health, the Company offers valuable and comprehensive health and welfare (H&W) benefits to you and your dependents:

- Medical
- Prescription drug
- Dental
- Vision
- Life and other optional insurance
- Sickness & accident
- Flexible spending accounts (FSAs)

Participating Employers

Participating employers have entered into collective bargaining agreements with the United Steelworkers and Other Unions to provide benefits under this Program to certain groups of employees (*Your Rights under ERISA* explains how to request a copy of a collective bargaining agreement). Participating employers may be added or removed from time to time.

Throughout this SPD, when the term "Company" is used, it refers to United States Steel Corporation and its subsidiaries listed in the Appendix to this booklet.

Want to know if a particular employer is a sponsor of the plan and if so, that employer's address? Check Appendix A for a list of participating employers (also called employing companies). To obtain the address, send an e-mail (or letter) to the plan administrator at the Benefits Service Center: BenefitsServiceCenter@uss.com

Eligibility

Employees

You and your Eligible Family Members (also known as dependents) are eligible for Program benefits if you are in regular service with the Company in a group of employees designated by the Company through its agreements with the union as covered under the Program. You and your dependents become eligible for coverage 60 calendar days from your date of hire.

Part-Time Employees

If you are a part-time employee, the amount of your life insurance and of your sickness and accident benefit are reduced in proportion to the hours you work in comparison to those of full-time employees. In addition, your dependents are not eligible for the medical, prescription drug, dental, and vision benefits of the Program. In applying the coordination of benefits provisions, any other group plan providing you benefits will be deemed to be the primary plan as compared to the Program.

Eligible Family Members (Dependents)

An Eligible Family Member (also known as a dependent) is a person who is:

- your legal spouse (or your common-law spouse, but only in states that recognize common-law marriage and only if approved by the plan administrator);

- your biological child, stepchild, or legally adopted (or placed with you for adoption) child who is under age 26; or

- your unmarried child who is age 26 or older, and who is:

  - a dependent as described above, and
  - incapable of self-support because of a continuously disabling illness or injury that occurred before age 26; and
  - principally supported by you.

- an unmarried child who is:

  - your grandchild or for whom you are legal guardian; and
  - under age 21, a full-time student under age 25, or disabled; and
  - considered a tax dependent, is permanently living in your home, and relies on you for support.

To obtain coverage for an Eligible Family Member (or dependent), you will be required to provide documentation establishing this person's relationship to you, date of birth, certification of disabled status of children age 26 and older (and, if applicable, any required certification for grandchildren and children for whom you are legal guardian), and their Social Security card.

Disabled Children

If you believe your child qualifies as a disabled dependent, obtain the Disabled Dependent Certification form from your medical claims administrator. You and your doctor should complete the form and follow all directions and deadlines shown on the form. You may be required to submit additional information.

Your medical claims administrator will determine if your dependent is disabled and eligible for coverage under the Program. If approved, you must submit evidence periodically showing that your dependent continues to be disabled.

If You and Your Spouse Both Work for the Company

If you and your spouse are employees of the Company, you can each make separate elections; however, your eligible dependent children can only be covered by you or your spouse – not both of you.

If You and Your Spouse Both Work

If your spouse is a full-time employee and eligible for health care coverage under his or her employer's plan, he or she must enroll under the employer's plan if participation is paid for in whole or in part by the employer. You may choose to also enroll your working spouse in Company-provided benefits, but benefits payable under this Program generally will be reduced as though your spouse was enrolled in his or her employer's plan.

Your working spouse may be covered under the Company's health care plan without a reduction in benefits in the following situations:

- Your spouse works less than 32 hours per week and is required to pay for his or her employer-provided health care benefits.

- There is a waiting period for your spouse to enroll in employer-provided coverage. Your spouse can be enrolled in Company health care benefits until the earliest date he or she can enroll in the employer plan. The earliest available enrollment date must be certified in writing to the plan administrator.

- Your spouse's employer-provided health care plan includes a medical pre-existing condition limitation.

- Your spouse is waiting for coverage to take effect under his or her employer-provided health care plan because your spouse has to provide evidence of insurability (complete a statement of health) before coverage will begin.

- Your spouse is rejected for coverage under his or her employer-provided plan because of evidence of insurability requirements. In this case, the Company will continue to cover your spouse but will contact your spouse's employer to investigate the reasons for rejection.

Working Spouse Reimbursement

If your spouse pays over $50 per month for coverage under his or her employer's plan, the Company will reimburse the excess up to a maximum benefit of $350 per month on a quarterly basis for coverage effective on or after January 1, 2016. To be eligible for this reimbursement, you must be enrolled for coverage under this Program, submit a reimbursement claim form, and provide evidence of the premiums paid by your spouse no later than six months after the end of the current year.

Print a working spouse reimbursement claim form using the Health & Welfare website, accessible from https://employee.uss.com.

Enrollment

When You First Become Eligible

If you are a new employee, you will be enrolled in the Program at the time of your employment with coverage becoming effective 60 calendar days from your date of hire. You enroll online for benefits using the Health & Welfare website.

If you have eligible dependents, your eligible dependents will be covered effective on the same date as your coverage. You must provide documentation establishing this dependent's relationship to you, date of birth, disabled status, or full-time student status if applicable, and Social Security card. Once the Benefits Service Center receives the required documentation, coverage for that dependent will be retroactive to the date of his or her initial eligibility.

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 dependents who are children, in which case, eligible dependent 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 dependents, if otherwise eligible, will automatically be enrolled as an eligible dependent of the other covered employee.

If you are a student hired on or after May 1 for summer employment, however, you will not be covered for the dental benefits of the Program unless such employment extends beyond September 30, in which case you will then be covered for dental benefits.

If you don't make elections within 30 days of your eligibility, you will be automatically enrolled in the benefits shown in *Default Coverage*. Automatic enrollment in default coverage ensures that the employee has medical, dental and vision coverage. If the 30-day period has expired, please contact the Benefits Service Center.

The elections you make (or the default elections if you don't enroll) remain in effect until December 31 of the current year unless you have a qualified life event that allows you to change your benefits before then (see *Changing Your Benefits during the Year*).

Annual Enrollment

During the annual enrollment period, you use the Health & Welfare website to make changes to your benefits for the next year. This is important because if you want to contribute to an FSA, you must make an election each year.

If you elect to enroll an Eligible Family Member (or dependent), you will be required to provide documentation establishing this person's relationship to you, date of birth, certification of disabled status of children age 26 and older (and, if applicable, any required certification for grandchildren and children for whom you are legal guardian), and their Social Security card. Once the Benefits Service Center receives the required documentation, coverage for that dependent will be retroactive to the beginning of the plan year.

If you don't make elections/changes by the annual enrollment deadline, you will be automatically enrolled the next calendar year in the benefits shown in *Default Coverage*.

The elections you make (or if you don't enroll, the default elections) remain in effect from January 1 through December 31 of the next year unless you have a qualified life event after January 1 that allows you to change your benefits (see *Changing Your Benefits during the Year*).

Qualified Life Event

If you experience a qualified life event (a change in your Family status, a significant cost or coverage change, or entitlement to Medicare) during the year (outside of the annual enrollment period), you may be able to enroll for coverage at that time. You generally have 60 days from the date of your qualified life event to enroll for benefits online through the Health & Welfare website. (The 60-day deadline does not apply if you want to add or delete PPO Medical Benefits, Prescription Drug Benefits, Dental Care Benefits and Vision Care Benefits coverage for an eligible dependent. You are encouraged to make a prompt election to avoid denial of claims and allow you to comply with COBRA requirements. See *Medical. Prescription Drug, Dental and Vision – Special Rule* under *Adding or Deleting Dependents* below.) If the 60-day period has expired and you have a question about your options, please contact the Benefits Service Center.

If you elect to enroll a new Eligible Family Member (dependent), you will be required to provide documentation establishing this person's relationship to you, date of birth, certification of disabled status of children age 26 and older (and, if applicable, any required certification for grandchildren and children for whom you are legal guardian), and their Social Security card. Once the Benefits Service Center

receives the required documentation, coverage for that dependent will be retroactive to the date of the qualified life event.

Any elections you make remain in effect until December 31 of the current year unless you have another qualified life event that allows you to change your benefits before then (see *Changing Your Benefits during the Year*).

Waiving Medical and Prescription Drug Coverage and Opt-Out Allowance

If you waive Company-provided coverage and certify that you have coverage under your spouse's employer-provided plan or your previous employer's plan (excluding a plan to which the Company or its subsidiaries contribute), you will receive a monthly opt-out allowance of $300. (If you waive coverage, you are not eligible to receive the working spouse reimbursement described previously in this booklet.)

To receive this allowance, you must apply, certify, and then recertify your eligibility on a quarterly basis using the forms and process established by the plan administrator.

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.

When Coverage Begins and Ends

When Coverage Begins

Coverage begins on these dates for you and your dependents:

- Medical, prescription drug, dental, vision, basic life and sickness and accident benefit coverage begins 60 calendar days after your date of hire. To ensure enrollment of your Eligible Family Members, enroll them through the Health & Welfare website or contact the Benefits Service Center. If you are not actively at work on the day coverage is scheduled to begin, coverage begins when you return to work.
- If you enroll for optional employee life insurance, optional spouse life insurance, optional child(ren) life insurance, optional accidental death and dismemberment insurance, optional critical illness coverage, optional accident coverage, or Flexible Spending Account within 30 days of your eligibility date, coverage for you and any enrolled Eligible Family Members (dependent) generally begins 60 calendar days after your date of hire. If you are not actively at work on the day coverage is scheduled to begin, coverage begins when you return to work.

  Remember, if you have an Eligible Family Member, you must provide documentation establishing this Eligible Family Member's relationship to you, date of birth, disabled status or full-time student status if applicable, and Social Security card. Once the Benefits Service Center receives the required documentation, coverage for that Eligible Family Member will be retroactive to the date of your initial eligibility.

- If you enroll during an annual enrollment period, coverage is effective January 1 of the following year.

- If you change coverage (optional employee life insurance, optional spouse life insurance, optional child(ren) life insurance, optional accidental death and dismemberment insurance, optional critical illness coverage, optional accident coverage, or change the amount of an existing Flexible Spending Account election) for yourself or an Eligible Family Member due to a qualified life event and you make the change within 60 days of the event, coverage takes effect on the event date.

- Elections for certain life insurance amounts may require you (or your spouse) to provide a statement of health (evidence of insurability). Coverage will take effect once the life insurance claims administrator approves the statement of health.

When Coverage Ends

Coverage ends on the earliest of these dates for you and/or your Eligible Family Members (also known as dependents):

- the date your employment is terminated for any reason other than retirement or death;

- the fifth day of an absence from work for reasons other than disability, layoff, leave of absence, suspension, vacation, jury duty, witness duty, or any other specifically authorized leave of absence;

- last day of the month in which your employment ends because of retirement or death;

- last day of the month in which you have a qualified life event, if you drop coverage due to that event;

- December 31, if during annual enrollment, you elect to drop coverage for the following year;

- the last day of the month in which you fail to make a required payment for coverage that is being continued for a specified period of time under COBRA, disability, layoff, suspension, or leave of absence; or

- last day of the month in which any individual ceases to be an Eligible Family Member.

Coverage End Dates for Non-Spouse Dependents

Situation Your biological child, stepchild, or legally adopted child…..	**Coverage End Date**
• Reaches age 26	End of the month in which age 26 is reached
• No longer meets the criteria of a disabled dependent after reaching age 26	End of the month in which situation occurs

Coverage End Dates for Non-Spouse Dependents	
Situation Your dependent grandchild or a dependent child for whom you have been appointed legal guardian….	**Coverage End Date**
• Reaches age 21 and is not a full-time student or disabled • Is a full-time student who reaches age 25 or loses full-time student status (if earlier) • No longer meets the criteria of a disabled dependent	End of the month in which situation occurs
• Has not had his or her student status certified by the last business day in August	August 31
• Has not had his or her student status certified by the last business day in December	December 31
• Is age 21 or older but under age 25, and loses full-time student status due to a medically necessary leave of absence	The earlier of the date that is one year after the first day of the medically necessary leave of absence or the date on which coverage would otherwise end under the terms of the Program

Other specific termination provisions may apply to a specific benefit. Refer to the appropriate section of this booklet for complete details.

You are responsible for notifying the Benefits Service Center when your spouse or other dependent is no longer eligible for coverage because of divorce, death, or a change in his or her eligibility or employment status.

You or your dependents may be eligible to continue health plan coverage (medical, prescription drug, dental, and vision coverage and Health Care FSA participation) after losing eligibility under the Program's terms, because, for example, you are no longer employed or a dependent reaches the age limit for coverage. See *COBRA Continuation Coverage* in *More Information about Your Benefits and Rights* for details about rights to continued coverage.

Your Benefits during an Absence from Work

If You Are on Layoff

As shown below, certain benefits under the Program will be continued based on your years of continuous service as of your layoff date (unless otherwise provided in your bargaining agreement).

Layoff		
Benefit	**Years of Continuous Service as of Your Layoff Date**	**Impact**
Sickness & Accident	N/A	Coverage ends on the date you stop working.
Medical, prescription drug, dental, vision, basic life insurance, and critical illness and accident	20 or more	Coverage continues during your layoff up to 24 months from the end of the month in which you last worked.
	More than 10 but less than 20	Coverage continues during your layoff up to 12 months from the end of the month in which you last worked. If your layoff continues beyond that period, you may elect prior to the date your coverage terminates, to continue your $50,000 of basic life insurance for the next 12 months by paying $30 per month for the coverage. If you don't make the required payment, basic life insurance coverage ends at the end of the last month for which payment was made.
	More than 2 but less than 10	Coverage continues during your layoff up to 6 months from the end of the month in which you last worked. If your layoff continues beyond that period, you may elect prior to the date your coverage terminates, to continue your $50,000 of basic life insurance for the next 18 months of layoff by paying $30 per month for the coverage. If you don't make required payments, insurance coverage ends at the end of the last month for which payment was made.

Layoff		
Benefit	**Years of Continuous Service as of Your Layoff Date**	**Impact**
Medical, prescription drug, dental, vision, basic life insurance, and critical illness and accident	Less than 2	Your medical, prescription drug, dental and vision coverage ends at the end of the month in which you last worked. Your basic life insurance continues during your layoff up to 6 months from the end of the month in which you last worked. If your layoff continues beyond 6 months, you may elect prior to the date your coverage terminates, to continue your $50,000 of basic life insurance for the next 18 months of layoff by paying $30 per month for the coverage. If you don't make required payments, insurance coverage ends at the end of the last month for which payment was made.
Optional employee, spouse, child(ren), and accidental death & dismemberment insurance	Same as above	You may continue these optional benefits for the same periods as described above for continuation of basic life insurance, but you must make the required monthly payments. If you don't make required payments, coverage for that optional benefit ends at the end of the last month for which payment was made. You will be considered to have voluntarily terminated your optional insurance and coverage will not be reinstated when you return to work.
Flexible spending accounts	N/A	Payroll deductions will be made as long as you have sufficient earnings from which the full deduction can be taken. If there aren't enough earnings to deduct the full amount, no deduction will be taken. As long as you remain eligible for medical benefits during your absence, FSA coverage continues. When you are no longer eligible for medical benefits during your absence, your FSAs end. (COBRA will be offered for both medical benefits and the Health Care FSA, if applicable).

If You Are on Disability

As shown below, certain benefits under the Program will be continued based on your years of continuous service as of your last day worked.

Non-Occupational Disability		
Benefit	**Years of Continuous Service as of Your Last Day Worked**	**Impact**
Medical, prescription drug, dental, vision, basic life	15 or more	Coverage continues until the end of the last month for which you are eligible for sickness & accident (disability) benefits (104 weeks maximum).
	More than 2 but less than 15	Coverage continues up to 12 months from the end of the month in which you last worked.
	Less than 2	Coverage continues up to 6 months from the end of the month in which you last worked. If still disabled beyond this period and meet other conditions, you may be eligible to continue basic life for up to 6 additional months.
Optional employee, spouse, child(ren), and accidental death & dismemberment insurance	Same as above	You may continue these optional benefits for the same periods as described above for your other benefits, but you must make the required monthly payments. If you don't make required payments, coverage for that optional benefit ends at the end of the last month for which payment was made. You will be considered to have voluntarily terminated your optional insurance and coverage will not be reinstated when you return to work.
Flexible spending accounts	N/A	Payroll deductions will be made as long as you have earnings from which the full deduction can be taken. If there aren't enough earnings to deduct the full amount, no deduction will be taken. As long as you remain eligible for medical benefits during your absence, FSA coverage continues. When you are no longer eligible for medical benefits during your absence, your FSAs end. (COBRA will be offered for both medical benefits and the Health Care FSA, if applicable).

Occupational Disability		
Benefit	**Years of Continuous Service as of Your Last Day Worked**	**Impact**
Medical, prescription drug, dental, vision, basic life	N/A	Coverage continues during disability and ends at the end of the month following the month in which workers' compensation payments stop.
Optional employee, spouse, child(ren), and accidental death & dismemberment insurance	N/A	You may continue these optional benefits for the same period as described above for your other benefits, but you must make the required monthly payments. If you don't make required payments, coverage for that optional benefit ends at the end of the last month for which payment was made. You will be considered to have voluntarily terminated your optional insurance and coverage will not be reinstated when you return to work.
Flexible spending accounts	N/A	Payroll deductions will be made as long as you have earnings from which the full deduction can be taken. If there aren't enough earnings to deduct the full amount, no deduction will be taken. As long as you remain eligible for medical benefits during your absence, FSA coverage continues. When you are no longer eligible for medical benefits during your absence, your FSAs end. (COBRA will be offered for both medical benefits and the Health Care FSA, if applicable).

If You Are on an Approved Leave of Absence

As shown below, certain benefits under the Program will be continued based on the type of leave.

Leave of Absence		
Benefit	**Type of Leave**	**Impact**
Sickness & accident	All types of leave	Coverage ends on the date you stop working.
Medical, prescription drug, dental, vision, and critical accident and illness	Military	Coverage continues for 30 days from the last day worked.
	Military special	Coverage continues for the duration of the leave (up to 2 years).
	Personal, temporary/permanent international union business	Coverage continues until the end of the month in which you stop working.
	FMLA	Coverage continues for the duration of the leave.
Optional employee, spouse, child(ren), and accidental death & dismemberment insurance	All types of leave	You may continue these optional benefits for the same periods as described below for continuation of basic life insurance, but you must make the required monthly payments. If you don't make required payments, coverage for that optional benefit ends at the end of the last month for which payment was made. You will be considered to have voluntarily terminated your optional insurance and coverage will not be reinstated when you return to work.
Basic life insurance	Military	Coverage continues for 30 days from the last day worked.
	Military special	Coverage continues for the duration of the leave (up to 2 years).
	Personal, FMLA, temporary/permanent international union business	Coverage continues for 6 months from the end of the month in which you stop working.
Flexible spending accounts	All types of leave	Payroll deductions will be made as long as you have earnings from which the full deduction can be taken. If there aren't enough earnings to deduct the full amount, no deduction will be taken. As long as you remain eligible for medical benefits during your absence, FSA coverage continues. When you are no longer eligible for medical benefits during your absence, your FSAs end. (COBRA will be offered for both medical benefits and the Health Care FSA, if applicable).

Inpatient Benefits after Termination of Coverage

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

- the maximum amount of benefits has been paid; or
- the inpatient stay ends; or
- you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program.

If you are pregnant on the date coverage ends, no additional coverage will be provided, unless you are receiving inpatient care as of the date of your termination.

Changing Your Benefits during the Year – Qualified Life Events

IRS rules define the qualified life events (changes in your personal situation) that allow you to change certain benefits. If you do not have a qualified life event during a plan year, except as described elsewhere, you may not be able to change your benefits until the next annual enrollment.

Qualified life events include family status changes such as:

- a change in legal marital status (marriage, divorce, legal separation, death of a spouse) for you or a dependent;
- birth of a child, date you adopt a child or placement for adoption, or date a child becomes your stepchild;
- death of a dependent;
- a change in a dependent's eligibility (for example, a child reaching age 26, a dependent becoming eligible for Medicare, or a dependent enrolling or losing coverage under the state's Medicaid or SCHIP program);
- a change in child care/elder care provider cost or coverage, such as a significant cost increase charged by your current daycare provider or a change in your daycare provider (applies only to a Dependent Care FSA that you are enrolled in); or
- a change in employment status (for you or a dependent).

If you recently experienced a qualified life event or are anticipating one in the near future, you should review your current benefit elections and determine if changes are needed.

Have a question on what benefits you can change due to a qualified life event?
Contact the Benefits Service Center at 412-433-5790 or toll free 877-877-4586 or via email to BenefitsServiceCenter@uss.com.

You have only 60 days from the date of the qualified life event to request a change to your coverage for the following benefits using the Health & Welfare website:

- Health care FSA (change in amount),
- Dependent care FSA (change in amount),
- Optional employee life insurance,
- Optional spouse life Insurance,
- Optional child(ren) life insurance,
- Optional accidental death & dismemberment insurance,
- Optional critical illness coverage, and
- Optional accident coverage.

If applicable, within 30 days of your request you must provide any required supporting documents (birth or marriage certificate, etc.). Your election will not take effect unless you provide the required documentation within 30 days of making your online election. If the 30-day period has expired, please contact the Benefits Service Center.

When you change your coverage due to a qualified life event, coverage may be retroactive to the date of the event (for example, the day your child was born). You will be responsible for paying any applicable employee contributions for the full period of coverage going back to the effective date, even if you wait a month before officially requesting a coverage change. If you miss contributions for coverage (such as for optional insurance) — for example, if you're out on a leave of absence — you must make up the missed contributions. As a result, your contributions for benefit coverage will be increased until the outstanding balance is repaid in full.

If you are changing your benefits as a result of a family status change, your change must be consistent with and correspond with the qualified life event. For example, you cannot add a dependent to your coverage if your qualified life event was a change in child care/elder care provider cost or coverage.

The plan administrator may request documentation for any coverage changes. If you misrepresent a qualified life event, or fail to submit required documentation, the coverage change may be canceled if the change added coverage that is not allowed, that coverage may be canceled retroactively, to the extent permitted by law, and the Company and the plan administrator may take other appropriate action. In that case, you and any ineligible individual may be required to repay any benefits paid on behalf of you or the ineligible individual.

Adding or Deleting Dependents

Medical. Prescription Drug, Dental and Vision – Special Rule

You may add or delete PPO Medical Benefits, Prescription Drug Benefits, Dental Care Benefits and Vision Care Benefits coverage for an eligible dependent at any time during the calendar year. The effective date of the change will be the date of your Family status change, significant cost or coverage change(s) or entitlement to Medicare. (This is permitted because there is no change to the amount of your pre-tax deduction). You are encouraged to make a prompt election to avoid having future claims denied for a newly-acquired eligible dependent who is not included in the claims administrator's eligibility files, and to allow you to comply with the requirements relating to COBRA continuation coverage.

