

Summary Plan Description

Health and Welfare Benefits



**Kenyon College
Medicare Supplement Plan**



Steelworkers Health and Welfare Fund

December, 2018

Dear Participant:

The Board of Trustees of the Steelworkers Health and Welfare Fund (the “Fund”) is pleased to provide you with this Summary Plan Description which summarizes the terms and conditions of the benefits provided from the Fund for which you are or may become eligible as a retired Employee represented under the collective bargaining agreement between the United Electrical, Radio and Machine Workers of America (“UE”) on behalf of UE 712 (the “Union”) and Kenyon College (the “Employer”). Kenyon College began participation in the Fund on behalf of these Employees effective August 1, 2008.

This letter, which is referred to as the Fund Letter in the Summary Plan Description, provides additional information about the specific benefits provided to you by the Fund in accordance with the collective bargaining agreement. Because this Fund Letter is designed specifically for benefits provided under the collective bargaining agreement, it may contain information that is different in some respects from the more general terms of the Summary Plan Description. For this reason, it is important that you read carefully and understand all of the information in this Fund Letter. *To the extent that any information in this Fund Letter is inconsistent with the information in the Summary Plan Description, the information in this Fund Letter – not the Summary Plan Description – will apply.*

Types of Benefits

You are, or may become eligible for the following benefits from the Fund:

- Medical Benefits – Medicare Supplement
- Prescription Drug Benefits

Effective Date of Coverage

As a retired Employee, you will generally become eligible for benefits as described in the collective bargaining agreement, provided the required contributions to the Fund are made on your behalf. The Summary Plan Description may set forth additional eligibility requirements with respect to specific benefits. Please refer to the Summary Plan Description for additional requirements.

Termination of Coverage

Your coverage will terminate in accordance with the rules described in Section I of the Summary Plan Description or as described in the collective bargaining agreement.

Open Enrollment

If you choose not to become a Participant on the earliest possible date, or if you elect to terminate your participation in a Fund benefit plan but you otherwise remain eligible, you may become a Participant during the next following open enrollment period so long as the required contributions are made to the Fund on your behalf. This also applies to your eligible Dependents. For purposes of the open enrollment, changes in your (or your Dependents) participation status can be made during the months of November for a January 1st effective date. Please contact your employer for additional information.

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SECTION I: GENERAL INFORMATION

INTRODUCTION

This booklet, along with the accompanying letter from the Fund identifying the particular benefits available to your group and other special rules, describes the benefits that are available to you as a Participant in the Steelworkers Health and Welfare Fund (the “Fund”), and the conditions under which the benefits are available. Please read this booklet carefully so you will understand your coverage. If you have questions about this booklet, or any other questions about the Fund (other than questions about a specific benefit or a specific claim), please contact the Steelworkers Health and Welfare Fund Administrative Office, Five Gateway Center, Fifth Floor, Pittsburgh, Pennsylvania 15222-1219 (“Fund Office”). You may also call the Fund Office toll-free at 1-888-296-7493 for assistance. Office hours are 8:00 am to 5:00 pm Eastern Time, Monday through Friday. At other times, you may leave a message and your call will be returned as soon as possible. If you have questions about a particular benefit or an outstanding claim, you should contact the benefit provider directly at the toll-free number listed on your identification card.

This booklet is intended only to provide a summary of your benefits. The terms and conditions of the benefits available from the Fund are more fully discussed in the document called the *Steelworkers Health and Welfare Plan* (the “Plan”). Please contact the Fund Office if you would like a copy of the Plan. If there are any contradictions between this booklet and the Plan, the terms of the Plan will govern.

The Fund was established in 1944. Its purpose is to provide health and other benefits to individuals employed under a collective bargaining agreement between the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (“USW”) (the “Union”) or other participating union and a participating Employer. The Fund is managed by a Board of Trustees.

All contributions to the Fund are made by the Employers (or covered individuals) in accordance with the provisions of a collective bargaining agreement (or other written agreement with the Fund) that require periodic contributions to the Fund.

The Fund Office will provide you, upon written request, with information as to whether a particular Employer is contributing to this Fund on behalf of Employees working under collective bargaining agreements and, at reasonable cost, a copy of any collective bargaining agreement authorizing contributions to the Fund. A complete list of the employers contributing to the Fund may be obtained upon written request to the Fund Office.

Benefits are provided from the Fund's assets, which are held in trust (along with their earnings) for the purpose of providing benefits to covered individuals and defraying reasonable administrative expenses. Benefits may be paid either directly by the Fund from trust assets or by an entity with whom the Fund has a contract to provide benefits, such as an insurance carrier.

What benefits are available from the Fund?

The Fund provides the following benefits:

- Medical Benefits
- Prescription Drug Benefits
- Dental Benefits
- Vision Benefits
- Death Benefits
- Accidental Death and Dismemberment Benefits
- Short Term Disability Benefits

Not all Participants are eligible for all of the benefits offered. The Fund Letter accompanying this booklet lists the benefits for which you are or may become eligible.

Whom do I contact with questions about benefits?

The identification card that you receive for Medical (including Prescription Drug), Dental and/or Vision Benefits includes a toll-free phone number and an address for questions about that benefit, including whether a particular service is covered, and questions about the status of your claim. You should contact the Fund Office or the insurance company for questions about Death, Accidental Death and Dismemberment and Short Term Disability Benefits and claims. For general questions about the Fund, or if you are having problems getting a satisfactory answer to your question about a benefit, please contact the Fund Office.

KEY TERMS

The meaning of some of the terms used most frequently throughout this booklet is explained below:

Benefit

A Benefit is one of the benefits offered by the Fund. The benefits for which you are or may become eligible are listed in the Fund Letter accompanying this booklet.

Board of Trustees

The Board of Trustees is the group of individuals appointed to manage the operation and administration of the Fund.

Claims Administrator

The Claims Administrator is the entity responsible for claims processing and payment.

Dependent

Dependents include the following persons:

- your spouse;
- each of your unmarried children who is under age 19;
- each of your unmarried children who is age 19 or older but younger than age 25, enrolled and recorded as a full-time student at an accredited high school, college, university or vocation training school (or who has been on a medically necessary leave of absence for one year or less in accordance with Michelle’s Law, PL 110-381), and resides with or is wholly dependent on you for financial support; and
- each of your unmarried children who is age 19 or older and incapable of self-support as the result of physical or mental incapacity that existed before he or she reached age 19, and who is wholly dependent upon you for support.

The term “children” includes any stepchild, legally adopted child or child placed for adoption with you, and a child for whom you have been appointed legal guardian.

Employee

An employee is an employee or former employee of an Employer who works or worked in a job classification covered by a collective bargaining agreement requiring contributions to be made to the Fund, or who works in a position set forth in some other written agreement accepted by the Board of Trustees.

Employer

An Employer is an employer that is or was a party to a collective bargaining agreement, or other written agreement accepted by the Board of Trustees, that requires contributions to be made to the Fund on behalf of its Employees.

ERISA

ERISA is the Employee Retirement Income Security Act of 1974, as amended, a federal law that governs the operation of the Fund.

Fund

The Fund is the Steelworkers Health and Welfare Fund.

Fund Letter

The Fund Letter is the letter from the Fund that accompanies this booklet and that identifies the particular benefits available to your group and other special rules for your group that are not reflected in this more general booklet.

Fund Office

The Fund Office is the Steelworkers Health and Welfare Fund Administrative Office, Five Gateway Center, Fifth Floor, Pittsburgh, Pennsylvania 15222-1219. The Board of Trustees has delegated the day-to-day administrative duties to persons who work in the Fund Office.

Group Insurance Policy

The Group Insurance Policy is the insurance policy that the Fund has purchased from an insurance company to pay a particular benefit. If a benefit booklet describing a particular benefit refers to the Group Insurance Policy for that benefit and you would like to review that Group Insurance Policy, please contact the Fund Office.

