

STEELWORKERS HEALTH AND WELFARE PLAN

Amended and Restated Effective January 1, 2011

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STEELWORKERS HEALTH AND WELFARE PLAN

Effective September 15, 1944, the predecessor to the United Steelworkers of America, AFL-CIO-CLC ("Union") established the Steelworkers Health and Welfare Fund ("Fund") to offer health and other welfare benefits ("Benefits") to individuals employed under collective bargaining agreements between the Union and a participating employer, and to certain other individuals.

Benefits from the Fund are funded primarily by employer contributions, which are held in trust in accordance with the terms and conditions of the Agreement and Declaration of Trust ("Trust Agreement"). Benefits may be paid directly by the Fund from trust assets or by insurance carriers with whom the Fund has contracted and to whom the Fund pays premiums from trust assets.

The Fund is managed by a group of individuals chosen by the Union and known as the Board of Trustees. The Board of Trustees, whose duties are set forth in the Trust Agreement, is authorized to delegate certain duties, including the day-to-day Plan administration, to another individual or entity ("Administrator").

This document, known as the Steelworkers Health and Welfare Plan ("Plan"), contains definitions and general administrative procedures that govern the Fund. The Benefits are described in more detail in the Benefit Program Documents. The terms and conditions, including any limitations or restrictions, of each Benefit Program as set forth in the applicable Benefit Program Documents are incorporated by reference in this Plan document and constitute a part of the Plan. In the event of any conflict between any Benefit Program Document and this Plan document, the terms of the Plan document shall be controlling.

This Plan is intended to qualify as a “welfare benefit plan” within the meaning of Section 419(e) of the Internal Revenue Code of 1986, as amended, and to meet the requirements of any other applicable provisions of law including Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended, and as a voluntary employees’ beneficiary association within the meaning of section 501(c)(9) of the Internal Revenue Code of 1986, as amended.

This Plan is maintained for the exclusive benefit of employees under the applicable provisions of this Plan document and the Internal Revenue Code of 1986, as amended, and the Employee Retirement Income Security Act of 1974, as amended.

This Plan as amended and restated effective January 1, 2011 amends and restates the Plan in effect as of January 1, 2003, and its terms and provisions shall be effective January 1, 2011 except as otherwise provided herein.

ARTICLE 1
DEFINITIONS

When used herein, the following terms shall have the meanings set forth below, unless a contrary meaning is clearly intended by the context. Other terms not defined herein may be defined in the Summary Plan Description.

- 1.01 **“Administrator”** means the person(s) or entity(ies) designated by the Board to administer the Plan on a day-to-day basis.
- 1.02 **“Benefit” or “Benefit Program”** means each of the benefits available to a Participant as described in Section 4.02.
- 1.03 **“Benefit Program Document”** means (i) any Summary Plan Description for the Plan that set forth terms and conditions of the Benefit Programs, and any supplements thereto, and (ii) all other plan documents, insurance policies, certificates of insurance, and other documents (each, if any) that set forth the terms and conditions of the Benefit Programs, as may be amended from time to time. Any amendment to a Benefit Program Document will constitute automatically an amendment to the Plan.
- 1.04 **“Board” or “Board of Trustees”** means the group of individuals appointed pursuant to the Trust Agreement to manage the operation and administration of the Fund.
- 1.05 **“Code”** means the Internal Revenue Code of 1986, as amended from time to time, and regulations issued thereunder.
- 1.06 **“Dependent”** means a dependent of an Employee, as determined under the applicable Benefit Program.

The Board of Trustees or its delegate may require proof of Dependent status at the time of enrollment, and from time to time as it deems appropriate or necessary, but in a uniform and consistent manner applicable to individuals in like circumstances.

1.07 **“Domestic Partner”** means a person who, along with the Participant, satisfies the definition of “domestic partner” or “party to a civil union” under applicable state law and can provide documentation of such status from the appropriate state authorities or, where state law provides no such definitions or the parties have not entered into such status pursuant to applicable state law, an individual with whom the Participant has entered into a relationship in which:

- The parties are not related by blood or a degree of closeness that would prohibit marriage under the law of the state in which they reside;
- Neither party is currently married to, or a domestic partner of, another person under either statutory or common law;
- The parties have shared the same household on a continuous basis for at least 6 months;
- The parties are each at least 18 years of age;
- The parties are mentally competent to consent to contract;
- The parties are financially interdependent; and
- The parties meet any other requirements set forth in the Participation Agreement.

If set forth in the Participation Agreement, a Domestic Partner will be considered to be a Spouse for all purposes under the Plan, except that a Domestic Partner is not eligible for COBRA continuation coverage or conversion coverage.

- 1.08 **“Employee”** means an individual who is, or at one time was, the common law employee of an Employer and who works or worked in a job classification covered by the applicable Participation Agreement.
- 1.09 **“Employer”** means an employer that is, or was at one time, party to a Participation Agreement.
- 1.10 **“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended.
- 1.11 **“Fund”** means the Steelworkers Health and Welfare Fund.
- 1.12 **“Participant”** means any Employee who has met the requirements in Section 2.01 to be eligible for Benefits from the Fund, and whose eligibility for Benefits has not terminated as specified in Section 2.03. Participant does not mean any participant in the Steelworkers Health and Welfare Retiree Plan.
- 1.13 **“Participation Agreement”** means an agreement entered into by an Employer and a union and accepted by the Board under which the Employer and the union agree to participate in the Fund.
- 1.14 **“Plan”** means the Steelworkers Health and Welfare Plan, as set forth in this Plan document and the Benefit Program Documents, as amended from time to time.
- 1.15 **“Spouse”** means an individual who is legally married to a Participant as determined under applicable state law and can provide documentation of such status from the appropriate state authorities. A same-sex spouse is not eligible for COBRA continuation coverage or conversion coverage.