All Other Benefits Under the Program

For all other benefits under the Program, the effective date of any change in dependent coverage is the earlier of:

- 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 of the event, or
- January 1 following the annual enrollment period during which you elect a change.

If you elect to enroll a new eligible dependent, you must provide documentation establishing this dependent's relationship to you, date of birth, disabled status or full-time student status if applicable, and Social Security card. Generally, once the Benefits Service Center receives acceptable documentation, coverage on the newly added dependent will be retroactive to the date of the qualified life event.

Who Pays the Cost for Coverage

You and the Company pay the cost of your coverage. You pay the applicable deductibles, copays, and coinsurance amounts for medical, prescription drug, dental, and vision coverage for you and your eligible dependents. The Company pays the remaining cost of coverage, except as otherwise provided under the Plan. The Company pays the cost of your basic life insurance, and sickness and accident coverage under the Program. You pay for any optional insurance coverage, Critical Illness and Accident Coverage, and Health Care or Dependent Care FSA contributions. The cost for coverage is communicated each year during annual enrollment.

You are responsible for your monthly contributions, which will be deducted on the Payroll Deduction Date. If your pay is insufficient to cover your contributions, you will receive a notice requesting that you pay your required contribution.

Default Coverage

If you do not make an election within 30 days of your initial eligibility, by the annual enrollment deadline, or within 60 days of a qualified life event, you will be enrolled automatically (defaulted) in the following benefits/coverage:

Default Coverage			
Type of Benefit	**Newly Eligible**	**Annual Enrollment**	**Qualified Life Events**
Medical	PPO, Employee only coverage	Current election	Current election
Dental	Employee only coverage	Current election	Current election
Vision	Employee only coverage	Current election	Current election
Health care FSA	Waived	Waived	Current election
Dependent care FSA	Waived	Waived	Current election
Basic life insurance	$50,000	$50,000	$50,000
Optional employee life insurance	Waived	Current election	Current election

Default Coverage			
Type of Benefit	**Newly Eligible**	**Annual Enrollment**	**Qualified Life Events**
Optional spouse life Insurance	Waived	Current election	Current election
Optional child(ren) life insurance	Waived	Current election	Current election
Optional accidental death & dismemberment insurance	Waived	Current election	Current election
Optional Critical illness coverage	Waived	Current election	Current election
Optional Accident coverage	Waived	Current election	Current election

You may not change your benefit elections until the earlier of:

- the date of any change in your family status,
- significant cost or coverage change(s),
- entitlement to Medicare, or
- the next annual enrollment period.

If You Become Eligible for Medicare due to Age 65 or Disability

If you or your dependent becomes eligible for Medicare, the Medicare-eligible person should enroll in 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. The Medicare-eligible person has several options:

- Continue in the Program and decline Medicare Part B coverage — Coverage under the Program continues without change as long as you continue working. If you are the Medicare-eligible person and you decide to retire at age 65, it is important that you (or your dependent) enroll for Medicare Part B immediately upon retirement to avoid a serious gap in your health care coverage. If you are the Medicare-eligible person but you are not retiring, or the Medicare-eligible person is your dependent, enroll for Medicare Part B within the allowable enrollment period. If not, you/your dependent can enroll for Medicare Part B coverage only during the months of January, February, and March of any year with Part B coverage taking effect July 1 of that year.

- Continue in the Program and enroll for Medicare Part B coverage — Coverage under the Program continues without change as long as you continue working. You/your dependent must pay a monthly premium for Medicare B coverage and will receive only limited Medicare benefits because Medicare benefits will be reduced by Program benefits. The Company will not reimburse you for the Medicare Part B premium.

- Cancel coverage under the Program and elect Medicare coverage — You must notify the Company in writing that you or your dependent enrolled for coverage under Medicare and is canceling medical coverage under the Program. Coverage under the Program will then be limited to life insurance, sickness and accident (disability), dental, and vision benefits only. The Company will reimburse you for the Medicare Part B premium.

If you are absent from work for more than two years because of an occupational disability but still have active employee status for seniority and benefit purposes, you should enroll for Medicare Part A within the allowable enrollment period and also enroll for Medicare Part B. Payment under the Program will be reduced by the amount of benefits you receive, or would upon application receive, under Medicare Part A or B. For any month in which you are covered by the health care benefits of this Program, the Company will pay the charge for Medicare Part B coverage for you.

If You Become Eligible for Medicare due to End-Stage Renal Disease

If you or your dependent becomes eligible for Medicare due to end-stage renal disease (permanent kidney failure requiring dialysis or a transplant), health care benefits under this Program will be payable for 30 months following the date you or your dependent became Medicare-eligible. At the end of this period, Medicare will become the primary payer and the following will apply:

- Payment under this Program will be the benefit that would otherwise be payable under this Program reduced by the amount of benefits you or your dependent receive, or would receive, under Medicare Part A or Part B. When calculating benefits, covered services will be reduced by Medicare benefits before applying the deductible, if any, imposed by this Program.

- For any month for which you or your dependent is covered under this Program, the Company will reimburse you for the Medicare Part B premium, except where the Part B charge for a dependent is deducted from Social Security or Railroad Retirement benefits.

Coverage for Retirees and Surviving Spouses

Medical

You and your dependents (including your surviving spouse if you die) may be eligible for medical coverage under another Company-sponsored benefits program for retirees if you were hired or rehired before January 1, 2016, have at least 15 years of continuous service and meet other conditions outlined in the United States Steel Corporation Retiree Health Program for USW-Represented Employees (RHP). You (or your surviving spouse) will be required to pay a portion of the cost for medical coverage during retirement.

See the applicable provisions of the RHP for a more detailed explanation of the eligibility requirements.

Life Insurance

Basic life insurance and any elected optional employee or spouse life insurance may continue into retirement under another Company-sponsored benefits program for retirees. You may be eligible for retiree life insurance if you were hired or rehired before January 1, 2016, have at least 10 years of continuous service, meet other eligibility requirements and qualify for an immediate pension under the Company's pension plan (whether or not you are a participant) as follows:

- Basic life insurance coverage of $50,000 will reduce to $10,000 at the end of the month you reach age 62 at no cost.

- Any elected optional employee and/or optional spouse life insurance coverage will continue until the end of the month in which you reach age 62 provided you make the full monthly contribution.

Generally, you qualify for an immediate pension if you have 30 years of continuous service or if you are at least age 60 with 15 years of continuous service.

If you do not qualify for retiree life insurance, your Basic, Optional Employee and Optional Spouse Life Insurance will terminate on the date you retire.

See the Program for a more detailed explanation of the eligibility requirements.

Insurance Grievances

If you file a claim for benefits and some or all of it is denied, you may appeal the denial with the appropriate claims administrator. Whether or not you appeal a denial with the claims administrator, you have the right to file a grievance appealing a denial of a claim under the Program. If at any time you elect to bypass the claims administrator and proceed directly to file a grievance, you will not be permitted to subsequently appeal to the claims administrator or request External Review, if applicable.

If you appeal the denial with the appropriate claims administrator and your appeal is denied, you have 60 days after the receipt of written notification of the denial to appeal. You may appeal to:

- 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

- 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.

The decision of the arbitrator is final and binding on the Company, the plan administrator, the United Steelworkers or Other Union, and you and your dependents.

The information above does not apply to a beneficiary's claim for life insurance or to critical illness and accident coverage.

MEDICAL

About This Section

The Program is designed to provide you and your family with comprehensive medical coverage. However, the Program does not pay for all services and supplies. Covered services must be medically necessary and must not be experimental or investigational.

This section describes your medical coverage —what is covered, and how benefits are paid. It also has important information about notification procedures you must follow to receive maximum benefits from the Program.

Some of the terms and phrases used in this SPD have a specific meaning. Refer to *Important Terms* for more information.

You should also refer to *Benefit Basics* and *More Information about Your Benefits and Rights* for more important information on eligibility, when elections can be changed, how to file claims, and your rights under ERISA.

ID Cards

If you enroll in a medical option, you will receive an ID card from your medical claims administrator that you should keep with you at all times and show when you need care.

- *If you live outside of western Pennsylvania,* Highmark Blue Cross/Blue Shield is your medical claims administrator.

- *If you live in or your Zip code extends into Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Washington, or Westmoreland counties in Pennsylvania,* Aetna is your medical claims administrator.

Your ID card shows the toll-free number for member services and the number to call to precertify certain types of care.

If your card is lost or stolen, call the medical claims administrator immediately. Your card is to be used only by persons covered under this Program.

To request additional ID cards, call the medical claims administrator at the number on your ID card.

How Medical Coverage Works

PPO

Your medical benefits are delivered through a Preferred Provider Organization (PPO). The PPO provides comprehensive medical coverage and the flexibility to choose providers inside or outside the network each time you need care. You do not need to choose a primary care physician in a PPO, and referrals to in-network specialists are not required.

You may use any licensed provider for health care services. **However, you'll receive a higher level of benefits by using network providers:**

- Certain in-network preventive care is covered at 100% with no deductible.

- Network providers agree to charge negotiated rates; you are not responsible for amounts over the Program's allowed amount except for certain non-covered items and for amounts over your maximum benefit. Out-of-network providers may charge more than the allowed amount, and you are responsible for amounts over the allowed amount.

- You pay a copayment for each doctor office visit.

- Network providers typically handle any necessary precertifications and file claim forms for you.

The network is made up of doctors, hospitals, and other health care providers who have agreed to provide medical services in accordance with negotiated rates and designated standards. To join a network, a provider must meet certain essential criteria.

Waive Coverage

You may choose to waive medical coverage. When you waive coverage, your dependents (if any) are no longer eligible to be enrolled. If you choose to waive coverage, you are still eligible to enroll in other benefits available under this Program. See *Waiving Medical and Prescription Drug Coverage and Opt-Out Allowance* in *Benefit Basics* for more details.

Who Pays the Cost for Coverage

There are no employee premium payments or payroll deductions. You pay the deductibles, copays and coinsurance amounts for covered medical services for you and your eligible dependents. The Company pays the remaining cost of coverage, except as otherwise provided under the Program.

Understanding Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximums

The PPO requires you to meet an annual deductible and pay coinsurance.

Deductible

A deductible is the amount you pay each year before you and the Program begin sharing expenses. Copayments for medical services or prescription drugs do not count toward meeting the medical deductible. See the *Summary Chart of Medical Benefits* for more information on services subject to the deductible.

Copayment

A copayment is a fixed, up-front dollar amount you pay for in-network office visits and certain covered services. Copayments do not count toward meeting your deductible but they do count toward meeting the out-of-pocket maximum. You continue to make copayments even after you've met your out-of-pocket maximum. See the Summary Chart of Medical Benefits for more information on services subject to a copayment and the amount of that copayment.

Coinsurance

Coinsurance is your share of the cost of a health care service. It's usually expressed as a percentage of the amount the Program allows to be charged for services. You pay coinsurance once you've met the

Program's deductible (for in-network office visits and prescription drugs, you'll pay a copayment instead of coinsurance). See the *Summary Chart of Medical Benefits* for your share of the coinsurance (based on the type of service and if you use in- or out-of-network providers and facilities).

Medical Out-of-Pocket Maximum

The out-of-pocket maximum protects you against high out-of-pocket medical expenses. During each calendar year, when your out-of-pocket costs for covered medical expenses reach the out-of-pocket maximum, additional covered medical expenses for services that normally require coinsurance are paid at 100% for the remainder of that year. Once the medical out-of-pocket maximum is reached, copayments are still required.

The following items do not count toward the out-of-pocket maximum and are not covered at 100% once the out-of-pocket maximum limit is reached:

- Services not covered under the medical plan
- Fees in excess of the allowable charge
- Amounts in excess of the medical claims administrator's reimbursement to out-of-network facilities
- Excess private room charges
- Prescription drugs

Total Maximum Out-of-Pocket Limit (including Prescription Drugs)

You are also protected by the Total Maximum Out-of-Pocket (TMOOP) limit on network covered medical expenses and any qualified prescription drug expenses of $7,350 for 2018 (as adjusted) per covered individual, or $14,700 for 2018 (as adjusted) for your family. (No individual can exceed $7,350 for 2018).

If you have reached the Total Maximum Out-of-Pocket, you will not owe any additional coinsurance, copayments and deductibles for covered in-network services under the PPO Medical Benefits and Prescription Drug Benefits of this Program during the remainder of the year.

Eligible in-network medical and prescription drug expenses count toward meeting the total maximum out-of-pocket amount. The total maximum out-of-pocket does not include services not covered under the Program, doctor's fees in excess of the allowable charge, amounts in excess of the medical claims administrator's reimbursement to non-participating facilities, excess private room charges, and non-covered drugs you pay for out of pocket outside of the Program.

Importance of Medically Necessary and Appropriate

Under this Program, services and supplies must be considered medically necessary and appropriate to be covered. See *Important Terms* for a definition of medically necessary and appropriate.

Summary Chart of Medical Benefits

This chart provides a summary of the amounts that you are required to pay for medical coverage under the Program. Refer to the following pages for a more detailed description of covered medical expenses, limitations, and exclusions.

Medical Coverage *		
Item	**In-Network**	**Out-of-Network**
Deductible Individual Family	 $200 ($150 Apr. – Dec. 2016) $400 ($300 Apr. – Dec. 2016)	 $500 ($375 Apr. – Dec. 2016) $1,000 ($750 Apr. – Dec. 2016)
Coinsurance	10%	30%
Out-of-pocket maximum Individual Family	 $1,000 $2,000	 $2,000 $4,000
Total out-of-pocket maximum (includes medical and prescription drug; may change based on IRS guidance) Individual Family	 $7,350 for 2018 $14,700 for 2018	 N/A N/A
Lifetime maximum	None	
Doctor's office visit (includes a PCP, a PCP's nurse practitioner or physician's assistant, a pediatrician, or an OB/GYN)	$20 copayment	30%
Specialist office visit	$25 copayment	30%
Preventive care (such as routine physical exam, gynecological exam, Pap test for adults, pediatric immunizations, and women's preventive services)	$0	30%
Emergency room care (doctor services)	$0	30%
Emergency room care (facility charges)	$75 copayment (waived if you are admitted)	
Ambulance	$0	
Urgent care	$30 copayment	30%
Retail clinic	$20 copayment	30%

Medical Coverage *		
Item	**In-Network**	**Out-of-Network**
Simple diagnostic services (lab, X-ray, standard imaging, and other tests)	$0	
Hospital expenses (inpatient and outpatient)	10%	30%
Maternity	10%	30%
Infertility counseling, testing, and treatment (includes coverage to correct a physical or medical problem associated with infertility and excludes all assisted fertilization procedures)	10%	30%
Medical/ surgical expenses (excludes office visits)	10%	30%
Advanced imaging (CT/PET scan, CTA, MRI, MRA)	10%	30%
Durable medical equipment, orthotics, and prosthetics	10%	30%
Hospice	$0	
Transplant expenses	10%	30%
Skilled nursing care	10%	30%
	Combined limit: 100 days/calendar year	
Home health care	10%	30%; up to 30 visits/calendar year
Spinal manipulations	$25 copayment	30%
	Combined limit: 18 visits/calendar year	
Physical therapy and occupational therapy	$25 copayment	30%
	Combined limit: 60 visits/calendar year for physical and occupational therapy	
Speech therapy	$25 copayment	30%
	Combined limit: 20 visits/calendar year	

Medical Coverage *		
Item	**In-Network**	**Out-of-Network**
Private-duty nursing care	10% Limit: $10,000 per calendar year	
Inpatient mental health and substance abuse treatment (includes inpatient detoxification and rehabilitation for substance abuse)	10%	30%
Outpatient mental health and substance abuse treatment	$20 copayment; for substance abuse, $0 after initial visit	30%
Hearing exams and aids	$0 $1,500 plan maximum benefit per ear every 36 months	

*** Note:** The Program covers a percentage of the allowable charge for covered services.

Eligible Providers

To be covered under this Program, a service must be received from one or more of the following types of providers (eligible providers). Visit your medical claims administrator's website (www.highmarkbcbs.com or www.aetna.com) to see if your provider is an eligible provider. Below is a sample of the types of eligible providers.

Health care facility providers:

- Hospital
- Psychiatric hospital
- Rehabilitation hospital
- 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

Professional providers*:

- 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

* Verify with the medical claims administrator that a particular specialist is eligible. If the medical claims administrator changes the list of authorized Professional providers, those changes are automatically made to this Program.

Precertification of Admissions

You must obtain precertification before being admitted for a non-emergency to a health care facility (hospital, alcohol or drug rehabilitation facility, skilled nursing facility or hospice) to determine whether your confinement is medically necessary and appropriate and covered under the Program.

If you use an in-network provider, the provider is responsible for inpatient preauthorization. For out-of-network inpatient services, you should obtain preauthorization to ensure that the procedure or service is medically necessary and appropriate.

How to Precertify an Admission

To receive the maximum benefit, your in-network provider or you should call your Medical Claims Administrator (Highmark Precertification at 800-452-8507 or Aetna Precertification at 800-333-4432) or at the number listed on the back of your medical ID card:

- before any scheduled hospital admission; or
- within 48 hours of an emergency or unscheduled admission or as soon as practical.

If you do not receive Precertification when it is required, your benefits will be reduced for any days not authorized.

If precertification determines the stay is not covered, the notification will explain why and how your medical claims administrator's decision can be appealed. You or your provider may request a review of the precertification decision by filing a claim as described in *Health Care Claims* in *More Information about Your Benefits and Rights*.

Scheduled Admissions

For scheduled admissions, you or your doctor should call the Medical Claims Administrator at the number listed on the back of your medical ID card. Do this at least two weeks before you expect to begin the treatment or enter the hospital.

Emergency Admissions

If you are admitted to a hospital because of an emergency, you, your doctor or the facility must call the claims administrator within 48 hours or as soon as practical. Medical professionals will review your case to determine how many days of treatment are medically necessary and appropriate. See *Health Care Claims* in *More Information about Your Benefits and Rights* for information on urgent care claims.

To Continue Your Treatment

When you have an inpatient admission to a facility, your Medical Claims Administrator will notify you, your doctor, and the facility about your precertified length of stay. If your doctor recommends that your stay be extended, the additional days must be certified. You, your doctor, or the facility will need to call your Medical Claims Administrator at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Your Medical Claims Administrator will review and process the request for an extended stay and notify you and your doctor of an approval or denial.

Childbirth

You, your doctor or the facility must call the Medical Claims Administrator within 48 hours or as soon as practical following childbirth. You or your doctor must notify the Medical Claims Administrator before an approved hospital stay is extended beyond the established limits (48 hours for a normal vaginal delivery and 96 hours for a Cesarean section).

Noncompliance with Preauthorization Procedures

If preauthorization is not obtained during the hospital stay, the hospital confinement will be reviewed on a retrospective basis. If it is determined subsequently that all or part of the hospital stay was not medically necessary and appropriate, all or part of the hospital confinement expenses may be denied and you will be responsible for costs not covered. Remember, the Program does not pay benefits for stays beyond the number of days the Medical Claims Administrator considers medically necessary and appropriate.

There is no penalty for non-compliance if the hospitalization, service or procedure is medically necessary and appropriate.

Discharge Planning

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 doctor. The discharge plan may include a variety of services/benefits to be utilized by the participant upon discharge from an inpatient stay.

Once it is determined that continued confinement is no longer necessary, the medical claims administrator and your doctor will discuss plans for discharge or for a continued course of less acute care in an alternate setting, if such a setting is immediately available. If a less acute care setting is not available within a reasonable distance, full benefits will be provided for your continued inpatient stay until the alternate setting is available. The medical claims administrator will notify you, your doctor 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 after that date.

Covered Services

The following overview describes the types of services and supplies covered by the Program. In general, for the Program to pay benefits, the services you receive must:

- be essential care performed by a licensed doctor or other licensed provider specified by the Program,
- be medically necessary and appropriate,
- meet the definition of a covered expense (see *Important Terms* in *More Information about Your Benefits and Rights*),
- begin and end while you are covered under the Program (see *Benefit Basics* for rules about when coverage begins and ends), and
- not be specifically excluded by the Program as described under *What's Not Covered*.

In addition, certain procedures and services must be approved in advance, as described in *Precertification*.

Your medical claims administrator determines medical necessity and whether a procedure or service is experimental or investigational. The medical claims administrator will use its clinical coverage guidelines, such as a medical policy, other internally developed clinical guidelines and preventive care clinical coverage guidelines, to assist in making these decisions. The medical claims administrator may review and update these clinical coverage guidelines periodically. Covered services are subject to these clinical coverage guidelines.

You can request, free of charge, copies of any medical policies or guidelines used to determine your coverage. To request this information, call the medical claims administrator at the number on your ID card.

If you anticipate needing significant medical services (any services beyond a routine office visit), always call your medical claims administrator before beginning a course of treatment to understand what is covered and not covered under the Program.

Remember: In-network care is covered at a higher level of benefits than out-of-network care.

The Program pays benefits as shown on the *Summary Chart of Medical Benefits* for the medical care expenses described next.

Ambulance Service

The Program provides coverage for local transportation by a specially designed and equipped vehicle used only to transport the sick and injured from your home or the scene of an accident or emergency to a hospital, between hospitals, or from a hospital to a skilled nursing facility or your home; to dialysis; or from a hospital or skilled nursing facility to your home. Ambulance services are covered only when medically necessary and appropriate.

Air ambulance service is covered only if the medical condition requires immediate transportation that cannot be safely and quickly provided by land ambulance and if transportation by land poses a threat to the patient's survival or seriously endangers the patient's health.

Trips must be to the closest local facility that can provide covered medical expenses appropriate for your condition. If there is no facility in the local area that can provide covered medical expenses 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 doctor certifies, and the medical claims administrator agrees, that such transportation is required.

Anesthesia

The 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 doctor.

Assistant at Surgery

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

Autistic Disease of Childhood and Attention Deficit Disorders

The Program covers 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 doctor or licensed psychologist as part of a written treatment plan that has been reviewed and approved by the medical 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 medical claims administrator. A behavioral health provider/practitioner is a licensed organization or professional providing diagnostic, therapeutic, or psychological services for behavioral health conditions.

Inpatient confinement for environmental change is not covered.

Care Management

Through the care management program, the medical claims administrator identifies 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. Services may include:

- an evaluation of your physical and psychosocial status
- development of an individualized treatment plan by a nurse in conjunction with your doctor

- education and training such as symptom monitoring, medication dosages and compliance, appropriate diet and nutrition, smoking cessation and exercise

- ongoing monitoring and treatment modifications

Individual case management is designed to assure that care for catastrophic and chronic illnesses and injuries is provided in the most appropriate and cost-effective setting. A catastrophic case typically involves the following types of illnesses or injuries:

- Neonatal high risk infant
- Cerebrovascular accident
- Cardiac surgery
- Multiple sclerosis
- Muscular dystrophy
- Cerebral palsy
- AIDS
- Major head trauma
- Spinal cord injury
- Amputations
- Multiple fractures
- Severe burns
- Chronic back injuries
- Knee injuries

Dental Services Related to Accidental Injury

Dental services that are provided by a doctor or dentist and are required because 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.