Participant

A Participant is an Employee who has met the requirements to be eligible for benefits from the Fund, and has not lost eligibility for those benefits.

Participation Agreement

A Participation Agreement is an agreement implementing the terms and conditions of a collective bargaining agreement requiring contributions to the Fund on behalf of Employees.

Plan

The Plan is the Steelworkers Health and Welfare Plan, which is a written document describing the operation of the Fund.

Plan Administrator

The Plan Administrator is the Board of Trustees of the Steelworkers Health and Welfare Fund.

Qualifying Event

A qualifying event is an event that entitles you to elect COBRA continuation health coverage from the Fund.

Union

The Union is the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (“USW”), or any successor thereto.

You

The terms “you” and “your” generally refer to Participants. In the section entitled Eligibility for Benefits, “you” and “your” include both Participants and Employees who are not yet Participants. In the section entitled Claims and Review Procedures the term “you” means all persons with a claim or potential claim for benefits. Also, in the section(s) describing the available benefits, the terms “you” and “your” include both Participants and Dependents.

FUND MANAGEMENT

Who manages the Fund?

The Fund is managed by the Board of Trustees, which meets periodically to review and decide Fund matters. The Board of Trustees may engage other persons or entities, such as those employed at the Fund Office, to conduct the day-to-day operations of the Fund. The Board of Trustees may also delegate certain of its duties to other persons or entities, as the Board considers advisable.

The Board (or, where applicable, the Board's delegate) has the exclusive authority, in its sole and absolute discretion, to:

- take all actions necessary to manage the Fund;
- administer and interpret the Plan and all other documents maintained in connection with the Plan; and
- decide all matters arising in connection with the operation or administration of the Plan.

The Board fully intends to continue to maintain the Plan indefinitely. However, the Board has the sole and absolute discretion to modify or terminate the Plan at any time.

What does the Fund Office do?

The Fund Office handles the day-to-day administrative functions for the Fund, including distributing this booklet and other information to you and your Dependents, responding to your requests about the Fund, and maintaining appropriate Participant and Employer information. You may contact the Fund Office with any questions that you have at the address or phone number set forth in the Introduction.

What role do Insurance Companies and other providers play?

In some cases, the Board of Trustees has contracted with an insurance company for the purchase of an insurance policy to pay benefits, or with an insurance company or other entity for the provision of administrative services for a particular benefit (such as to process claims). This booklet discusses the role that an insurance company or other entity plays, if any, with respect to a particular benefit. Because of these arrangements, if you contact the Fund Office with questions about a particular benefit, the Fund Office may in some cases refer you to an insurance carrier or other entity for an answer.

You should keep in mind that, even though a claim may initially be processed by an insurance company or other entity, the Board of Trustees is ultimately responsible for paying benefits. It is for this reason that, as explained in the Claims and Review Procedures section, the Board of Trustees has the final authority to grant or deny a claim.

The benefits described in this Summary Plan Description (SPD) are guaranteed under a contract of insurance issued to the Fund by the following insurance companies, each of which provides claims payment and other administrative services to the Fund.

Benefit	Claims Administrator
Medical, Prescription Drug, Vision	Highmark Blue Cross Blue Shield Fifth Avenue Place 120 Fifth Avenue Pittsburgh, PA 15222
Dental	United Concordia Companies, Inc. 100 Senate Avenue Senate Plaza Camp Hill, PA 17011
Vision	Davis Vision 159 Express Street Plainville, NY 11803
Death, Accidental Death & Dismemberment	The Hartford Group Life/AD&D Claims Unit P.O. Box 946790 Maitland, FL 32794-6790
Short Term Disability	The Hartford 5600 West American Boulevard Bloomington, MN 55437

Detailed information concerning the claims and appeals procedures of each insurance company is included in the applicable benefits section of this SPD.

ELIGIBILITY FOR BENEFITS

How do I become eligible for benefits from the Fund?

You will become a Participant in the Fund on the first day for which the required contributions to the Fund are made on your behalf for one or more benefits. That date is specified in the Fund Letter.

Once you become a Participant, you will generally be eligible to receive all of the benefits set forth in this booklet and in the Fund Letter. This booklet may also contain additional eligibility requirements for a particular benefit, such as completing an enrollment form, so you should read this booklet carefully.

If you choose not to become a Participant on the earliest possible date, or if you elect to terminate your participation in a Fund benefit plan but you otherwise remain eligible, you may become a Participant on any of the following dates, so long as the required contributions are made to the Fund on your behalf:

- a date permitted under the annual open enrollment period applicable to your Employer, if any. (the Fund Letter describes any applicable annual open enrollment period);
- the next rate renewal date as agreed to in the Participation Agreement;
- if you are or were covered under another group health plan, a date that is no later than thirty (30) days after (a) you lose coverage under that plan due to divorce, legal separation, or a termination or reduction in your hours of employment; or (b) Employer contributions to that plan stop, but only if you notify the Fund Office within thirty (30) days of losing coverage or of the termination of Employer contributions;
- if you acquire a new Dependent (including a new spouse), a date that is no later than thirty (30) days from the date on which you acquire the Dependent, so long as you notify the Fund Office within thirty (30) days of acquiring the Dependent; or
- the date you lose 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, so long as you notify the Fund Office within sixty (60) days of losing coverage.

How do my spouse and other Dependents become eligible for benefits from the Fund?

Your Dependents (including your spouse) will become eligible for benefits on the day that you become a Participant (so long as the required contributions are made to the Fund on their behalf). This booklet may contain additional eligibility requirements for a particular benefit, such as completing an enrollment form, so you should read this booklet carefully.

If you choose not to enroll your Dependents on the earliest possible date, or if you elect to terminate their participation in a Fund benefit plan but they otherwise remain eligible, any Dependent may be enrolled on any of the following dates, so long as the required contributions are made to the Fund on his or her behalf:

- a date permitted under the annual open enrollment period applicable to your Employer, if any (the Fund Letter describes any applicable open enrollment period);
- the next rate renewal date as agreed to in the Participation Agreement;
- if your Dependent is or was covered under another group health plan, a date that is no later than thirty (30) days after (a) he or she loses coverage under that plan due to divorce, legal separation, or a termination or reduction in hours of employment; or (b) Employer contributions to that plan stop, but only if you or your Dependent notifies the Fund Office within thirty (30) days of losing coverage or of the termination of Employer contributions; or
- the date your 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 so long as you notify the Fund Office within sixty (60) days of losing coverage.

How do I lose eligibility for benefits?

You will be a Participant until the earliest of the following events occurs (unless the Fund Letter contains different rules, in which case those rules will apply):

- you cease employment with an Employer;
- your Employer is no longer required to make contributions for you, in which case you will continue to be a Participant through the last day of the month for which your Employer is required to make contributions for you;
- the Fund does not receive contributions required to be made for your coverage for any particular month, in which case you will cease to be a Participant as of the last day of the previous month; or
- the date on which the Plan terminates.

Once you stop being a Participant, you will no longer be eligible to receive any benefits, except to the extent that COBRA coverage (discussed below) applies to you. In addition, in limited circumstances, benefits may be continued to the extent provided in the applicable insurance contract.

How do my spouse and other Dependents lose their eligibility for benefits?

Each of your Dependents (including your spouse) will continue to be eligible for benefits until one of the following events occurs (unless the Fund Letter contains different rules, in which case those rules will apply):

- he or she no longer meets the definition of Dependent set forth above;
- the Fund does not receive contributions required to be made for a Dependent's coverage for any particular month, in which case he or she will cease to be eligible for benefits as of the last day of the previous month; or
- the date on which you stop being a Participant, except to the extent that COBRA coverage applies.

How do payroll deductions affect my coverage?

