PROGRAM OF INSURANCE BENEFITS

for employees

of

EMPIRE IRON MINING PARTNERSHIP
AND
TILDEN MINING COMPANY L.C.
THE CLEVELAND-CLIFFS IRON COMPANY, Managing Agent

Pursuant to an Agreement with

The United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union

As Amended Effective
January 1, 2023

FOREWORD

This booklet is the summary plan description required by the Employee Retirement Income Security Act of 1974 (ERISA) of the Program of Insurance Benefits (the "Program or plan") which has been established pursuant to the Insurance Agreement dated January 1, 2023 between Empire Iron Mining Partnership and Tilden Mining Company L.C., The Cleveland-Cliffs Iron Company, Managing Agent and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, which is reproduced as an addendum to this booklet. This booklet is applicable to hourly paid employees of Empire Iron Mining Partnership and Tilden Mining Company L.C., The Cleveland-Cliffs Iron Company, Managing Agent (hereinafter referred to as "Empire Iron Mining Partnership and Tilden Mining Company L.C., The Cleveland-Cliffs Iron Company, Managing Agent" or the "Company"), whose headquarters are located at 200 Public Square, Suite 3300, Cleveland, Ohio 44114-2589, represented by the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union ("Union"), whose headquarters are located at 60 Boulevard of the Allies, Pittsburgh, PA 15222. This booklet constitutes a part of the Insurance Agreement, which continues until February 1, 2027 and thereafter, subject to negotiations between the Company and the Union which may take place no earlier than 2026.

Details relating to the operation of the Program will be included in reasonable rules, regulations and arrangements with insurance carriers; provided, however, that such rules, regulations and arrangements shall not apply to the matters covered by paragraphs 8.13 through 8.22.

The medical benefits and sickness and accident benefits under the Program are provided by the Company. Anthem Blue Cross/Blue Shield ("Anthem") administers the payment of medical claims. The Company administers the payment of sickness and accident claims. The life insurance and dental are provided by the Company, and Metropolitan Life Insurance Company ("Metropolitan") administers the payment of claims. The prescription drug benefits are provided by the Company, and Express Scripts, Inc. (or its affiliate) administers the payment of claims. The vision care benefits are provided by the Company, and EyeMed Vision Care administers the payment of claims. The Flexible Spending Accounts are administered by Optum Bank.

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

The name of the plan under which benefits are provided is the Program of Insurance Benefits - for Hourly Employees. The employer identification number assigned by the Internal Revenue Service is 34-1186059 for Empire Iron Mining Partnership and 38-2801658 for Tilden Mining Company L.C. and the Plan Numbers are 504. This is a welfare benefit plan as defined by ERISA.

Empire Iron Mining Partnership and Tilden Mining Company L.C., The Cleveland-Cliffs Iron Company, Managing Agent, 200 Public Square, Suite 3300, Cleveland, Ohio 44114-2589, is the Plan Administrator, Plan Sponsor and agent for service of legal process under the plan. The telephone number for the Plan Administrator is (216) 694-5700.

The plan covers all hourly employees of Empire Iron Mining Partnership and Tilden Mining Company L.C., The Cleveland-Cliffs Iron Company, Managing Agent. The Plan is maintained pursuant to a collective bargaining agreement. As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

(i) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as the local human resources office at your place of employment, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed for the plan with the U.S. Department of Labor, available at the Public Disclosure Room of the Employee Benefits Security Administration.

(ii) Obtain upon written request to the Plan Administrator copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

(iii) Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

(i) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

(ii) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. If you need more information about your certificate of creditable coverage or want to request a certificate of creditable coverage, contact the Plan Administrator. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining an insurance benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for an insurance benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court within 90 days of the denial. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-800-998-7542 or via the internet at www.dol.gov/ebsa/.

Except as otherwise provided in this booklet, the benefits described herein are provided without cost to you. Such benefits and the cost of administering the plan are paid by Empire Iron Mining Partnership and Tilden Mining Company L.C., The Cleveland-Cliffs Iron Company, Managing Agent. The plan's fiscal records are maintained on a calendar year.

Questions on medical benefits provided under the Program should be directed to Anthem by calling 1-866-583-6288.

The claims administrators for the benefits described in this booklet are as follows:

Health Benefits:
Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348
www.anthem.com
1-866-583-6288

Employee Assistance Program:
Anthem Blue Cross and Blue Shield
1-800-865-1044
www.AnthemEAP.com

Prescription Drug Benefits:
Express Scripts Pharmacy
P.O. Box 66301
St. Louis, MO 63166-6301
www.express-scripts.com
1-800-903-8662

Vision Benefits:
EyeMed Vision Care
P.O. Box 8504
Mason, OH 45040-7111
www.eyemed.com
1-800-334-7591

Dental Benefits:
MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282
www.metlife.com/mybenefits
1-800-942-0854

Life Insurance:
Metropolitan Life Insurance Company
P.O. Box 6100
Scranton, PA 18505
www.metlife.com
1-800-638-6420

Sickness and Accident Benefits:
Cleveland-Cliffs Disability Management
9227 Centre Pointe Dr.
3rd Floor
West Chester, OH 45069
Disability.Management@clevelandcliffs.com

COBRA/Direct Bill Administrator:
Cleveland-Cliffs Inc.
200 Public Square, Suite 3300
Cleveland, OH 44114
Attn: Employee Benefits Department
1-800-964-0153

Flexible Spending Account and Dependent Day Care Account Administrators:
Optum Bank
P.O. Box 30516
Salt Lake City, UT 84130
www.optumbank.com
1-800-243-5543

TABLE OF CONTENTS

HIGHLIGHTS OF PROGRAM BENEFITS

The following sections of this booklet contain a detailed explanation of the benefits and related provisions of the Program. A summary is provided here to give you an initial overall view of the Program's main features. All the benefits of the Program are paid for entirely by the Company, without cost to you, except during certain absences from work, as described in paragraphs 8.9, 8.10, 8.11, 8.12, 8.13, 8.14, 8.15 or 8.16 of this booklet and paragraph 3 of the Insurance Agreement. Employees who elect optional and/or dependent life insurance will make contributions sufficient to cover the entire cost of such coverage.

Basic Life Insurance

If you should die while you are an active employee, or during retirement on Company pension before you reach age 62, the beneficiary named by you will receive basic life insurance of $50,000. Additional life insurance is available on an optional basis. If you die after you have retired on pension and have reached age 62, the amount of basic life insurance is $25,000.

A detailed explanation is in Section 1.

Sickness and Accident Benefits

If you are totally disabled because of sickness or accident, have at least 26 weeks of continuous service, and meet certain requirements, you will receive a weekly benefit equal to 75% of your standard hourly rate based on a 40 hour week for the first third of your total eligible leave, 60% for the second third of your total eligible leave, and 45% for the last third. Benefits for those eligible with less than 26 weeks of continuous service, will be paid at 60%. The benefits are provided during the continuance of your disability for a maximum of 104 weeks if you have 15 or more years of service, 78 weeks if you have 10 but less than 15 years of service, 52 weeks if you have 2 but less than 10 years of service, and for shorter maximum period if you have less than two years of service.

A detailed explanation is in Section 2.

MEDICAL BENEFITS

You and your eligible dependents are covered by the Medical Benefits of this Program as detailed in Section 3. The Medical Benefits under the Program are administered by Anthem Blue Cross Blue Shield ("Anthem"), utilizing a Preferred Provider Organization (PPO) which is designed to cover all Medically Necessary confinements, services, supplies or treatments required to treat a definite condition of illness or injury that are not Experimental or Investigational. Certain preventive services are also covered under the Medical Benefits section of this Program. A PPO allows you to choose between two levels of care: In-Network or Out-of-Network. In-Network care is that which you receive from facilities and Professional Providers who participate in the PPO Network and are generally paid at a higher level. Out-of-Network care is that which you receive from facilities and Professional Providers who do not participate in the network and are subject to higher out-of-pocket expense.

A detailed explanation is in Section 3.