Diabetes Treatment

The Program provides the following coverage when required for the treatment of diabetes and when prescribed by a doctor who is legally authorized to prescribe such items:

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

- Outpatient diabetes education: When your doctor certifies that you require diabetes education as an outpatient, coverage is provided for the following when provided through an outpatient diabetes education program:

  - visits that are medically necessary and appropriate for a diagnosis of diabetes
  - additional visits under circumstances where your doctor identifies:

    - or diagnoses a significant change in your symptoms or conditions that require changes in self-management, or
    - as medically necessary and appropriate, a new medication or therapy related 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. This program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered according to the medical claims administrator's criteria. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association.

Diagnostic Services

Covered medical expenses 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
- allergy testing consisting of percutaneous, intracutaneous, and patch tests

Durable Medical Equipment

Coverage is provided for the rental or, at the option of the medical claims administrator, the purchase, adjustment, repair, and replacement of, durable medical equipment for therapeutic use when prescribed by a professional provider. Rental costs cannot exceed the total cost of purchase.

Emergency Care Services

Emergency care provides services and supplies, including drugs and medicines, for the outpatient emergency treatment of a medical emergency in an emergency department of a hospital:

- without the need for any prior authorization
- 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).

For out-of-network providers, the Program pays an amount equal to the greatest of the amount:

- negotiated with in-network providers,
- calculated under the Program's normal out-of-network method, but substituting the in-network cost-sharing provisions, and
- that Medicare would have paid

Out-of-network providers may bill you for the difference between the provider's charges and the amount paid by the Program.

If you receive emergency care at an out-of-network hospital and it is later determined that you did not have a medical emergency, the services and supplies you received will be subject to the out-of-network deductible and coinsurance provisions of this Program.

Enteral Formulae

Coverage is provided for enteral formulae when administered on an outpatient basis primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria.

Enteral formulae is a liquid source of nutrition administered under the direction of a doctor that may contain some or all the nutrients necessary to meet minimum daily nutritional requirements.

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 when provided:

- through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and used instead of regular shelf food or regular infant formulas, or

- orally and identified as one of the following types of defined formula with:
  - hydrolyzed (pre-digested) protein or amino acids
  - specialized content for special metabolic needs
  - modular components
  - 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.

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 used 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

- normal food products used in the dietary management of rare hereditary genetic metabolic disorders

Facility Services (Bed, Board, and General Nursing Services)

The Program covers the services outlined below that you receive in a hospital or other facility provider:

- semi-private room
- private room with the allowance limited to the amount negotiated between the facility provider and the medical claims administrator
- bed in a special care unit that gives intensive care to the critically ill

Facility Services (Other Services)

The Program covers the services outlined below that you receive in a hospital or other facility provider:

- 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 and 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

Hearing Aid Benefits

Benefits are provided for hearing aids, repairs, and examinations. To receive the highest level of benefits, use in-network providers.

The Program offers hearing screening (pass/fail measure) to determine the need for more testing. By using network providers, you may receive significant savings on hearing aids and hearing protection. The maximum benefit payable is $1,500 per ear, once every 36 months.

Home Health Care/Hospice Care Services

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:

- skilled nursing services, excluding private-duty nursing services
- physical, occupational, and speech therapy

- medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care
- oxygen and its administration
- medical social service consultations
- health aide services when you are also receiving covered nursing or therapy services
- family counseling related to your terminal condition

No home health care/hospice care benefits will be provided for:

- dietician services
- homemaker services
- maintenance therapy
- dialysis treatment
- custodial care
- food or home-delivered meals

Home Infusion Therapy Services

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 non-intravenous therapies are included when administered only in conjunction with home infusion therapy.

Infertility Counseling, Testing and Treatment

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

Inpatient Medical Services

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

- inpatient medical care visits
- intensive medical care, which is constant attendance and treatment by a professional provider, when your condition requires it for a prolonged time
- concurrent care, which is care for a medical condition by a professional provider who is not your surgeon while you are in the hospital for surgery, or care by two or more professional providers during one hospital stay, when the nature or severity of your condition requires the skills of separate doctors
- consultation by another professional provider when requested by the attending professional provider; excludes staff consultations required by hospital rules
- newborn care, which is professional provider visits to examine the newborn infant while the mother is an inpatient

Maternity Care

If you think you are pregnant, the Program covers your contact with your doctor and visit to an obstetrician or nurse midwife. When your pregnancy is confirmed, you are covered for follow-up care that includes prenatal visits, sonograms, delivery, and postpartum and newborn care.

Maternity Home Health Care Visit

You are covered for one maternity home health care visit within 48 hours of discharge when the discharge from a facility provider occurs before:

- 48 hours of inpatient care following a normal vaginal delivery or
- 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 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 does not require any copayment, coinsurance, or deductible amounts.

Medical/Surgical Services

See Anesthesia, Assistant at Surgery, Inpatient Medical Services, Second Surgical Opinion, and Surgical Services.

Mental Health Services

The Program covers the services identified below that you receive from an eligible provider to treat mental illness.

- Inpatient Facility Services - Covered inpatient hospital services provided by a hospital or other facility provider.

- Inpatient Medical Services - Covered inpatient medical services provided by a professional provider:

    - individual psychotherapy
    - group psychotherapy
    - psychological testing
    - counseling with family members to assist in your diagnosis and treatment
    - 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 - Partial hospitalization for mental health care services provided by a partial hospitalization program that has been approved by the medical claims administrator. Such programs are subject to periodic review.

- Outpatient Mental Health Services - Covered 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.

Orthotic Devices
The purchase, fitting, necessary adjustment, repair, and replacement of a rigid or semi-rigid supportive device that restricts or eliminates motion of a weak or diseased body part is covered.

Pre-Admission Testing
Coverage is provided for outpatient tests and studies required for your scheduled inpatient admission.

Preventive Care – see Routine and Preventive Care

Private-Duty Nursing Services
Coverage is provided for private-duty nursing services up to a $10,000 annual limit when ordered by a doctor, provided the nurse does not ordinarily live in your home or is not a member of your immediate family and you are:

- confined to a hospital or other facility provider, only when the medical claims administrator determines the required nursing services are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.

- at home, only when the medical claims administrator determines the nursing services require the skills of a medical professional.

Prosthetic Appliances
The Program covers the purchase, fitting, necessary adjustments, repair, and replacement of prosthetic devices and supplies that replace all or part of a missing body organ and its adjoining tissues or the function of a permanently inoperative or malfunctioning body organ. Dental appliances are not covered.

Routine and Preventive Care
Routine and preventive care services vary based on age, sex, and certain risk factors, based on requirements of the Patient Protection and Affordable Care Act of 2010 (ACA) and recommendations by organizations such as the U.S. Preventive Services Task Force, American Academy of Pediatrics, American College of Physicians, American Cancer Society, the medical claims administrator, and medical consultants. The frequency and eligibility of services may change periodically.

To be covered under this Program, all routine and preventive care services must be listed on the medical claims administrator's preventive schedule, which you can find online at its website or by calling the number on your ID card. Any routine and preventive care service that is not required by ACA is at the discretion of the claims administrator.

Benefits include periodic physical examinations, well child visits, immunizations, selected diagnostic tests, and women's preventive services.

Preventive Health Services
Coverage is provided for the items and services designated by the medical claims administrator as preventive health services under ACA, and no in-network cost-sharing requirements are imposed for these items or services. For preventive services provided in a doctor's office setting on an in-network basis, there is no cost-sharing if the primary purpose of the visit is the preventive care. However, an office visit copayment may be charged in situations where the preventive services are not billed separately and the primary purpose of the office visit is for other than the preventive care.

Second Surgical Opinion
A second doctor's opinion and related diagnostic services to determine the need for elective covered surgery recommended by your first doctor are covered.

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

If the consulting opinion is against elective covered surgery and you decide to have the elective surgery, the surgery is a covered medical expense.

Skilled Nursing Facility Services
The Program covers services provided in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital up to 100 days per calendar year.

No benefits are payable for skilled nursing facility services:

- after you reach the maximum level of recovery possible for your condition and no longer require 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
- for treatment of substance abuse or mental illness

Spinal Manipulations
Coverage is provided for spinal manipulations for the detection and correction of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column, up to a combined limit (in and out-of-network) of 18 visits per calendar year.

Sterilization and Implants
Surgical tubal ligation and the non-surgical Essure contraceptive implant are covered at 100% (with no copayment, deductible or coinsurance).

Substance Abuse Services (Inpatient and Outpatient)
The Program covers the services that you receive in a hospital or other facility. For outpatient rehabilitation, covered medical expenses include individual and group counseling and psychotherapy, psychiatric and psychological testing, and family counseling for the treatment of substance abuse.

Surgery (Outpatient)
The Program covers 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.

Surgical Services

Surgery performed by a professional provider is a covered medical expense. Payment includes visits before and after surgery.

- Sterilization procedures such as tubal ligation and vasectomy are covered, regardless of whether medically necessary and appropriate.

- Elective abortions are covered where permitted by law.

- Lap band surgery that is medically necessary and appropriate is covered.

- Oral surgery benefits are provided for the following limited oral surgical procedures in an outpatient setting when preauthorized by the medical claims administrator or in an inpatient setting if determined to be medically necessary and appropriate:

  - extraction of teeth to prepare for radiation therapy
  - mandibular staple implant when not done to prepare the mouth for dentures
  - facility provider and anesthesia services in conjunction with non-covered dental procedures when determined by the medical claims administrator 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 that 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

- A mastectomy performed on an inpatient or outpatient basis, as well as surgery to re-establish symmetry or alleviate functional impairment are 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 is 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 doctor, if discharge occurred within 48 hours after admission for a mastectomy.

Therapy Services

The following services you receive from an eligible professional provider are covered up to certain limits:

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

See also Home Infusion Therapy Services and Spinal Manipulations

Transplant Services

The Program provides benefits for covered medical expenses provided by a hospital that are directly and specifically related to the transplantation of organs, bones, or tissue. 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:
  - 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 or any government program
  - 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:
  - 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
  - no benefits will be provided to the non-covered transplant recipient
- 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

What Is Not Covered

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

- not medically necessary and appropriate
- not prescribed by, performed by, or upon the direction of a professional provider
- provided by other than hospitals, other facility providers, or professional providers
- experimental/investigative in nature
- incurred before the patient's effective date or after the termination date of coverage under the Program, except as explicitly described above
- for any illness or injury suffered after your effective date as a result of any act of war
- for which you would have no legal obligation to pay

- 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

- 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 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.

- to the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Department of Veterans Affairs facilities for service-connected illness or injury unless you have a legal obligation to pay

- 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

- for prescription drugs that were paid or are payable under a freestanding prescription drug program

- for methadone hydrochloride treatment for which no additional functional progress is expected to occur

- submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same patient

- provided by an individual who is a member of your immediate family

- 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 surgery to correct:

  - a condition resulting from an accident
  - functional impairment that results from a covered disease, injury, or congenital birth defect

- for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form

- for personal hygiene and convenience items, including, but not limited to air conditioners, humidifiers, physical fitness equipment, stair glides, elevators/lifts, or barrier-free home modifications, whether or not specifically recommended by a professional provider

- for inpatient admissions primarily for physical therapy or diagnostic studies

- for custodial, domiciliary, residential, protective, and supportive care including educational services, rest cures, and convalescent care

- for respite care

- directly related to the care, filling, removal, or replacement of teeth; and 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, frenectomy, alveolectomy, and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided above.

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

- 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

- 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, toenails (except surgery for ingrown toenails), 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

- for any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery

- 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

- for reversal of sterilization

- 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)

- 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 LASIK

- for nutritional counseling, except as provided above

- for weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate

- for preventive care services, wellness services or programs, except as provided in this SPD booklet or as mandated by federal law

- 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 that are not medically necessary and appropriate, except as provided in this SPD booklet or as mandated by federal law
- for treatment of sexual dysfunction not related to organic disease or injury
- for any care, treatment, or service that has been disallowed under the provisions of the medical claims administrator, acting on behalf of the plan administrator
- for any condition related to hyperkinetic syndromes, learning disabilities, behavioral problems, and mental retardation that extends beyond traditional medical management, or for inpatient confinement for environmental change
- for immunizations required for foreign travel or employment
- for ambulance services, except as provided above
- for allergy testing, except as provided above or as mandated by federal law
- for well-baby care visits, except as provided above
- for any other medical or dental service or treatment, except as provided above or as mandated by federal law, and
- for nicotine cessation support programs and/or classes

Program Does Not Determine What Medical Services You Should Receive

The Program does not determine and should not influence what medical services you should receive. Rather, it only determines what confinements, services, supplies or treatments will be reimbursed in whole or in part. However, under certain circumstances, Individual Case Management may authorize the coverage of services and supplies for which benefits are not normally provided under the Program. The fact that the Program does not cover a given confinement, service, supply or treatment, or that you have been advised that the Program does not cover a given confinement, service, supply or treatment, does not constitute medical advice that you should not receive such confinement, service, supply or treatment. The decision as to whether you or your eligible dependent should receive a given confinement, service, supply or treatment is a decision which must be made solely by you and/or the eligible dependent, taking into consideration the medical advice which you are receiving from the treating provider. Neither the Program, the Company nor the Plan Administrator is liable for any decision not to obtain any confinement, service, supply or treatment regardless of whether or not the confinement, service, supply or treatment will be reimbursed under the Program.

Nationwide Coverage

The Program provides nationwide coverage, and you are free to choose your medical provider. However, there are significant benefits to using in-network providers.

Medical Care for a Dependent Child While 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.

- If other medical care is needed and not provided by the school's medical center, your dependent child is required to use network providers to receive the higher level of benefits.

Medical Care While Traveling Outside of the United States

The medical claims administrator has a program that provides assistance with emergency medical problems you may incur while traveling outside of the United States. Services include:

- making referrals and appointments for you with nearby doctors 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

For outpatient or professional services received abroad, you should pay the provider and contact the medical claims administrator for details on how to submit a claim for reimbursement.

If You Are Covered under Medicare

If you are a Medicare participant covered under the Program, Medicare does not cover most medical care received outside of the United States. If Medicare benefits are not payable because the services were received outside of the United States, medical benefits will be payable under this Program as if you were not eligible for Medicare. You should pay the provider and contact your medical claims administrator for details on how to submit a claim.

PRESCRIPTION DRUGS

About This Section

You and your eligible dependents are automatically covered by the prescription drug benefits unless you waive coverage. The prescription drug benefits under the Program are administered by Express Scripts, Inc. ("Express Scripts"). Prescription drug benefits help pay for the cost of drugs that are medically necessary to treat an illness or injury. You don't make a separate election for prescription drug coverage.

Some of the terms and phrases used in this SPD have a specific meaning. Refer to *Important Terms* for more information.

You should also refer to *Benefit Basics* and *More Information about Your Benefits and Rights* for more important information on eligibility, how to file claims, and your rights under ERISA.

Your Coverage

The Program provides for prescription drugs to be filled as follows:

- **Retail Pharmacy**
  You can purchase up to a 30-day supply of your prescription medications from any retail pharmacy. However, there are advantages when you use a participating retail pharmacy. See Home Delivery below for an explanation of the requirement to use Home Delivery for any long-term/maintenance medications you may be taking.

- **Home Delivery (Required for Maintenance Drugs)**
  You can order up to a 90-day supply of medications prescribed for treatment of chronic or long-term illness (such as arthritis, diabetes, or high blood pressure) through the prescription drug administrator's home delivery pharmacy.

  You are 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.

  You cannot use the home delivery service for drugs for acute, short-term illnesses (as determined by the prescription drug claims administrator), even if prescribed for 30 days or more, or for drugs that may not be legally provided through the mail.

- **Specialty Pharmacy Program**
  You may receive a 30-day supply of high-cost or specialty injectable and oral prescription medications for hemophilia, hepatitis, cancer, multiple sclerosis, rheumatoid arthritis, and other illnesses that require personalized care and ongoing patient support.

ID Cards

You will receive an ID card from the prescription drug claims administrator that you should keep with you at all times and show when you need to fill a prescription. Your ID card shows the toll-free number to call with any questions.

If your card is lost or stolen, call the prescription drug claims administrator immediately. Your card is to be used only by persons covered under this Program.

To request additional ID cards, call the prescription drug claims administrator at the number on your ID card.

Who Pays the Cost for Coverage

There are no deductibles, coinsurance, or employee premium payments or payroll deductions for prescription drug coverage for you and your eligible dependents. You pay a copayment for each prescription as shown in the *Summary Chart of Prescription Drug Benefits*. The Company pays the remaining cost of coverage, except as otherwise provided under the Plan.

Pharmacy Management Strategies

The Program uses pharmacy management strategies to control costs and utilization. These strategies include, among others, the use of a drug formulary, quantity limits, prior authorization, and utilization review.

Importance of a Formulary

This Program uses the Express Scripts' National Preferred formulary. This formulary is an extensive list of FDA-approved generic and brand-name prescription drugs selected by an independent group of doctors and pharmacists for their quality, safety, and effectiveness.

Not all drugs are included, but alternatives are available in each therapeutic class. If you are prescribed a drug that is excluded from the formulary, the prescription drug claims administrator will work with your prescriber to determine an alternative. If none of the alternatives are effective, an exception to provide the excluded drug can be requested and approved.

To receive a copy of the formulary, call the number on the back of your ID card. You can also access the applicable formulary online at the prescription drug claims administrator's website.

Prior Authorization Programs

These programs help reduce potential abuse or misuse of certain medication by ensuring the medication is prescribed per FDA-approved indications and used only for an appropriate medical condition.

Therapeutic Interchange

Within specific classes of medications, multiple drugs are available to treat the same condition. Therapeutic interchange ensures you try clinically effective, lower-cost medications before receiving a higher-cost medication.

Drug Quantity Management

This program manages drug costs by limiting the quantity of some medications covered within a specified period of time consistent with FDA approved dosage guidelines. For coverage of additional quantities of these medications, a coverage review may be necessary.

For a list of prescription drugs with coverage limitations, or for more information on coverage or limitations, visit the prescription drug claims administrator's website at www.express-scripts.com.

Concurrent Drug Utilization Review

This review identifies the most important drug and patient-specific pharmaceutical care concerns at the time your prescription is being filled. The prescription drug claims administrator's processing system reviews each electronically transmitted claim to identify pertinent clinical or utilization concerns and, when applicable, provide a safety alert to the pharmacist.

Understanding Brand Name and Generic Drugs

A brand-name drug and its generic equivalent must be chemically identical and have the same therapeutic effect. Generic drugs are subject to the same rigid FDA standards for quality, strength, and purity and are as safe, efficient, and effective as brand-name drugs. While they may not look the same, generic drugs have the same active ingredient, strength, and dose as the brand-name drugs, act the same way in your body, and cost up to 70% less. Therefore, ask your doctor to authorize generic substitution when an approved generic is available.

Limited Reimbursement for Brand Name Drug if a Generic is Available

Ask your doctor to authorize generic substitution when an approved generic is available. The Program covers both brand-name and generic drugs, and generic drugs will be substituted where permissible by law. If you use a brand-name drug when a generic is available, you can receive the brand-name drug, but the Program will pay benefits at the generic level. You will pay the generic copayment *plus* the difference in cost between the generic and brand-name drug.

If your doctor determines a generic equivalent is not acceptable for your specific need, under this Program your doctor must provide Express Scripts with the appropriate medical reasons a brand-name drug is required. Contact Express Scripts at 1-800-287-4508 or at www.express-scripts.com.

Any subsequent refills and prescriptions authorized by your doctor will be filled only if the claims administrator determines, on the basis of the doctor's explanation, that the brand-name drug is required in accordance with accepted standards of medical practice. If Express Scripts agrees with your doctor, the prescriptions will be filled and you will pay the applicable brand-name copay. If Express Scripts does not agree, and you elect to use the brand-name drug, the prescription will be filled and you will pay the generic copayment plus the difference in cost between the generic and brand-name drug.

What Are the Quality Standards?

All prescriptions filled through home delivery, the specialty pharmacy, and at a participating retail pharmacy meet the 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. Under the drug utilization review program, prescriptions 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 dependents 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.

Importance of Medically Necessary and Appropriate

Under this Program, prescription drugs must be considered medically necessary and appropriate to be covered. See *Important Terms* for a definition of medically necessary and appropriate.

Summary Chart of Prescription Drug Benefits

Your prescription drug benefits are provided through a network of national chain and local pharmacies, the prescription drug claims administrator home delivery pharmacy, and the specialty pharmacy.

Your copayments (cost per prescription) are shown below.

Prescription Drug Coverage		
Item	**Participating Pharmacy**	**Non-Participating Pharmacy**
Network Pharmacies	50,000+	
Formulary used (list of preferred drugs)	Express Scripts, Inc. National Preferred Formulary Drug List Some drugs are not covered. Visit www.express-scripts.com for a list of drugs covered.	
Home Delivery (Required for Maintenance Drugs)		
Cost for preferred generic	$20 copayment	Not covered
Cost for preferred brand	$40 copayment	Not covered
Cost for non-preferred generic and brand	$60 copayment	Not covered
Excluded drugs	Not covered	
Mandatory generic	Yes	
Maximum days supply	Up to 90	
Pharmacy management programs	Yes	
Retail		
Cost for preferred generic	$10 copayment	50% copayment (via reimbursement)
Cost for preferred brand	$20 copayment	50% copayment (via reimbursement)
Cost for non-preferred generic and brand	$30 copayment	50% copayment (via reimbursement)

Prescription Drug Coverage		
Item	**Participating Pharmacy**	**Non-Participating Pharmacy**
Excluded drugs	Not covered	
Mandatory generic	Yes	
Maximum days supply	Up to 30	
Pharmacy management programs	Yes	
Specialty Drugs		
Cost for generic	$0	Not covered
Cost for brand name	$20	Not covered
Excluded drugs	Not covered	
Maximum days supply	Up to 30	

Retail Pharmacy

Retail pharmacies are a convenient way to fill prescriptions for medications you'll take on a short-term basis. To make the most of your prescription drug benefit in a participating retail pharmacy, ask your doctor to write your prescription for up to a 30-day supply and to either prescribe the drug in generic form or agree to generic substitution.

Participating Pharmacies

Over 50,000 retail pharmacies participate in the prescription drug claims administrator's pharmacy network, including selected national chains and local drugstores. The list of participating pharmacies is subject to change. To find a participating retail pharmacy near you, call the number on your ID card or visit the prescription drug claims administrator's website at www.express-scripts.com.