If your Employer requires you to contribute towards your coverage through payroll deductions and you make a change in coverage or enrollment for yourself or your Dependents, you may need to change the amount you have authorized your Employer to deduct from your pay. If you do not do so, your Employer may not make the appropriate contributions to the Fund on behalf of you and/or your Dependents, resulting in termination of your benefits. Check with your Employer for details.

What if I go on leave for family or medical reasons?

The Family and Medical Leave Act (FMLA) is a federal law that permits eligible Employees to take up to twelve (12) weeks of unpaid, job-protected leave each year from their Employer for certain specified reasons. If you qualify, you may take FMLA leave for any of the following reasons:

- the birth of your child and to care for that child;
- the placement of a child with you for adoption or foster care;
- to care for your spouse, child or parent with a serious health condition; or
- a serious health condition that makes you unable to perform your job.

During your FMLA leave, your Employer must provide you with the same health benefits that you were receiving immediately before your leave. This means that your Employer must continue to make the same contributions to the Fund on your behalf during your FMLA leave that it was making while you were at work.

Contact your Employer for further information and instructions on how to apply for FMLA leave.

What if I have military service?

If you leave employment with your Employer for certain types of military training or service, and return to your Employer within ninety (90) days, your Employer may be required under federal law to begin to contribute to the Fund on your behalf immediately upon your return, in which case you would not have to satisfy any waiting period. Contact your Employer for details.

What if I terminate employment and my new Employer's plan doesn't cover pre-existing conditions?

The Fund does not limit medical coverage for pre-existing conditions, but some plans do. Most plans are required to reduce this limit if you had prior coverage. For this reason, when you lose eligibility for medical benefits, the Fund is required to provide you with a Certificate of Coverage showing the amount of time that you were continuously covered by the Fund. If you are eligible for and elect COBRA coverage as described elsewhere in this booklet, you will receive another Certificate of Coverage after your COBRA coverage expires. You may also request a Certificate of Coverage at any time while you are still covered by the Fund or during the twenty-four (24) months after you lose your eligibility for medical benefits.

EXTENDED COVERAGE

How can I continue coverage once I am no longer eligible for benefits?

Once you are no longer eligible for medical benefits, you may be able to continue coverage in two ways: by electing COBRA coverage as described below or, if your benefits are insured by a company that provides conversion rights, by purchasing an individual insurance policy. (If such a provision is offered, it will be described later in this booklet.)

What is COBRA coverage?

COBRA continuation coverage is a continuation of the group health coverage available to you and your covered Dependents from the Fund when coverage would otherwise end because of a life event known as a “qualifying event”. Specific qualifying events are listed below.

Individuals who elect COBRA continuation coverage must pay for COBRA continuation coverage. The administration of COBRA coverage is the responsibility of the Fund Office.

In order to protect your and your family’s rights, it is important to keep the Fund Office informed of the current addresses of all of your family members who are or could become eligible for COBRA coverage. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Which of my family members are eligible for COBRA coverage?

Each of your Dependents who is covered from the Fund when a qualifying event as defined below occurs is eligible for COBRA coverage unless he or she is entitled to Medicare. In addition, if a child is born to or adopted by you while your COBRA coverage is in effect, that child is eligible for COBRA coverage. You and each of your Dependents eligible for COBRA coverage is referred to as a “qualified beneficiary”.

What events are qualifying events that make me and my Dependents eligible for COBRA coverage?

You and your eligible Dependents will each become a qualified beneficiary and may independently elect COBRA coverage when a qualifying event occurs. A qualifying event may be different for you and your eligible Dependents.

Qualifying Events for You

The following events are qualifying events for you if they result in a loss of coverage, unless you are entitled to Medicare:

- reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct);
- you are a retiree of an Employer contributing to the Fund on behalf of its retired employees and your former Employer commences federal bankruptcy proceedings under title 11 of the U.S. Code.

Qualifying Events for Your Dependents

The following are qualifying events for your Dependents if they result in a loss of coverage:

- your death;
- reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct);
- your divorce or legal separation;
- you are a retiree of an Employer contributing to the Fund on behalf of its retired employees and your former Employer commences federal bankruptcy proceedings under title 11 of the U.S. Code;
- your becoming enrolled in Medicare (Part A, Part B, or both); or
- for a child, ceasing to qualify as a Dependent.

Employer Withdrawals from the Fund

If you or one of your Dependents has a qualifying event and your Employer withdraws from the Fund or ceases to be a participating Employer due to non-payment of contributions, you and your Dependents will be eligible for COBRA coverage until your Employer makes group health coverage available to (or starts contributing to another multiemployer plan with respect to) a class of employees formerly covered from the Fund, at which point the other plan will be required to assume the COBRA obligation with respect to you and your Dependents.

If a qualifying event occurs, how do my Dependents and I get COBRA coverage?

NOTE If your Fund Letter provides that your Employer has elected to retain responsibility for the administration of COBRA coverage, this section does not apply and you will need to contact your Employer for details on how to obtain COBRA coverage.

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is termination of employment or reduction in your hours of employment, your death, commencement of a proceeding in bankruptcy with respect to the Employer, or your becoming enrolled in Medicare (Part A, Part B or both), the Employer must notify the Fund of the qualifying event within thirty (30) days of the qualifying event.

For the other qualifying events (your divorce or legal separation, or your child losing eligibility for coverage as a Dependent), you or your Dependent(s) must notify the Fund Office within sixty (60) days of the qualifying event.

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Fund coverage would otherwise have been lost.

Is there a special rule if I am eligible for Trade Adjustment Assistance benefits?

Each qualified beneficiary is entitled to a second COBRA election period if: (a) you are certified by the Department of Labor as eligible for trade act assistance (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 your 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. Specifically, each qualified beneficiary has another opportunity to elect COBRA during the sixty (60) day period that begins on the first day of the month in which you were certified, and the election must also be made within six months after the date Fund coverage is lost. You or your Dependent(s) are responsible for notifying the Fund Office of your TAA eligibility and providing a copy of the certification. Accordingly, if you are eligible for TAA benefits, you or your Dependent(s) must contact the Fund Office immediately after you become certified or all qualified beneficiaries will lose the special COBRA rights. If a qualified beneficiary elects COBRA coverage under this provision, 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.

How long will my COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. Unless there is an early cut-off as described below, COBRA continuation coverage lasts for up to eighteen (18) months if the qualifying event is the termination of or reduction in hours of your employment, or up to thirty-six (36) months if the qualifying event is your death, your divorce or legal separation, your becoming enrolled in Medicare (Part A, Part B or both), or a child losing eligibility as a Dependent. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability Extension of Eighteen (18) Month Period of Continuation Coverage

If you or any covered Dependent are determined by the Social Security Administration to be disabled at some time before the 60th day of COBRA continuation coverage, you and each of your covered Dependents can receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. You must make sure that the Fund Office is notified of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage to be eligible for the additional eleven (11) months of COBRA continuation coverage.

Second Qualifying Event Extension of Eighteen (18) Month Period of Continuation Coverage

If you or a covered Dependent has another qualifying event while receiving COBRA continuation coverage, your covered Dependents can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to your spouse and dependent children if you die, become enrolled in Medicare (Part A, Part B or both), or get divorced or legally separated. The extension is also available to a child when that child stops being eligible under the Fund as a Dependent. In all of these cases, you must make sure that the Fund Office is notified of the second qualifying event within sixty (60) days of the second qualifying event and within the initial eighteen (18) months of continuation coverage.

What will cause an early cut-off of COBRA coverage?

COBRA coverage will automatically end as of the date any of the following cut-off events occurs:

- the covered individual does not pay the premium for COBRA coverage on time;
- the covered individual becomes covered under any other group health plan that does not limit coverage for his or her pre-existing conditions;
- the covered individual becomes enrolled in Medicare (Part A, Part B or both);

- your Employer withdraws from the Fund and makes other group health coverage available to (or starts contributing to another multiemployer plan with respect to) a class of employees formerly covered from the Fund; or
- for a covered individual who is receiving COBRA coverage based on a determination of disability, the first day of the month immediately following the month in which there is a final determination by the Social Security Administration that the individual is no longer disabled.