- 1.16 **“Summary Plan Description”** means the booklet describing the terms of the Plan and including a detailed description of the available Benefits.
- 1.17 **“Trust Agreement”** means the Steelworkers Health and Welfare Fund Agreement and Declaration of Trust, as amended from time to time, which establishes the funding vehicles for the Fund and sets forth the rights and obligation of the Board of Trustees.
- 1.18 **“Union”** means the United Steelworkers of America, AFL-CIO-CLC, or any successor thereto.

ARTICLE 2
ELIGIBILITY AND PARTICIPATION

2.01 Eligibility to Participate.

- (a) An Employee shall become a Participant on the first day for which contributions are made to the Fund on his or her behalf under the terms of a Participation Agreement. In no event may the effective date of participation precede the month in which contributions are first made except as otherwise provided in an insurance contract between the Fund and the applicable carrier.
- (b) If an Employee is eligible to become a Participant as set forth in subsection (a) above under the terms of a Participation Agreement, but declines to become a Participant on the earliest date possible, he or she may become a Participant on the earliest to occur of: (i) a date that is during any annual enrollment period set forth in the Participation Agreement or as otherwise determined by the Fund; (ii) the date on which he or she acquires a Dependent (or within 30 days from such date); (iii) the date on which he or she loses coverage, including COBRA coverage, under another group health plan for any reason (or within 30 days from such date); (iv) the date on which employer contributions under another group health plan covering the participant terminate (or within 30 days from such date); or (v) upon requesting coverage within 60 days of the date on which the Employee loses coverage under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act.
Notwithstanding the foregoing, the Benefit Program Document shall control to the extent that it permits more frequent enrollment dates with respect to coverage under a health maintenance organization.

2.02 **Eligibility Requirements for Dependents**

Subject to the terms of a Participation Agreement, a Dependent shall become eligible for Benefits on the date upon which the Employee becomes a Participant or, if the Dependent declines to enroll on such date, may enroll on the earliest to occur of: (i) a date that is during any annual enrollment period set forth in the Participation Agreement or as otherwise determined by the Fund; (ii) within 30 days of losing coverage, including COBRA coverage, under another group health plan for any reason; (iii) within 30 days of the date on which employer contributions under another group health plan covering the Dependent terminate; or (iv) upon requesting coverage within 60 days of the date on which the Dependent loses coverage under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act.

2.03 **Termination of Participation**

- (a) Subject to the provisions of subsections (b) and (c) below, a Participant shall cease to be a Participant on the earliest to occur of the following dates:
- (1) the date on which he or she is discharged from employment or quits, except as otherwise provided in a Participation Agreement.
 - (2) The last day of the month in which the Employer ceases to be obligated to make contributions on his or her behalf for any reason, including work stoppages or layoffs.
 - (3) The last day of the month preceding the month for which the Fund fails to receive the contributions that are required to be made on his or her behalf under the terms of a Participation Agreement, except that one or more insured Benefits may be continued to the extent provided in an insurance contract between the Fund and the applicable carrier.

- (4) The date the Plan terminates.
- (b) A Participant may elect to continue to receive medical coverage either by self-paying for coverage in accordance with procedures established by the Board, by electing COBRA continuation coverage under Section 2.04, or, if the Participant is eligible under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), as amended, by electing USERRA continuation coverage in accordance with procedures established by the Board.
- (c) Once a Participant has ceased to be a Participant, Benefits will cease to be paid for any claims incurred following termination of participation, except as otherwise provided in the Benefit Program Document.

2.04 **Continuation of Coverage under COBRA**

- (a) Certain individuals may elect to continue coverage under the Plan to the extent such continuation is required for a group health plan by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”), and in accordance with the terms and conditions of continuation coverage provided by COBRA and this Section 2.04. The provisions of this Section 2.04 shall be effective regardless of any other provision herein.
- (b) For purposes of this Section 2.04, the following terms shall have the meaning set forth below unless a contrary meaning is clearly indicated:
 - (1) “Covered Employee” means any individual who is or was a Participant under the Plan.
 - (2) “Election Period” means the period beginning on the date a Qualified Beneficiary’s coverage terminates under the Plan by reason of a Qualifying Event, ending 60 days after the later of such date or the date the Qualified Beneficiary is

notified of his or her rights under this Section 2.04 regarding the Qualifying Event.

- (3) "Qualified Beneficiary" means any individual who is covered by the Plan on the day before the Qualifying Event as:
 - (A) the Covered Employee;
 - (B) the Spouse of a Covered Employee;
 - (C) a Dependent child of the Covered Employee, including a child who is born to or placed for adoption with the Covered Employee during the continuation period under this Section 2.04;
 - (D) a surviving Spouse of the Covered Employee for purposes of Section 2.04(b)(4)(F) only.
- (4) "Qualifying Event" means any of the following which results in the loss of coverage under the Plan for a Qualified Beneficiary:
 - (A) The Covered Employee's death;
 - (B) Termination or reduction of hours of the Covered Employee's employment (except termination for gross misconduct);
 - (C) Divorce or legal separation of the Covered Employee and his or her Spouse;
 - (D) The Covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act;
 - (E) Dependent child ceases to qualify as a Dependent under the terms of the Plan; or
 - (F) An Employer's commencing bankruptcy proceedings under Title 11, United States Code, with respect to a Covered Employee who is a retiree of the Employer.