To obtain your medication at a participating retail pharmacy, present your prescription drug ID card and pay your share of the discounted price (your copayment) as shown in the *Summary Chart of Prescription Drug Benefits*. No claim forms are required when you use a participating retail pharmacy.

Non-Participating Pharmacies

If you fill a prescription at a non-participating retail pharmacy, you must pay the pharmacy its charge for the medication and then submit a claim for reimbursement. Visit the prescription drug claims administrator's website to print a copy of the required claim form. You will be reimbursed for 50% of the pharmacy's charge. Claims filed later than one year after purchase are not eligible for reimbursement.

Home Delivery (Required for Maintenance Drugs)

If you need a maintenance prescription drug (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 Program's 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 through the home delivery program, you will pay 100% of the discounted negotiated cost. Express Scripts will notify you if your prescription is a maintenance drug subject to the requirement to use home delivery.

Initial Prescription

To make the most of your prescription drug benefit using the home delivery pharmacy, ask your doctor to write a prescription for up to a 90-day supply of all needed maintenance drugs, plus the appropriate number of refills, either prescribing the drug in generic form or agreeing to generic substitution where permitted by law. Contact the prescription drug claims administrator for instructions on how to submit your prescription.

Refill Prescriptions

Choose one of the following refill options:

- **Website** — Visit the prescription drug claims administrator's website 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.

- **Telephone** — Call 1-800-287-4508 or the number on your ID card. 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.

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

If you need medication immediately for a chronic or long-term condition, have your doctor write two prescriptions; one for a two-week supply that you can have filled at a retail pharmacy, and one for up to a 90-day supply that you can send to the home delivery pharmacy.

If you need medication for an acute short-term illness or injury, and the prescribed medication is FDA-approved only for short-term use, you can't use the home delivery pharmacy. You must obtain medication prescribed for less than a 30-day period from a participating retail pharmacy under the Retail Pharmacy option.

How Soon Will I Receive My Home Delivery Prescription?

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.

Specialty Pharmacy Program

The Program uses a dedicated specialty pharmacy, Accredo, to provide access and manage specialty drugs due to their high cost, special handling and storage needs. The specialty pharmacy also provides 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:

- requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes;

- need for intensive patient training and compliance assistance to facilitate therapeutic goals;

- limited or exclusive product availability and distribution;

- specialized product handling and/or administration requirements.

Initial Prescription
You or your doctor should call the specialty pharmacy program administrator at **1-800-803-2523** to start your service. A representative will verify your coverage, help with letters of medical necessity, and coordinate delivery of your medications.

Refill Prescriptions
Your specialty pharmacy representative will call you before you run out of your prescription to coordinate the delivery of your next refill. You also may call the specialty pharmacy program administrator at **1-800-803-2523** or mail prescriptions in the postage-paid envelope along with your copayment.

How Soon Will I Receive My Prescription?
Your specialty pharmacy representative will work with you to schedule delivery of your medication based on your specific needs.

Covered Prescription Drugs
Your prescription drug benefits cover medications that are medically necessary and appropriate for the treatment of an illness or injury, legally require a prescription, and meet FDA-approved indications and usage guidelines for treatment.

You may receive a 1- to 30-day supply under the retail pharmacy program, a 30- to 90-day supply through the home delivery pharmacy, and a 30-day supply through the specialty pharmacy. Refills are not to exceed one year. Controlled substances are limited to a 30-day supply with up to five refills permitted; except, Schedule II drugs (such as Percodan and Demerol) cannot be refilled (each order requires a new prescription). If you are not sure the drug you are taking is a controlled substance, ask your doctor or call the prescription drug claims administrator.

Insulin and blood glucose testing agents and strips provided over the counter are covered with a valid prescription.

Preventive Care
The Program covers certain preventive services. The schedule of covered preventive prescription drug services below is periodically revised and subject to change.

Certain Over-the-Counter Drugs and Medicines
As required under the preventive care services benefit provisions of the ACA, the Program covers the following medicines prescribed by your doctor at 100%:

- 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
- effective January 1, 2018, statins (generic only; single entity; low/moderate doses; adults over age 39 and under 76; no medical claim or drug marker for cardiovascular disease (CVD), presence of one or more CVD risk factor drugs (diabetes, hypertension or smoking) in claims history)

- folic acid supplementation for women of child-bearing age, age 18 to 45
- immunizations — recommended ages per CDC Vaccination Schedule
- iron supplementation for children from 6 to 12 months of age who are at an increased risk for iron deficiency anemia

Contraceptives

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.

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 described above.

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)

Smoking Cessation

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.

- 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;
- 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.

- Brand name Preferred and Non-Preferred smoking cessation drugs are covered at Program copayment/coinsurance, for individuals 18 and over, up to 90 days of therapy per rolling 365 days.
- Zyban®, Wellbutrin® and certain nasal sprays purchased at a local retail pharmacy and not described above are covered at the generic copayment.

For a complete list of covered drugs, visit the prescription drug claims administrator's website at www.express-scripts.com.

What Is Not Covered

Benefits are not provided for:

- drugs not medically necessary and appropriate to treat a condition of illness or injury, except for FDA-approved oral contraceptives and smoking cessation drugs described previously
- drugs prescribed for cosmetic purposes, except those prescribed for treatment of acne age 25 and younger or older than age 25 with prior authorization
- drugs or medicines that can be purchased over the counter without a prescription, except for insulin and blood glucose testing agents and strips and drugs covered under the ACA provisions described previously
- experimental/investigative drugs
- drugs prescribed for a weight loss that is not medically necessary and appropriate
- growth-promoting agents
- drugs prescribed for treatment of infertility
- allergy serums (see *Diagnostic Services* in *Medical*)
- prescription homeopathic medications
- refills of any prescription older than one year
- certain compound drugs
- home infusion therapy drugs (see *Home Infusion Therapy Services* in *Medical*)
- drugs listed as excluded drugs on the National Preferred Formulary

DENTAL

About This Section

Good dental care is essential to your good health. Seeing your dentist regularly for routine preventive care check-ups helps you catch minor problems before they become more serious and costly. The dental benefits under the Program help protect your health by encouraging preventive and diagnostic dental care.

This section describes the dental coverage provided automatically to you and your family. You don't make a separate election for this benefit.

Some of the terms and phrases used in this SPD have a specific meaning. Refer to *Important Terms* for more information.

You should also refer to *Benefit Basics* and *More Information about Your Benefits and Rights* for more important information on eligibility, how to file claims, and your rights under ERISA.

Your Coverage

You and your eligible family members (dependents) are covered by the dental benefits outlined in this section, even if you waive medical coverage under the Program. You will be required to verify eligibility of dependents for coverage.

ID Cards

You will receive an ID card from the dental claims administrator that you should keep with you at all times and show when you need dental care. Your ID card shows the toll-free number to call with any questions.

If your card is lost or stolen, call the dental claims administrator immediately. Your card is to be used only by persons covered under this Program.

To request additional ID cards, call the dental claims administrator at the number on your ID card.

Who Pays the Cost for Coverage

There are no employee premium payments or payroll deductions for dental coverage for you and your eligible dependents. You pay deductibles and coinsurance for dental services as shown in the *Summary Chart of Dental Benefits*. The Company pays the remaining cost of coverage, except as otherwise provided under the Program.

Understanding Deductibles, Coinsurance, and Annual and Lifetime Maximums

Dental coverage has deductibles, coinsurance, and annual and lifetime maximums.

Deductible

A deductible is the amount you pay each calendar year before you and the plan begin sharing expenses. Benefit payment for all services, supplies, and treatments (other than diagnostic and preventive services) is subject to an annual deductible. The *Summary Chart of Dental Benefits* shows the individual and family deductible.

If, during the last three months of a year, you incur dental expenses and have not met the annual deductible, those expenses will be applied to meeting your annual deductible for the next year.

Coinsurance

Coinsurance is your share of the cost of a dental service, after you have met the Program's annual deductible. It's usually expressed as a percentage of the amount the Program allows to be charged for services. See the *Summary Chart of Dental Benefits* for your coinsurance, which is based on the type of service and whether you use in- or out-of-network providers and facilities.

Annual and Lifetime Maximums

Benefit payment is limited to a maximum of $2,250 per year per individual. For orthodontics, payment is limited to a lifetime maximum of $2,250 per covered dependent under age 19.

Importance of Dentally Necessary and Appropriate

Under this Program, services and supplies must be considered dentally necessary and appropriate to be covered. See *Important Terms* for a definition of dentally necessary and appropriate.

Summary Chart of Dental Benefits

This summary of benefits provides an overview of the dental benefits available to you. Read the following pages for a more detailed description of covered services, limitations, and exclusions.

You are strongly encouraged to have your provider request a pretreatment determination from the dental claims administrator before you receive any Class II or Class III services.

Dental Coverage	
Item	**What You Pay***
Deductible Individual Family	 $25 (except Diagnostic / Preventive Services) $50 (except Diagnostic / Preventive Services)
Annual maximum (per individual)	$2,250 **(excludes orthodontics)**
Lifetime orthodontic maximum for each dependent under age 19	$2,250
Diagnostic and Preventive Services • Routine oral exams and cleanings • Full-mouth and bitewing X-rays • Cleanings & fluoride treatments • Space maintainers • Palliative treatment (emergency) • Basic restorative (fillings)	$0 (covered 100%)
General, Restorative, Periodontal and Oral Surgery • Sealants • Simple extractions • Inpatient consultations • Repair of crowns, inlays, onlays, bridges & dentures • Endodontics • Surgical and nonsurgical periodontics • Complex oral surgery • General anesthesia, IV sedation, nitrous oxide	20% coinsurance
Prosthetics, Crown, Inlay and Onlay Restorations • Inlays, onlays, crowns • Prosthetics (bridges, dentures)	40% coinsurance .
Orthodontics for dependents under age 19 (includes diagnostic, active treatment, retention treatment)	40% coinsurance

* Note: The Plan covers a percentage of the allowable charge for covered services.

Participating Providers

The Program provides coverage for dental services through a dental network. Although you are not required to use providers who participate with United Concordia (the dental claims administrator) to receive benefits, there are advantages to using them:

- Providers accept the allowable charge and receive payment for their services directly from the dental claims administrator.

- Covered benefits are payable as a percentage of the allowable charge.

- Your responsibility for provider payment is limited to the portion, if any, of the allowable charge that is not payable under your dental coverage, including any deductibles and coinsurance.

You are responsible for paying for services, supplies and treatments that the dental claims administrator determines not to be dentally necessary or appropriate.

Non-Participating Providers

The dental claims administrator will reimburse charges from non-participating providers up to a certain amount; but, if you use a non-participating provider, you may pay higher out-of-pocket costs because:

- Providers may not accept the allowable charge.

- You are responsible for paying the difference, if any, between the provider's actual charge and the allowable charge. This is known as balance billing.

- Providers may bill you directly for their entire fee, which would require you to file a claim with the dental claims administrator to be reimbursed for the portion of the allowable charge payable under the Program.

- Providers may bill you for services that are determined by the dental claims administrator not to be dentally necessary or appropriate.

How to Find a Participating Provider

You can call 1-800-332-0366 or the toll-free telephone number on the back of your ID card to see whether 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 dental claims administrator's website (www.ucci.com). The participating provider network is called the Alliance network.

Payment of Benefits

The dental claims administrator will pay participating providers directly for covered services. As long as you pay your share of the allowable charge and any coinsurance or amounts exceeding the maximum within 60 days of the date the dental claims administrator advises you of your share of the charge, the participating provider will accept the dental claims administrator payment plus your payment, if any, as payment in full.

If you do not pay within 60 days of being notified by the dental claims administrator, the participating provider may bill you for the difference between the normal charge and the allowable charge and for any amount you owe as your deductible or coinsurance.

Date Expenses Are Incurred

Benefits are provided for covered services on or after the date coverage becomes effective. Covered services are considered to have been incurred on the date the services, supplies, or treatments are received.

The Program does not pay benefits for any services begun before your or your covered dependents' effective date of coverage. Multi-visit procedures are 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 taken. For root canals, the procedure is started when the tooth is opened and pulp is removed.

If coverage is terminated, coverage for dental procedures requiring two or more visits on separate days will be extended for a period of 90 days after the termination date to allow the procedure to be completed. The procedure must be started, as described above, before the termination date. For covered orthodontic treatment, coverage will be extended through the end of the month of the termination date.

Pretreatment Estimate (Predetermination)

A pretreatment estimate is used by the dental claims administrator to determine patient eligibility, review the treatment plan, and determine coverage. This assures both the patient and the dentist the particular service to be performed is a covered service. Pretreatment estimates are encouraged for prosthetics, crowns, inlay and onlay restorations, periodontal services, and orthodontics.

Alternate Treatment

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, the dental claims administrator will make payment based on its allowable charge for the less expensive procedure if it meets the accepted standards of dental treatment.

The dental claims administrator'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, but you will be responsible for the additional charges that are beyond those paid for by the dental claims administrator.

Experimental/Investigative Treatment

The Program does not cover services the dental claims administrator determines are experimental/ investigative in nature. Experimental/investigative services are those the general dental community determines 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/investigative treatment.

If your provider performs an experimental procedure, you are responsible for the charges. You or your provider may contact the dental claims administrator to determine if a service is considered experimental/investigative.

Services that Do Not Meet Accepted Standards of Dental Practice

The Program does not pay for services that are considered unusual procedures or techniques, or for which supplies or other services used do not meet the accepted standards of dental practice. A participating provider accepts the dental claims administrator's decision and will not bill you for these services without your consent. However, a non-participating provider 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.

Covered Services

The following services provided by a licensed dentist are covered benefits under this Program, provided they are dentally necessary and appropriate. See the *Summary Chart of Dental Benefits* for your share of the cost for certain services.

This list does not describe all limitations, such as how often you can have a dental service. Contact the dental claims administrator for more information on other limitations.

Diagnostic Services

- full-mouth X-rays — once every 36 consecutive months
- two sets of bitewing X-rays – once every six consecutive months
- periapical X-rays — as required
- palliative emergency treatment of an acute condition requiring immediate care
- routine oral examinations (including cleaning, scaling, and polishing of teeth) — once every six consecutive months

Preventive Services

- routine prophylaxis (cleaning) — once every six months with additional cleaning during pregnancy
- fluoride application — once every six months for covered children under age 19
- space maintainers for covered children under age 19 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
- collection of microorganisms for culture and sensitivity — once per lifetime
- caries susceptibility tests — once per lifetime

General Services

- repair of broken partial or full removable dentures
- simple extractions
- endodontics, including pulpotomy and root canal treatment — one per tooth per lifetime
- inpatient consultations if the condition requires it and the dentist in charge of the case requests the consultation — one consultation per consultant during any one inpatient stay
- pulpal therapy
- repairs of broken crowns, inlays, onlays, and bridges (repair, recementation, relining, rebasing, and adjustment)
- labial chairside veneers for non-cosmetic purposes as determined by the dental claims administrator
- sealants for dependents 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 every three years
- crown lengthening — one per tooth per lifetime

Minor Restorations

- amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth — once every 12 months
- composite restorations on posterior teeth limited to the allowance for amalgam restoration; you are responsible for the balance of the cost

Oral Surgery

- administration of nitrous oxide, general anesthesia, and IV sedation
- alveolus
- apicoectomy (surgical removal of the end of a root)
- alveolectomy/alveoplasty, per quadrant
- excision pericoronal gingiva (operculectomy)
- frenulectomy
- maxillary or mandibular frenectomy
- procedures performed for the preparation of the mouth for dentures
- removal of cyst or tumor
- removal of exostosis
- removal of impacted teeth
- removal of tori
- root recovery (surgical removal of residual tooth root) — completely covered by bone
- surgical exposure of impacted or unerupted tooth
- surgical reduction of tuberosity
- surgical removal of maxillary or mandibular intrabony cysts
- surgical removal of tooth
- surgical removal of erupted tooth
- tooth reimplantation
- transseptal fiberotomy
- vestibuloplasty
- 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 performs and bills for another surgical procedure during the same operative session

Orthodontics

The following orthodontic services prescribed by a treatment plan that's been approved by the dental claims administrator:

- diagnosis, including radiographs
- active treatment, including necessary appliances
- retention treatment following active treatment

Periodontal Services

- diagnosis and treatment planning, including periodontal examinations
- surgical periodontal therapy — once every 24 months per area of the mouth
- post-treatment preventive periodontal procedures (periodontal prophylaxis)
- periodontal scaling and root planing — once every 24 months per area of mouth
- full-mouth debridement to enable comprehensive evaluation and diagnosis — once per lifetime
- brush biopsy (transepithelial sample collection) – once per lifetime

- antimicrobial agents (localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report) — six occurrences per 12 months; regardless of tooth number or area of the mouth

Prosthetics, Crowns, Inlay and Onlay Restorations

Coverage may be limited to the least expensive but adequate treatment plan, consistent with established dental standards. You may select a more expensive treatment plan than that covered with the understanding that you will be responsible for paying the difference in cost between the treatment received and the dental plan claims administrator's allowance.

- initial insertion of bridges (including pontics and abutment crowns, inlays and onlays)

- initial insertion of partial or full dentures and adjustments for six months after insertion

- replacement of an existing partial or full denture or bridge by a new denture or a new bridge, but only if satisfactory evidence is presented that the existing denture or bridge was inserted at least five years before replacement and 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 that are necessary to render the appliance serviceable.

- single unconnected crown, inlays, and onlays (none of which is part of a bridge or are splinted together)

    - replacement of crowns, inlays, and onlays, but only if satisfactory evidence is presented that at least five years have passed 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

- addition of teeth to an existing partial denture or 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

- relining or rebasing of dentures more than six months after the insertion of an initial or replacement denture, if provided by the same dentist — one relining or rebasing every 36 consecutive months.

What Is Not Covered

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

- not specifically listed as a covered benefit;

- not dentally necessary or appropriate;

- necessitated by lack of patient cooperation or failure to follow a professionally prescribed treatment plan;

- started by any dentist before the patient's eligibility under this Program, including, but not limited to endodontics, crowns, bridges, inlays, onlays, and dentures, except as described previously;

- incurred before the patient's effective date or after the termination date of coverage under the Program, except as described previously;

- not accepted standards of dental treatment, experimental/investigative in nature, or considered enhancements to standard dental treatment as determined by the dental claims administrator;

- for hospitalization costs;

- determined by the dental claims administrator to be the responsibility of workers' 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, the dental claims administrator would have the right to recovery for any benefits paid in excess;

- for prescription drugs;

- cosmetic in nature as determined by the dental claims administrator, including, but not limited to bleaching, veneers, personalization or characterization of crowns, bridges, and/or dentures;

- elective procedures including, but not limited to the prophylactic extraction of third molars;

- retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect, or repair of an orthodontic appliance;

- for any dental or medical services performed by a doctor and/or services for which benefits are otherwise provided under a medical plan of the patient;

- 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 does not apply to newly born dependent children;

- for dental treatment of fractures and dislocations of the jaw;

- for treatment of malignancies or neoplasms;

- for 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;

- for the cost to replace lost, stolen, or damaged prosthetic or orthodontic appliances;
- deemed by the dental claims administrator to be of questionable efficacy;
- for failure to keep a scheduled visit;
- the result of 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;
- for house calls for dental services; and
- for any services for which the patient failed to follow the guidelines of the Program.

VISION

About This Section

Vision benefits include coverage for eye exams, eyeglasses or contact lenses, and discounts for laser surgery. The way you pay for care and the amount you pay depends on whether you receive services from a vision claims administrator network provider/affiliate or a provider outside the network.

This section describes the vision coverage provided automatically to you and your family. You don't make a separate election for this benefit.

Some of the terms and phrases used in this SPD have a specific meaning. Refer to *Important Terms* for more information.

You should also refer to *Benefit Basics* and *More Information about Your Benefits and Rights* for more important information on eligibility, how to file claims, and your rights under ERISA.

Your Coverage

You and your eligible family members (dependents) are eligible for coverage under the vision benefits outlined in this section. Even if you waive medical coverage under the Program, you will receive these vision benefits. You will be required to verify eligibility of dependents for coverage.

This Program provides you with flat dollar payment and designated copayments for vision services and supplies. To obtain the highest level of coverage, you should receive services from a full-service participating provider who performs exams and dispenses glasses and contacts.

ID Cards

You will receive an ID card from the vision claims administrator that you should keep with you at all times and show when you need vision care. Your ID card shows the toll-free number to call with any questions.

If your card is lost or stolen, call the vision claims administrator immediately. Your card is to be used only by persons covered under this Program.

To request additional ID cards, call the vision claims administrator at the number on your ID card.

Who Pays the Cost for Coverage

There are no employee premium payments or payroll deductions for vision coverage for you and your eligible dependents. You pay for certain covered vision services and supplies at negotiated, discounted rates as shown in the *Summary Chart of Vision Benefits*. The Company pays the remaining cost of coverage, except as otherwise provided under the Program.

Summary Chart of Vision Benefits

This summary of benefits provides an overview of the vision benefits available to you under this Program. Refer to the following pages for a more detailed description of covered services and exclusions.

Payment is limited to one set of frames, lenses, or contact lenses in any 12-month period. Eligibility is determined from the date of your last previous refraction. Payment will not be made for both contact lenses and frames within the same 12-month period. Payment is limited to one eye exam and refraction in any 12-month period.

Vision Coverage			
Item	**In Network You Pay:**	**Out of Network You Pay:**	**Frequency**
Eye examination	$0	Provider's charge and file a claim to be reimbursed for $48 Allowance	Once per 12 months
Single vision lenses (standard)	$0	Provider's charge and file a claim to be reimbursed for $36 Allowance	Once per 12 months
Bifocal lenses (standard)	$0	Provider's charge and file a claim to be reimbursed for $54 Allowance	Once per 12 months
Trifocal lenses (standard)	$0	Provider's charge and file a claim to be reimbursed for $69 Allowance	Once per 12 months
Aphakic/Lenticular lenses	$0	Provider's charge and file a claim to be reimbursed for $108 Allowance	Once per 12 months
Non-standard lenses (e.g., photochromatic, polycarbonate)	Provider's charge	$0 Allowance	Once per 12 months
Progressive lenses	$50 - standard $90 - premium $140 – Ultra	Provider's charge and file a 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 a claim to be reimbursed for $36 Allowance	Once per 12 months
Contact lens fitting and evaluation	$0	Provider's charge and file a claim to be reimbursed for Daily: $30 Allowance Extended: $45 Allowance	Once per 12 months

Vision Coverage			
Item	**In Network You Pay:**	**Out of Network You Pay:**	**Frequency**
Standard contact lenses	$0	Provider's charge and file a claim to be reimbursed for $72 Allowance	Once per 12 months
Specialty contact lenses	$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 a 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 a 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	$0 Allowance	Once per 12 months

Eligible Providers

To receive coverage under this Program for a service, you must receive it at or from an eligible provider.