The covered individual is required to notify the Fund Office of any of the above cut-off events and the Fund may terminate COBRA coverage retroactively to the date of the cut-off event.

How can I get additional information about COBRA?

If you have questions about your COBRA continuation rights and coverage, you should contact the Fund Office or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

What if a court orders the Fund to cover my children?

The Fund will comply with the terms of any judgment, decree or order that creates or recognizes the right of one or more of your children to receive medical benefits, so long as that judgment, decree or order is a Qualified Medical Child Support Order (QMCSO) under Section 609 of ERISA. Coverage under such an order will not extend the maximum period of COBRA coverage. A description of the procedures governing QMCSOs may be obtained, without charge, from the Fund Office.

CLAIM AND REVIEW PROCEDURE

How do I file a claim for benefits?

Each benefit section of this booklet sets forth a procedure for filing claims for that particular benefit with the appropriate Claims Administrator and a time limit within which your claims must be filed. The Plan document contains a general explanation of the claims procedures, including the items to be taken into account by the Claims Administrator (or Board of Trustees) and the required elements of the notification of denial of your claim or appeal. Contact the Fund Office for details.

When will I be notified of the Claims Administrator's decision on my claim?

You will be notified of the Claims Administrator's decision on your claim no later than the following date:

- **Urgent Care Claims**

In the case of an Urgent Care Claim, you will be notified of the Claims Administrator's decision within seventy-two (72) hours after its receipt of the claim. An Urgent Care Claim is a claim for medical care or treatment where your life or health or ability to function properly would be seriously jeopardized by applying the longer time periods set forth below. If you do not provide enough information for the Claims Administrator to determine the benefits that are due, the Claims Administrator will notify you of the specific information necessary to complete the claim within twenty-four (24) hours after it receives the claim. You will then have a reasonable amount of time (at least forty-eight (48) hours) to provide the requested information, and the Claims Administrator will notify you of its decision within forty-eight (48) hours after it receives the information. If your claim is to extend the course of treatment beyond the period of time or number of treatments approved by the Claims Administrator and you make your claim at least twenty-four (24) hours before the period of time or number of treatments ends, you will be notified of the Claims Administrator's decision on your claim within twenty-four (24) hours of the Claims Administrator's receipt of the claim.

- **Concurrent Care Decisions**

In the case of a claim involving an ongoing course of treatment, you will be notified of the Claims Administrator's decision in enough time before any reduction or termination of the treatment to permit you to file an appeal and obtain a decision on appeal before the benefit is reduced or terminated. (This rule does not apply to reductions or terminations of benefits as a result of an amendment or termination of the Plan.)

- **Pre-Service Claims**

In the case of any other claim that must be approved in advance of obtaining the service or care, you will be notified of the Claims Administrator's decision within fifteen (15) days of its receipt of the claim or thirty (30) days if the Claims Administrator determines that an extension is necessary due to matters beyond its control, in which case it will notify you within the fifteen (15) day period of why the extension is required, when a decision is expected to be made, and any additional information that it needs to decide the claim. You will then have forty-five (45) days to provide that information.

- Other Claims

In the case of all other claims (except for claims for Death Benefits and Accidental Death and Dismemberment Benefits, which are discussed below), you will be notified of the Claims Administrator's decision within thirty (30) days of its receipt of the claim or forty-five (45) days if the Claims Administrator determines that an extension is necessary due to matters beyond its control, in which case it will notify you within the thirty (30) day period of why the extension is required, when a decision is expected to be made, and any additional information that it needs to decide the claim. You will then have forty-five (45) days to provide that information.

- Claims for Death Benefits or Accidental Death and Dismemberment Benefits

In the case of a claim for Death Benefits and Accidental Death and Dismemberment Benefits, you will be notified of the Claims Administrator's decision within ninety (90) days of its receipt of the claim or one hundred eighty (180) days if the Claims Administrator determines that an extension is necessary due to matters beyond its control, in which case it will notify you within the ninety (90) day period of why the extension is required and when a decision is expected to be made.

If my claim is denied, how do I appeal?

If you file a claim for benefits in accordance with the applicable benefit provisions and the Claims Administrator either denies the claim or fails to respond to you by the deadline set forth above, you may file a written appeal with the Claims Administrator within one hundred eighty (180) days of the date you were notified that the claim was denied or one hundred twenty (120) days in the case of a claim for Death Benefits or Accidental Death and Dismemberment Benefits. In support of your appeal, you may submit written comments, documents, and other information relating to your claim, and the Claims Administrator will provide you with reasonable access to, and copies of, all documents, records or other information relevant to your claim upon your request. In the case of an Urgent Care Claim (as defined above), you may request an expedited review process. If you request an expedited review process, you may submit your request for appeal orally or in writing and all information necessary to the appeal will be transmitted between the Claims Administrator and you by telephone, fax, or other similarly expeditious method.

When will the Claims Administrator notify me of its decision on my appeal?

The Claims Administrator will notify you of its decision on your appeal by the following date:

- **Urgent Care Claims**
In the case of Urgent Care Claims, the Claims Administrator will notify you of its decision within seventy-two (72) hours after its receipt of the appeal.
- **Pre-Service Claims; Concurrent Care Decisions**
In the case of Pre-Service Claims and Concurrent Care Decisions (as described above), the Claims Administrator will notify you of its decision within thirty (30) days of its receipt of the appeal.
- **Disability and Post-Service Claims**
In the case of Disability and Post-Service claims, the Claims Administrator will notify you of its decision on the appeal within a reasonable period of time, but no later than forty-five (45) days (in the case of a Disability Claim) or sixty (60) days (in the case of a Post-Service Claim) after receipt of the appeal. If the Claims Administrator provides for two levels of appeals, a thirty (30) day period will apply instead of the forty-five (45) and sixty (60) day periods.
- **Other Claims**
In the case of all other claims, the Claims Administrator will notify you of its decision on the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal, which may be extended up to an additional sixty (60) days if special circumstances require an extension of time for processing the claim, in which case the Claims Administrator will notify you of the extension (along with a description of the special circumstances and the date by which it expects to render a decision).

What if the Claims Administrator denies my appeal?

If your appeal is denied by the Claims Administrator, you may file another appeal with the Board of Trustees within one hundred twenty (120) days of the date you were notified that your appeal was denied. In support of your appeal, you may submit written comments, documents, records and other information relating to the claim. In reviewing the appeal, the Board of Trustees will take into account only materials and information you submitted to the Claims Administrator, or that was considered in connection with the initial claim or a prior appeal. The decision of the Board of Trustees will be in writing and will be final and binding on all parties, subject to your rights under ERISA.

SECTION II: MEDICAL BENEFITS

PLAN OVERVIEW

Your former Employer has entered into an agreement with the Steelworkers Health and Welfare Fund to provide a plan to complement the federal government's Medicare program. The benefits of this Medicare supplement plan, together with Medicare Part A and Medicare Part B, are designed to provide full payment of the allowable charges for Medicare covered services. In addition, this Medicare supplement provides benefits for certain services that are not covered by Medicare. These services are discussed in more detail in this section.

KEY TERMS

Benefit Period

That period which begins on the first day (which is not part of a prior Benefit Period) of confinement in a hospital or skilled nursing facility. The Benefit Period ends when you have not been an inpatient of a hospital or skilled nursing facility for 60 consecutive days. Most Medicare Part A and Part B benefits are renewed when a new Benefit Period begins. There is no limit to the number of Benefit Periods you may have.

Benefit Maximum

The greatest amount payable by the plan for a specific covered service.