- (c) A Qualified Beneficiary who would lose coverage under a group health plan due to a Qualifying Event may elect continuation coverage under such group health plan during the Election Period

from the date of the Qualifying Event to the earliest of:

- (1) The date which is 18 months after an event described in Section 2.04(b)(4)(B) (or 29 months after such event if a Qualified Beneficiary is determined to be “disabled” under Title II or Title XVI of the Social Security Act within 60 days of the Qualifying Event and provides adequate proof of such disability no later than 60 days of the determination and within the initial 18 months of continuation coverage);
- (2) The date which is 36 months after the date of an event described in Section 2.04(b)(4)(B) if a second Qualifying Event (except an event described in Section 2.04(b)(4)(F)) occurs during the 18-month period following the event described in Section 2.04(b)(4)(B) or during the 29-month period under Section 2.04(c)(1);
- (3) The date which is 36 months after the Covered Employee’s death, for a Spouse or Dependent child of a Covered Employee for an event described in Section 2.04(b)(4)(A);
- (4) The date which is 36 months after the date of the Qualifying Event except an event described in Section 2.04(b)(4)(B) or Section 2.04(b)(4)(F);
- (5) The date which is 36 months after an event described in Section 2.04(b)(4)(D) for Qualified Beneficiaries other than the Covered Employee;
- (6) The date on which coverage ceases due to failure of the Qualified Beneficiary to make timely premium payments;
- (7) The date the Qualified Beneficiary first becomes entitled to benefits under Title XVIII of the Social Security Act;
- (8) The date the Qualified Beneficiary first becomes covered under any other group health plan which does not contain any pre-existing condition limitation; or
- (9) The month that begins more than 30 days after the final

determination date that the Qualified Beneficiary is no longer “disabled” under Title II or Title XVI of the Social Security Act for a Qualified Beneficiary who is disabled at termination (except termination for gross misconduct or reduction in hours of a Covered Employee);

- (10) If the Employer withdraws from the Plan, the date on which the Employer makes group health coverage available to (or starts contributing to another multiemployer plan with respect to) a class of employees formerly covered under the Plan; or
 - (11) The date on which the Employer ceases to provide any group health plan to any employee.
- (d) A Qualified Beneficiary who elects continuation coverage under this Section 2.04 shall pay 102% of the “applicable premium” as defined in Section 604 of ERISA. For a Qualified Beneficiary who is “disabled” under Title II or Title XVI of the Social Security Act, the applicable premium shall be 150% for each month of continuation coverage after the initial 18-month period in Section 2.04(c)(1) or Section 2.04(c)(2). Payment shall be due monthly on the first of the month. The first payment shall include all past due payments for continuation coverage during the Election Period. Payment shall be considered late if made more than 30 days after the payment due date, except that the first payment shall be considered late if made more than 45 days after the election date.
- (e) The Employer must notify the Plan of an event described in Section 2.04(b)(4)(A), Section 2.04(b)(4)(B), Section 2.04(b)(4)(D) or Section 2.04(b)(4)(F) within 30 days of that event. The Qualified Beneficiary must notify the Fund of an event described in Section 2.04(b)(4)(C) or Section 2.04(b)(4)(E) within 60 days of that event.
- (f) The Plan will provide written notice of COBRA rights to each Covered Employee and Spouse, if any:

- (1) within 90 days after coverage begins under the Plan; and
 - (A) (2) within 30 days after the Plan is notified that a Qualifying Event has occurred.
- (g) A Qualified Beneficiary who receives continuation coverage based on the determination that he or she is “disabled” under Title II or Title XVI of the Social Security Act shall notify the Plan of any determination that he or she is no longer “disabled.”
- (h) Special Rule for Individuals Eligible for Trade Act Assistance. The special rule set forth in this subsection (h) applies to each Qualified Beneficiary where: (a) the Employee is certified by the Department of Labor as eligible for trade adjustment assistance or alternative trade adjustment assistance (collectively, “TAA”) benefits under the Trade Act of 1974 on or after November 4, 2002; (b) the Qualified Beneficiary lost coverage under the Fund due to the Employee’s job loss that resulted in eligibility for TAA benefits; and (c) the Qualified Beneficiary did not elect COBRA coverage during the initial election period resulting from that job loss. Each Qualified Beneficiary who satisfies the requirements set forth in the foregoing sentence will have a second opportunity to elect COBRA during the sixty (60) day period that begins on the first day of the month in which the Employee was certified as eligible for TAA benefits, provided that the election is made within six months after the date Fund coverage is lost. If a Qualified Beneficiary elects COBRA coverage under this subsection (h), it will begin on the first day of the sixty (60) day election period and will last the same length of time as if an election had been made based on the original Qualifying Event.

2.05 **Qualified Medical Child Support Orders**

Benefit coverage shall be provided in accordance with the provisions of any court order, judgment or decree that:

- (a) requires group health coverage for an Employee's child, whether or not the Employee is a Participant; and
- (b) meets the requirements of Section 609(a) of ERISA as a qualified medical child support order. Benefit coverage shall be provided for as long as the child satisfies the definition of Dependent for the applicable Benefits, the required Employee contributions are made to the Fund for the period of coverage indicated in the qualified medical child support order, and the qualified medical child support order is effective.