- For professional services and post-refractive services, an eligible provider is a licensed doctor of medicine, osteopathy, ophthalmology, or optometry.

- For post-refractive services, an eligible provider is an optician or retail optical dispensing firm that dispenses contact and eyeglass lenses using a prescription written by a professional provider.

Payment of Benefits

Payment for Professional Services

Participating providers accept the amounts shown in the Summary Chart of Vision Benefits 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 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

Eyeglasses

- Frames: Contracting suppliers and participating providers 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 for the difference between $60 and the charge.

- Lenses: Contracting suppliers and participating providers 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 vision claims administrator. 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 include, but are not limited to, photochromatic and 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 vision claims administrator.

Contact lenses

Contracting suppliers and participating providers 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 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.

Participating providers and contracting suppliers accept as payment for their services and supplies the amount described in the *Summary Chart of Vision Benefits* and charge you only the copayments described in the *Summary Chart of Vision Benefits*. By using 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.

Covered Services

The *Summary Chart of Vision Benefits* shows your share of the cost for certain services. This list does not describe all limitations, such as how often you can have a vision service. Contact the vision claims administrator for more information on other limitations.

Eye examination and refractive services include, but are not limited to the following:

- case history
- visual acuity, near and far
- external examination, including biomicroscopy or other magnified evaluation of the anterior chamber
- objective, subjective, and ophthalmoscopic examinations
- binocular measure
- summary, findings, and recommendations

Contact lens prescription and fitting services include, but are not limited to, the following:

- keratometry, or "K" reading, through the use of a keratometer to determine measurements of the eyes, curvature and base curve
- proper fitting of appropriate contact lenses, including the application of trial contact lenses to the patient's corneas
- 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 above.

Post-Refractive Services

Post-refractive services consist of:

- ordering lenses and frames (facial measurements, lenticular formula, any other specifications)
- cost of the materials
- verification of the completed prescription
- adjustment of the completed glasses
- subsequent servicing (refitting, realigning, readjusting, tightening) for 90 days

What Is Not Covered

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

- for examinations and materials not listed as a covered service or item;
- for the cost of any insurance premiums indemnifying you against losses for lenses or frames;
- for industrial safety glasses and safety goggles;
- for procedures determined by the vision claims administrator to be special or unusual, including but not limited to, orthoptics, vision training, subnormal vision aids, and tonography;
- for medical or surgical treatment of the eye;
- for diagnostic services such as diagnostic X-rays, cardiographic, encephalographic examinations, and pathological or laboratory tests;

- for drugs or any other medications;
- for eye examinations or materials necessitated by the participant's employment or furnished as a condition of employment;
- 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);
- to the extent benefits are provided by any governmental unit, unless payment is required by law;
- for which you would have no legal obligation to pay in the absence of this or any similar coverage;
- 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;
- performed before the effective date of coverage;
- incurred after coverage has ended except for lenses and frames prescribed before coverage ended and delivered within 31 days from that date;
- for telephone consultations, failure to keep a scheduled visit, or completion of a claim form;
- for temporary devices, appliances, and services;
- for which you incur no charge;
- 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;
- 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;
- 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 does not apply when the Company is obligated by law to offer you all the benefits of this Program and you elect this coverage as primary; and
- treatment or services for injuries resulting from the maintenance or use of a motor vehicle if the 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.

SICKNESS & ACCIDENT BENEFITS

About This Section

The goal of the sickness and accident benefit is to provide a weekly benefit if you become totally disabled due to sickness or an accident and are unable to work.

Some of the terms and phrases used in this SPD have a specific meaning. Refer to *Important Terms* of for more information.

> You should also refer to *Benefit Basics* and *More Information about Your Benefits and Rights* for more important information on eligibility and your rights under ERISA.

Eligibility

If you become totally disabled as a result of sickness or accident (as certified by a doctor) and are unable to work, you are eligible to receive weekly sickness and accident benefits. Benefits are payable if you have an approved claim on file and are under the care of a doctor.

Benefits are not payable if you:

- are not under the care of a doctor
- work for another employer (unless the work is allowed by your doctor), or
- are receiving salary or sick leave continuance.

Who Pays the Cost for Coverage

The Company pays the cost of your sickness and accident benefits under the Program. There are no employee premium payments or payroll deductions.

Payment of Benefits and Filing of Claims

Sickness and accident benefits are administered through the Company's claim unit. To be eligible for benefits, the claim unit must receive written notice of your claim within 21 days after your disability begins (for salaried employees, within 21 days after any period of salary or sick leave salary continuance is paid), but this requirement will be waived if you were unable to give notice or if someone else provided notice on your behalf.

You (or someone on your behalf) can obtain a sickness and accident benefits claim form from the employee benefits office at the plant or office where you work. You should complete your portion of the form and have your doctor, a nurse practitioner, or a doctor assistant complete the attending doctor's portion of the form. Return the completed form to United States Steel Claim Unit, P.O. Box 1308, Pittsburgh, PA 15230-1308 within 21 days of your disability.

In the case of disability due to:

- Accident — benefits are payable beginning the first day of total disability (for salaried employees, beginning with the first day of total disability for which no salary or sick leave salary continuance is paid or payable).

- Sickness — 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 (for salaried employees, beginning with the first day of total disability for which no salary or sick leave salary continuance is paid or payable).

If you are a salaried employee at the Fairfield Works and you become disabled after reporting on your first scheduled work day in any pay period, you will be eligible for sickness and accident benefits:

(1) if your disability is due to accident: during that pay period beginning with the first day of total disability resulting from an accident, and

(2) if your disability is 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.

Duration of Benefits

Sickness and accident benefits are payable as follows, depending on your continuous service as of the date your period of disability begins:

Continuous Service as of the Date a Period of Disability Begins	Duration of Sickness and Accident Benefits
Two or more years	Benefits are payable for up to 52 weeks for any one continuous period of disability — reduced, if you are salaried, by any period for which sick leave salary continuance is paid during this period. If you have 15 or more years of continuous service as of your last day worked, and you are not permanently disabled as determined by Social Security (or the Company medical department if you are age 62 or older), benefits will be continued for up to 52 additional weeks.
Less than two years	Benefits are payable for up to 26 weeks for any one continuous period of disability — reduced, if you are salaried, by any period for which sick leave salary continuance is paid during this period. 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 will not exceed the number of full weeks of continuous service you had on the date the continuous period of disability started — reduced, if you are salaried, by any period for which sick leave salary continuance is paid during this period.

Successive periods of disability separated by a period of less than 60 days of continuous active employment with the Company are considered to be one continuous period of disability, unless it is clear that these periods arise from unrelated causes, provided you meet the eligibility requirements shown above. Benefits are not payable for a continuous period of disability that started before your coverage became effective.

Amount of Benefits

Your weekly benefit will be equal to 70% of your weekly Base Rate of Pay for your incumbent job as of the first date of disability, with a minimum weekly benefit of $500. Any changes to your Base Rate of Pay while you are receiving weekly sickness and accident benefits will not affect the amount you receive.

If you become totally disabled due to a work-related sickness or accident, the weekly sickness and accident benefit amount otherwise payable will be reduced by any weekly benefits you are or could become entitled to receive due to your eligibility for workers' compensation, any occupational disease, or other similar applicable law.

Payments for hospitalization or medical expense or specific allowances for loss will not reduce the amount of your sickness and accident benefits.

If you are entitled to sickness and accident benefits and there is a dispute regarding your entitlement to payments you are claiming under workers' compensation, occupational disease, or other similar applicable law, sickness and accident benefits will be paid in full if arrangements are made to assure you will pay back any overpayment of sickness and accident benefits.

Your weekly sickness and accident benefit amount will be reduced, for each week of disability, by the amount of any Social Security primary disability benefits or unreduced primary old-age benefits to which you are entitled, except no reduction will be made for the first 26 weeks of sickness and accident benefits during any one continuous period of disability — however, if you are salaried, 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 these benefits and sick leave salary continuance during any one continuous period of disability.

The claim unit will assume you are receiving a Social Security disability benefit, and your sickness and accident benefits will be reduced by an estimated amount until the claim unit receives a copy of your Social Security award. Once this copy is received, the exact amount of your reduction will be determined. If, however, you are eligible for sickness and accident benefits (and if you are salaried, sick leave salary continuance as well) for more than 26 weeks and you give the claim unit written proof within the initial 15 weeks of disability that you have applied for and are pursuing Social Security disability benefits and do not receive the benefits when they are initially due, full weekly benefits will be continued until the earlier of the date:

- the Social Security disability benefits begin, or
- 34 weeks of weekly benefits (and/or if you are salaried, sick leave salary continuance) have been paid.

If you continue to be eligible for sickness and accident benefits beyond 34 weeks, and you do not have a Social Security disability benefit award or denial, the amount of benefits you receive will be reduced by 50%, provided you have given the claim unit written evidence that you will continue to cooperate and fully pursue Social Security disability benefits, and you make arrangements to assure any overpayment of weekly benefits resulting from the Social Security award will be repaid. Once the claim unit is furnished with a copy of the Social Security award, your sickness and accident benefits will be restored to 100% (subject to the offsets described above).

To be eligible for this arrangement, you must make satisfactory arrangement to repay any overpayment of weekly benefits because you received Social Security benefits. 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.

The sickness and accident benefit otherwise available to you will not be subject to the offset for primary disability benefits if you:

- provide documentation from your doctor confirming you will be able to return to employment within 12 months of the start of your disability,

- have not been disabled long enough to qualify for Social Security disability benefits, or

- 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 the denial notice; however, weekly sickness and accident benefits will be paid beyond 34 weeks 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.

Transplant Benefits

If you are an organ or tissue donor, the surgery to remove the organ or tissue for transplant is considered a disability due to sickness. In no event will the disability be considered to have begun before the date of your hospital confinement.

Disability During Suspension

If you become disabled during a suspension that is not converted into discharge, you may be eligible for sickness and accident benefits. To be eligible you must promptly notify the claim unit of your disability. Also, if requested and if you can, report for examination to the medical department of the plant or office where you work, or to a doctor as designated by the Company.

If you meet these criteria, sickness and accident benefits will be payable. The days of your suspension period will not count toward any waiting period and will not be payable.

Administration of Benefits

The claim unit administers claims. In a 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 investigate medical and other aspects of the claim. Benefit checks will be issued by the Company.

Dispute Resolution Process

The dispute resolution process will be used if the Company doctor indicates you can return to work but your doctor disagrees.

The dispute resolution process is your examination by a Company-appointed doctor and your doctor. If they disagree, the question will be submitted to a third doctor selected by the first two doctors. The medical opinion of the third doctor, after examining you, consulting with the other two doctors, and reviewing all medical records relating to the disputed claim, will make the final decision. Your sickness and accident benefits will begin or continue to be paid during the dispute resolution process, as long as you give any necessary authorization for 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.

The fees and expenses of the third doctor will be paid equally by the Company and the Union.

If the Company doctor indicates you cannot return to work but your doctor disagrees, the issue will be submitted to a review group composed of the Company medical director, the USS safety director, and a representative from the USW International Union. Your sickness and accident benefits will continue to be paid as long as the Company doctor indicates you are unable to perform the duties of your job.

Your sickness and accident benefits will continue to be paid if your doctor or the Company doctor indicates you can return to work with restrictions, but no such position is available. If your doctor and the Company doctor disagree on the restrictions placed on you, the dispute resolution process will take place.

Refer to Insurance Grievances in *Benefit Basics* for the appropriate procedures to follow to file a grievance if your claim is not subject to resolution discussed above.

LIFE AND OTHER OPTIONAL INSURANCE

About this Section

The Company provides a basic level of life insurance coverage and offers additional options you can purchase to design the benefit package that's right for you and designed to provide you and your family with important financial protection. This section describes these benefits in detail.

Some of the terms and phrases used in this SPD have a specific meaning. Refer to *Important Terms* for more information.

> You should also refer to *Benefit Basics* and *More Information about Your Benefits and Rights* for more important information on eligibility, how contributions are made, when elections can be changed, how to file claims, and your rights under ERISA.

Basic Life Insurance

The Company provides $50,000 of basic life insurance at no cost to you. Your basic life insurance ends when your employment ends for any reason other than retirement (*see Coverage for Retirees and Surviving Spouses*). This coverage is subject to the terms of a group policy.

Your Options

The following **optional** coverages are available to you:

- Optional Employee life insurance
- Optional Spouse life insurance
- Optional Child(ren) life insurance
- Accidental death and dismemberment (AD&D) insurance
- Optional Critical illness coverage
- Optional Accident coverage (this not the same as sickness and accident benefits)

Important Note: The optional coverage is not endorsed by the Union. The Union makes no recommendation regarding the purchase of this coverage.

Optional Employee Life Insurance

You may elect optional employee life insurance in amounts equal to:

- $25,000
- $50,000
- $75,000
- $100,000
- $125,000
- $150,000
- $175,000
- $200,000

Optional employee life insurance is provided with a guarantee issue for up to 30 days after your eligibility date. You may also enroll or change your optional employee life insurance coverage during annual enrollment or mid-year if you experience certain qualified life events. If you enroll or increase coverage during annual enrollment or within 60 days of certain qualified life events, you'll be required

to submit, at your own expense, a statement of health (evidence of insurability). Optional employee life insurance ends when your employment ends for any reason other than retirement (see *Coverage for Retirees and Surviving Spouses*). This coverage is subject to the terms of a group policy.

Monthly Cost

The cost of your optional employee life insurance coverage is deducted from your earnings on an after-tax basis on the Payroll Deduction Date. If your earnings are not enough to cover the full monthly deduction, no deduction will be taken. The tables below show the current age- and tobacco use-related monthly contributions for optional employee life insurance:

Monthly After-Tax Contribution – Non-Tobacco Rate								
Age	Amount of Coverage							
	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000
<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

Monthly After-Tax Contribution – Tobacco Rate								
Age	Amount of Coverage							
	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000
<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

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.

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

Payment of Benefits

If you die, your basic life insurance and optional employee life insurance benefits will be paid to your designated beneficiary. The applicable death benefit will be paid using methods established by the life insurance claims administrator and in a form elected by the beneficiary(ies).

Beneficiary

You may make separate beneficiary designations for basic life insurance and for optional employee life insurance. You may change your beneficiary designations at any time by going to the MetLife web site to designate your beneficiaries. You can access the MetLife website from the Health & Welfare website. Instructions are provided on who you can designate, and how to designate a beneficiary on the website. Use this same website to make your online designation and any future changes or updates to your designation. Beneficiary designations are subject to the terms of the group policy,

If your beneficiary dies before you, your life insurance will be payable according to the schedule contained in the group policy. You may wish to consult your tax advisor before making a beneficiary designation.

Optional Spouse Life Insurance

You may elect optional spouse life insurance in amounts equal to:

- $20,000
- $40,000
- $60,000
- $80,000
- $100,000

Benefits will be paid to you if you survive your spouse.

Optional spouse life insurance is provided with a guarantee issue for up to 30 days after your eligibility date (or within 60 days of your marriage). You may also enroll or change your coverage amount during annual enrollment or within 60 days of certain qualified life events. If you request an increase to the amount of optional spouse life insurance during annual enrollment or within 60 days of certain qualified life events, you must submit, at your own expense, evidence of your spouse's good health. You may also decrease your optional spouse life insurance coverage during annual enrollment and within 60 days of certain qualified life events. This coverage is subject to the terms of a group policy.

Monthly Cost

The cost of your optional spouse life insurance coverage is deducted from your earnings on an after-tax basis on the Payroll Deduction Date. If your earnings are not enough to cover the full monthly deduction, no deduction will be taken. The tables below show the current age- and tobacco use-related monthly contributions for optional spouse life insurance:

Monthly After-Tax Contribution – Non-Tobacco Rate					
Age of Spouse	Amount of Coverage				
	$20,000	$40,000	$60,000	$80,000	$100,000
<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

Monthly After-Tax Contribution – Tobacco Rate					
Age of Spouse	Amount of Coverage				
	$20,000	$40,000	$60,000	$80,000	$100,000
<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 becomes effective on the first of the month of your spouse's birth.

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.

Optional spouse life insurance ends on the date your spouse is no longer a dependent or on the date your employment ends for any reason other than retirement (see *Coverage for Retirees and Surviving Spouses*).

Optional Child(ren) Life Insurance

You may elect optional child(ren) life insurance at coverage levels of $5,000 and $10,000 for your dependent children (excluding grandchildren or children for whom you are the legal guardian).

Benefits will be paid to you if you survive your dependent child.

Optional child(ren) life insurance is provided with a guarantee issue. 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. You also can decrease your optional child(ren) life insurance coverage during annual enrollment and within 60 days of certain qualified life events.

This coverage is subject to the terms of a group policy.

Monthly Cost

The cost of your optional child(ren) life insurance coverage is deducted from your earnings on an after-tax basis on the Payroll Deduction Date. If your earnings are not enough to cover the full monthly deduction, no deduction will be taken. The table below shows the current monthly contributions for optional child(ren) life insurance:

Monthly After-Tax Contribution		
	Amount of Coverage	
	$5,000	$10,000
Monthly Cost	$0.52	$1.03

Optional child(ren) life insurance ends on the date your dependent is no longer a dependent or the date your employment ends for any reason, including retirement.

Optional Accidental Death & Dismemberment Insurance

You may elect optional accidental death & dismemberment (AD&D) insurance, which pays benefits if you suffer an accident that results in death, paralysis or loss of a limb, speech, hearing or sight, or other conditions. You may elect AD&D insurance for you, or for you and your spouse, in amounts equal to:

- $50,000
- $100,000
- $150,000
- $200,000
- $250,000

You may make separate beneficiary designations for your optional AD&D insurance. You are automatically the beneficiary for coverage elected for your spouse.

If you elect to include your spouse, you both will be covered at the same coverage level. You can enroll within 30 days of your eligibility date, during annual enrollment, or within 60 days of certain qualified life events. You may also decrease your optional AD&D coverage during annual enrollment and within 60 days of certain qualified life events. No evidence of insurability is required. This coverage is subject to the terms of a group policy.

Monthly Cost

The cost of your optional AD&D coverage will be deducted from your earnings on a pre-tax basis on the Payroll Deduction Date. If your earnings are not enough to cover the full monthly deduction, no deduction will be taken. The table below shows the current monthly contributions for optional AD&D insurance:

Monthly Pre-Tax Contribution					
Coverage Level	Amount of Coverage				
	$50,000	$100,000	$150,000	$200,000	$250,000
Employee Only	$1.05	$2.10	$3.15	$4.20	$5.25
Employee + Spouse	$1.65	$3.30	$4.95	$6.60	$8.25

Optional AD&D insurance for you ends when your employment ends. Optional AD&D insurance for your spouse ends on the date he or she is no longer a dependent or when your employment ends.

If Both You and Your Spouse are Employees

If you and your spouse are employees covered under this Program, both of you may elect optional employee life insurance and optional spouse life insurance, and AD&D insurance for employee and spouse. However, both you and your spouse may not cover the same child(ren) under optional child(ren) life insurance.

Accelerated Benefits Option (ABO)

If while actively employed, you are diagnosed as having a terminal illness with a life expectancy of 12 or fewer months, up to 80% of your basic life insurance (maximum of $40,000) and up to 80% of your optional employee life insurance coverage (maximum of $160,000) in effect at the time of your application may be received in a lump-sum payment if you meet specified criteria.

If your spouse is covered under optional spouse life insurance while you are actively employed and is diagnosed as having a terminal illness with a life expectancy of 12 or fewer months, up to 80% of the optional spouse life Insurance coverage applicable to your spouse (maximum of $80,000) in effect at the time of application may be received in a lump-sum payment if specified criteria are met.

Claiming an accelerated benefit will reduce the amount of basic and/or optional life insurance in effect and any coverage eligible for conversion. It also may affect your personal tax situation and your eligibility, or that of your spouse or family, for public assistance programs.

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 at 877-877-4586 to obtain an Accelerated Benefits Claim Form. Approval of an ABO claim is determined by the claims administrator and subject to an independent medical review by the claims administrator.

Other Optional Benefits

Coverage for accident and critical illness benefits is available to you, your spouse, and your dependent children, with no requirement to answer health questions or undergo a medical exam. You may elect these additional benefits within 30 days of first becoming eligible, during annual enrollment or within 60 days of certain qualified life events.

You must be actively at work to elect coverage or change your coverage level, or to increase critical illness coverage. You may keep such coverage if you are on an inactive status and remain eligible for continuing your medical benefits.

You pay for these optional benefits through after-tax contributions that are deducted from your pay. You also can take your accident and critical illness coverage with you if you leave the Company, as long as you continue to pay your premiums. For more details and costs, contact Aetna at the number shown in *Who to Call*.

Coverage is guaranteed if you are actively at work, and you and your dependents are not subject to medical restriction as described in the certificate. These additional benefits are subject to the terms of a group policy. See your outline of coverage/disclosure document for full details. Contact Aetna for additional details or questions.

Important Note:
The optional accident coverage and optional critical illness coverage are not endorsed by the Union. The Union makes no recommendation regarding the purchase of this coverage.

Optional Accident Coverage

While medical plans typically cover care for an injury, they don't cover the unexpected costs that come with it. The Aetna Accident Plan can help. The plan pays cash benefits directly to you when you have a covered accident. You can use the money for expenses like coinsurance, deductibles, or everyday expenses like mortgage payments, child care, or groceries. It's up to you.

Please see the Group Accident Certificate for a schedule of benefits, limitations and exclusions.

The cost of your accident coverage is deducted from your earnings on an after-tax basis on the Payroll Deduction Date. If your earnings are not enough to cover the full monthly deduction, no deduction will be taken. The table below shows the current monthly contributions for accident coverage:

Costs for Optional Accident Coverage	
Coverage Level	**Monthly After-Tax Contribution**
Employee	$9.67
Employee + Family	$21.45

Note - Accident coverage is a voluntary benefit and is separate and distinct from sickness and accident benefits.

Optional Critical Illness Coverage

The Aetna Critical Illness Plan can help you protect your finances. The plan pays cash benefits to you when you are diagnosed with a covered condition. You can use the money to help cover your deductible or everyday expenses like utility bills, mortgage payments and groceries. You may elect coverage levels of $15,000 or $30,000. Your benefit amount is based on the coverage level you elect and the terms of the group policy.

The Critical Illness plan pays a **lump sum** benefit if you or your eligible dependent is diagnosed with a covered condition for the first time, after coverage is effective and while coverage is in effect. If an insured person has been initially diagnosed with and received a benefit for a critical illness, and then the insured person is diagnosed again with the same critical illness a **Recurrence** benefit will be paid. This plan is subject to certain limitations and exclusions. Please see the Group Critical Illness Certificate for a list of covered critical illness conditions, along with plan limitations and exclusions.