PRESCRIPTION DRUG BENEFITS

You and your eligible dependents are covered by the Prescription Drug Benefits of this Program as detailed in Section 4. The Prescription Drug Benefits are administered by Express Scripts Holding Company. Prescription Drug Benefits are provided using a select drug list or formulary. The formulary is an extensive

list of Food and Drug Administration ("FDA") approved prescription drugs selected for their quality, safety and effectiveness and includes products in every major therapeutic category. The Program provides coverage for both formulary and non-formulary drugs when purchased at the retail pharmacy or through the mail.

A detailed explanation is in Section 4.

DENTAL EXPENSE BENEFITS

If you or one of your dependents incurs Covered Dental Expenses, payment is made for reasonable and customary charges as follows:

100% for preventive services (such as oral examinations, teeth cleaning, topical application of fluoride, X-rays), certain oral surgical procedures and administration of general anesthetics;

80% Restorative, sealants, simple extractions and surgical periodontics;

60% for inlays, onlays, crowns, prosthetics (bridgework and dentures); and

60% Orthodontics for dependent children under the age of 19.

Except for Diagnostic and Preventive Services, the benefits are subject to a $25 per calendar year Deductible per individual (but not in excess of $50 per family). In addition, certain of the benefits are subject to Annual or Lifetime Maximums.

The detailed explanation is in Section 5.

VISION CARE BENEFITS

You and your eligible dependents are covered by the Vision Care Benefits of this Program. Vision Care benefits are administered by EyeMed Vision Care. In order to obtain the highest level of coverage for Vision Care Benefits, you should seek services from a Participating Provider or supplier. Benefits are available when Non-Participating Providers and suppliers are used, but at a lower reimbursement level.

If you or one of your dependents incurs Covered Vision Expenses, the Program pays actual charges up to $48 for vision examination.

A detailed explanation is in Section 6.

Conversion Privileges

Whenever coverage under the Program terminates you may obtain an individual policy of life insurance from the Claims Administrator as explained in paragraphs 8.20-8.23 and you or your dependents may obtain Medical Benefits and Prescription Drug Benefits on a direct-pay basis from the Claims Administrator in accordance with paragraphs 8.24 and 8.25.

Continuation of Health Coverage

In certain circumstances, termination of health coverage under this Plan entitles you to continue, at your expense, such coverage for you and/or your dependents. Your option to so continue health coverage is explained in Appendix A.

The remaining sections of this booklet describe the benefits, general provisions relating to them, how you and your dependents become covered, when and how coverage terminates and the effect of coverage by other group plans, no-fault automobile insurance or Medicare. You should read the following explanations for more complete information as to the Program.

SECTION 1. LIFE INSURANCE

1.0 General

In the event of your death, your basic life insurance in the amount of $50,000 will be payable to any person or legally recognized entity you designate as beneficiary. You have the right to change the beneficiary at any time by completing and returning to the Company the proper beneficiary-change form.

1.1 Optional Life Insurance

In addition to the basic life insurance, you may enroll for Optional Life Insurance in amounts equal to $25,000; $50,000; $75,000; $100,000; or $125,000. Monthly contributions for such coverage may change annually to cover the entire cost of such insurance. If you so enroll, you must make the specified contribution. The Optional Life Insurance coverage includes, at no additional charge, an Accidental Death benefit equal to the amount of your Optional Life Insurance. The Optional Life Insurance is provided with a Guarantee Issue (meaning without evidence of good health) effective January 1, 2023, and honored thereafter up to 30 days after eligibility date. In the event you decide to enroll or increase coverage more than 30 days after eligibility, you will be required to submit, at your own expense, evidence of good health satisfactory to the carrier. You may increase or decrease the Optional Life Insurance election at any time. Monthly contributions for such coverage may be changed annually to cover the entire cost of such insurance. Notwithstanding paragraph 1.3, if an employee retires from the Company prior to age 62, the employee will be required to pay the full monthly contributions to continue the Optional Life Insurance coverage until the end of the month he/she attains age 62, otherwise such coverage will terminate on his/her date of retirement.

1.2 Total Disability

If, while insured under the Program and before age 60, you become totally disabled for a period in excess of six months and thereafter submit satisfactory evidence of continuing total disability as required by Metropolitan, your life insurance, including any optional life insurance will be continued, without contributions from you, in the full amount until the end of the month in which you attain age 62. Thereafter, any optional life insurance will be terminated and your life insurance will be reduced to $25,000.

1.3 Basic Life Insurance After Retirement

If you retire under the Company pension plan prior to age 62 and your basic life insurance is not being continued in accordance with the provisions relating to total disability described in paragraph 1.2, your basic life insurance will be continued, without contributions from you, in the full amount until the end of the month in which you attain age 62. At the end of the month in which you attain age 62 the amount of your basic life insurance will then be reduced to $25,000.

1.4 If you become eligible for a deferred vested pension, you will not be eligible to have basic life insurance continued either before or after age 62.

1.5 If you retire under the Company pension plan applicable to you at or after age 62 and, at the time of such retirement, have at least 10 years of service, your basic life insurance will be reduced to $25,000.

1.6 Optional Dependent Life Insurance

You may elect to purchase spouse and dependent life insurance in the amounts shown below with a Guarantee Issue (meaning without evidence of good health), effective January 1, 2023, and thereafter honored up to 30 days after eligibility date. In the event you decide to enroll or increase coverage more than 30 days after eligibility, you may be required to submit, at your own expense, evidence of good health satisfactory to the carrier.

Spouse	**Child(ren)**
$10,000	$3,000
$20,000	$4,000
$40,000	$5,000
$80,000	$7,000

Monthly contribution for such coverage may be changed annually to cover the entire cost of such insurance. Optional Dependent Life Insurance will terminate on the date the person ceases to be a dependent or the Optional Life Insurance terminates if it were elected. No conversions are available for children when they attain age 26.

1.7 Conversion Privilege either basic or optional

When your life insurance is reduced or terminated as a result of layoff, leave of absence, disability, termination of employment, or retirement, you will have the right to convert to an individual policy as explained in paragraphs 8.20 through 8.23.

1.8 Accelerated Death Benefit Option

In the event of terminal illness you will have the right to take an accelerated death benefit option under the basic life and optional life insurance programs in accordance with Metropolitan Life Insurance Company's protocols.

1.9 Beneficiary

The Beneficiary is the person, persons or legally recognized entity designated by the Employee on a form approved by the Insurance Company and filed with the records maintained by the Employer, in connection with the insurance under the Group Policy. The Employee may change their Beneficiary at any time by filing written notice thereof on such form with the Employer. Consent of the Beneficiary shall not be requisite to any change of beneficiary. After receipt of such written notice by the Employer, the change shall relate back and take effect as of the date the Employee signed said written notice of change, whether or not the Employee is living at the time of such receipt, but without prejudice to the Insurance Company on account of any payment made before receipt of such written notice.

1.10 If, at the death of the Employee, there shall be more than one designated Beneficiary, then, unless the Employee shall have specified the respective interests of such Beneficiaries, the interests of such Beneficiaries shall be several and equal.

1.11 If any designated Beneficiary shall die before the Employee, the rights and interest of such Beneficiary shall thereupon automatically terminate. If, at the death of the Employee, there be no designated Beneficiary as to all or any part of the insurance, then the amount of insurance payable for which there is no designated Beneficiary shall be payable to the estate of the Employee, provided, however, that Metropolitan may, in such case, at its option, pay such amount to any one of the following surviving relatives: wife, husband, mother, father, child or children.

1.12 Optional Modes of Settlement

Arrangements may be made with Metropolitan whereby the amount of Life Insurance payable at the death of the Employee will be retained by Metropolitan and paid to the Beneficiary in installments instead of in one sum. Information concerning such Optional Modes of Settlement may be obtained from the Employer upon request.

1.13 How to File a Claim

Your designated beneficiary will be provided the necessary forms for claiming the life insurance proceeds by notifying the Insurance office at your place of employment. Claims will be determined within 90 days of the date Metropolitan receives a claim.

1.14 Metropolitan shall have the right and opportunity to have a physician designated by it examine the person of the Employee when and so often as it may reasonably require whenever proof of total disability is submitted for the continuation of the Employee's Life Insurance.