2.06 **Health Insurance Portability and Accountability Act of 1996**

The Fund will comply with the applicable terms and conditions of the Health Insurance Portability and Accountability Act of 1996, including but not limited to, the requirement that it provide Participants and their Dependents with a certificate of coverage showing creditable coverage under the Fund upon all of the following events: (i) loss of eligibility for Medical Benefits; (ii) the expiration of COBRA coverage; and (iii) upon the written request of a Participant or former Participant on or before the expiration of the 24 months following the date he or she loses eligibility for Medical Benefits.

ARTICLE 3
FUNDING

3.01 Funding

The Plan is funded by contributions made to the Fund by Employers, and by investment earnings on those contributions.

3.02 Establishment of Funding Policy

The Board of Trustees shall establish, carry out and revise, from time to time, the funding policy of the Plan. The Board may, in its discretion, purchase insurance contracts to provide any or all of the Benefits under this Plan.

3.03 Contributions

Contributions shall be made in such amounts and at such times as required under the terms of the applicable Participation Agreement, and in accordance with Article 7 of the Trust Agreement.

ARTICLE 4
BENEFITS

4.01 Benefits Offered by the Plan

The Plan offers a number of different Benefits, as follows:

- (a) Medical Benefits;
- (b) Prescription Drug Benefits;
- (c) Dental Benefits;
- (d) Vision Benefits;
- (e) Accidental Death and Dismemberment Benefits;
- (f) Death Benefits; and
- (g) Short-term Disability Benefits.

4.02 Description of Benefits

Detailed descriptions of the Benefits provided through the Plan under Section 4.01 above are contained in the Benefit Program Documents, which are incorporated herein by reference but only to the extent that they describe the terms and conditions of Benefits and only to the extent that they do not contradict an express provision set forth in this Plan.

4.03 Change in Benefits

In the event that any Benefits are modified or amended, any summary of material modification, amendment to any Benefit Program Document, or other Participant notice shall be automatically incorporated herein by reference and made part of this Plan. The terms of such modification or amendment shall supersede any contrary terms of any other Benefit description until such time as such other Benefit description shall be changed to incorporate such modification or amendment.

ARTICLE 5
ADMINISTRATION

5.01 Authority

The Board of Trustees shall have the authority to control and manage the administration of this Plan, and to delegate authority as permitted by the Plan and ERISA, and pursuant to the terms of the Trust Agreement. The members of the Board of Trustees shall be the “named fiduciaries,” within the meaning of Section 402(a) of ERISA, and the “plan administrator” and “plan sponsor,” within the meaning of Sections 3(16)(a) and (b) of ERISA, of the Plan and Fund.

5.02 Discretionary Authority

The Board (or, where applicable, its delegate) shall have the exclusive authority, in its sole and absolute discretion, to administer and interpret the Plan and Trust Agreement, to decide all matters arising in connection with the operation or administration of the Plan, and to take such actions as are described in Article 4 of the Trust Agreement. All determinations of the Board (or its authorized delegate) shall be final and binding on all parties affected thereby.

5.03 Delegation of Power

The Board may delegate to other fiduciaries the responsibilities or duties involved in the operation or administration of the Fund under the direction of the Board (other than trustee responsibilities or duties, as defined in section 405(c)(3) of ERISA); may engage such person or persons as it may deem necessary or desirable as the Administrator to conduct the day-to-day operations of the Plan and the Fund and delegate such of its administrative duties to such persons, agents or organizations as it may deem advisable; and may delegate any of its ministerial powers or duties under the Trust Agreement to any one or more agents or

employees.

5.04 **Standard of Care**

The Board shall exercise its authority under this Plan with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. All actions with respect to Benefits or with respect to the classification of Employees shall be uniform in nature and applicable to all persons similarly situated, and non-discriminatory in favor of highly compensated individuals or against an individual based solely on health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability; or disability.

ARTICLE 6
COORDINATION OF BENEFITS AND SUBROGATION

6.01 Coordination of Benefits in General

- (a) Benefits payable under this Plan for expenses of a covered person who is also covered under another group health plan or governmental program shall be coordinated so that the total amount payable from all plans shall not exceed 100 percent of covered Benefits or expenses actually incurred, whichever is the lesser amount. When this Plan is a secondary plan, this Plan shall provide Benefits for covered expenses that were not payable under the primary plan or any other health plan, subject to any co-payment, deductible, and coinsurance amounts, regardless of whether the primary plan actually meets its obligation to pay for covered expenses. In no event shall the benefits provided by this Plan exceed the benefits that would have been provided by this Plan as the primary plan.
- (b) If the Plan is secondary and the primary plan establishes to the satisfaction of the Board that it is unable to pay the claim in question, then the Plan may be in the sole discretion of the Board pay a portion or all of the claim that would ordinarily be a covered expense of the primary plan.
- (c) Notwithstanding the coordination of benefits provisions of this Article 6, to the extent that they are inconsistent with the coordination of benefits provisions with respect to any insured benefit set forth in any Benefit Program Document, the provisions of the Benefit Program Document will control.

6.02 Definitions

For purpose of this Article, certain terms are defined as follows:

- (a) “primary plan” means a health plan which is responsible for

payment of covered expenses first, without regard to benefits payable by any other health plan.

- (b) “secondary plan” means any health plan which is responsible for payment of covered expenses following payment by the primary plan.