The cost of your critical illness coverage is deducted from your earnings on an after-tax basis on the Payroll Deduction Date. If your earnings are not enough to cover the full monthly deduction, no

deduction will be taken. The table below shows the current monthly contributions for critical illness coverage:

$15,000 of Optional Critical Illness Coverage		
	Monthly After-Tax Contribution	
Age	Employee Only	Family
Younger than 25	$5.05	$10.47
25 – 29	$6.98	$13.84
30 – 34	$9.50	$17.03
35 – 39	$11.58	$19.69
40 – 44	$14.70	$23.99
45 – 49	$16.78	$26.94
50 – 54	$25.54	$39.48
55 – 59	$28.96	$43.91
60 – 64	$37.13	$55.34
65 – 69	$76.77	$113.04
70 and older	$107.37	$160.31

$30,000 of Optional Critical Illness Coverage		
	Monthly After-Tax Contribution	
Age	Employee Only	Family
Younger than 25	$10.10	$21.53
25 – 29	$13.96	$28.48
30 – 34	$19.01	$35.03
35 – 39	$23.17	$40.50
40 – 44	$29.40	$49.35
45 – 49	$33.56	$55.41
50 – 54	$51.08	$81.22
55 – 59	$57.92	$90.32
60 – 64	$74.25	$113.84
65 – 69	$153.55	$232.53
70 and older	$214.73	$329.77

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

Total Disability

If, while covered under this Program and before age 60, you become totally disabled for more than six months and submit satisfactory evidence of continuing total disability, your basic life insurance will be continued, with no contributions required from you, until your employment ends. If you reach age 62 while still covered, your basic life insurance coverage will reduce to $10,000.

Any optional employee life, spouse life, child(ren) life, and AD&D insurances will be continued with contributions from you, until the end of the month in which you reach age 62.

Conversion Privilege

If 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, or retirement, you have the right to convert to an individual policy. To convert your policy(ies), you must submit an application within 31 days of the termination of your life insurance coverage.

Contact the life insurance claims administrator to learn more about converting your life insurance policy(ies).

FLEXIBLE SPENDING ACCOUNTS (FSAs)

About this Section

Flexible spending accounts (FSAs) allow you to save on taxes while providing a convenient way to budget for certain predictable health care and dependent care expenses. When you enroll in one or both accounts, you contribute to your FSAs on a pre-tax basis, which reduces your taxes and saves you money. You choose the amount to save, depending on your personal situation.

Some of the terms and phrases used in this SPD have a specific meaning. Refer to *Important Terms* for more information.

You should also refer to *Benefit Basics* and *More Information about Your Benefits and Rights* for more important information on eligibility, how contributions are made, when elections can be changed, how to file claims, and your rights under ERISA.

Your Options

The Program offers two FSAs as described below. In general, you may participate in one or both FSAs if you are eligible to participate in the Program (see *Eligibility* in *Benefit Basics).*

- A Health Care FSA (HCFSA) helps you pay for eligible health care expenses incurred by you or your eligible dependents (as defined by the IRS).

- A Dependent Care FSA (DCFSA) helps you pay for the child or elder day care expenses you incur on behalf of an eligible dependent (as defined by the IRS) so you (or you and your spouse) can work or look for work.

FSAs offer significant tax advantages. Amounts you contribute are not subject to Social Security or federal income taxes or, in most cases, state and local income taxes. (Check with your tax advisor to see how FSA contributions are treated in your state.) Because your FSA contributions are deducted from your pay before your taxes are calculated, you are taxed on a lower amount and pay less in taxes.

FSA contributions reduce the amount of taxable income for Social Security purposes. If your taxable wages are below the Social Security taxable wage base for the year, this could result in a lower Social Security benefit. You can find the current Social Security taxable wage base at www.ssa.gov.

Health Care Flexible Spending Account (HCFSA)

Enrollment

Each year during the annual enrollment period, you can elect to establish an HCFSA for the following calendar year. If you are a new employee, you must enroll in an HCFSA within 90 calendar days from your date of hire (i.e., 30 days after the date you become eligible for coverage under this Program).

To establish an HCFSA, you authorize a monthly pre-tax deduction (based on an annual amount) on the Payroll Deduction Date. You may contribute from $120 to the IRS maximum (for 2018, $2,650) per year to an HCFSA.

Monthly deductions will begin as soon as possible following the effective date of your election. If you do not have enough earnings to cover the full deduction, no deduction will be taken. Your HCFSA contribution rate does not roll over from year to year; you must re-elect participation every year.

Eligible Family Members (Dependents)

For the purposes of the HCFSA, dependents include family members who are eligible for coverage as described in *Eligibility*, as well as any person who could qualify as a dependent on your federal income tax return. Certain exceptions may apply for children of separated/divorced parents. For more details, obtain IRS Publication 504 and/or consult a tax advisor.

Covered Expenses – General Rules

Covered expenses are those related to health care, which are defined as medical care under Internal Revenue Code Section 213(d), provided such expenses are:

- incurred by you and/or your dependents within the applicable claim period. Starting with the 2017 Plan Year, the applicable claim period the 14-1/2 month period beginning on January 1 of the plan year and ending on March 15 of the following calendar year. For example, the applicable claim period for the 2017 plan year is January 1, 2017 to March 15, 2018. (For the 2016 plan year, the applicable claim period was January 1, 2016 to December 31, 2016),
    - Covered expenses are incurred on the date the applicable medical services, supplies, or treatments are received, except that orthodontia expenses are incurred on the date the initial procedure is performed if the orthodontist requires full payment at the start of treatment.
- incurred after your HCFSA participation begins,
- not reimbursable as medical, vision, or dental benefits under any other plan or policy,
- not claimed as a deduction or tax credit on your federal income tax return,
- properly substantiated, and
- not over-the-counter (OTC) medications, unless obtained with a prescription or for insulin.

Examples of covered expenses that can be reimbursed from an HCFSA include:

- your share of expenses under the PPO medical option and prescription drug benefits, such as Program deductibles, coinsurance, or copayments, and amounts in excess of Program limits, including doctors' fees that exceed the allowable charge
- expenses that are not covered under the PPO medical option, prescription drug benefits, or vision benefits
- expenses that are not reimbursed as dental benefits
- medical, prescription drug, dental, hearing, and vision expenses that you pay for persons who are dependents under this HCFSA, but not covered under the Program

Non-Covered Expenses

Visit the FSA claims administrator's (PayFlex for 2018) website at www.payflex.com or call 844-729-3539 for a list of excluded expenses.

How Does the HCFSA Work?

When you elect an HCFSA, it is funded with the full amount you elected during annual enrollment. Three convenient payment options are available:

- Debit 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 OTC drugs at the pharmacy counter unless you provide a valid prescription for the OTC drugs at the time of purchase. You can 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. Save receipts when using the card; the IRS requires you keep them for your tax records, and you will also need them if the FSA claims administrator requests documentation for verification.

- Pay your provider — An online feature (automatic bill pay system) used to pay your provider directly from your account. Appropriate documentation of the expense is required, such as a detailed invoice or explanation of benefits that contains the patient's name, service start and end date, name of the service provider, description of service rendered, and the amount paid or owed.

- Pay yourself back — You pay for eligible expenses with cash, check, or your personal credit card, and then submit a claim for reimbursement to the claims administrator online, by fax or mail, according to its procedures.

Maximum Amount of Reimbursement

The full annual HCFSA 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 HCFSA with respect to a plan year cannot exceed the total contributions authorized by you for allocation to your HCFSA during the plan year. If your employment ends (or your HCFSA coverage ends), and if you do not elect COBRA continuation coverage, the full annual HCFSA election amount is available for reimbursement; however, reimbursements are limited to expenses incurred before your termination date.

Forfeiture of Unused Contributions

Starting with the 2017 plan year, covered expenses must be filed for reimbursement no later than June 15 immediately following the end of the applicable claim period. The applicable claim period 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. For example, the deadline for filing claims for the 2017 plan year is June 15, 2018. (For the 2016 plan year, the applicable claim period is the calendar year, and the deadline for filing reimbursement claims is April 15, 2017). At the end of this period of time, all remaining contributions in your HCFSA for that plan year are forfeited. These forfeitures may be reallocated to participants.

Cessation after Termination of Employment (or Termination of Coverage)

Unless you make a COBRA election, contributions to your HCFSA will end if your employment with the Company ends. Covered expenses incurred by you and/or your dependent prior to the end of the month of the termination of your employment (or coverage) will be reimbursed. Covered expenses incurred by you and/or your dependents following the end of the month of your termination of employment (or

termination of coverage) will not be reimbursed unless you make a COBRA election to continue your coverage.

Continuation of Coverage (After Termination of Employment or Coverage)

If your employment or your HCFSA coverage is terminated, you may elect COBRA continuation coverage for your HCFSA if (a) is greater than (b) below:

a) the net of:
   (i) the sum of your elected monthly contributions to your HCFSA 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 HCFSA for the portion of the entire 12-month plan year that occurs after the qualifying life event, multiplied by 102%.

The term "qualifying life event" means the date your employment with the Company ends. However, if you do not return to work at the end of an FMLA leave, "qualifying event date" means the last day of FMLA leave. If you elect COBRA continuation coverage, the maximum period of coverage extends from the qualifying event date to the end of the plan year.

Payment in the Event of Your Death

If you die, payment of covered expenses for a claim that has been filed timely will be made at the discretion of the FSA claims administrator to either your estate or one or more persons in the group consisting of your descendants, parents, or heirs-at-law.

Penalties for Misuse

An HCFSA is governed by federal law, which is enforced by the IRS and other tax authorities. In addition to other legal remedies, your refusal to follow the terms of any applicable agreement with the FSA claims administrator or providing false or fraudulent statements about the items or services you have purchased may result in deactivation of your Health Care Card, termination of participation in the HCFSA, or other consequences. The tax authorities may also initiate tax collections against you.

Dependent Care Flexible Spending Account (DCFSA)

Enrollment

You may elect each year during the annual enrollment period to establish a DCFSA. If you are a new employee, you must enroll within 90 calendar days from your date of hire (i.e., 30 days after the date you become eligible for coverage under this Program).

To establish a DCFSA, you authorize a monthly pre-tax deduction on the Payroll Deduction Date. You may contribute to a DCFSA from $120 to $5,000 per year if you have one or more qualifying persons (the maximum changes to $2,500 per year if you are married and do not file a joint federal income tax return). These maximum amounts include any Company contributions to your DCFSA if provided for in your bargaining agreement.

Monthly deductions will begin as soon as possible following the effective date of your election. If you do not have enough earnings to cover the full deduction, no deduction will be taken. Your contribution rate does not roll over from year to year; you must re-elect participation every year.

Qualifying Persons

A qualifying person is:

- your spouse, if that spouse is physically or mentally incapable of self-care, or
- any person you claim or could claim as your dependent under federal income tax regulations who is younger than age 13, or age 13 or older and physically or mentally incapable of self-care.

Certain exceptions may apply for children of separated/divorced parents and with respect to the income of disabled dependents. For more details, obtain IRS Publications 503 and 504 and/or consult a tax advisor.

Covered Expenses

Covered expenses are expenses incurred primarily for the care of a qualifying person so that you can work or actively look for work, provided the expenses comply with federal income tax regulations. If the care is provided outside your household, the care for a qualifying person may be eligible only if the person spends at least eight hours a day in your household. Covered expenses include, but are not limited to, the following:

- charges for baby-sitters or companions
- charges for a day care center that meets local regulations, provides care for more than six non-resident individuals, and charges a fee for service, whether or not for profit
- schooling costs for children before entry into kindergarten
- charges for before- or after-school care
- charges for ancillary household services performed by an individual who is primarily providing care for a qualifying person.

Visit the FSA claims administrator's website for a list of covered expenses. The website address is listed in *Who to Call*.

Expenses reimbursed under the DCFSA 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 DCFSA.

Non-Covered Expenses

Non-covered expenses include, but are not limited to, the following:

- 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
- charges for services provided by your non-dependent child who is under age 19 at the end of the plan year
- food and clothing expenses related to the qualifying person
- educational expenses in or beyond kindergarten for a qualifying child who is not incapacitated
- overnight camp expense

Visit the FSA claims administrator's website for a list of excluded expenses. The website address is listed in *Who to Call*.

How Does the DCFSA Work?

When you elect a DCFSA, you can use these convenient payment options:

- Pay your 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 dates, the name of the service provider, description of service rendered, and the amount paid or owed.

- Pay yourself back — Paper-based claim forms that provide rapid turnaround and real-time online visibility. You may file a claim for reimbursement online or by fax or mail.

Maximum Amount of Reimbursement

The maximum amount of expenses reimbursable from a DCFSA for a plan year will be equal to the lesser of the following:

- $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 (refer to IRS Publication 503 for special rules and/or exceptions)
- the amount allocated to your DCFSA
- your annual compensation if you are not married at the close of the plan year
- the lesser of your annual compensation or the earned income of your spouse, if you are married at the close of the plan year

These maximum amounts include any Company contributions to your DCFSA if provided for in your bargaining agreement.

If your spouse is a student or is mentally or physically incapable of self-care, he or she is considered 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.

If you submit claims for covered expenses that exceed the balance in your DCFSA, you will be reimbursed up to the amount of contributions credited to your DCFSA. The excess expense will be pended and automatically reimbursed as additional contributions are made to your DCFSA during the plan year.

Forfeiture of Unused Contributions

Covered expenses 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 DCFSA for that plan year are forfeited. Forfeitures of employee contributions may be reallocated in the future in such manner as the plan administrator deems to be consistent with IRS regulations.

Continuation of Coverage (after Termination of Employment)

If your employment with the Company ends, contributions to your DCFSA stop. Covered expenses incurred during the remainder of the plan year will be reimbursed up to the amount remaining in your DCFSA.

Payment in the Event of Your Death

If you die, payment of covered expenses for a claim that has been filed timely will be made at the discretion of the FSA claims administrator either to your estate or to one or more persons in the group consisting of your descendants, parents, or heirs-at-law.

Penalties for Misuse

An HCFSA is governed by federal law, which is enforced by the IRS and other tax authorities. In addition to other legal remedies, your refusal to follow the terms of any applicable agreement with the FSA claims administrator or providing false or fraudulent statements about the items or services you have purchased may result in termination of participation in the DCFSA or other consequences. The tax authorities may also initiate tax collections against you.

DCFSA vs. Federal Income Tax Credit

You have a choice between two methods of saving taxes on your eligible dependent care expenses: contribute to a DCFSA, or take a tax credit on your federal income tax return for your dependent care expenses based on your number of dependents and your adjusted household gross income.

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 provide advice. 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.

MORE INFORMATION ABOUT YOUR BENEFITS AND RIGHTS

About This Section

This section provides general information and certain details required by the Employee Retirement Income Security Act of 1974 (ERISA). If you have any questions about your rights or privileges under this Program, the operation of the Program, or the forms and information you need to submit a claim for benefits, contact the Benefits Service Center.

Some of the terms and phrases used in this SPD have a specific meaning. Refer to *Important Terms* for more information.

Filing a Claim

This section gives you important information about filing a claim for benefits provided under this Program. Information on how and when to file a claim for each type of benefit is provided in the chart below. Claims may be filed by you or your authorized representative. Your medical provider may also file a claim.

Not sure who to call? Check with the Benefits Service Center first at 877-877-4586.

Summary Chart for Claims Filing			
Type of Claim	**Where to Get Forms**	**Time Limit to File Claims**	**Reminders**
Medical	www.highmarkbcbs.com or www.aetna.com	End of calendar year following the calendar year in which service was received	File only for out-of-network services. Attach itemized bills.
Prescription Drugs Retail Pharmacy	www.express-scripts.com	For non-participating pharmacies, within one year from the purchase date	You may order up to a 30-day supply.
Mail-Order Pharmacy	www.express-scripts.com	N/A	You may order up to a 90-day supply.
Accredo (specialty pharmacy)	www.accredo.com	N/A	You may order up to a 30-day supply.

Summary Chart for Claims Filing			
Type of Claim	**Where to Get Forms**	**Time Limit to File Claims**	**Reminders**
Dental	www.ucci.com	Within 1 year from the date of service	File only for out-of-network services. Attach itemized bills.
Vision	www.davisvision.com	Within 1 year from the date of service	File only for out-of-network services. Attach itemized bills. Notify vision claims administrator in writing of choice of authorized representative.
Life and Other Optional Insurance	www.metlife.com/mybenefits	By the deadline set by the life insurance claims administrator	
FSAs	www.payflex.com (beginning with the 2018 Plan Year) www.wageworks.com (Plan Years prior to 2018)	HCFSA – June 15 for expenses incurred through March 15 of the following year; DCFSA - April 15 for expenses incurred through December 31 of the prior year	File a claim by using your Debit Card at time of service, using the Pay your provider Service, or requesting reimbursement
Optional Critical Illness and Accident Coverage	www.aetnavoluntaryforms.com (beginning with the 2018 Plan Year) www.metlife.com (Plan Years prior to 2018)	You or your authorized representative	By deadline established by the third-party admin

When to File a Claim

If you believe you are eligible to receive benefits under the Program, you should file a claim for benefits. Claim forms are available online from the claims administrator's website. Under certain health care plans, you may not need to file a claim to receive benefits. For example, most network medical, dental, and vision care providers submit claims directly to the claims administrator. For details on when you need to file a claim, refer to the benefit-specific topic in this section.

All claims submitted to the claims administrator must be on forms provided by the claims administrator. If forms are not currently available, you can send the applicable claims administrator a written statement outlining the details of your claim.

Complete the claim form and return it to the appropriate claims administrator within the specified timeframe. If you do not submit a claim within the specified timeframe, your claim may be denied.

Claims must be submitted to the claims administrator at the address provided on the claim form. Once your claim has been reviewed, you will receive the appropriate benefit or a notification of adverse benefit determination (denial of benefit) from the claims administrator.

Health Care Claims

Under the Employee Retirement Income Security Act of 1974 (ERISA), health care plans are required to establish and maintain reasonable claims procedures. A claims procedure will be considered reasonable only if it satisfies certain specific requirements. The following procedures are intended to comply with those requirements and reflect the procedures in place for the self-funded medical plans.

The following table provides an overview of who is responsible for reviewing health care claims at each step of the process. For benefit claims, if your claim is denied, you should begin the process by contacting your claims administrator.

Who Reviews and Responds to Your Claim Requests and Appeals	
Type of Claim	**Responsible Group**
Claim denial	Claims administrator
First-level appeal	Claims administrator
Second-level appeal	Claims administrator
External review	Independent review organization
Insurance Grievance and Arbitration	as defined in your bargaining agreement

Types of Health Care Claims

There are three types of claims:

- A **pre-service claim** is a claim for a benefit for which prior approval is required as a condition of receiving the benefit, in whole or in part.

- An **urgent care claim** is a type of claim which, if the regular time periods for handling such a claim were adhered to, it:

  - Could seriously jeopardize your life or health or your ability to regain maximum function, or
  - Would, in the opinion of a professional provider with knowledge of your condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

- A **post-service claim** is a claim for benefits that involves payment or reimbursement for medical care that has already been provided.

Authorized Representatives

You may designate an authorized representative to act on your behalf at any stage of the claims process. This designation must be made in writing, signed by you, and sent to the relevant claims administrator. For an urgent care claim, a doctor or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law and who has knowledge of your medical

condition will be acknowledged as your authorized representative even if no written designation is submitted.

Submitting Health Care Claims

A claim for benefits is a specific request for a health care plan benefit that is submitted according to the plan's procedures for filing claims. A general request for information about a benefit is not a claim.

Urgent Care Claims

An urgent care claim is considered submitted when a request for prior approval is made according to the plan's utilization review procedures or as otherwise described in this booklet.

- To file an urgent care claim, call the number on your ID card. The claims administrator will make a decision on your urgent care claim as soon as possible after your call, 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.

- If you do not provide enough information with your urgent care claim to allow the claims administrator to determine whether or to what extent benefits are provided, you will be notified of the specific information needed to complete your claim within 24 hours after the claims administrator receives your claim. You will be given at least 48 hours from the receipt of the notice to provide the specific information. The claims administrator will notify you of its decision on your claim within 48 hours of the time it:

  - received the additional specific information from you, or
  - informed you it must receive the additional specific information.

- The 72-hour timeframe may be shortened where your urgent care claim seeks to extend a previously approved course of treatment and it is made at least 24 hours before the expiration of the previously approved course of treatment. The claims administrator will notify you of its decision on your urgent care claim to extend that course of treatment not later than 24 hours after its receipt.

Pre-Service Claims

If your pre-service claim is denied, you will receive written notification of that denial stating the specific reason(s) for the adverse benefit determination and describing your right to file an appeal.

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 claims administrator receives the claim.

Filing a Post-Service Claim

If you receive services from a network provider, you do 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 using the following steps:

- Review the *Medical Benefits* section of this booklet to see if the services you received are covered services.

- Get an itemized bill, which must include:

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

- If you've already paid for the services you received, submit proof of payment (receipt from doctor) with your claim form. Canceled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- 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.

- Complete a claim form.

  - Make sure all information is completed properly, and then sign and date the form. Claim forms are available from the claims administrator's website.

- Attach itemized bills to your claim form and mail all documents to the address provided on the claim form.

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

Explanation of Benefits Statement

Once a claim is processed, you will receive an explanation of benefits (EOB) statement that shows:

- the provider's charge
- allowable amount
- the copayment, deductible, and coinsurance amounts, if any, you are required to pay; total benefits payable
- the total amount you owe

If you believe the copayment, coinsurance, or deductible amount identified in your EOB statement is not correct or that any portion of these amounts is covered, you may file a post-service claim with the claims administrator. For instructions on how to file a post-service claim, please contact the applicable claims administrator using the number on your ID card.

When Post-Service Claims Must Be Filed

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

The claims administrator will notify you in writing of its determination on your post-service claim within a reasonable period of time following the claims administrator's receipt of your claim. That period of time will not exceed 30 days from the date your claim was received.

If your post-service claim is denied you will receive written notification of that denial stating the specific reason(s) for the adverse benefit determination and describing your right to file an appeal.

If Your Claim for Health Care Benefits Is Denied

If your claim for benefits is denied, written notification of the adverse benefit determination will be provided within the applicable timeframes described above. For purposes of this claim and appeal procedure, a benefit determination includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- a determination that a benefit is not a covered benefit; or

- a determination that a benefit is experimental, investigational, or not medically necessary or appropriate. In addition, if your coverage is terminated retroactively, that decision also will be considered a benefit determination that can be appealed as provided in this section.