1.15 How to Appeal a Claim

If your designated beneficiary has any question concerning a denial in whole or in part of life insurance benefits, your beneficiary should write within 60 days from the date the claim was denied to Group Insurance Claims Review at the address of Metropolitan office which denied the claim, furnishing all pertinent data. Your beneficiary's appeal will be reviewed by that office and reply made within 60 days of the date the appeal is received. When requesting a review your beneficiary should state the reason your beneficiary believes the claim was improperly denied and submit any data, questions or comments deemed appropriate.

1.16 Metropolitan will re-evaluate all of the information submitted, and your beneficiary will be informed of the decision in writing in a timely manner.

1.17 If your beneficiary is not satisfied with the decision rendered by that office, your beneficiary may further appeal the claim by writing within 60 days from the date of the reply to the initial appeal to the Vice President-Claims, Group Life Claims, at the address listed on page iv for Metropolitan Life Insurance Company. Your beneficiary will be advised by that office of the final decision within 60 days.

1.18 No action at law or in equity shall be brought to recover on the Group Policy prior to the expiration of sixty days after proof of claim has been filed in accordance with the requirements of the Group Policy, nor shall such action be brought after three years from the expiration of the time within which proof of claims is required by the Group Policy.

SECTION 2. SICKNESS AND ACCIDENT BENEFITS

2.0 Eligibility

If you become totally disabled as a result of sickness or accident so as to be prevented from performing the duties of your employment and a licensed physician certifies thereto, you will be eligible to receive weekly sickness and accident benefits. Sickness and accident benefits under this Program are administered by Cleveland-Cliffs Disability Management, whose address and phone number are listed on page iv. Benefits will not be payable for any period during which you are not under the care of a licensed physician. Benefits are also payable if you undergo outpatient pre-admission testing and outpatient surgery.

2.1 Filing of Claims

In order for you to be eligible for benefits the Company must receive written notice of your claim within 21 days after your disability commences, but this requirement will be waived upon showing of good and sufficient reason that you were unable to furnish such notice or have it furnished by someone else on your behalf. The following applies in the administration of this provision:

Normally it is anticipated that you will obtain or have someone on your behalf obtain a sickness and accident claim form from your local human resources office at your place of employment and complete your portion of the form and have it signed by either a Physician, a Nurse Practitioner, or a Physician Assistant and return it to the Company within 21 days of commencement of your disability.

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

It is the intent of this provision to encourage prompt notice of your claim for sickness and accident benefits so that the evaluation of the claim, including any necessary investigation of the medical and other factual aspects of the claim can be made in an expeditious manner. It is not the intent of this provision that your claim be denied for failure to comply with the notice requirement if such failure did not interfere with the ability of the insurance company to establish the medical and other factual aspects of the claim.

In the event that an employee fails to receive a sickness and accident payment within ten (10) working days after the Company's receipt of the completed application form, such employee will be eligible upon request to receive an advanced payment from the Company. However, in order to receive such advanced payment, the employee must execute an appropriate form authorizing the payroll deduction of any amounts advanced and later duplicated in payments to the employee or payments later determined to be inappropriately paid pursuant to the eligibility provisions of the program.

2.2 Duration of Benefits

Sickness and accident benefits begin with the first day of total disability resulting from an accident and with the eighth day of total disability resulting from a sickness except, if you are hospitalized due to sickness or have out-patient surgery within such eight-day period, such benefits begin on the first day of hospitalization or out-patient surgery, and are payable for the following periods:

(a) Level 1: If you have less than twenty-six (26) weeks of continuous service, the period for which benefits are payable in the case of a non-occupational disability shall equal the number of full weeks of continuous service you had on the date such continuous period of disability commenced.

(b) Level 2: If you have at least twenty-six (26) weeks but less than two (2) years of continuous service on the date a period of disability commences, for a period not to exceed twenty-six (26) weeks for any one continuous period of disability.

(c) Level 3: If you have at least two (2) but less than ten (10) years of continuous service on the date a period of disability commences, for a period not to exceed fifty-two (52) weeks for any one continuous period of disability.

(d) Level 4: If you have at least ten (10) but less than fifteen (15) years of continuous service on the date a period of disability commences, for a period not to exceed seventy-eight (78) weeks for any one continuous period of disability.

(e) Level 5: If you have at least fifteen (15) years of continuous service on the date a period of disability commences, for a period not to exceed one hundred four (104) weeks for any one continuous period of disability.

(f) if you undergo outpatient pre-admission testing, one day's benefit will be payable.

The Sickness and Accident Benefits shall automatically cease on the date of expiration of the maximum number of weeks for which Weekly Benefits are payable under the Group Plan on account of the Employee's disability. It may be reinstated only if and when the Employee returns to active work.

2.3 In determining the maximum period for which sickness and accident benefits are payable, successive periods of disability separated by a period of continuous active employment with the Company of less than seven weeks will be considered to be one continuous period of disability, unless it is clear that they arise from unrelated causes; provided that if an employee acquires service entitling them to a longer period of benefits under Section 2.2 after the start of one continuous period of disability and before the start of a succeeding period of disability which is considered to be part of such continuous period of disability, the employee shall be entitled to the longer period of sickness and accident benefits.

Employees currently at work who become disabled due to a prior Worker's Compensation injury will be permitted to receive a supplemental sickness and accident benefit for the difference between the current Worker's Compensation weekly benefit and the benefits associated with the prior injury. The duration and amount of the supplement is subject to the limitations provided for in the Program.

2.4 Amount of Benefits

The amount of weekly sickness and accident benefits shall be paid at a rate equal to an employee's applicable standard hourly wage rate based on a 40 hour week multiplied by the applicable percentage as provided in the following schedules:

Level 1

	All Weeks
Applicable Percentage	60%

Level 2

	Weeks 1-9	Weeks 10-18	Weeks 19-26
Applicable Percentage	75%	60%	45%

Level 3

	Weeks 1-17	Weeks 18-35	Weeks 36-52
Applicable Percentage	75%	60%	45%

Level 4

	Weeks 1-26	Weeks 27-52	Weeks 53-78
Applicable Percentage	75%	60%	45%

Level 5

	Weeks 1-35	Weeks 36-70	Weeks 71-104
Applicable Percentage	75%	60%	45%

The Company will annually publish specific rate tables by job class that specify the weekly benefit payable at each of the five (5) levels of coverage available to employees.

2.5 In the event you become totally disabled due to sickness or accident arising out of or in the course of your employment, the amount of weekly sickness and accident benefits otherwise payable will be reduced by any weekly benefits which you are or could be entitled to receive during the period of your absence from work due to such disability pursuant to any workers' compensation law or any occupational disease law or other similar applicable law, reduced by any applicable attorney fees. Payments under any such law for hospitalization or medical expense or specific allowances for loss of members or disfigurements in excess of the portion of such allowances attributable to temporary total disability will not reduce the amount of your sickness and accident benefits.

If you are otherwise entitled to sickness and accident benefits and there is a dispute as to your entitlement to payments for which you are making claim pursuant to any workers' compensation or occupational disease law or other similar applicable law, the sickness and accident benefits will be paid in full if satisfactory arrangements are made to assure that any overpayment of sickness and accident benefits which may result by virtue of your success in pursuing such claim shall be reimbursed by you. Such arrangements shall include the execution by you of necessary documents authorizing the deduction of any such overpayment from any payments becoming due as a result

of such claim or from any amount payable to you by or on behalf of the Company, including benefits, wages and pension payments.

2.6 The amount of weekly sickness and accident benefits otherwise payable will be reduced for each week of disability by the amount of any primary disability benefits or unreduced primary old-age benefits under the Social Security Act which you are entitled to receive or could become entitled to receive by making proper application, except that no reduction for such unreduced primary old-age benefits will be made for any of the first 26 weeks of sickness and accident benefits during any one continuous period of disability.