6.03 **Order of Responsibility**

Except as otherwise expressly provided herein, the following shall be the order of responsibility for payment of covered expenses for purposes of coordination of benefits:

- (a) Any health plan which does not have a coordination of benefits provision shall be the primary plan and this Plan shall be the secondary plan.
- (b) Any health plan, including this Plan, which covers the covered person as an employee shall be the primary plan, and any health plan which covers the covered person in any other capacity shall be the secondary plan for purposes of providing benefits on behalf of the employee.
- (c) Any health plan, including this Plan, which covers the covered person in any capacity other than as a dependent shall be the primary plan, and a health plan which covers the covered person as a dependent shall be the secondary plan for purposes of providing benefits to that dependent.
- (d) Any health plan, including this Plan, which covers a child as a dependent of the person whose birthday falls earlier in the calendar year shall be the primary plan for purposes of providing benefits on behalf of such dependent child. This provision shall apply only if the other health plan also follows this “birthday rule.”
- (e) In cases of divorce or legal separation:
 - (i) If the parent with legal custody of the child has not remarried, the benefits of the health plan which covers the

child as a Dependent of the custodial parent shall be the primary plan and the health plan which covers the child as a Dependent of the noncustodial parent shall be the secondary plan for purposes of providing benefits on behalf of such Dependent child.

- (ii) If the custodial parent of the child has remarried, the benefits of the health plan which covers the child as a Dependent of the custodial parent shall be the primary plan and the health plan which covers the child as a Dependent of the custodial parent's spouse shall be the secondary plan for purposes of providing benefits on behalf of the Dependent child. The health plan which covers the child as a Dependent of the noncustodial parent shall pay benefits after the secondary plan for purposes of providing benefits on behalf of the Dependent child.
- (iii) Notwithstanding these provisions, if a court order, judgment or decree establishes financial responsibility for the medical, dental, or other health care expenses of a child, the health plan designated by the court to cover the child shall be the primary plan. Any other health plan which covers that child as a Dependent shall be the secondary plan or pay after the secondary plan pursuant to the foregoing for purposes of providing benefits on behalf of the Dependent child.
- (f) Where the order of responsibility cannot be determined pursuant to the provisions set forth above, the health plan which has covered the covered person for the longest period of time shall be the primary plan, and the health plan which has covered the covered person for the shorter period of time shall be the secondary plan for purposes of providing benefits on behalf of the covered person.
- (g) Where there are two or more secondary plans, the order of

responsibility in subsections (a) through (f) above shall be repeated until this Plan's responsibility has been determined with respect to each other health plan.

- (h) When this Plan is the primary plan, the benefits payable by any secondary plan shall be ignored for the purpose of determining the benefits payable under this Plan.

6.04 **Coordination with No-fault Auto Insurance**

Where covered expenses are payable by a no-fault automobile insurer, or other automobile insurer which pays without regard to fault, this Plan shall always be the secondary plan.

6.05 **Coordination with Medicare**

Medicare generally shall be the secondary plan with respect to any Employee or Dependent Spouse who is Medicare-eligible. Medicare shall be the primary plan with respect to a retired Employee and any Dependent Spouse who is Medicare-eligible. Both the Employee and the Dependent Spouse have the option of rejecting the Plan in order to retain Medicare as the primary plan. For persons eligible for Medicare because of end-stage renal disease, Medicare is secondary only for the first 30 months after the person becomes eligible for Medicare; after that time, Medicare will pay first.

6.06 **Coordination with TRICARE**

In any case in which a covered person is also eligible for coverage under TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), TRICARE shall be the secondary plan.

6.07 **Service Benefits**

When a plan provides benefits in the form of services, the reasonable

cash value of each service rendered will be considered a covered expense. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan to the extent that benefits for the services are covered by the primary plan and have not already been paid. Nothing in this provision shall be interpreted to require the Plan to reimburse a covered person in cash for the value of service provided by a plan that provides benefits in the form of service.

6.08 Right to Information

For the purpose of determining the applicability of, and implementing this Article 6 or any provision of similar purpose of any other health plan, the Board of Trustees without the consent of or notice to any person, may release to or may obtain from any insurance company, organization or person any information which the Board of Trustees deems necessary for such purposes. Any individual claiming benefits from this Plan shall furnish, upon request, to the Board of Trustees in writing such information as may be necessary to implement this provision. This Plan shall not be required to determine the existence of any other health plan or the amount of benefits for covered expenses payable under any other health plan. Should the Board of Trustees not be provided with full and complete information, the Board of Trustees reserves the right to withhold any and all Benefit payments until such information is provided.

6.09 Right to Make Payments

Whenever payments which should have been made under this Plan in accordance with this Article have been made under any other health plan, the Board of Trustees shall have the right, exercisable alone and at its sole discretion, to pay over to any organization making such other payments or, if appropriate, to a covered person, any amounts it shall

determine to be warranted in order to satisfy the intent of this Article, and amounts so paid shall be deemed to be benefits provided under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

6.10 **Subrogation and Reimbursement**

This section 6.10 shall apply only to self-funded Benefit Programs. Any Benefit Program that is insured shall be subject to the subrogation and reimbursement provisions set forth in the applicable Benefit Program Document.