The notice will contain all of the following information:

- the specific reason(s) for the denial;

- references to the specific plan provisions on which the adverse benefit determination is based; a description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

- a description of the plan's appeals procedures, including applicable time limits, plus a statement of your right to bring suit under Section 502 of ERISA with respect to any adverse benefit determination on final review;

- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claim;

- if the adverse benefit determination is based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or other similar criterion, or a statement of such rule, guideline, protocol, or other similar criterion, will be provided to you free of charge upon request;

- if an adverse benefit determination is based on medical necessity, or a determination of experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for such determination applying the terms of the plan to your medical circumstances, or a statement of such explanation will be provided to you free of charge upon request;

- if an adverse benefit determination involved an urgent care claim, a description of the expedited review process applicable to such claims; and

- (Highmark only) disclosure of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793

If new or additional evidence is considered, relied upon, or generated in connection with the claim, or if any new or additional rationale is used for a denial at the internal appeals stage, that evidence or rationale will be provided to you free of charge. You will be given the opportunity to respond to such new evidence or rationale.

Appeal Procedure – General

The appeal process for urgent care claims involves the following steps:

- initial review by claims administrator
- second review by claims administrator (Aetna only)
- external review as described below
- insurance grievance as described in *Benefit Basics*

After the initial review by the claims administrator, you may choose to proceed directly to the insurance grievance procedure.

The appeal process for all other claims involves the following steps:

- initial review by claims administrator
- second-level review by claims administrator (voluntary for pre-service claims with Highmark)
- external review as described below
- insurance grievance procedure as described in *Benefit Basics*

At any point during the appeal process, including before the initial review by the claims administrator, you may choose to proceed directly to the insurance grievance procedure under the applicable labor agreement.

For all appeals:

- Your decision to appeal a claim is completely voluntary. You are not required to appeal before using the insurance grievance procedure. You will not be penalized for voluntarily seeking (or not seeking) an appeal.

- 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; and the diagnosis and treatment codes and their corresponding meanings.

- At any time during the appeal process, you may contact Member Services at the telephone number listed on your ID card to inquire about the filing or status of your appeal.

- All disputes over whether an item is an Allowable Charge, Experimental/Investigative, or Medically Necessary and Appropriate are subject to review by the Medical Claims Administrator, external review, and the grievance and arbitration process.

Health Care Claims Administrator Address for Appeals

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

Aetna
Appeals Resolution Team
PO Box 14463
Lexington, KY 40512

Health Care Claims Review Process

Review of your appeal will take into account all comments, documents, records, and other information that you submitted relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not take into account the initial determination, and will be conducted by someone other than the individual who made the initial determination or his/her subordinate.

If the initial determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the plan will consult with a health care professional who was not involved in the original benefit determination and who has appropriate training and experience in the field of medicine involved in the medical judgment. Upon request the plan will provide the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with an adverse benefit determination, whether or not the advice was relied upon in making the benefit determination.

Timeframe for Health Care Claims and Appeals Decisions

The total timeframe in which the final determination on appeal must be made will depend on the type of claim involved:

- **Urgent care claims** — The claims administrator will notify you of the determination on appeal as soon as possible, taking into account the medical necessities, but no more than 72 hours after your appeal is received by the plan. The notification will be in writing or will be provided according to the expedited procedures for urgent care claims described above.

- **Pre-service claims** — Highmark will notify you of the determination on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 calendar days after your appeal is received by the plan. Aetna will notify you of the determination on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 15 calendar days after your appeal is received by the plan.

- **Post-service claims** — The claims administrator will notify you of the determination on review within a reasonable period of time but not later than 30 calendar days after your appeal is received by the plan.

The first level of the appeal process shown in the following chart reflects the maximum amount of time you have to file a first-level appeal and receive a response from the claims administrator.

Timeframe – First Level of Appeal Process			
For the following type of claim…	**You must appeal within…**	**Claims administrator must respond within…**	
		Highmark	**Aetna**
Urgent care	180 days	72 hours	36 hours
Pre-service	180 days	30 days	15 days
Post-service	180 days	30 days	30 days

The deadline for filing your appeal is 180 days, as noted above, measured from the date you received notice from the claims administrator of an adverse benefit determination.

In all instances, the period of time for making the determination will begin at the time the appeal is filed, regardless of whether all the necessary information accompanies the filing.

If the decision on appeal is to continue to deny your claim in whole or in part, you may make a second-level appeal to the claims administrator (except for urgent care claims with Highmark). See below for details.

The following table outlines the maximum amount of time you have to file a second-level appeal to the claims administrator and the maximum amount of time the claims administrator has to respond throughout the claim process.

Timeframe – Second Level of Appeal Process				
For the following type of claim…	**You must appeal within…**		**Claims administrator must respond within…**	
	Highmark	**Aetna**	**Highmark**	**Aetna**
Urgent care	N/A	60 days	N/A	36 hours
Pre-service (voluntary)	45 days	60 days	30 days	15 days
Post-service	45 days	60 days	30 days	30 days

If your claims administrator is Highmark, your decision to proceed with a second-level review of a pre-service claim (other than an urgent care claim that involves one level of review) is completely voluntary. You are not required to pursue the second-level review of a pre-service claim before pursuing a claim for benefits in court or using the insurance grievance procedure. If you 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., you failed to proceed with a second-level review) before 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.

Notification of Health Care Claims Appeals Decisions

You will receive written notification of an adverse benefit determination on appeal within the applicable timeframes described above. The notice will contain the information listed in *If Your Claim for Health Care Benefits Is Denied*. This notice may also contain the following statement (Highmark only): You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

External Review

You must submit your request for an external review to the plan administrator within four months of the notice of your final internal adverse determination.

A request for an external review must be in writing unless the plan administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information you think is important for review.

A request for an external review must be in writing unless the plan administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the claims administrator's decision, can be sent between the claims administrator and you by telephone, facsimile, or other similar method. To proceed with an expedited external review, you or your authorized representative must contact the appropriate claims administrator and provide at least the following information:

- identity of the claimant
- date(s) of the medical service
- specific medical condition or symptom
- provider's name
- service or supply for which approval of benefits was sought
- any reasons why the appeal should be processed on a more expedited basis

All other requests for external review should be submitted in writing unless the plan administrator determines it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to the claims administrator.

This is an additional step that you must take to fulfill your appeal procedure obligations described above. Your decision to seek external review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Prescription Drug Claims

How you file a prescription drug claim depends on the type of claim. There are three types of prescription drug claims:

- An **urgent care claim** is a type of claim which, if the regular time periods for handling such a claim were adhered to, it:
  - could seriously jeopardize your life or health or your ability to regain maximum function, or
  - would, in the opinion of a professional provider with knowledge of your condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

- A **pre-service claim** is a claim for a benefit for which prior approval is required as a condition of receiving the benefit, in whole or in part.

- A **post-service claim** is a claim for benefits that involves payment or reimbursement for prescription drugs that have already been provided.

For a post-service claim, you will receive notice of the decision that has been made within 30 days of the claims administrator's receipt of the claim. A 15-day extension is available. To be eligible for benefits under the Program, your claim must be submitted to claims administrator within one year from the prescription purchase date.

Authorized Representatives

You may designate an authorized representative to act on your behalf at any stage of the claims process. The claims administrator reserves the right to establish reasonable procedures for determining whether or not an individual has been authorized to act on your behalf. For purposes of an urgent care claim, a doctor or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law, and who has knowledge of your medical condition, will be acknowledged as your authorized representative even if no written designation is submitted.

Appealing a Claim for a Prescription Purchased at a Retail Pharmacy or through Home Delivery

If you want to appeal the denial of a prescription claim, you should do so by using the following procedures.

- For post-service claims, the appeal procedure involves the following steps:
  - initial review by the claims administrator
  - review by the plan administrator
  - external review
  - insurance grievance procedure

- For pre-service and urgent care claims, the appeal procedure involves the following steps:
  - initial review by the claims administrator
  - voluntary second review by the claims administrator

- external review
- insurance grievance procedure

- At any point in the appeals process, including before the initial review by the claims administrator, you may choose to proceed directly to the insurance grievance procedure. 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.

Initial Review by Claims Administrator

If you receive notification that a pre-service claim has been denied by the claims administrator, you may appeal the decision by writing to:

Express Scripts, Inc.
Attention: Pharmacy Appeals-TTS
6625 West 78th Street
Mail Route #BL0390
Bloomington, MN 55439

Your appeal will be reviewed and decided by the claims administrator. Your appeal must be submitted within 180 days from the date you received notice from the claims administrator of the adverse benefit determination.

Upon request to the claims administrator, you may review all documents, records, and other information relevant to the claim which is the subject of your appeal and you will have the right to submit any written comments, documents, records, information, data, or other material in support of your appeal.

The following table shows the time period in which the claims administrator must respond to your appeal.

Timeframe for Appeals	
For the following type of claim…	**Claims administrator responds within…**
Urgent care	24 hours
Pre-service	30 days
Post-service	30 days

A notification of an adverse benefit determination on your appeal will include the specific reason(s) for the adverse benefit determination and a statement describing your right to file a further appeal.

The following additional information will be included in the notification, if applicable:

- any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination will be set forth

- an explanation of any scientific or clinical judgment forming the basis for the conclusion that a prescription was not covered

The decision of the claims administrator on appeal is final unless you seek external review. 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.

At any point during the initial review by the claims administrator, you may proceed directly to the insurance grievance procedure.

Second Review

For Pre-Service Claims

You may further appeal the claim within 60 days of your receipt of an adverse determination from the claims administrator by writing to:

MCMC LLC, ERISA Appeal Team
U. S. Steel - Express Scripts Appeal Program
88 Black Falcon Avenue, Suite 353
Boston, Massachusetts 02210

Your decision to proceed with a second-level review of a pre-service claim is completely voluntary. You are not required to pursue the second-level review of a pre-service claim before pursuing a claim for benefits in court. If you pursue the second-level review of a pre-service claim 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., you failed to proceed with a second-level review) before 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.

For Post-Service Claims

You may further appeal the claim within 60 days of your receipt of an adverse determination from the claims administrator 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.

For All Claims

Notification of an adverse benefit determination by the plan administrator/claims 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.

The decision of the plan administrator/claims administrator is final unless you seek external review under, or you may choose to proceed directly to, the insurance grievance procedure.

The insurance grievance procedure is the final level of appeal under the Program. 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.

External Review Requirements

The prescription drug claims and appeals procedure includes an external review process. In general, you must file a request for an external review within four months after the date of receipt of a notice of:

- an adverse benefit determination (including a final internal adverse benefit determination) by a plan that involves medical judgment, as determined by the external reviewer; and

- 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 you and the plan, except to the extent other remedies are available under state or federal law, and that the requirement that the decision be binding does not prohibit 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.

Dental Claims

Filing a Claim

If you receive care from a network provider, the provider will file the claim on your behalf. However, if you receive care from an out-of-network provider, you will need to submit a claim. You may obtain a claim form by calling 1-800-332-0366 and requesting a form. 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

The claims administrator will process the claim in 30 days after it receives all requested information. To be eligible for benefits under the Program, your claim must be submitted to the claims administrator within one year from the date of service.

Proof of Claim

The claims administrator reserves the right to accept, or to require verification, of any alleged fact or assertion pertaining to any claim for dental benefits under this Program. As part of the basis for determining benefits payable, the claims administrator 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 the claims administrator 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 Appeal If You Disagree with a Claim Decision

If a claim for benefits is denied either in whole or in part, you will receive notice explaining the reason(s) for denial. If the denial was for additional information, the notice will tell you what additional information is needed and why.

At any point in the appeals process, including before the initial review by the claims administrator, you may choose to proceed directly to the insurance grievance procedure.

You may file an appeal within 180 days of the notice of denial. To file an appeal, send a letter to the claims administrator stating why you think your claim should not have been denied, along with any additional information, documents, data, or comments applicable to your claim. The claims administrator will review your appeal and notify you of its decision within 30 days of receipt of your appeal. The notice will include the reason for the decision, reference to specific provisions on which the decision was based, and inform you of your rights to receive information relevant to the claim, whether or not it was relied upon in making the benefit determination.

The decision of the claims administrator on appeal is final unless you appeal to the plan administrator within 60 days of your receipt of notice of denial 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 the second appeal is received by the plan administrator. 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.

The decision of the plan administrator is final unless you decide to further appeal such claim for benefits by filing a grievance.

Vision Claims

Filling a Vision Claim

If you receive care from a network provider, the provider will file the claim on your behalf. However, if you receive care from an out-of-network provider, you will need to submit a claim. You may obtain a claim form by visiting the claims administrator's website.

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, NY 12110

To be eligible for payment or reimbursement under the Program, your claim must be submitted to the claims administrator within one year of the date of service.

Authorized Representatives

You may designate an authorized representative to act on your behalf at any stage of the claims process. If you wish to do so, you must notify the claims administrator 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 will be provided to you by the claims administrator upon request.

Claims Determination

The claims administrator 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 the claims administrator. However, this 30-day period of time may be extended one time by the claims administrator for an additional 15 days, provided the claims administrator

determines the additional time is necessary due to matters outside its control, and notifies you of the extension before the expiration of the initial 30-day determination period. If an extension of time is necessary because you failed to submit information necessary for the claims administrator 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.

How to Appeal If You Disagree with a Claim Decision

If a claim for benefits is denied either in whole or in part, you will receive notice explaining the reason(s) for denial. If the denial was for additional information, the notice will tell you what additional information is needed and why.

At any point in the appeals process, including before the initial review by the claims administrator, you may choose to proceed directly to the insurance grievance procedure.

You may file an appeal within 180 days of the notice of denial. To file an appeal, send a letter to the claims administrator stating why you think your claim should not have been denied, along with any additional information, documents, data, or comments applicable to your claim. The claims administrator will review your appeal and notify you of its decision within 30 days of receipt of your appeal. The notice will include the reason for the decision, reference to specific provisions on which the decision was based, and inform you of your rights to receive information relevant to the claim, whether or not it was relied upon in making the benefit determination.

The decision of the claims administrator on appeal is final unless you appeal to the plan administrator within 60 days of your receipt of notice of denial 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 the second appeal is received by the plan administrator. 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.

The decision of the plan administrator is final unless you decide to further appeal such claim for benefits by filing a grievance.

Basic Life Insurance, Optional Life and AD&D Claims

How to File a Claim

For life insurance claims, the Benefits Service Center will provide your designated beneficiary with the necessary forms for claiming life insurance proceeds.

How to Appeal a Claim

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

Optional Critical Illness/Optional Accident Coverage Claims

How to File a Claim

You can obtain a claim form at www.aetnavoluntaryforms.com. For each Covered Accident or 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 third-party administrator at the address indicated on the claim form.

How to Appeal a Claim

If you have any questions concerning a denial in whole or in part of your claim, you must write within 90 days from the date you receive the denial to third-party administrator 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 third-party administrator to give your appeal proper consideration). The third-party administrator will carefully evaluate all the information and will advise you of its decision within 60 days.

FSA Claims

When to File a Claim

You may file a claim for reimbursement of covered expenses at any time but no later than

- Health Care FSA - June 15 of the following year for claims incurred between January 1 of the previous year and March 15 of the current year. For example, claims for covered expenses incurred between January 1, 2017, and March 15, 2018, must be filed no later than June 15, 2018.
- Dependent Care FSA - April 15 of the following year for claims incurred between January 1 and December 31 of the previous year. For example, claims for covered expenses incurred between January 1, 2018, and December 31, 2018, must be filed no later than April 15, 2019.

How to File a Claim

You can file a claim in one of three ways:

- use the Debit Card (only for HCFSA)
- use the Pay your provider service
- submit a form for reimbursement

For each item of expense for which reimbursement is requested on your form, you must attach required supporting documentation. Send the completed claim form and accompanying documentation of expenses to the claims administrator at the address shown 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 direct deposit.

How to Appeal a Claim

If you have any questions concerning a denial of your claim, you should write within 180 days from the date of the denial to:

PayFlex Systems, Inc.
P.O. Box 981158
El Paso, TX 79998-1158

Provide all information supporting your position. If you are not satisfied with the decision, you may further appeal by writing within 60 days from the date of the reply to:

United States Steel and Carnegie Pension Fund
Vice President - Administration
600 Grant Street
Room 1681
Pittsburgh, PA 15219-2800

Coordination of Benefits

If you or any covered dependents are covered by more than one group medical, vision, or dental plan, reimbursements are coordinated between the plans so that benefits are not duplicated.

When you are covered by more than one plan, the plan that pays benefits first is called the primary plan. The primary plan pays its benefits without considering what the other plan may pay. The other plan (secondary plan) may pay additional benefits depending on its coordination of benefits (COB) provisions.

When the Company's plan is secondary, your reimbursement is adjusted so that the total reimbursement you receive from both plans is not more than the amount that would have been paid if you were only covered by the Company plan. This means if the Company benefit payable is:

- less than or equal to the other plan's payment, no payment is made by the Company plan.

- greater than the other plan's payment, the Company plan will pay the difference between what the other plan pays and what the Company plan would have paid if you had no other coverage. For example, if the other plan pays $80 and the Company plan would have paid $85, the Company plan will make a payment of $5.

You must apply for benefits under the primary plan before the medical, dental, or vision claims administrator will consider a claim under this Program.

How the Primary Plan Is Determined

The following rules determine which plan will pay first:

- The plan covering the person as an employee is the primary plan. (The Company plan is primary for all covered employees.)

- If you and your spouse both cover your children and you are not separated or divorced, the plan of the parent whose birthday (month and day) occurs first in the calendar year is primary. If you both have the same birthday, the plan of the parent who has been covered longer is primary. If your spouse's plan requires contributions, the birthday rule does not apply, unless your child is covered under your spouse's plan.

- The plan covering the person as an active employee, or the dependent of an active employee, pays benefits before a plan that covers the person as a laid off or retired employee or his/her dependents. (If the other plan does not include this or a similar rule, it will not apply.)

If you and your spouse are legally separated or divorced and you both cover your children, the following rules apply:

- If a court or administrative order makes one parent financially responsible for the child's health care coverage, that parent's plan is primary. If the court does not assign financial responsibility for the child's health care through a qualified medical child support order (QMCSO), the plan of the parent with legal custody is primary.

- If the parent with legal custody remarries, the order of payment is the plan of the:

  - parent with custody is primary,
  - stepparent is secondary, and
  - parent without custody is third.

Subrogation

If any health care benefits are provided under the Program to you or one of your dependents, Highmark, Aetna, 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 dependent will be required to execute and deliver such instruments and papers and do whatever else is necessary to secure such rights.

Misstatement of Fact

If a misstatement of any fact affecting your coverage under Company-sponsored health care plans is discovered, the true facts will be used to determine the coverage in force.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverage or entitlement.

Retroactive Cancellation or Discontinuation of Coverage

Your coverage may be retroactively canceled or discontinued if fraud or intentional misrepresentation of a material fact is discovered or if you fail to timely pay required premiums or contributions toward the cost of coverage.

Refund of Overpayments

If you or your dependent receives benefits in excess of the amount payable under the Program provisions, you or your dependent must refund the excess amount to the Company.

Certificate of Creditable Coverage

Upon request, the plan administrator will issue a certificate to you. This certificate of creditable coverage provides evidence of your prior coverage.

You can also request a certificate from your previous employer or insurance company.

Reinstatement or Reemployment

If you return to work after layoff, leave of absence, or disability and some or all of your coverage under the Program ended and before a break in continuous service, all your coverage under the Program, other than optional employee life insurance, optional spouse life insurance, and optional child(ren) life insurance, will be reinstated on the day you return to work. If your FSAs have not ended, then your FSA deductions will resume, but only if you return to work in the same Plan Year in which your FSA deductions ended.

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 had a break in continuous service and, at the time of the break you were eligible for an immediate or deferred vested pension under the Company pension plan applicable to you, (b) if you had a break in continuous service and if your break in continuous service was removed at the time of your reemployment, or (c) you had a break in continuous service before 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 before your break in service will count toward the 60 calendar days that you must complete before becoming covered under the Program.

COBRA Continuation Coverage

In special situations, you may continue health care coverage for you and/or your covered dependents when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows employees and certain dependents to continue group health coverage at their own expense for a specific period of time after employer-provided coverage ends.

The length of COBRA continuation coverage depends on the reason that the benefits end, called the "qualifying event."

If you and/or your covered dependent(s) choose COBRA coverage, the Company is required to offer the same medical, prescription drug, dental and vision coverage in effect prior to the loss of coverage. Proof of good health is not required to choose COBRA coverage. Each of your covered dependents has an independent right to elect COBRA, regardless of whatever election you or any other covered dependent may make.

Health care coverage for you and/or your covered dependents may continue for up to 18 months (or 29 months in the event of disability or 36 months for a dependent who loses coverage, as described below) after the date of the qualifying event if your:

- employment is terminated for any reason other than your gross misconduct; or
- hours of employment are reduced.

This coverage also applies to a child born to or adopted by you during the continuation period.

Making a COBRA Election

If you are eligible for, and want, COBRA continuation coverage, you must make your election on the form provided by the COBRA administrator within 60 days after the later of the following events:

- coverage ends as a result of a qualified life event
- receiving notice from the COBRA administrator that coverage has ended and that COBRA continuation coverage is available

Your election to receive COBRA continuation coverage, if mailed, must be postmarked no later than the last day of the 60-day election period.

If a spouse is notified, that notice also applies for all other covered dependents residing with the spouse — however, each dependent has an independent right to elect continued coverage. No "evidence of insurability" (proof of good health) is required to continue coverage under COBRA.

Your right to elect COBRA will not be affected by other coverage you may have before you elect COBRA coverage (for example, if you have coverage under your spouse's plan at the time your coverage under the Company's plan ends). However, if you obtain Medicare or other group coverage after electing COBRA, your COBRA coverage will end.

If you or your dependents do not elect COBRA continuation coverage, coverage will end on the date explained previously under *When Coverage Ends* in *Benefit Basics*.

How Long COBRA Lasts

An individual's coverage under COBRA ends as explained in the table below. In general, COBRA coverage for an individual previously covered as an employee, and his or her dependents, can last for up to 18 months after the date of the qualifying event, while COBRA coverage for a dependent who has lost eligibility can last for up to 36 months after the date of the qualifying event.

The table below shows how long COBRA coverage will continue based on various events.

How Long COBRA Continuation Coverage Lasts	
For the Following Event…	**Coverage Will End No Later Than…**
Your termination	The last day of the 18-month period following the date group coverage ended, or the date the Company stops providing any group health coverage, subject to the Note below
Dependent loses coverage due to divorce, separation or death	The last day of the 36-month period following the qualifying event, or on the date the Company stops providing any group health coverage
Your child no longer meets the requirements to be considered a dependent	The last day of the 36-month period following the qualifying event, or on the date the Company stops providing any group health coverage
Non-payment of premium by the end of the grace period	Retroactive to the last month coverage was paid

How Long COBRA Continuation Coverage Lasts	
For the Following Event…	**Coverage Will End No Later Than…**
You obtain coverage under any other group health plan that does not include any pre-existing condition limitations that would apply to that individual or you become entitled to Medicare (i.e., enrolled in Medicare)	The date new coverage begins (this date may vary for different individuals in the same family)

NOTE: The maximum continuation period will be reduced by any period that health care coverage is continued at Company cost during absence from work.