The Company will assume that you are receiving a benefit under the Social Security Act, in an estimated amount, and your sickness and accident benefits will be reduced by such estimated Social Security benefit until the Company is furnished a copy of your Social Security award so that it may determine the exact amount of reduction. If, however, you are eligible for sickness and accident benefits for a period in excess of 26 weeks and you furnish to the Company written proof within the initial 15 weeks of disability that you have applied for disability benefits under the Social Security Act and do not receive such benefits when they are initially due, full weekly benefits will be continued until the earlier of:

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

(b) the date 34 weeks of weekly benefits have been paid, provided you make satisfactory arrangements with the Company to assure that any overpayment of weekly benefits which may result by reason of receipt of Social Security benefits will be repaid to the Company. To be eligible for this arrangement you will be required to sign an agreement to reimburse the Company promptly upon receipt of retroactive payment of Social Security disability benefits and authorize deduction of such overpayment from any amount payable to you by or on behalf of the Company, including benefits, wages and pension payments. You will also be required to sign an authorization for the Social Security Administration to release relevant information to the Company.

In any event, you will be paid the full weekly benefit amount if you are not old enough to qualify for an unreduced primary old-age benefit and if:

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

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

(c) you inform the Company that your application for Social Security disability benefits has been denied; however, weekly sickness and accident benefits will be paid beyond 34 weeks only if within four weeks of the date of the denial letter you request reconsideration of such denial.

NOTE: If you fail to request reconsideration of a denial within four weeks of the date of the denial letter, sickness and accident benefits will not be paid beyond 34 weeks until Social Security disability benefits have been awarded or your request for reconsideration has been denied. The Company will notify you of your responsibility to apply for Social Security disability benefits and to request reconsideration of any denial of such application on a timely basis.

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

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

The Claims Administrator shall have the right and opportunity to have a physician designated by it examine the person of the Employee when and so often as it may reasonably require while Weekly Benefits are being claimed under the Employee's Sickness and Accident Benefits.

2.7 Outpatient Pre-admission Testing/Surgery

Sickness and Accident benefits are payable for absences due to:

(a) Outpatient pre-admission testing prior to surgery if the tests are performed within five (5) days of the hospital confinement (unless such confinement is delayed by the attending physician or the hospital); the tests are not repeated during the confinement; and the employee is not admitted to the hospital any earlier than the day prior to the date of surgery.

(b) Outpatient surgery performed by a physician when:

(1) the physician certifies that the individual is totally disabled because of the outpatient surgery; and

(2) this method of treatment is more economical than other methods available.

(c) Benefits under (a) above are payable for one day only, the day on which the tests are made.

2.8 Transplant Benefits

If you are a donor of a human organ or tissue transplant requiring surgical removal of the donated part from the donor, disability resulting from the surgical removal of such transplant will be deemed to be a disability due to sickness. In no event, however, will disability be considered to have commenced prior to the date of hospital confinement.

2.9 Disability During Suspension

If during a suspension, which is not converted into discharge, you satisfy all the eligibility conditions for receipt of sickness and accident weekly benefits and

(a) promptly notify the Company of your disability, and

(b) if requested to do so, report for examination to the medical department of the plant where you work, or to such other physician as may be designated by the Company or the Claims Administrator (unless you are unable to do so for good and sufficient reason),

sickness and accident weekly benefits will be payable in accordance with paragraph 2.2, except that days during the suspension period will not count toward any applicable waiting period nor will benefits be payable for any days during the period of suspension.

2.10 Administration of Sickness and Accident Benefits

The payment of sickness and accident benefits is an obligation of the Company, but the Agreement with the Union permits the Company to provide the payment through a policy with an insurance company. The Company performs important administrative functions in connection with the handling of claims, which may include the issuance of benefit checks. In the typical case, such handling is routine and a claim is paid within 10 days after it is received by the Company. The Company is authorized to make benefit payments on claims without prior approval of the insurance company when Company personnel engaged in claims work determine the claim meets the standards established by the insurance company for Company approval. If you have a claim which does not meet these standards it is referred to the insurance company for a decision and you are notified of such action within 10 days after the claim is received by the Company. In reaching its decision, the insurance company may take reasonable steps to investigate the medical and other factual aspects of the claim.

2.11 When you have provided written notice or proof of disability to the insurance company and any difference shall arise between you and the Company whether you (1) have submitted sufficient evidence to demonstrate you are or continue to be totally disabled as a result of sickness or accident so as to be prevented from performing the duties of your employment or (2) are or continue to be totally disabled as a result of sickness or accident so as to be prevented from performing the duties of your employment, the dispute resolution process outlined in paragraphs 2.12 - 2.14 below will be utilized.

2.12 You shall be examined by a physician appointed for this purpose by the Company and by your attending physician. If they shall disagree concerning whether you are totally disabled within the meaning of Section 2.0, that question shall be submitted to a third physician selected by such two physicians. The medical opinion of the third physician, after examining you and consulting with the other two physicians and reviewing all medical records relating to the disputed claim, shall decide such question. Your Sickness and Accident Benefits will commence or continue to be paid, as the case may be, during the dispute resolution process provided that you give any necessary authorization to permit deduction of any overpayment of Sickness and Accident Benefits from any amount payable to you by or on behalf of the Company. The amount of recovery will not exceed $50 per week.

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

2.14 Claims and Appeal Procedures
Initial Claim Decision

The Claims Administrator will make a benefit determination within 45 days of its receipt of an application for benefits. This period may be extended up to an additional 30 days, if the Claims Administrator provides you with written notice of the extension within the initial 45-day period. The extension notice will explain the reason for the extension and the date by which the Claims Administrator expects a decision will be made. The Claims Administrator may obtain a second 30-day extension by providing you written notice of such second extension within the initial 30-day extension. The second extension notice must include an explanation of the special circumstances necessitating the second extension and the date by which the Claims Administrator's decision will be made. If the extension is necessary because additional information is needed to decide the claim,

the extension notice will describe the required information. You will have 45 days after receiving the extension notice to provide the required information.

The Claims Administrator will notify you in writing, delivered in person or mailed by first-class mail to your last known address, if any part of a claim for benefits under the Plan has been denied. The notice of a denial of any claim will include:

- the specific reasons for the denial;
- reference to specific provisions of the Program upon which the denial is based;
- a description of any internal rule, guidelines, protocol or similar criterion relied on in making the denial (or a statement that such internal criterion will be provided free of charge upon request);
- a description of any additional material or information deemed necessary by the Claims Administrator for you to perfect your claim, and an explanation of why such material or information is necessary; and
- an explanation of the claims review procedure under the Program.

If the notice described above is not furnished and if the claim has not been granted within the time specified above for payment of the claim, the claim will be deemed denied and will be subject to review as set forth below.

How to Appeal a Claim Denial

If your claim for benefits is denied, in whole or in part, you may request to have your claim reviewed. You will have 180 days in which to request a review a claim. Your request must be in writing and delivered to the Claims Administrator. If no such review is requested, the initial decision of the Claims Administrator will be considered final and binding.

The request for review must specify the reason you believe the denial should be reversed. You may submit additional written comments, documents, records, and other information relating to and in support of your claim; all information submitted will be reviewed whether or not it was available for the initial review. You may request reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. If you request a review, a full and fair review of the decision will be made by a different person who is not a subordinate of the original decision maker. The review will not defer to the initial adverse determination. If your denial was based in whole or in part on a medical judgment, the Claims Administrator will consult with an appropriate health care professional who was not consulted in the initial determination of your claim and who is not the subordinate of someone consulted in the initial determination. Names of the health care professionals will be available upon request.

The Claims Administrator will notify you of its decision following the review. The Claims Administrator will render its final decision within 45 days of receipt of an appeal or such shorter period as may be required by law. If the Claims Administrator determines that an extension of the time for processing the claim is needed, it will notify you of the reasons for the extension and the date by which the Claims Administrator expects a decision will be made. The extended date may not exceed 90 days after the date of the filing of the appeal. If after review your claim continues to be denied, you will receive a notice of the denial.

You must complete the appeals process described above before taking any other action, except that you may proceed directly to the Grievance Procedure described in Section 9 of this Booklet prior

to completing the appeals process described above. You are, however, encouraged to use the appeals process described above prior to using the Grievance Procedure.

SECTION 3. MEDICAL BENEFITS
(For You and Your Dependents)

3.0 Introduction

You and your eligible dependents are covered by the medical benefits detailed in this Section 3 (the "Medical Benefits"). Medical Benefits under this Program are administered by the entity listed on page iv as the Claims Administrator for Health Benefits. The Medical Benefits of this Program are designed to cover all Medically Necessary and Appropriate, confinements, services, supplies or treatments required to treat a definite condition of illness or injury that are not Experimental or Investigational. This Medical Benefits Section also covers certain preventive services.