Claim

A request for payment or reimbursement of the charges or costs associated with a covered service.

Coinsurance

The percentage of the Medicare eligible expenses, or Medicare reasonable charges over and above the Medicare deductible, which you have the responsibility to pay under Medicare.

Deductible

That amount which is payable by you during each Benefit Period or calendar year before payment of benefits begin under Medicare Part A and /or Medicare Part B.

Experimental or Investigative

The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by the Claims Administrator to be medically effective for the condition being treated. An intervention will be considered experimental or investigative if the intervention does not have FDA approval to market 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 outcome, or the intervention is not proven applicable outside the research setting. If an intervention is determined to be experimental/investigative at the time of service, it will not receive retroactive coverage even if it is found to be in accordance with the above criteria at a later date.

Lifetime Reserve Days

The sixty (60) lifetime days that Medicare will pay for when a Medicare beneficiary is put in a hospital for more than ninety (90) days. These sixty (60) reserve days can be used only once during a lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness)

Services, supplies or covered medications that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (iii) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered medication is medically necessary and appropriate. No benefits will be provided unless Highmark determines that the service, supply or covered medication is medically necessary and appropriate.

Medicare

The Health Insurance for the Aged Act, Title XVII of the Social Security Amendments of 1965 as then constituted or later amended. Medicare Part A is the Hospital Insurance Benefits provided by the United States Government under Public Law 89-97, Title XVIII of the Social Security Act as amended from time to time. Medicare Part B is the Supplementary Medical Insurance Benefits provided by the United States Government under Public Law 89-97, Title XVIII of the Social Security Act as amended from time to time.

Medicare Eligible Expenses

Expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary and appropriate by Medicare. The Claims Administrator has the right to determine whether benefits not covered by Medicare but covered under this plan are medically necessary and appropriate.

Medicare Reasonable Charge

The approved amount for services and supplies as determined by Medicare.

Participating Provider

A facility or professional provider licensed where required and performing within the scope of their licensure, that has an agreement with the Claims Administrator or its designated agent pertaining to payment for covered services rendered to a covered person.

Provider's Reasonable Charge

The charge that the Claims Administrator determines is reasonable for non-Medicare covered services. For services rendered by a participating facility provider or participating professional provider the reasonable charge is the amount agreed to as payment in full by the Claims Administrator and the provider. For the services of a non-participating provider the provider's reasonable charge is the amount the Claims Administrator determines is reasonable for non-Medicare covered services.

Summary of Benefits and Coverage (SBC)

The summary document required under the Patient Protection and Affordable Care Act of 2010, which described certain Covered Services, cost-sharing obligations, benefit limitations, exclusions and certain other coverage information.

SUMMARY OF BENEFITS

Covered Services	This Plan Pays
Medicare Part A Covered Services	
Inpatient Hospital (Medicare inpatient mental health care coverage in a psychiatric facility is limited to 190 inpatient hospital days in a lifetime.)	
Days 1 - 60	Medicare Part A deductible
Days 61 – 90	Medicare Part A coinsurance
Days 91 – 150 For 60 Medicare lifetime reserve days that may be used only once	Medicare Part A coinsurance
Additional Inpatient Hospital Days	100% of Medicare eligible expenses for 365 lifetime days after the 60 Medicare inpatient lifetime reserve days are exhausted.
Skilled Nursing Facility Care	
Days 21 to 100	Medicare Part A coinsurance
Day 101 and beyond	Not covered by this plan
Blood	First three pints per calendar year
Medicare Part B Covered Services	
Deductible	Medicare Part B yearly deductible
Coinsurance	Medicare Part B coinsurance
Therapy Services	
Outpatient Physical Therapy	Medicare Part B coinsurance
Outpatient Occupational Therapy	Medicare Part B coinsurance
Outpatient Speech Therapy	Medicare Part B coinsurance
Outpatient Hospital Services (except Outpatient Psychiatric Treatment)	Medicare Part B coinsurance
Outpatient Psychiatric Treatment	Medicare Part B coinsurance
Blood	First three pints per calendar year and Medicare Part B coinsurance for additional pints if not replaced.
Outpatient Prescription Drugs used in Immunosuppressive Therapy	Medicare Part B coinsurance

Covered Services	This Plan Pays
Emergency Care	
Emergency Accident Care	Medicare Part B coinsurance
Emergency Medical Care	Medicare Part B coinsurance
Preventive Services	
Mammogram Screening	Medicare Part B coinsurance (not subject to Medicare Part B deductible)
Gynecological Services	Medicare Part B coinsurance (not subject to Medicare Part B deductible)
Colorectal Cancer Screening	Medicare Part B coinsurance
Diabetes Monitoring	Medicare Part B coinsurance
Bone Mass Measurements	Medicare Part B coinsurance
Prostate Cancer Screening	Medicare Part B coinsurance
Vaccinations	Medicare Part B coinsurance
Durable Medical Equipment	Medicare Part B coinsurance
Additional Medicare Part B Benefits	Medicare Part B coinsurance
Additional Benefits Not Covered By Medicare	
Emergency Care in a Foreign Country	80% of the provider's reasonable charge after the member satisfies a \$250 deductible Subject to a lifetime maximum benefit of \$50,000
Inpatient Rehabilitation	100% of the provider's reasonable charge for 365 additional inpatient hospital days per benefit period, after the Medicare inpatient hospital days have been exhausted.
Out of Area Services	80% - 100% of the provider's reasonable charge.

Covered Services	This Plan Pays
Additional Inpatient Psychiatric Treatment	100% of Medicare Eligible Expenses for 40 additional Inpatient Hospital days per lifetime.
At-Home Recovery Benefit	\$50 per visit for 1 visit per day and up to 7 days per week up to a maximum of \$2,500 per calendar year.
Drug and Alcohol Abuse Rehabilitation	100% of the provider's reasonable charge for 365 additional inpatient hospital days per benefit period, after the Medicare inpatient hospital days have been exhausted.
Chemotherapy	80% of the provider's reasonable charge
Enteral Formulae	80% of the provider's reasonable charge
Routine Gynecological Exams and Papanicolaou Smear	80% of the provider's reasonable charge

UNDERSTANDING YOUR MEDICARE SUPPLEMENT

Eligible Providers

The following are eligible providers under this plan:

Facility Providers

- Hospital
- Home health care agency
- Pharmacy provider
- Skilled nursing facility

Professional Providers

- Audiologist
- Certified Clinical Nurse Specialist*
- Certified Community Health Nurse*
- Certified Enterostomal Therapy Nurse*
- Certified Psychiatric Mental Health Nurse*
- Certified Registered Nurse Anesthetist*
- Certified Registered Nurse Practitioner*
- Chiropractor
- Clinical laboratory
- Dentist
- Nurse-midwife
- Optometrist
- Osteopath
- Physical therapist
- Physician
- Podiatrist
- Psychologist
- Registered nurse
- Speech-language pathologist
- Suppliers

*Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.

Providers Who Accept Assignment

Under the terms of assignment, you transfer to the provider the right to both Medicare Part B and the Medicare supplement payment based on covered services specified on the claim. The provider, in turn, agrees to accept the reasonable charge set by Medicare Part B as the total charge for covered service.

The sum of the reasonable charge payments, 80% by Medicare Part B and 20% by the Medicare supplement, constitute payment in full, except where maximums or deductibles are specified. The Claims Administrator reserves the right to make payment directly to the provider.

Providers Who Do Not Accept Assignment

You are responsible to pay any difference between the provider's charge and the combined Medicare Part B and Medicare supplement payment if the provider does not accept assignment. The plan reserves the right to make payment directly to you.

COVERED SERVICES

This plan may not cover all of your health care expenses. Read this booklet carefully to determine which health care services are covered. All benefit maximums, deductibles or copayment amounts are described in the Summary of Benefits.