- (a) If the Plan pays benefits to or for any covered person for any injury, illness, expense or loss, the Plan will be subrogated for the full amount of such payments to all rights of the covered person or any assignee of the covered person against any person, firm, corporation or other entity in connection with any claim related to the injury, illness, expense or loss.
- (b) If the Plan pays benefits to or for any covered person for any injury, illness, expense or loss caused, or alleged to be caused, by any person, and the covered person (or someone acting on behalf of the covered person) or any assignee of the covered person obtains any recovery from any source in connection with the injury, illness, expense or loss, whether by lawsuit, settlement or otherwise, including any recovery from the covered person's insurance, and regardless of how the recovery is characterized or named, the Plan shall be entitled to full reimbursement from the covered person (or person acting on behalf of the covered person) or any assignee of the covered person to the full extent of the Plan's payments.
- (c) The Plan's rights of subrogation and reimbursement under (a) and (b) above shall have first priority and shall not be reduced for any reason, including for attorney's fees, the "fund" doctrine, the

“common fund” doctrine, comparative or contributory negligence, “collateral source” rule, “attorney’s fund” doctrine, regulatory diligence or any other defenses or doctrines that may affect the Plan’s right to subrogation or reimbursement. Likewise, the Plan’s right to subrogation or reimbursement shall exist and be enforceable without regard to whether the covered person (or person acting on behalf of the covered person) is “made whole” for his or her loss. Notwithstanding the above, the Board of Trustees or the Board’s designee may determine, in the exercise of its sole discretion, to reduce the Plan’s recovery in appropriate circumstances, which may include, with respect to attorney’s fees, a condition that the attorney representing the covered person or assignee, has agreed in advance to honor the rights of the Plan with respect to subrogation and reimbursement contained herein.

- (d) Once a covered person has any reason to believe that he/she may be entitled to recovery from any source, the covered person must notify the Plan. Prior to payment by the Plan to or for a covered person (or someone acting on behalf of the covered person) for any injury, illness, expense or loss caused, or alleged to have been caused, in circumstances that may support a recovery from any person, the covered person (or other adult acting on behalf of a minor covered person) will be asked to execute a subrogation and reimbursement agreement consistent with the terms of Section 6.10. Failure to request or obtain such an agreement prior to the payment by the Plan shall not in any way diminish the Plan’s rights of subrogation and reimbursement herein. If a covered person fails or refuses to execute the required subrogation or reimbursement agreement, the Plan may deny payment of any benefits to the covered person until the agreement is signed. Alternatively, if a covered person fails or refuses to execute the required subrogation or reimbursement agreement and the Plan

nevertheless pays benefits to or on behalf of the covered person, the covered person's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement, and the covered person's agreement to a constructive trust, lien and/or equitable lien by agreement in favor of the Plan on any payment, amount or recovery that the covered person recovers from any source.

- (e) By participating in the Plan, each covered person consents and agrees that, once Plan benefits are paid, a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any payment, settlement or recovery relating to an injury, illness, expense or loss for which the Plan has provided benefits. In accordance with that constructive trust, lien or equitable lien by agreement, each covered person agrees to cooperate with the Plan by reimbursing it for Plan benefits received.
- (f) The covered person shall do nothing to prejudice the Plan's rights under Section 6.10 and shall promptly inform the Plan of the name and address of any attorney representing the covered person or assignee. The covered person shall assist the Plan upon request, including instituting legal proceedings against any appropriate persons, firms, corporations or entities.
- (g) In the event that the Plan is not fully reimbursed as set out in Section 6.10, the Plan shall have the right, as the Board of Trustees or the Board's designee may determine, in the exercise of its sole discretion, to reduce any future benefits to which the covered person or assignee is or may become entitled, by the amount not reimbursed or recovered by the Plan.

ARTICLE 7
CLAIMS PROCEDURES AND APPEALS

7.01 General

Each claim for Benefits by a Participant, Dependent or duly authorized representative (“Claimant”) must be filed in accordance with the procedures set forth in the applicable Benefit Program Document. All claims for Benefits must be duly filed no later than the deadline for such Benefit Program set forth in the applicable Benefit Program Document. All claims for Benefits will be processed and may be appealed in accordance with the procedures for such Benefit Program set forth in the applicable Benefit Program Document.

7.02 Request for Review by the Board of Trustees

- (a) This Section 7.02 provides for a request for review by the Board (or a Committee thereof) of a decision by the Board’s third-party designee to reject an appeal made under the procedures set forth in the applicable Benefit Program Document.
- (b) A Claimant may request review of an adverse decision by filing a written request with the Board within 120 days of receipt of notification of a denial of an appeal. The following procedures will apply to the request:
 - (i) In support of the request for review, the Claimant may submit written comments, documents, records and other information relating to the claim.
 - (ii) The scope of the Board’s review will be limited to a determination of whether the decision to reject the appeal was based on a reasonable interpretation of the Plan. The Board shall be under no duty to conduct an independent medical review of the decision to reject the appeal or to take into account any materials or information other than

materials and information submitted by the Claimant relating to the claim or considered in connection with the initial claim or appeal.

- (c) If a Claimant files a request for review, any statute of limitations or defense with respect to the claim based on timeliness is tolled during the time that such request is pending.
- (d) The Plan will provide to the Claimant, upon request, sufficient information relating to his or her request for review to enable the Claimant to make an informed judgment about whether to make request for review, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the Claimant's rights to any other benefits under the Plan and information about the applicable rules, the right of a Participant or Dependent to have the request for review brought by an authorized representative as described in Section 7.01, and the conditions, if any, that could impair the impartiality of the Board with respect to the request for review .
- (e) No fee or cost will be imposed on the Claimant with respect to his or her request for review under this Section 7.02.
- (f) The Board will not treat a Claimant's failure to file a request for review under this Section 7.02 as a failure to exhaust his or her administrative remedies under the Plan with respect to the claim.