3.1 Participating Providers

Under the Medical Benefits of this Program, you have complete freedom of choice to utilize whichever medical services provider you choose. However, there are significant benefits to utilizing providers who participate in the Claims Administrator's Preferred Provider Organization ("PPO"). Such providers are called PPO or Network providers.

(a) Benefits for the services of PPO providers are generally payable at up to 100% of the Allowable Charge (as opposed to generally up to 70% of the Allowable Charge if you use an Out-of-Network provider).

(b) Benefits for services of PPO providers are not subject to a Deductible, whereas benefits for services of Out-of-Network providers are generally subject to a Deductible.

(c) PPO providers will accept the Claims Administrator's determination of the Allowable Charge and will not bill you for more than the Copayment required by this Program; Out-of-Network providers may balance bill you for the difference between their charge and the amount paid by the Claims Administrator.

(d) If you use a PPO in-network hospital or facility, any services provided by hospital-based providers such as radiologists, anesthesiologists, pathologists, and assistant surgeons will be paid at the in-network level regardless of whether that provider is in the network.

(e) In-network benefits will be paid if a PPO provider refers you to a physician, specialist, hospital or other provider that is not in the PPO network, or if a PPO provider is not available.

(f) PPO providers will receive reimbursement for services directly from the Claims Administrator and will bill you only for your Copayment; Out-of-Network providers may bill you for their entire fee with the result that you will have to file a claim form to obtain reimbursement for the portion of the Allowable Charge payable under this Section.

(g) You can call the number on your I.D. card for information on the nearest PPO participating providers or to determine if a particular provider is in the Network or to find out how to obtain a list of PPO providers.

3.2 Terms You Should Know

As used herein:

(a) Allowable Charge (*also called "Provider's Reasonable Charge*") - is the dollar amount that the PPO has determined is reasonable for Covered Services provided under this Section. This is an important term to know if you go outside the Network for care. The amount paid under this Section for Out-of-Network care is based on the Allowable Charge – not the provider's actual charge.

(b) Nurse On Call[SM] - is a 24-hour, 7 days a week health decision support number that provides health care information.[1] Anthem LiveHealth Online (livehealthonline.com) is a web based tool the allows you to have an online doctor office visit for medical or mental health needs.

(c) Claim - is a request for precertification or prior approval of a Covered Service or for the payment or reimbursement of the charges or costs associated with a Covered Service.

(d) Coinsurance - is the percentage of the Allowable Charge paid under this Section; the remaining percentage is the percentage you pay.

(e) Copayment (or copay) - is the fixed up-front dollar amount you pay for certain covered expenses. This amount will be deducted from the provider's reasonable charge before a determination of benefits payable is made under this Section. The Copayment you are required to pay does not vary with the cost of the services. You are expected to pay the provider at the time of service.

(f) Covered Services - are the services, confinements, supplies, and/or treatments you receive from an Eligible Provider, as defined in paragraph 3.20 below, to the extent they are (1) determined to be Medically Necessary and Appropriate, and (2) specifically identified in paragraphs 3.22 - 3.77 below, subject to modification by mutual agreement of the Company and the Union. However, such Covered Services are subject to the limitations, Deductibles, and Copayments outlined in this Section.

(g) Deductible - is the initial amount you must pay each year for Covered Services before payment for benefits begins under this Section.

To assist employees with several covered dependents, the Deductible you pay for the entire family, regardless of its size, is specified under "Family" Deductible. To reach this total, you can count the expenses incurred by two or more family members. However, the Deductible contributed toward the total by any one family member cannot be more than the amount of the Individual Deductible. If one family member meets the Individual Deductible and again needs to use benefits, payment for that person's Covered Services will begin even if the Family Deductible has not been met.

(h) Experimental/Investigative - is the use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not medically effective for the

[1] **Nurse On Call is a service mark of the Blue Cross Blue Shield Association.**

condition being treated. The Claims Administrator will consider an intervention to be Experimental/Investigative if:

(1) the intervention does not have Food and Drug Administration ("FDA") approval to be marketed for the specific relevant indication(s);

(2) available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes;

(3) 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;

(4) the intervention does not improve health outcomes; or

(5) the intervention is not proven to be applicable outside the research setting.

Covered exceptions to this policy shall include: (1) MRIs for breast cancer screening where there is personal history OR dense breasts; and (2) use of IMRT for one or both breasts during cancer treatment, whether or not a mastectomy has been performed.

(i) Medical Emergency - is a medical condition with acute symptoms of severity or severe pain for which care is sought as soon as possible after the medical condition becomes evident and the absence of immediate medical attention could result in: placing health in serious jeopardy; serious impairment of bodily functions; serious dysfunction of any body part and/or other serious medical consequences. Notwithstanding any provisions to the contrary, coverage for visits for ambulance services and emergency care will be evaluated using a prudent layperson standard: whether from the perspective of an ordinary person, the patient's condition, judged based on presenting symptoms, reasonably warranted immediate attention.

(j) Medically Necessary Health Care Benefits under the Program are payable only if the services rendered are medically necessary. Medically necessary means that the services and supplies in question are medically reasonable and necessary for the diagnosis or treatment of an illness or accidental injury and are given at the appropriate level of care. The fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary. In determining questions of reasonableness and necessity, due consideration shall be given to the customary practices of physicians in the community where the service is performed. Services which are not reasonable and necessary shall include, but are not limited to the following:

(1) procedures which are experimental or of unproven or questionable current usefulness;

(2) procedures which tend to be redundant when performed in combination with other procedures;

(3) diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly;

(4) procedures which are not ordered by a physician or which are not documented in timely fashion in the patient's medical record; and

(5) procedures performed in an inpatient setting which could be performed with equal safety and effectiveness in an outpatient setting or treatment which can be performed with equal efficiency and quality at a lower level of care.

(k) Out-of-Pocket Limit - is the highest dollar amount for which you are responsible each year before 100% (except for required Copayments) of all covered expenses are paid under this Section. The Out-of-Pocket Limit includes Coinsurance, Deductibles, and Mental/Nervous, Substance Abuse treatment (not including prescription drug expenses), but does not include expenses in excess of the Allowable Charge.

To help employees with several covered dependents, the out-of-pocket amount you pay for the entire family, regardless of its size, is specified under "Family" Out-of-Pocket Limit in paragraph 3.3. To reach this total, you can count the expenses paid by two or more family members. However, the out-of-pocket expenses contributed toward the total by any one family member cannot be more than the amount of the Individual Out-of-Pocket Limit. If one family member meets the Individual Out-of-Pocket Limit and again needs to use benefits, payment would begin at 100% (except for required Copayments) for that person's Covered Services even if the Family Out-of-Pocket Limit has not been met.

(l) Precertification - is a process through which it is determined whether certain services, confinements, supplies, and treatments are Medically Necessary and Appropriate.

(m) Preferred Provider Organization (PPO) - is the provider network made up of physicians, specialists, hospitals and other health care facilities in the PPO Network that is used by the Claims Administrator. This provider network helps assure that you receive maximum coverage under this Section.