In some cases COBRA coverage may continue for a period longer than that specified in the above table. These circumstances are described below.

Extended COBRA Coverage

The following information applies to you and/or your dependents' COBRA coverage, unless otherwise noted.

Extended Coverage Due to Disability

If coverage was lost due to your termination of employment or reduction in hours, you and your dependent who have COBRA coverage (due to the same qualifying event), will be allowed to continue coverage under COBRA for an additional 11 months if you (or the dependent) either:

- are disabled when your employment ends or your hours are reduced, or
- become disabled at any time during the first 60 days of COBRA coverage.

This brings your total COBRA eligibility to 29 months after the date of the qualifying event. In the event of a disability, this coverage will be extended to the disabled individual and any other family members covered under COBRA.

To be eligible for this additional continued coverage, you must notify the COBRA administrator:

- within 60 days following the later of the date Social Security notifies you that you are disabled or the qualified life event, but
- no later than the end of your 18-month COBRA coverage period.

You will be instructed on how to provide the required information, which must include the employee's name, the name of the disabled individual and a copy of the Social Security Administration disability determination.

If notice is not provided within the above timeframes, the 18-month maximum coverage period will not be extended.

You must also notify the COBRA administrator of the determination that you are no longer disabled within 30 days of receiving the determination. The additional COBRA continuation coverage (i.e., coverage beyond the original 18 months) will end if you are no longer disabled.

Extended Coverage Due to Another Qualifying Event

If a dependent has continued coverage due to your termination or reduction in hours worked, and another qualified life event (such as your death or a divorce) occurs during the 18-month continuation period, the dependent will be allowed additional COBRA continuation coverage. This extension will be granted for up to a maximum of 36 months from the date of the initial qualifying event. You must notify the COBRA administrator within 60 days of any additional qualifying event.

Extended Coverage Due to Medicare Entitlement

A special rule applies if you become entitled to Medicare benefits less than 18 months before the end of your employment or reduction in hours. In this situation, you are still entitled to up to 18 months of COBRA continuation coverage. However, COBRA continuation coverage for your dependents may last up to 36 months after you became entitled to Medicare. For example, if you were entitled to Medicare eight months before your employment ends, COBRA continuation coverage for your dependents can last up to 36 months after the date of your Medicare entitlement. In this example, your dependent's COBRA continuation coverage may continue for up to 28 months after the date of the Medicare entitlement qualifying event (36 months minus eight months).

The Cost of COBRA Coverage

You (or your covered dependents) must pay a premium for COBRA continuation coverage. This premium is actuarially determined and may include:

- the amount you paid toward the cost of this coverage while you were covered as an active employee, plus
- any portion of the premium formerly paid by the Company, plus
- a 2% administration fee.

The premium will not exceed 102% of the rate that would apply for an active plan participant with similar coverage on the date this premium was due. However, the amount charged disabled individuals during the 11-month disability extension may be increased to 150% of the current active rate.

Each COBRA premium is payment for a complete month of coverage. If you elect to end your COBRA coverage in the middle of a month, your premium for that month will not be prorated and you will not receive a refund. (You may, however, pay for a partial month of coverage at the beginning or end of your COBRA eligibility if your eligibility begins and/or ends in the middle of a month.)

The premium rate will be determined at the beginning of the plan year and will apply to anyone who elects to continue coverage during that period. The premium rate will not change during the plan year, unless the Company revises the group health care program for all participants, or continuing dependent coverage is terminated because there are no longer any eligible dependents under COBRA coverage.

COBRA Enrollment

- Within 4 to 6 weeks after the loss of coverage, you will receive your COBRA election packet in the mail explaining your continuation rights, an election form, your deadline for making your election, and how to make payments.

- The first payment must be made in full within 45 days from the date of the initial COBRA election.

- Your COBRA coverage will not become effective until you enroll and pay for your first month of coverage.

- Once your payment is posted to your account, your coverage will be reinstated as of the date you lost eligibility for group coverage through the Company. Therefore, you will have no gap in coverage. This process will be completed within 10 business days after your payment has been posted.

- If you incur eligible expenses before your COBRA coverage is activated, you may file a claim for reimbursement once your coverage is activated with the medical, dental, or vision claims administrator.

When Payment Is Due

After your COBRA coverage becomes effective, 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.

For More Information

Additional information about COBRA coverage will be provided to you (or your dependents) when you (or your dependents) become eligible.

The following table is a re-cap of the coverage options and their availability for continuation of coverage.

Benefits You May Continue under COBRA	
Coverage	**Continuation Rights**
Medical, Dental, Vision	You are eligible to continue coverage through COBRA if you were enrolled when you lost eligibility for coverage through the Company. The COBRA administrator will send you a packet explaining how to elect COBRA coverage. If you do not receive a COBRA election packet within 4-6 weeks, call the Benefits Service Center at 1-877-877-4586.
Health Care Flexible Spending Account (HCFSA)	You will not be able to continue using your HCFSA once your eligibility for HCFSA coverage ends, unless you elect FSA coverage through COBRA. However, even if you do not elect COBRA, any expenses that you incurred before you lost eligibility for group coverage may be submitted for reimbursement. If you choose to elect FSA coverage through COBRA, you may continue to file claims for reimbursement of eligible health care expenses incurred through the end of the calendar year in which you lost eligibility for group coverage, as long as you continue to participate in COBRA. However, your FSA debit card will be deactivated. You must file claims for reimbursement of eligible health care expenses incurred while you are enrolled in the FSA though COBRA. For information on your account balance or the deadline to submit claims, call the FSA administrator at 1-844-729-3539.

Call the COBRA administrator with any questions on continuation coverage or how much it will cost.

Military Leave of Absence

If you go on a leave protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may continue your participation in the Health Care Flexible Spending Account (HCFSA) for the remainder of the current plan year, provided you continue your timely contributions during the leave. If you do not make these contributions, participation will end on the last day for which contributions were made. USERRA continuation coverage is separate from COBRA continuation coverage.

Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office at plant personnel offices and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report and updated summary plan description. You may be required to pay a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Program for your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, and you followed the Plan's claim and appeals procedure, you may (i) file an insurance grievance in accordance with the terms of the Program, or (ii) file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a child support order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Other Rights under Federal Law

Under the Newborns' and Mothers' Health Protection Act of 1996, neither the Program nor an insurance carrier nor its medical review agency may restrict benefits for any hospital stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section, or require that the provider obtain authorization from the Program, the medical review agency, or the insurance carrier for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods.

This Program is intended to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which provides for the protection of individually identifiable health information as described in the General Provisions of the Plan.

The Women's Health and Cancer Rights Act of 1998 requires health plans that cover mastectomies to also cover (after any applicable Deductible and Coinsurance applicable to all medical services) reconstruction

of the breast on which the mastectomy was performed; reconstruction of the other breast for symmetry; prostheses; and physical complications in all stages of mastectomy, including lymphedemas.

The Program is intended to comply with the Genetic Information Nondiscrimination Act of 2008 (GINA), which prohibits group health plan discrimination against individuals on the basis of genetic information.

Qualified Medical Child Support Order

You may be required to provide medical plan coverage for your child(ren) pursuant to a qualified medical child support order (QMCSO). If you receive a court order related to enrollment of a child, contact the Benefits Service Center. In some cases, the orders will be directed to the Company from a court or child welfare agency. The Company will determine whether the order is a QMCSO.

To be considered qualified, the order must:

- specify the name and last known mailing address of the covered employee and the employee's child(ren) who is (are) the subject of the order;

- indicate the type of coverage to be provided (or the manner in which such coverage will be determined);
- identify the period covered by the order; and
- specify each plan to which the order applies.

If the QMCSO is qualified, you must enroll yourself, if not already enrolled, and the specified child(ren) for medical coverage. For a copy of the plan's administrative procedures related to QMCSOs, contact the Benefits Service Center.

General Plan Information

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, 600 Grant Street, Pittsburgh, Pennsylvania 15219-2800. 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 insurance, disability, medical, prescription drug, dental, vision, and sickness and accident benefits, is a welfare benefit plan that is a group health benefit plan as defined by ERISA. Non-ERISA benefits provided under the Program include the DCFSA.

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 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. Records of the Plan are kept on a calendar-year basis.

Contributions

Except for any employee contributions required under the Program, the benefits provided under this Program are paid for by the Company. Expenses relative to the administration of the Program may be paid by the Company. Employee contributions are required for any elected optional employee life insurance,

optional spouse life insurance, optional child(ren) life insurance, optional AD&D insurance, optional critical illness, optional accident coverage, and FSAs.

Benefits under the Program are either insured or self-funded. Benefits for insured plans are guaranteed and paid under a contract of insurance according to policy terms.

Plan Documents and Other Communications

The descriptions of Program benefits contained in this Summary Plan Description summarize the main features of the Program of Insurance Benefits for Employees of United States Steel Corporation and are not intended to amend, modify, or expand the plan provisions. In all cases, the provisions of any plan document, the insurance contracts, or trust agreement control the administration and operation of the plans.

If a conflict arises between verbal descriptions, any plan document, information in this Summary Plan Description, and the plan or insurance contracts, the following documents will govern, in this order:

- the official plan document,
- applicable insurance contract,
- applicable certificate of coverage, and
- this Summary Plan Description.

From time to time, additional communications may be made about benefits under the Program, for example, benefit summaries other than this book, enrollment materials, and verbal representations made by individuals at the Benefits Service Center. These communications do not govern benefits under the Program. Your benefits are controlled solely by the plan document, insurance contract, certificate of coverage, and except as otherwise provided in those documents, this Summary Plan Description.

No Rights to Employment

Nothing in this SPD or in the Program constitutes any guarantee of continued employment, creates any employment rights in any employee or restricts in any way the Company’s right to terminate any such employee.

IMPORTANT TERMS

ACA: the Affordable Care Act, also known as the Patient Protection and Affordable Care Act of 2010.

Adverse Benefit Determination: a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is experimental/ investigative or not medically or dentally necessary or appropriate.

Allowable Charge (also called Provider's Reasonable Charge): the dollar amount that the claims administrator used to determine payment for covered medical expenses and is based on the type of provider 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 for out-of-network care is based on the allowable charge — not the provider's actual charge. For out-of-network claims, Allowable Charges are 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.

Approved Facility or Agency: a health care facility or home health care agency that has been approved by the medical claims administrator based on the following criteria:

- it qualifies under Medicare or the medical claims administrator determines that it meets the standards of Medicare certification, or
- 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
- where applicable, it is a state licensed Birthing Center which meets the approval standards established by the medical claims administrator or (pending establishment of Medicare and Joint Commission on Accreditation standards), and
- where necessary, it has been approved by the applicable area-wide health care planning agency.

Authorized Representative: a person granted authority by you and a claims 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.

Balance Billing: the difference between the provider's actual charge and the claims administrator's allowance.

Charge: the actual bill for services that you would pay in the absence of coverage under this Program and that 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 claims administrator.

Claim: 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:

- Pre-service claim — A request for precertification or prior approval of a covered service that must be approved before you receive the covered service.

- 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 doctor with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. The applicable claims administrator is solely responsible for determining if a claim is an urgent care claim. This is not the same as a claim for benefits received from an urgent care provider.

- Post-service claim — A request for payment or reimbursement of the charges or costs associated with a covered service that you received.

Claims Administrator: the organizations selected by the plan administrator who are responsible for paying claims for benefits under this Program, performing administrative functions, and resolving claims and appeals on behalf of the plan administrator. It also means the organization responsible for administering precertification provisions and determining medical policy for medical benefits.

Coinsurance: the percentage of charges for covered expenses that are shared between you and the Program.

Company: United States Steel Corporation and its subsidiaries listed in the Appendix.

Continuous Service: is based generally on rules for pension eligibility under the Company's pension plan (whether or not you participate in that plan); see the Program for details.

Copayment: flat dollar amount you pay for covered services; the Program pays the remainder of the cost.

Covered Services: the services, confinements, supplies, and/or treatments you receive from an eligible provider as long as they are medically or dentally necessary and appropriate and specifically covered by the Program.

Custodial Care: services and supplies primarily intended to help you meet personal needs. They are not covered expenses under this Program.

Deductible: the portion of eligible expenses you must pay annually before you can receive benefits for an eligible expense. Copayments for medical services or prescription drugs, amounts in excess of the allowable charge for out-of-network or network-not-available services, and any payments you make under the prescription drug, dental, or vision benefits sections of this Program do not count toward meeting the medical deductible.

Dentally Necessary or Appropriate: a service is dentally necessary and appropriate if it is necessary and meets acceptable standards of practice. Review guidelines are developed in consultation with dentist consultants engaged in clinical practice. Taken into consideration are factors such as that which is deemed acceptable in the dental community; what the current literature, research, and studies have proven; and the position of recognized organizations within dentistry.

Eligible Family Member (Dependent): a person who is:

- your legal spouse (or your common-law spouse, but only in states that recognize common-law marriage and only if approved by the plan administrator)**;**

- your biological child, stepchild, or legally adopted (or placed with you for adoption) child who is under age 26; or

- your unmarried child who is age 26 or older, and who is:

  - a dependent as described above, and
  - incapable of self-support because of a continuously disabling illness or injury that occurred before age 26; and
  - principally supported by you.

- an unmarried child who is considered a tax dependent, who is permanently living in your home and relies on you for support, provided the child is:

  - your grandchild or you are the child's legal guardian, and
  - under age 21, a full-time student under age 25, or disabled.

For purposes of the HCFSA, a dependent also is any person who could qualify as a dependent on your federal income tax return.

For purposes of the DCFSA, a dependent also is:

- your spouse, if he or she is physically or mentally incapable of self-care; and
- any person who can be claimed as dependent on your federal income tax return if that person is:

  - younger than age 13; or
  - physically or mentally incapable of self-care.

Experimental/Investigative (medical and prescription drugs): services, treatment, or supplies not generally accepted in medical practice for the prevention, diagnosis, or treatment of an illness or injury as determined by the medical or prescription drug claims administrator. The claims administrator will consider an intervention to be experimental/investigative if:

- the intervention does not have Food and Drug Administration 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

- the intervention is not proven to be applicable outside the research setting

The Program does not cover treatments, procedures, equipment, drugs, devices, or supplies that are experimental or investigational, as determined by the medical or prescription drug claims administrator.

Experimental/Investigative (dental): is any treatment, procedure, facility, equipment, drug, or drug usage device or supply that the dental claims administrator determines is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered. The dental plan claims administrator will rely on the advice of the general dental community including, but not limited to dental consultants, dental journals, and/or governmental regulations, to make this determination.

Health Care Facility: any of the following permanent facilities:

- 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 doctors and surgeons, that provides 24-hours-a-day nursing service by registered graduate nurses, and that 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.

- Substance abuse rehabilitative facility — a facility specifically engaged in providing rehabilitation services, and detoxification if necessary, to patients addicted to drugs or alcohol.

- Skilled nursing facility — a facility 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. The care is provided by or under the supervision of licensed doctors, 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.

- Ambulatory surgical facility — a facility with an organized staff of licensed doctors and permanent equipment for the primary purpose of performing surgical procedures on an outpatient basis and that provides treatment by or under the supervision of a doctor and nursing services, and that does not provide inpatient accommodations.

- Birthing center — a facility with inpatient beds primarily organized with staff and equipment to provide prenatal, labor, delivery, and postpartum care for medically uncomplicated pregnancies.

- Hospice facility — a permanent facility that provides a coordinated program of inpatient, outpatient, and home care of a palliative and supportive nature for the terminally ill.

- Free-standing kidney dialysis, radiation therapy, or chemotherapy facility — a permanent stand-alone facility that administers kidney dialysis, radiation therapy, or chemotherapy.

Home Health Care Agency: an organization with permanent administrative facilities that 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.

Licensed Doctor: 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.

Maintenance Drugs: medications taken on a long-term, continuous basis for a chronic or on-going condition.

Maximums — Lifetime and **Annual:** the maximum amount of dental benefits provided for any covered individual during your lifetime or during a particular calendar year.

Medical Emergency: 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.

Medically (Dentally) Necessary and Appropriate: services, supplies, and prescription drugs are considered medically necessary and appropriate if a doctor, dentist, or other health care 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. The provision of the service, supply, or prescription drug must:

- be in accordance with generally accepted standards of medical or dental practice;
- be clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease;
- not be primarily for the convenience of the patient, doctor, other health care or dental provider; and
- not be more costly than an alternative service or sequence of services that are at least as likely to produce equivalent results as for the diagnosis or treatment of that patient's illness, injury, or disease.

Generally accepted standards of medical or dental practice are based on credible scientific evidence published in literature generally recognized by the relevant medical or dental community and the views of doctors or dentists practicing in relevant clinical areas and any other relevant factors.

The medical, prescription drug, or dental claims administrator makes the final determination on if a service, supply, or medication is medically necessary and appropriate. The fact that your doctor 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. Benefits will be provided only if the medical, prescription drug, or dental claims administrator determines the service, supply, or medication is medically necessary and appropriate.

Out-of-Pocket Maximum: the maximum out-of-pocket covered expenses incurred by an individual (or family) covered under this Program in a calendar year when reimbursement increases to 100% for additional covered expenses incurred by that individual (or family) during the remainder of that year.

The following items accumulate toward the out-of-pocket maximum:

- deductibles
- copayments
- coinsurance

The following items do not accumulate toward the out-of-pocket maximum:

- services not covered under the medical benefits of this Program (including services that are not medically necessary and appropriate)
- doctor fees in excess of the allowable charge
- amounts in excess of the medical claims administrator's reimbursement to non-participating health care facilities
- excess private room charges
- prescription drugs

Although reimbursement increases to 100% for additional covered expenses incurred by that individual (or family) during the remainder of that year when the out-of-pocket maximum is met, the following items are not covered at 100%:

- copayments
- services not covered under the medical benefits of this Program (including services that are not medically necessary and appropriate)
- doctor fees in excess of the allowable charge
- amounts in excess of the medical claims administrator's reimbursement to non-participating health care facilities
- excess private room charges
- 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.

Payroll Deduction Date: 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.

Plan Administrator: United States Steel and Carnegie Pension Fund.

Plan Year: the calendar year.

Precertification: a process through which the medical claims administrator determines if certain services, confinements, supplies, and treatments are medically necessary and appropriate.

Psychiatric Condition: a condition of psychological or physiological origin normally treated by a psychiatrist or psychologist or treated on an inpatient basis in a psychiatric hospital or in the psychiatric unit of a general hospital.

Total Maximum Out-of-Pocket: maximum out-of-pocket amount you are required to pay under the ACA before the Program begins paying 100% of all covered expenses. Once you reach this limit, no additional coinsurance, copayments, and deductibles will be incurred for covered network services. The total maximum out-of-pocket limit is $7,350 for 2018 for employee only coverage and $14,700 for 2018 for family coverage. (No individual can exceed $7,350 for 2018.)

Eligible in-network medical and prescription drug expenses count toward meeting the total maximum out-of-pocket amount. The total maximum out-of-pocket does not include services not covered under the Program, doctor's fees in excess of the allowable charge, amounts in excess of the medical claims administrator's reimbursement to non-participating facilities, excess private room charges, and non-covered drugs you pay for out of pocket outside of the Program.

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

APPENDIX

BARGAINING UNITS COVERED BY THE PROGRAM

This Program applies to employees in the USW bargaining units and locations listed below.

USS Steel Operations – Hourly P&M

	Location
USS Clairton*	Clairton, PA
USS East Chicago Tin*	East Chicago, IN
USS Edgar Thomson*	Braddock, PA
USS Fairfield Steel*	Fairfield, AL
USS Fairfield Flat Roll*	Fairfield, AL
USS Fairfield Pipe*	Fairfield, AL
Fairfield Seamless Tubular Operations**	Fairfield, AL
USS Fairless*	Fairless Hills, PA
USS Gary Sheet and Tin*	Gary, IN
USS Gary Steel*	Gary, IN
USS Granite City*	Granite City, IL
USS Great Lakes*	Ecorse, MI
USS Irvin*	West Mifflin, PA
USS Lorain Tubular*	Lorain, OH
Seamless Tubular Operations – Lorain**	Lorain, OH
USS Midwest*	Portage, IN

USS Steel Operations – Salaried O&T

USS Clairton*	Clairton, PA
USS East Chicago Tin*	East Chicago, IN
USS Edgar Thomson*	Braddock, PA
USS Fairfield*	Fairfield, AL
Fairfield Seamless Tubular Operations**	Fairfield, AL
USS Fairless*	Fairless Hills, PA
USS Gary Sheet and Tin*	Gary, IN
USS Gary Steel*	Gary, IN
USS Granite City*	Granite City, IL
USS Great Lakes	Ecorse, MI
USS Irvin*	West Mifflin, PA
USS Lorain Tubular*	Lorain, OH
Seamless Tubular Operations – Lorain**	Lorain, OH
USS Midwest*	Portage, IN

USS Steel Operations – Salaried Plant Protection

USS Clairton*	Clairton, PA

USS East Chicago Tin*	East Chicago, IN
USS Edgar Thomson*	Braddock, PA
USS Fairfield*	Fairfield, AL
Fairfield Seamless Tubular Operations**	Fairfield, AL
USS Gary Sheet and Tin*	Gary, IN
USS Gary Steel*	Gary, IN
USS Granite City*	Granite City, IL
USS Great Lakes*	Ecorse, MI
USS Irvin*	West Mifflin, PA
USS Midwest*	Portage, IN
USS Minnesota Ore Operations – Hourly P&M	
Minntac*	Mt. Iron, MN
Keetac*	Keewatin, MN
USS Minnesota Ore Operations – Salaried O&T*	Mt. Iron, MN

EMPLOYEES OF
FAIRFIELD SOUTHERN COMPANY

United Steelworkers	
Fairfield Southern Company	Various

EMPLOYEES OF
U.S. STEEL TUBULAR PRODUCTS, INC.

United Steelworkers	
USSTP Lone Star Tubular Operations – Hourly P&M	
Lone Star Plant	Lone Star, TX
Star Tubular Plant	Lone Star, TX

*** United States Steel Corporation is the employing company.**
**** U.S. Steel Seamless Tubular Operations, LLC is the employing company.**

The Program also applies 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 Appendix from time to time by written agreement of the parties.

The Program also applies to employees in the non-USW bargaining units and locations listed below.

EMPLOYEES OF
UNITED STATES STEEL CORPORATION

Laborers' International Union of North America – Local #397	
USS Steel Operations	Location
Granite City	Granite City, IL

Bricklayers and Allied Craftworkers International Union – Local #8 IL	
USS Steel Operations	
Granite City	Granite City, IL

Temporary employees are excluded. Other bargaining units of employees represented by the unions listed above may be added to Appendix from time to time.