The Medicare supplement provides benefits for Medicare Part A and Medicare Part B coinsurance and deductible amounts when Medicare covered services are rendered by a hospital, skilled nursing facility or professional provider. The benefits for Medicare coinsurance and deductible amounts will be updated automatically to coincide with changes under Medicare.

In addition, this plan provides benefits for certain services that are not covered by Medicare so long as they are determined by the Claims Administrator to be medically necessary and appropriate for the treatment of your condition, illness or bodily injury.

Medicare Part A Services

Hospital and Related Benefits

Benefits are provided for semi-private accommodations and all other services provided and billed for by the hospital. Coverage includes, but is not limited to, meals and special diets, general nursing care, drugs and medicines, use of operating, recovery and other specialty service rooms, anesthesia, laboratory tests, x-ray examinations, dressings, plaster casts and splints, oxygen, processing and administration of blood and blood plasma, physiotherapy and hydrotherapy, radiation therapy, EKG and EEG, basal metabolism testing, intravenous fluids and prosthetic devices surgically implanted.

Continued Stay Review

The medical progress of patients is reviewed to identify the continued medical necessity and appropriateness of the inpatient stay. If you elect to continue to receive inpatient services after receipt of written notification by the Claims Administrator that such level of care is no longer medically necessary and appropriate, you will be financially responsible for the full amount of the professional providers' charges from the date appearing on the written notification.

Skilled Nursing Facility Care

Coverage is provided for a semi-private room, meals, skilled nursing and rehabilitative services and other services and supplies when: you need daily skilled nursing or rehabilitation services; services as a practical matter can only be provided in an inpatient facility; and the care begins within 30 days of your discharge from a hospital stay of at least three days.

Medicare Part B Services

Medical and Surgical Benefits

Coverage of Medicare Part B coinsurance is provided for physician services and inpatient and outpatient medical and surgical supplies. Generally, Medicare Part B coverage includes, but is not limited to the following:

- x-ray, radium and radioactive isotope therapy;
- diagnostic x-ray, diagnostic laboratory and other diagnostic tests;
- rental or purchase of durable medical equipment for use in your home, when prescribed by a provider;
- splints, casts and surgical dressings;
- ambulance services where transportation by other means could endanger the patient's health, but only to the extent provided in the Medicare Part B regulations;
- surgical services performed by a professional provider, including services involving surgery of the jaw or related structures or setting of fractures of the jaw or facial bones;
- transplant services including the services for the removal of an organ from a donor when the donor is not a member;
- medical services performed by a professional provider;
- services and supplies furnished as part of a professional provider's professional care and which are commonly included in the charge;
- obstetrical delivery including pre- and post-natal care for a female member;
- devices (other than dental) which replace all or part of an internal body organ, including replacement of the devices;
- leg, arm, back and neck braces and artificial legs, arms and eyes, including replacements, if required, because of a change in the member's physical condition.

Additional Benefits Not Covered by Medicare

This plan provides benefits for the following services that are not covered by Medicare:

- one routine gynecological examination, including a pelvic examination and clinical breast examination and one routine papanicolaou smear per calendar year for covered females.
- individual and group counseling and psychotherapy, psychological testing and family counseling for the treatment of alcohol abuse and drug abuse when rendered by a hospital for 60 additional days per calendar year after the Medicare inpatient days are exhausted.
- emergency hospital and medical care in a foreign country needed immediately because of an injury or illness of sudden and unexpected onset that would have been covered by Medicare if provided in the United States. The emergency must arise during the first 60 consecutive days of each trip outside the United States.
- inpatient treatment of mental illness when services are provided in a hospital or psychiatric facility after the 190 Medicare inpatient mental health care lifetime days have been exhausted.
- Medicare Part B eligible expenses for services and supplies excluded under Medicare Part B because of the geographic area in which they were furnished.
- Medicare eligible expenses for inpatient rehabilitation after the Medicare inpatient hospital days are exhausted.
- chemotherapy for the treatment of malignant diseases regardless of the type of facility in which treatment is rendered.
- custodial care in addition to Medicare-covered home health visits. To receive this benefit, you must already be receiving Medicare-covered home health services. This benefit also covers some home health care after skilled care is no longer needed.
- Enteral Formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. Normal food products used in the dietary management of rare hereditary genetic metabolic disorders are not covered.

PRESCRIPTION DRUGS

Your plan pays for prescription drugs when you purchase them from a **Premier** Network Pharmacy. The pharmacy network includes both major chains and independent stores. **No benefits are available if drugs are purchased from a non-network pharmacy.**

To help contain costs, if a generic drug is available, you will be given the generic. As you probably know, generic drugs have the same chemical composition and therapeutic effects as brand names, and must meet the same requirements of the Food & Drug Administration (FDA). **Should you choose a brand name drug when a generic is available, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount.**

SUMMARY OF BENEFITS

PRESCRIPTION DRUG	
<ul style="list-style-type: none"> • Benefits available through the Premier Pharmacy Network only₂ • Mandatory generic¹ 	<ul style="list-style-type: none"> • Retail – 34-day supply • Copayment: \$5 generic \$15 brand • Mail Order – 90-day supply Copayment: \$10 generic \$30 brand

1. Under the mandatory generic provision, the member is responsible for the payment differential when a generic drug is available and the **patient** elects to purchase a brand name drug. The member payment is the price difference between the brand drug and the generic drug in addition to the brand drug copayment or coinsurance amount which may apply.

Covered Drugs

Covered drugs include:

- drugs which, under Federal law, are required to bear the legend: “Caution: Federal law prohibits dispensing without a prescription;
- legend drugs under applicable state law and dispensed by a licensed pharmacist
- compounded medications, consisting of a mixture of at least two ingredients other than water, one of which must be a legend drug;
- prescribed injectable insulin;
- diabetic supplies, including needles and syringes and;
- certain drugs that may require prior authorization from the Claims Administrator.

Covered drugs also include selected prescription drugs within, but not limited to, the following drug classifications only when such drugs are covered medications and are dispensed through an exclusive pharmacy provider. These particular prescription drugs will be limited to your plan’s retail cost-sharing provisions and retail days supply.

These selected prescription drugs may be ordered by a physician or other health care provider on your behalf or you may submit the prescription order directly to the exclusive pharmacy provider. In either situation, the exclusive pharmacy provider will deliver the prescription to you.

- Oncology related therapies
- Interferons
- Agents for multiple sclerosis and neurological related therapies
- Antiarthritic therapies
- Anticoagulants
- Hematinic agents
- Immunomodulators

- Growth hormones
- Fertility drugs

For additional information about drugs that must be obtained through an exclusive pharmacy provider, contact Member Services at the toll-free number on the back of your identification card.

Premier Pharmacy Network

Premier Pharmacies have an arrangement with the Claims Administrator to provide prescription drugs to you at an agreed upon price. When you purchase covered drugs from a pharmacy in the Premier Pharmacy Network, present your prescription and identification card to the pharmacist. Prescriptions that the pharmacy receives by phone from your physician or dentist may also be covered. You should request and retain a receipt for any amounts you have paid if needed for income tax or other purpose.

To determine if your pharmacy is in the network, look for the Premier logo at the store, or call the toll-free Member Services number on your identification card for assistance.

The Premier Pharmacy Network also includes mail service suppliers designated by the Claims Administrator. Mail service prescriptions or refills for covered drugs shall be dispensed for not less than a thirty (30) day supply and not more than a ninety (90) day supply. Mail service prescription drug forms may be obtained by calling Member Services at the toll-free number on your identification card.

Refer to the Summary of Benefits in this section for the copayment, coinsurance and/or deductible amounts applicable to your prescription drug benefits. Prescription drug benefits are not coordinated against any other health care or drug benefit coverage. In addition, the Plan shall not exercise any subrogation rights against any person or organization for prescription drug charges you incur under this plan.