3.3 Summary of Medical Benefits

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

SUMMARY OF MEDICAL BENEFITS		
Benefits	**In-Network**	**Out-of-Network**
Deductible Individual Family	 None None	 $300 $600
Coinsurance	90%	70% after Deductible
Out-of-Pocket Limits Individual Family	 $1,000 $2,000	 $2,000 $4,000
Balanced Billing	None	Possible
Physician Office Visits	100% after $15 Copay	70% after deductible
Preventive Care *Adult* Routine physical exams Routine GYN exams including PAP tests Mammograms as required *Pediatric* Routine physical exams Pediatric immunizations	 100%, no Copay 100%, no Copay 100%, no Copay 100%, no Copay 100%, no Copay	 70% after deductible 70% after deductible 70% after deductible 70% after deductible 70% after deductible
Urgent Care Center or Clinic	100% after $15 Copay	70% after deductible
Emergency Room Services Physician services	 100%	 70% after deductible
Emergency Room Services Facility Charges	100% after $75 Copay (which is waived if you are admitted)	
Ambulance Service (including Air Ambulance)	100%	100%
Hospital Services Inpatient Outpatient	 90% 90%	 70% after deductible 70% after deductible
Hearing Aids	90%	70% after deductible
	Prior Approval required for charges in excess of $2,500 per ear	
Maternity Services	90%	70% after deductible
Infertility counseling, testing and treatment	90%	70% after deductible
Assisted Fertilization Procedures	Excludes all assisted fertilization procedures	
Medical/Surgical/Physician Services (except office visits)	90%	70% after deductible
Spinal Manipulations	100% after $15 Copay	70% after deductible
	Combined Limit: 26 visits per calendar year	

SUMMARY OF MEDICAL BENEFITS		
Benefits	**In-Network**	**Out-of-Network**
Anesthesia Services	90%	70% after deductible
Diagnostic Services (Lab, X-ray, Standard Imaging, and other tests)	100%	
Advanced Imaging (CT scan, CTA, MRI, MRA, PET scan, PET/CT scan	90%	70% after deductible
Radiation and Chemotherapy (including freestanding facilities)	90%	70% after deductible
Physical Therapy (Professional)	100% after $15 Copay	70% after deductible
Occupational Therapy (Professional)	100% after $15 Copay	70% after deductible
	PT and OT Combined Limit: 60 visits per calendar year	
Speech Therapy (Professional)	100% after $15 Copay	70% after deductible
	Limit: 20 visits per calendar year	
Durable Medical Equipment	90%	70% after deductible
Orthotics and Prosthetics	90%	70% after deductible
Skilled Nursing Facility Services	90%	70% after deductible
	Combined Limit: 100 days per calendar year	
Home Health Care	90%	70% after deductible, limit 30 visits per calendar year
Private Duty Nursing	90%	
	$10,000 maximum per calendar year	
Hospice Care	100%	
Birthing Center	90%	70% after deductible
Well Baby Care	90%	70% after deductible
Transplant Services	90%	70% after deductible
Mental Health Services *Inpatient*	90%	70% after Deductible
Outpatient	100% after $15 Copay	70% after deductible
Substance Abuse Services *Inpatient*	90%	70% after Deductible
Substance Abuse Services *Outpatient*	100% after $15 Copay for initial visit; 100% thereafter	70% after deductible
Other Covered Services	90%	70% after deductible
Precertification Requirements	Performed by Member	

Note: The percentages shown in the above table refers to the portion of Allowable Charge for a Covered Service which are paid by the Plan (see 3.2(a)). The remaining percentage is the amount you are required to pay.

3.4 Identification Card

The Claims Administrator will issue you an Identification (I.D.) Card. It is recommended that you carry your I.D. card with you at all times and destroy any previously issued cards.

3.5 When you or one of your dependents receives health care services:

(a) show your I.D. card to the hospital, physician, or other professional health care providers; and

(b) ask the provider to file a Claim for you.

3.6 The following information will be displayed on your I.D. card:

(a) Your name;

(b) I.D. number (an alpha prefix followed by your Unique Member Identifier Number);

(c) Group number;

(d) Copayment for In-Network physician office visits and emergency room visits;

(e) Member Service toll-free number (on back of card);

(f) Precertification toll-free number (on back of card); and

(g) "PPO in Suitcase" symbol.

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

3.8 To request additional I.D. cards, contact Member Service at the number listed on your I.D. card.

3.9 Medically Necessary and Appropriate
For benefits to be paid under this Section, at either the In-Network or Out-of-Network level, services and supplies must be considered Medically Necessary.

3.10 Precertification (Required for Inpatient Admissions)
Prior to a non-emergency admission to a Facility Provider (hospital, alcohol or drug rehabilitation facility, skilled nursing facility, birthing center or hospice), you must obtain certification from the Claims Administrator to determine whether your confinement is Medically Necessary and Appropriate for purposes of reimbursement. Accordingly, you should contact the Claims Administrator by calling the precertification telephone number listed on your I.D. card. For an emergency or maternity admission, you must contact the Claims Administrator within 48 hours following admission, or as soon as is reasonably possible.

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

3.12 A Claims Administrator nurse reviewer will review your inpatient admission to ensure it is:

- appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury;

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

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

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

3.15 Discharge Planning

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

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

- level of function pre- and post-admission;
- ability to perform self-care;
- primary caregiver and support system;
- living arrangements pre- and post-admission;
- special equipment, medication and dietary needs;
- obstacles to care;
- need for referral to Case Management or Disease Management; and
- availability of benefits or need for benefit adjustments.

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

3.18 Individual Case Management Services

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

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

3.19 Individual Case Management can help:

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

3.20 Eligible Providers

To be covered under this Section, services must be obtained from one or more of the following types of providers ("Eligible Providers"). Services obtained from providers other than Eligible Providers will not be covered even if they would have been covered had they been obtained from Eligible Providers.

(a) Facility Providers

- Hospitals
- Psychiatric Hospitals
- Rehabilitation Hospitals
- Alcohol abuse treatment facility
- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/Night psychiatric facility
- Drug abuse treatment facility
- Freestanding radiation facility
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Freestanding gambling addiction treatment facility

- Home health care agency
- Home infusion therapy provider
- Hospice
- Outpatient alcohol abuse treatment facility
- Outpatient drug abuse treatment facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Pharmacy provider
- Residential treatment facility for alcohol and substance abuse
- Skilled nursing facility

(b) Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor
- Clinical laboratory
- Dentist
- Licensed certified Masters-Level social workers**
- Nurse-midwife
- Nurse practitioner
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Physician's assistant
- Podiatrist
- Registered nurses (RNs) and licensed practical nurses (LPNs)***
- Psychologist
- Respiratory therapist
- Speech-language pathologist
- Teacher of hearing impaired

* Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.
** For mental health and substance abuse services.
*** For skilled nursing care.

3.21 Covered Services

This Program provides benefits for the following confinements, services, supplies and treatments you receive from an Eligible Provider when such services are determined to be Medically Necessary and Appropriate. All Deductibles, Copayment amounts, Coinsurance levels, Out-of-Pocket Limits and frequency limitations are described in the Summary of Medical Benefits outlined in paragraph 3.3. Covered Services include the services, confinements, supplies, and treatments provided in paragraphs 3.22 - 3.77.

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

Routine and Preventive Care

3.22 Adults 18 Years of Age and Older - Routine Physical Examinations

The Program covers services for Routine and Preventive Care (which are not subject to a copay or deductible). Preventive Care benefits may vary based on the age, sex, and personal history of the individual. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the benefits applicable to diagnostic services.

Some examples of Preventive Care Covered Services are routine or periodic exams. Examinations include, but are not limited to:

(a) Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines.

(b) Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests. Please refer to the Periodic Exam Table following this section for visit intervals.

(c) Adult routine physical examinations.

(d) Pelvic examinations.

(e) Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.

(f) Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follow the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians. These include, but are not limited to:

- Hepatitis A vaccine
- Hepatitis B vaccine
- Hemophilus influenza b vaccine (Hib)
- Influenza virus vaccine
- Rabies vaccine
- Diphtheria, Tetanus, Pertussis vaccine
- Mumps virus vaccine
- Measles virus vaccine
- Rubella virus vaccine

- Poliovirus vaccine
- Human Papilloma Virus
- Herpes Zoster vaccine ("Shingles")

3.23 Children Under Age 18 - Pediatric Care and Immunizations

Pediatric preventive services cover one examination during each of the age categories in the table below. Benefits are not subject to the Program Deductibles or maximums and are limited to eligible dependents under age 18.

Pediatric Periodic Physical Exam (once during each age category)	
Newborn	5 years
By 1 month	6-7 years
2 months	8-9 years
4 months	10 years
6 months	11 years
9 months	12 years
12 months	13 years
15 to 18 months	14 years
24 months	15 years
3 years	16 years
4 years	17 years

3.24 Screening Examinations

Coverage for Routine and Preventive Care also includes certain screening services (which are not subject to a copay or deductible). These include, but are not limited to:

(a) Routine screening mammograms; additional mammography views required for proper evaluation and any ultrasound services for screening of breast cancer;

(b) Routine cytologic and chlamydia screening (including pap test);

(c) Routine bone density testing for women;

(d) Routine prostate specific antigen testing;

(e) Routine colorectal cancer examination and related laboratory tests.

Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

3.25 Routine Gynecological Examination and Pap Test (not subject to a copay or deductible):

(a) Women, regardless of age, are covered for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year. Benefits are not subject to Program Deductibles or maximums.

(b) Women age 19-26 and girls are covered for the Human Papilloma Virus (HPV) Vaccine. Benefits are not subject to Program Deductibles or maximums.

(c) HPV tests are also covered for women, regardless of age, when recommended by a physician.

Care of Illnesses and Injuries

3.26 Physician Visits
The following services are covered:

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

3.27 Responsive Emergency Care
Emergency room visits made in or outside the PPO Network are covered at the higher, In-Network level of benefits.

3.28 Your outpatient emergency room visits are subject to a Copayment, which is waived if you are admitted as an inpatient.

3.29 If the reason for your visit is determined not to be a Medical Emergency and you receive care at an Out-of-Network hospital, your benefits will be subject to the Out-of-Network Deductible and Coinsurance provisions of this Section. Such visits for emergency care will be evaluated using a *prudent layperson standard*: whether from the perspective of an ordinary person, the patient's condition, judged based on presenting symptoms, reasonably warranted immediate attention.

3.30 Facility Services
The Program covers the services outlined in paragraphs 3.31 - 3.34 below that you receive in a hospital or other Facility Provider.

3.31 Bed, Board and General Nursing Services
In a semi private room.

- In a private room with the allowance limited to the average semi-private room charge.
- In a bed in a Special Care Unit which gives intensive care to the critically ill.

3.32 Other Services

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

- Hyaluronic acid injections.
- Inpatient Admissions and Outpatient Visits-Dental Cases

Hospital benefits provided under the Program are available:

(a) If you are admitted to a hospital

(i) for extraction of impacted teeth, or
(ii) for extraction of teeth other than impacted teeth or for other dental processes provided hospitalization is certified by a licensed physician or a doctor of dental surgery as being necessary to safeguard the health of the person confined;
(iii) for any oral surgery or emergency care.

(b) if you receive treatment in the outpatient department of a hospital for

(i) extraction of impacted teeth, or
(ii) extraction of teeth other than impacted teeth or for other dental processes, provided hospital outpatient care is necessary to safeguard the health of the patient.

3.33 Surgery

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

3.34 Pre-Admission Testing

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

3.35 Medical/Surgical Services

The Program covers the services outlined in paragraphs 3.36 - 3.40 that you receive from a Professional Provider.

3.36 Surgical Services

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

(a) When more than one surgical procedure is performed by the same Professional Provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure plus 50% of the amount that would have been payable for each of the additional procedures had those procedures been performed alone. Refer to Section 3.1(c).

(b) Sterilization procedures such as tubal ligation and vasectomy are covered, regardless of whether Medically Necessary and Appropriate.

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

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

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

(e) A mastectomy performed on an inpatient or outpatient basis, as well as surgery to re-establish symmetry or alleviate functional impairment is covered, including but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy, as required under the Women's Health and Cancer Rights Act of 1998 or if needed as a result of an accident. Physical complications of all stages of mastectomy are also covered, including lymphedemas. Also covered are the use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof and one home health care visit within 48 hours after discharge, as determined by your physician, if discharge occurred within 48 hours after admission for a mastectomy.

(f) Medically necessary oral surgical procedures related to temporomandibular joint dysfunction (TMJ).

3.37 Assistant at Surgery

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

3.38 Anesthesia

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

3.39 Second Surgical Opinion

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

Keep in mind that:

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

3.40 If the consulting opinion is against elective covered surgery and you decide to have the elective surgery, the surgery is a Covered Service. In such instance, you will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

3.41 Inpatient Medical Services

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

(a) Inpatient Medical Care Visits

(b) Intensive Medical Care

- Constant attendance and treatment by a Professional Provider when your condition requires it for a prolonged time.

(c) Concurrent Care

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

(d) Consultation

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

(e) Newborn Care

- Professional Provider visits to examine the newborn infant while the mother is an inpatient.

3.42 Ambulance Service

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

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

- from a skilled nursing facility to your home; or
- air ambulance services when ordered by the attending physician or other emergency response personnel in conjunction with acute or life saving care

3.43 Trips must be to the closest local facility that can provide Covered Services appropriate for your condition. If there is no facility in the local area that can provide Covered Services appropriate for your condition, you are covered for trips to the closest such facility outside your local area that can provide the necessary service.

3.44 Maternity Care

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

3.45 Maternity Home Health Care Visit

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

3.46 Diagnostic Services

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

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

3.47 Therapy Services

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

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

3.48 Spinal Manipulations

Coverage is provided for spinal manipulations for the detection and correction, by manual or mechanical means, of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column. See the Summary of Benefits in paragraph 3.3 for any benefit limitations.

3.49 Home Infusion Therapy Services

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

3.50 Private Duty Nursing Services

Coverage is provided for the services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a physician, provided the nurse does not ordinarily reside in your home or is not a member of your immediate family and:

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

3.51 Skilled Nursing Facility Services

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

3.52 No Benefits are Payable under this Section for Skilled Nursing Facility Services:

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

3.53 Home Health Care/Hospice Care Services

The Program covers the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care:

(a) skilled nursing services of an RN or LPN, excluding private duty nursing services;

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

(c) medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care;

(d) oxygen and its administration;

(e) medical social service consultations;

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

(g) family counseling related to your terminal condition.

(h) hemodialysis

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

(a) dietician services;

(b) homemaker services;

(c) maintenance therapy;

(d) kidney dialysis treatment;

(e) custodial care; or

(f) food or home delivered meals.

3.55 Dental Services Related to Accidental Injury

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

3.56 Durable Medical Equipment

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

3.57 Hearing Aids

Hearing aids including digital aids, and examinations for the fitting of hearing aids once every three years if (a) the hearing aid is prescribed by an otolaryngologist (ear, nose and throat specialist) or (b) the replacement is certified as necessary by an otolaryngologist and such replacement occurs more than three years after the later of the installation of the initial hearing aid or the last replacement of the hearing aid. Any hearing aid whose cost exceeds $2,500 required pre-approval of the Plan Administrator.

3.58 Prosthetic Appliances

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

(a) replace all or part of a missing body organ and its adjoining tissues; or

(b) replace all or part of the function of a permanently inoperative or malfunctioning body organ.

Dental appliances are not covered.

3.59 Orthotic Devices

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

3.60 Transplant Services

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

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

(a) when both the recipient and the donor are covered by this Program, each is entitled to the benefits of this Program;

(b) when only the recipient is covered by this Program, both the donor and the recipient are entitled to the benefits of this Program subject to the following additional limitations: (1) the donor benefits are limited to only those not provided or available to the donor from any other source, including but not limited to, other insurance coverage, including other coverage provided by any Claims Administrator, or any government program, and (2) benefits provided to the donor will be charged against the recipient's coverage under this Program;

(c) when only the donor is covered by this Program, the donor is entitled to benefits, subject to the following additional limitations: (1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Program, and (2) no benefits will be provided to the non-covered transplant recipient; and

(d) if any organ or tissue is sold rather than donated to the covered recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the covered recipient's Program limit.

3.62 Enteral Formulae

Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits for such enteral formulae are exempt from any applicable Deductible requirements.

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

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

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

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

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

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

3.65 Coverage for Enteral Formulae Excludes the Following:

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

3.66 Diabetes Treatment

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

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

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

- visits determined to be Medically Necessary and Appropriate upon the diagnosis of diabetes; and
- subsequent visits under circumstances whereby your physician: (a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in self-management, or (b) identifies, as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.

The Outpatient Diabetes Education Program is a program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to the Claims Administrator's criteria acting on behalf of the Program. These criteria are based

on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).