7.03 Finality of Decision and Legal Action

A Claimant must exhaust the applicable claims procedures described in the Plan and any applicable Benefit Program Document before taking action in any other forum regarding a claim for benefits under the Plan. If the Claimant does not file an initial claim for benefits or an appeal within the time periods specified under the applicable claims procedures, the Claimant will have permanently waived and abandoned his or her claim, and his or her claim shall be precluded. Any suit or legal action

initiated by a Claimant under the Plan must be brought by the Claimant no later than one year following a final decision on the claim for benefits under these claims procedures. The one-year statute of limitations on suits for benefits applies in any forum where a Claimant initiates such suit or legal action. If a civil action is not filed within this period, the Claimant's benefit claim is deemed permanently waived and abandoned, and the Claimant will be precluded from asserting it.

ARTICLE 8
PLAN AMENDMENT AND TERMINATION

8.01 Amendment or Termination of Plan

The Board of Trustees, at a meeting held either in person or by telephone or other electronic means, or by unanimous written consent in lieu of a meeting, reserves the right at any time and from time to time, and retroactively if deemed necessary or appropriate, to amend, suspend or terminate the Plan for any reason, in whole or in part, and to adopt any amendment or modification thereto, all without the consent of any Employee or other person. Any action taken by the Board of Trustees shall be consistent with the terms of the Trust Agreement. Upon termination of the Plan, any assets remaining in the Fund may be used to provide welfare benefits to Employees, Dependents, or beneficiaries as the Board of Trustees determines in its sole and absolute discretion.

ARTICLE 9
HIPAA PRIVACY AND SECURITY REQUIREMENTS

9.01 General; Definitions; Application

(a) General. The provisions of this Article 9 will be interpreted in accordance with the regulations issued by the Department of Health and Human Services (“DHHS”) under 45 CFR parts 160 and 164 (“HIPAA Privacy Regulations”) and 45 C.F.R. Parts 160 and 162 (“HIPAA Security Standards”), which are incorporated herein by reference.

(b) Definitions.

- (1) Protected health information (“PHI”) shall have the meaning set forth in 45 CFR § 164.501 – generally, information that relates to an individual’s medical condition, the provision of medical care for that individual, or the payment for that individual’s medical care that identifies the individual to whom it relates and is created or received by the Fund, a health care provider, an employer, or a health care clearinghouse.
- (2) Privacy Officer shall mean the individual designated by the Executive Director to develop and implement the Fund’s privacy policies and procedures.
- (3) Designated Record Set shall have the meaning set forth in 45 CFR § 164.501.

(c) Application. The provisions of this Article 9 shall only apply with respect to any health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards. The provisions of Sections 9.02, related to the HIPAA Privacy Regulations, are effective as of April 14, 2003. The provisions of Section 9.03, related to the HIPAA Security Standards, are effective as of April 20, 2005.

9.02 **Uses and Disclosures of Personal Health Information By the Board**

- (a) The Fund will disclose PHI to the Board only for the purposes of plan administration functions that the Board performs for the Fund as described in (b) below. For purposes of this Section 9.02, disclosure to the Board includes disclosure to the Fund's Executive Director, Director of Fund Administration, Director of Fund Development, Information Processor/Clerk, Member Inquiry Representative, Member Services Coordinator, and Marketing Coordinator, all of whom are under the control of the Board.
- (b) PHI may be used and disclosed by the Board only for the purposes of plan administration functions, including without limitation quality assurance, claims processing, and auditing and monitoring Fund service providers and monitoring Fund employees. The Board will not use or disclose PHI except as permitted or required by the Plan or by law, and will not use or disclose PHI for any employment-related actions or in connection with any other employee benefit plan.
- (c) Disclosure of PHI to the Board is conditioned upon Board certification that the Plan has been amended to incorporate the provisions of this Section 9.02 and that the Board agrees to comply with the provisions.
- (d) The Board will ensure that any agents or subcontractors to whom it provides PHI received from the Fund agree to the restrictions that apply to the Board's receipt of PHI.
- (e) The Board will report to the Privacy Officer any use or disclosure inconsistent with the uses or disclosures permitted under this Section 9.02.
- (f) The Board will make PHI available for inspection, will make PHI available for amendment, and will make available the information required to provide an accounting of disclosures.
- (g) The Board will make its internal practices and records relating to

the use and disclosure of PHI received from the Fund available to the U.S. Department of Health and Human Services upon request.

- (h) Except as otherwise required by law, the Board will return or destroy all PHI that it receives from the Fund and shall retain no copies of such information when no longer needed for the purpose for which disclosure was made.
- (i) If any individual receiving PHI under this Section 9.02 fails to comply with the provisions of this Section 9.02, the Board shall determine the consequences of such noncompliance based on the particular facts and circumstances of the noncompliance, including without limitation discipline up to and including termination of employment in the case of a Fund employee and prohibition on the future receipt of PHI in the case of a Trustee.

9.03 **HIPAA Security Standards**

- (a) **Safeguards.** The Board will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPAA Security Standards.
- (b) **Agents.** The Board will ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate safeguards to protect such information.
- (c) **Security Incidents.** The Board will report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

- (d) Adequate Separation. The Board will establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Board in support of the requirements of this Article.

ARTICLE 10
GENERAL PROVISIONS

10.01 No Diversion of Assets

Except as provided in Section 8.01 of this Plan and Section 2.2(b) of the Trust Agreement, it shall be impossible at any time for any assets of the Plan to be used for or diverted to any purpose other than for the exclusive benefit of persons entitled to Benefits under the Plan, or to inure (other than through payments made pursuant to the Plan) to the benefit of any private individual.