Important Information About Your Prescription Drug Coverage and Medicare

If you (and/or your Dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage.

This notice has information about your current prescription drug coverage from the Steelworkers Health and Welfare Fund (the “Fund”) and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. If you are considering enrolling in a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Steelworkers Health and Welfare Fund has determined that the prescription drug coverage offered by the Fund is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you decide to join a Medicare drug plan at a later date.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Fund prescription drug coverage will be affected. If you enroll in a Medicare prescription drug plan you can keep your Fund prescription drug coverage, but it will be secondary to Medicare prescription drug coverage. If you wish to drop your Fund prescription drug coverage you must notify your former Employer. If you drop your prescription drug coverage from the Fund you will also lose the hospital and medical coverage that supplements Medicare Part A and Medicare Part B.

If you do decide to join a Medicare drug plan and drop your current Fund coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage from the Fund and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Steelworkers Health and Welfare Fund at 1-888-831-3863 for further information. Note: You will get a notice of Creditable Coverage each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage from the Fund changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

EXCLUSIONS

Except as otherwise covered by Medicare or as specifically provided in this Plan, no benefits will be provided for services, supplies or charges:

- Which are not covered by Medicare and are not specifically provided for in this Plan;
- Which are not covered by Medicare but are covered under this Plan, and are not medically necessary and appropriate as determined by the Claims Administrator;
- Which are not covered by Medicare and are incurred due to confinement in a free-standing psychiatric facility;
- Which are not prescribed or performed by or upon the direction of a professional provider;
- Rendered by other than hospitals, facility providers or professional providers;
- Which are experimental/investigational;
- Which are rendered prior to your effective date of coverage;
- 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 employers, a mutual benefit association, labor union, trust, or similar person or group;
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers compensation, occupational disease, or similar type legislation. This exclusion applies whether or not you file a claims for said benefits or compensation;
- To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury, unless you have a legal obligation to pay;
- For treatment of 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 any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
- For outpatient prescription drugs except as provided for under Medicare Part B;
- Which are submitted by a Certified Registered Nurse and another professional provider for the same services performed on the same date for the same person;
- Rendered by a professional provider who is a member of your immediate family;
- Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program;
- For ambulance services except to the extent covered by Medicare Part B;

- 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: a) surgery to correct a condition resulting from an accident; and b) surgery to correct functional impairment which 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 such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or “barrier free” home modifications, whether or not specifically recommended by a professional provider;
- For inpatient admissions which are primarily for diagnostic studies;
- For inpatient admissions which are primarily for physical therapy;
- For custodial care, domiciliary care, residential care, 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, 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, alveolectomy and treatment of periodontal disease;
- For oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, unless specifically provided for herein;
- 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, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet except when such devices or services are related to the treatment of diabetes;
- For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
- For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
- Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with the assisted fertilization, unless mandated or required by law;
- For sterilization and reversal of sterilization;
- For artificial insemination;
- For in vitro fertilization;

- For impotency treatment drugs;
- 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 correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
- For nutritional counseling and services intended to produce weight loss;
- For preventive care services, wellness services or programs;
- For any food, including but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis;
- For spinal manipulations;
- For well baby care visits, except as provided herein;
- For allergy testing;
- For routine or periodic examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp sports or travel, which are not medically necessary and appropriate;
- For immunizations required for foreign travel or employment;
- For treatment of sexual dysfunction not related to organic disease or injury;
- For therapy services for which no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, and which are determined not to be medically necessary and appropriate;
- For private duty nursing services;
- For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, which extends beyond traditional medical management, or for inpatient confinement for environmental change;
- For any other medical or dental service or treatment except as provided in this Plan.

MEMBER SERVICES

Identification Card

An identification card will be issued to you. This card includes the following information:

- your name;
- your identification number;
- group number;
- member Services toll-free telephone number;
- address for filing claims.

Only you or a covered family member are permitted to use this card. If your card is lost or stolen, contact Member Services immediately to request a new card.

Member Services Unit

An important component of your program is the dedicated Steelworkers Health and Welfare Fund Member Services unit. Trained representatives are available to assist you by answering any questions you may have about claims or benefits. Call the toll-free Member Services number on the back of your identification card for assistance. Written correspondence may be directed to:

Highmark Blue Cross Blue Shield
P.O. Box 1210
Pittsburgh, PA 15230

Summary of Benefits and Coverage (SBC)

You will receive the Summary of Benefits and Coverage (“SBC”) in accordance with applicable state or federal requirements. SBCs will be issued to you each year prior to your open enrollment period. SBCs will also be re-issued in the event that certain benefit modifications are implemented.

Information for Non-English Speaking Participants

If you do not speak English, call the toll-free Member Services number on the back of your identification card to be connected to an AT&T interpreter line for assistance. The Member Services representatives in the dedicated unit are trained to make this connection.

HOW TO FILE A CLAIM

When you receive care from a health care provider, show them your Medicare ID card and your Medicare supplement ID card. Many health care providers will assist you by submitting your claim to Medicare and to this plan. However, you may need to file your own claims in some situations. The procedure is simple. Just take the following steps.

- **Know your benefits.** Review this information to see if the services you received are eligible under your Medicare supplement.
- **For benefits covered by Medicare:**
 - You must submit a copy of the Explanation of Medicare Benefits (EOMB) that states the Medicare portion of the claim has been paid. ***Do not send a claim to this Plan until after Medicare has reviewed and finalized their portion of the claim.***
 - Write your ID number on the top right corner of the Medicare EOMB. Your ID number can be found on your Highmark Blue Cross Blue Shield identification card.
- **For benefits not covered by Medicare or not submitted by the provider:**
 - Mail a completed claim form and your itemized bill(s) to the Claims Administrator at the address provided below. Itemized bills must include:
 - The name and address of the provider of service;
 - The patient's full name;
 - The date of the service or supply;
 - A description of the service or supply;
 - The amount charged;
 - The diagnosis or nature of illness
 - Write your ID number on the top right corner of the bill.

Claim forms are available by contacting Member Services at the toll-free number on your identification card.

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

- **Keep a copy for your records.** You must submit originals, so you will want to make copies for your records. Once your claim is received, itemized bills cannot be returned.

Claims should be mailed to:

Highmark Blue Cross Blue Shield
PO Box 1210
Pittsburgh, PA 15230-1210

TIME LIMIT FOR FILING CLAIMS

Claims should be submitted as soon as reasonably possible after you receive a covered service. Claims for services covered by Medicare should be submitted within one year from the date the Medicare claim was finalized. Claims for services not covered by Medicare must be submitted no later than twelve (12) months after the end of the calendar year for which the benefits are payable.

EXPLANATION OF BENEFITS

Once your claim is processed, an Explanation of Benefits (EOB) statement will be issued within 30 days of receipt of the claim, unless extended for reasons outside the control of the Claims Administrator. The Claims Administrator reserves the right to require additional information and documents as needed to support a claim. In the event the Claims Administrator renders an adverse decision on your claim, the notification shall include, among other items, the specific reason or reasons for the adverse decision and your right to file an appeal as described below.

ADDITIONAL INFORMATION ON HOW TO FILE CLAIMS

Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting Member Services at the toll-free number on your identification card.

Authorized Representative

You have a right to authorize someone else to file or pursue a claim on your behalf. The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Contact Member Services at the toll-free number on your identification card if you wish to designate an authorized representative to act on your behalf.