10.02 Employee Rights

Nothing contained in this Plan shall give any Employee the right to be retained in the employment of an Employer or affect the right of an Employer to dismiss the Employee at any time and for any reason. The adoption and maintenance of this Plan shall not constitute a contract between an Employer and any Participant or Dependent or consideration for, inducement to, or condition of the employment of any Employee.

10.03 Physical or Other Disability

If the Board of Trustees shall find that any person to whom an amount is payable under the Plan is unable to care for his or her affairs because of illness or accident, or is a minor, or has died, then any payment due him or her, or his or her estate (unless a prior claim has been made by a duly appointed legal representative) may be paid to his or her spouse, a child (in accordance with the Uniform Gifts to Minors Act or State "gifts to minors" act, if applicable), a relative, an institution maintaining or having custody of such person, or any other person deemed by the Board of Trustees to be a proper recipient on behalf of such person otherwise entitled to payment. Any such payment shall constitute a complete discharge of the liability of the Union, the Fund,

the Board of Trustees, and the Plan.

10.04 Right to Recover Payments

If, for any reason, payments are made to any person or entity in excess of the amount payable under this Plan, the Board shall have full authority to recover the amount of overpayments. That authority shall include, but shall not be limited to, the right to reduce benefits payable in the future to the person who received the overpayments.

10.05 Transmittal of Notices

All notices, statements, reports and other communications from the Board of Trustees to any Participant or Dependent or other person, required or permitted under the Plan, shall be deemed to have been duly given when delivered to such Participant or Dependent or other person, or mailed to him or her at the address last appearing on the records of the Board of Trustees.

10.06 Controlling Law

This Plan and all rights thereunder shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania, except where applicable Federal laws and regulations control.

10.07 Liability of Plan

The use of services of any health care provider is the voluntary act of the Participant or Dependent, even in cases where the Plan limits coverage to certain providers. The health care providers rendering service in connection with this Plan are independent contractors, and the Plan makes no representation regarding the quality of service or treatment of any provider and is not responsible for the negligence of any provider rendering services or supplies in connection with this Plan.

10.08 Text Prevails Over Captions

The headings and subheadings of the Articles and Sections of the Plan are included herein solely for the convenience of reference and if there is any conflict between such headings and subdivisions and the text of this Plan, the text shall control.

10.09 Counterparts

This Plan may be executed in several counterparts, each of which shall be deemed an original, and said counterparts shall constitute but one and the same instrument which may be sufficiently evidenced by any one counterpart.

10.10 Successor and Assigns

This Plan shall inure to the benefit of and be binding upon the parties hereto and their successors and assigns.

10.11 Construction

Notwithstanding any other provision of this Plan, no provision of this Plan shall be construed so as to violate the requirements of ERISA, the Code, or other applicable law.

10.12 Successor Provisions of Law

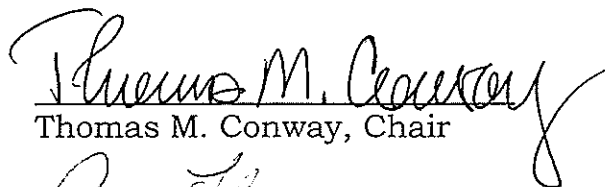
Any references to a section of ERISA or the Code (or any other statute), or to any other regulations or administrative pronouncements thereunder, shall be deemed to include a reference to any successor provision of ERISA or the Code (or of any successor federal law), or to any successor regulations or administrative pronouncements thereunder.

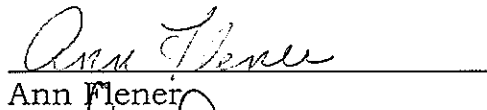
10.13 **Required Information**

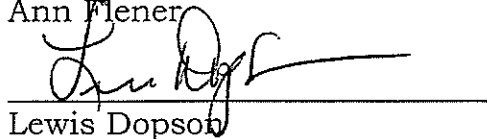
- (a) A Participant or Dependent must furnish the Plan with such information or proof as requested by the Plan.
- (b) The Plan may rely on any information furnished by a Participant or Dependent, and this information will be conclusively binding upon the Participant or Dependent furnishing the evidence.
- (c) If a person claiming benefits under the Plan performs an act or practice constituting fraud, makes an intentional misrepresentation of material fact, or makes a false statement that is material to the person's claim for benefits, the Board of Trustees may adjust the benefits payable to the person or require that the payments be returned to the Plan, or take any other action as deemed reasonable.
- (d) Failure on the part of a Participant or a Dependent to comply with a request by the Plan, for information or proof within a reasonable period of time is sufficient grounds for delay in the payment of any benefits that may be due under the Plan until such information or proof is received.

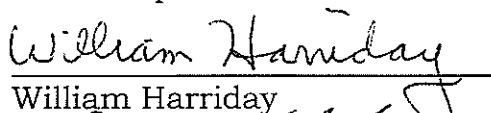
IN WITNESS WHEREOF, the Board of Trustees of the Steelworker Health and Welfare Fund has caused this instrument to be executed ^{as of the} ~~this~~ 31st day of December, 2011.

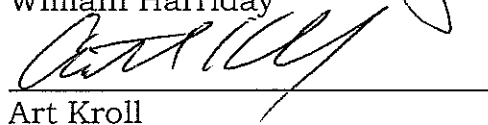
BOARD OF TRUSTEES


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