APPEAL PROCEDURE

The Claims Administrator maintains an appeal process involving one level of review. You have the right to appeal any adverse benefit determination with which you disagree. Your appeal should be directed to the address below and be made in writing within one hundred eighty (180) days following the receipt of the notice of a claim denial or other issue that is the subject of the appeal. Mail the appeal to:

Highmark Blue Cross Blue Shield
PO Box 535095
Pittsburgh, PA 15253-5095
Attention: Review Committee

Your appeal will be reviewed by the Appeal Review Department. No individual or subordinate of an individual who participated in any prior decision concerning the claim will be involved in reviewing the appeal. If a decision on your appeal is based in whole or in part on medical judgment, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment prior to making a decision on your appeal. The health care professional providing the consultation will not have participated in or be the subordinate of any individual that participated in any prior decision to deny the claim that is the subject of your appeal.

You may, upon request, review all documents, records, and other information that may be relevant to your appeal. Upon request, copies of all such materials will be made available to you free of charge. You also have the right to submit any written data, comments, documents, records and other information that you wish to have the Appeal Review Department consider prior to rendering a decision on your part.

Your appeal will be promptly investigated and decided. Before making a decision, the Appeal Review Department will consider all of the comments, documents, records, reports and other information that have been made available and will make its own determination independent of any previous decision that has been made to deny your claim.

You will be notified of the decision that has been made on your appeal within sixty (60) days following receipt of the appeal. In the event of an adverse determination, the notification will include, among other items, the reasons for the decision and your right to pursue legal action in accordance with ERISA Section 502.

At any time during the appeal process, you or your representative may phone the toll-free number listed on your identification card to inquire about the filing or status of an appeal.

SECTION III: COORDINATION OF BENEFITS AND SUBROGATION

COORDINATION OF BENEFITS

Most group health care plans, including this Plan, contain a coordination of benefits provision. This provision is used when you or your Dependents are eligible for payment under more than one group health plan. The object of coordination of benefits is to assure you that your covered expenses will be paid, while preventing duplicate benefit payments. Here is how the coordination of benefits provision in this Plan works:

- If you or your Dependents are eligible to receive benefits under another group health plan, benefits under this Plan will be coordinated with the benefits from any other group health plan so that not more than the provider's reasonable charge for covered services will be paid by this Plan.
- When your other group coverage does not mention coordination of benefits, then that coverage pays first. Benefits paid or payable by the other group coverage will be taken into account in determining if additional benefit payments can be made under this Plan.
- When the person who received care is covered as an Employee under one plan and as a Dependent under another, the plan under which the person is covered as an Employee is primary and pays first.
- When a child is covered under two group plans, the plan covering the parent whose birthday falls earlier in the calendar year is primary and pays first. If both parents have the same birthday, the plan which covered the parent longer will be the primary plan.
- If you and your spouse are separated or divorced, the following applies to your children:
 - If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
 - If the divorced parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent's coverage pays before the coverage of the parent who does not have custody.
 - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:

- (a) the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the

benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person; and

- (b) if the other plan does not have a provision regarding laid-off or retired employees and, as a result, the benefits of each plan are determined after the other, then the provisions of (a) above shall not apply.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

Coordination of benefits prevents duplication and works to the advantage of all members of the Plan.

SUBROGATION

If the Fund makes payment for a Benefit on account of sickness or accidental bodily injury, and you recover monies from another source on account of or in connection with that sickness or accidental bodily injury, you are responsible for reimbursing the Fund any monies paid by another source up to the amount paid by the Fund. If legal action is instituted against any such other source, the Fund is entitled to intervene and participate in that action. If you do not institute legal action, the Fund may do so in your name. If you are injured through an act or omission of another party (for example, a car accident) or where another person is otherwise responsible for your sickness or accidental bodily injury, benefits under this Fund will be provided in connection with that sickness or accidental bodily injury only if you agree in writing to:

- reimburse the Fund (to the extent of benefits provided) immediately upon receipt of any payment from any other source on account of or in connection with such sickness or accidental bodily injury; and
- authorize the insurance carrier for the responsible party (or the uninsured motorist or no-fault insurance carrier) to make payment to the Fund to the extent of benefits provided; and
- provide the Fund with a lien against any monies recovered as described in paragraph 1 above; and
- authorize the Fund to intervene in any suit or other proceedings against a responsible party as described above, and/or to institute such legal action in your name in the circumstances described above.

The foregoing provisions shall also apply to your Dependents with respect to benefits provided to them.

SECTION IV: FUND PRIVACY POLICY

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ *See page 2 for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➤ *See page 3 for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ *See pages 3 and 4 for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

***Example:** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

***Example:** We use health information about you to develop better services for you.*

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

***Example:** We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

***Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

.....
Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone’s health or safety

.....
Do research

- We can use or share your information for health research.

.....
Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

.....
Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

.....
Address workers’ compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers’ compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

.....
Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
-

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This notice is effective as of September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

The Steelworkers Health and Welfare Fund

HIPAA Privacy Officer, Steelworkers Health and Welfare Fund, 5 Gateway Center, 7th Floor, Pittsburgh, PA 15222. Telephone: 1-888-831-3863 Fax: (412) 562-2276

SECTION V: STATEMENT OF ERISA RIGHTS

As a Participant, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These include the right to:

- examine, without charge, all Fund documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. You may look at these documents at the Fund Office or other locations such as union halls and worksites where at least fifty (50) participants work;
- obtain, upon written request to the Board of Trustees, copies of documents governing the operation of the Fund, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund may make a reasonable charge for the copies;
- receive a summary of the Fund's annual financial report. The Board of Trustees is required by law to provide each participant with a copy of the summary annual report every year; and
- continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Fund as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Fund on the rules governing your COBRA continuation rights.

In addition to creating rights for Fund Participants, ERISA requires the people who operate the Fund to meet certain responsibilities. These people, called "fiduciaries," must act solely in the interest of you and other Participants and beneficiaries, and must act prudently in performing their duties.

Although the Fund does not guarantee your employment, no one may fire you or discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA (not your Employer, the Union or any other person).

If your claim for a benefit is denied, 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:

- If you ask the Board of Trustees for a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such case, the court may require the Board of Trustees to provide the

materials and pay you a fine of up to \$110 a day until you receive them, unless the materials were not sent because of reasons beyond the Board of Trustees' control.

- If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court.
- If you disagree with the Board of Trustees' (or its delegate's) decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
- If Plan fiduciaries ever misuse the Fund's money or 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 the court costs and legal fees – possibly the person you have sued if your case is successful. However, if you lose the case, the court may order you to pay court costs and legal fees – if the court finds your claim is frivolous, for example.

If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Board of Trustees, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution 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 Pension and Welfare Benefits Administration.

OTHER FACTS ABOUT THE FUND

General Information: The Fund is a multiemployer welfare fund established by the Union. The Board of Trustees is the Plan Administrator within the meaning of, and for the purposes of, section 16(A) of ERISA, and has been designated as the agent for the service of legal process. Its address is the same as that of the Fund Office. Service of process may also be made on any individual Trustee.

Type of Administration: Self-administration, contract administration and insurer administration.

Other Information: The Plan Number assigned to the Fund is 501. The Board of Trustees' Employer Identification Number is 23-1317409. The Fund's fiscal records are maintained on the basis of a Plan Year that is the 12-month period beginning each January 1 and ending each December 31.

SECTION VI: TRUSTEES

Thomas Conway, Chairman
International Vice President – Administration
United Steelworkers
60 Boulevard of the Allies
Pittsburgh, PA 15222

Pete Trinidad, Trustee
President
USW Local Union 6787
1100 N. Max Mochal Highway
Chesterton, IN 46304

Ann Flener-Gittlen, Trustee
Women of Steel
United Steelworkers
60 Boulevard of the Allies
Pittsburgh, PA 15222

Lewis Dopson, Trustee
Staff Representative
USW District 10
625 N. Charlotte Street
Unit 2 North
Pottstown, PA 19464

Arthur Kroll, Trustee
Assistant Director
USW District 2
20600 Eureka Road
Suite 300
Taylor, MI 48180

Nellie Caraballo
Staff Representative
USW District 1
955 Commerce Drive
Perrysburg, OH 43551