3.67 Disease State Management

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

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

3.68 Weight Loss

(a) The Program provides coverage for weight reduction programs and surgical treatment for morbid obesity. Eligible procedures will include gastric bypass and gastric restrictive procedures with a Roux-en-Y procedure up to 150 cm, laparoscopic adjustable gastric banding, vertical banded gastroplasty, or biliopancreatic bypass with duodenal switch for the treatment of clinically severe obesity for selected adults (18 years and older) who meet ALL the following criteria:

(1) Body-Mass Index (BMI) of 40 or greater, or BMI of 35 or greater with co-morbid conditions including, but not limited to, life threatening cardio-pulmonary problems (severe sleep apnea, Pickwickian syndrome and obesity related cardiomyopathy), diabetes mellitus, cardiovascular disease or hypertension; and

(2) The patient must have actively participated in non-surgical methods of weight reduction; these efforts must be fully appraised by the physician requesting authorization for surgery; and

(3) The physician requesting authorization for the surgery must confirm the following:

A. the patient's psychiatric profile is such that the patient is able to understand, tolerate and comply with all phases of care and is committed to long-term follow-up requirements; and

B. the patient's post-operative expectations have been addressed; and

C. the patient has undergone a preoperative medical consultation and is felt to be an acceptable surgical candidate; and

D. the patient has undergone a preoperative mental health assessment and is felt to be an acceptable candidate; and

E. the patient has received a thorough explanation of the risks, benefits, and uncertainties of the procedure; and

F. the patient's treatment plan includes pre- and post-operative dietary evaluations and nutritional counseling; and

G. the patient's treatment plan includes counseling regarding exercise, psychological issues and the availability of supportive resources when needed.

(b) Coverage is also provided for the surgical removal of excess skin (including body contouring or body lifts) when recommended by doctor and performed 2 years following the start of any massive weight loss program.

(c) Prescription drugs for weight loss are covered under the Prescription Drug Program as outlined in paragraph 4.5(b).

Mental Health Services

3.69 The Program covers the services identified in paragraphs 3.70 - 3.74 below that you receive from an Eligible Provider to treat mental illness.

3.70 Inpatient Facility Services
Covered inpatient hospital services provided by a hospital or other Facility Provider, including a Freestanding Gambling Addiction Treatment Facility.

3.71 Inpatient Medical Services
Covered inpatient medical services provided by a Professional Provider:

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

3.72 Partial Hospitalization Mental Health Services
Partial hospitalization for mental health care services provided by a partial hospitalization program which has been approved by the Claims Administrator. Such programs are subject to periodic review by the Claims Administrator.

3.73 Outpatient Mental Health Services
Covered medical services (except room and board) provided by a hospital, or other Facility Provider or Professional Provider when you are an outpatient.

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

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

3.76 Autistic Disease of Childhood and Attention Deficit Disorders

The Program provides coverage for the procedures and services required to manage the medical conditions of autistic disease of childhood and attention deficit disorder (ADD/ADHD). These services include, but are not limited to, the diagnostic testing, counseling and ongoing monitoring of medication usage.

3.77 Inpatient confinement for environmental change is not covered.

What is Not Covered by Medical Benefits

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

(a) which are not Medically Necessary;

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

(c) rendered by other than hospitals, other Facility Providers, Professional Providers or suppliers as defined in paragraph 3.20 above;

(d) which are Experimental/Investigative in nature, as defined in paragraph 3.2(h);

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

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

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

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

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

(j) for any amounts you are required to pay under the Deductible and/or Coinsurance provisions of Medicare or any Medicare supplement coverage;

(k) to the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the Company is obligated by law to offer you all the benefits of this Program and you elect this coverage as primary;

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

(m) 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;

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

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

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

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

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

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

(t) for inpatient admissions primarily for physical therapy;

(u) for inpatient admissions primarily for diagnostic studies;

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

(w) for respite care;

(x) for dental services, other than covered services under 3.36(d), 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, frenectomy, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided herein;

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

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

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

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

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

(dd) for reversal of sterilization;

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

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

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

(hh) for weight loss programs and drugs, except as provided herein in paragraph 3.68;

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

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

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

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

(mm) 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;

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

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

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

(qq) for well-baby care visits, except as provided herein;

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

(ss) for nicotine cessation support programs and/or classes. Nicotine cessation prescriptions are covered under Section 4. Prescription Drug Benefits.

Care Away From Home

3.79 Out-of-Area Care

The Program also covers care when you are away from home to the extent listed in paragraphs 3.80 - 3.83. If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic. If the illness or injury is a Medical Emergency, it will be paid at the In-Network benefit level. If the treatment results in an admission, you have certain responsibilities under Precertification (See paragraph 3.10).

3.80 If the illness or injury is not an emergency and you receive care from an Out-of-Network provider, benefits for covered services will be provided at the lower, Out-of-Network level.

3.81 Out-of-Area Care for Eligible Dependents

For a child or spouse who is away from home:

- emergency care will be reimbursed at the higher In-Network level in an emergency situation;
- for non-emergency care, the eligible dependent is required to use Network providers in order to be reimbursed at the higher benefit level; dependents who receive Covered Services from a provider who does not belong to the network will receive the lower level of benefits. If the eligible dependent is in an area where there are no network Providers or an insufficient number of network providers (including specialists), eligible expenses will be reimbursed at the higher benefit level. Student dependents and other family members are encouraged to schedule visits for eligible preventive services, including routine physical examinations, with Network physicians while at home.

3.82 Services Provided for a Student While Away at School

For a child who is away at school:

- emergency will be reimbursed at the higher In-Network level in an emergency situation; and
- if other medical care is needed and is not provided by the school's medical center, the student is required to use Network providers to receive the higher level of benefits.

3.83 The BlueCard Worldwide Program

The Program provides assistance with medical problems you may incur while traveling outside of the United States. Services include: making referrals and appointments for you with nearby physicians and hospitals; verbal translation from a multilingual service representative; providing assistance if special help is needed; making arrangements for medical evacuation services; processing inpatient hospitalization Claims; and for outpatient or professional services received abroad, you should pay the provider, then complete an international Claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE (2583) or the Member Service telephone number on your I.D. card. Claim forms can also be downloaded from www.anthem.com.

3.84 BlueCard PPO Program
Outlined below in paragraphs 3.85 - 3.89 are specific provisions provided by the Association.

3.85 When you obtain Covered Services through BlueCard outside the geographic area the Claims Administrator serves, the amount you pay for Covered Services is calculated on the lower of:

- the billed charges for Covered Services; or
- the negotiated prices that the on-site Plan ("Host Blue") passes on to the Claims Administrator PPO.

3.86 Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with the health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

3.87 Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard method noted above in paragraph 3.84 - 3.86 or require a surcharge, the Claims Administrator would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received care.

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

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

(b) the inpatient stay ends; or

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

3.89 If you are pregnant on the date coverage terminates, no additional coverage will be provided, except as provided in paragraph 3.88.

How to File a Claim

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

3.91 Authorized Representatives

You have the right to designate an authorized representative to file or pursue a Claim on your behalf. The Claims Administrator on behalf of the Plan Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by the Claims Administrator will, in the case of an Urgent Care Claim, permit a physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative.

3.92 Types of Claims

A Claim is a request for precertification or for the payment or reimbursement of the charges or costs associated with a Covered Service. Claims include:

(a) Urgent Care Claim - A Pre-Service Claim which if decided within the time period established for deciding Pre-Service Claims that are not urgent could seriously jeopardize your life, health or ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the requested Covered Service. The Claims Administrator is responsible for determining whether a Claim is an Urgent Care Claim.

(b) Pre-Service Claim - A request for precertification or prior approval of an inpatient admission or other Covered Service as described in paragraph 3.10.

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

3.93 Urgent Care Claims

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

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

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

3.94 Filing and Determination on Non-Urgent Care Pre-Service Claims
The procedures for filing a Pre-Service Claim with the Claims Administrator are described in paragraph 3.10.

3.95 If your Pre-Service Claim is denied, in whole or in part, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal. For a description of your right to file an appeal concerning an adverse benefit determination of a Pre-Service Claim, see paragraph 3.103-3.107.

3.96 You will receive written notice of any decision on a Pre-Service Claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date the Claims Administrator receives the Claim. However, the Claims Administrator may extend this 15 day period one time for an additional 15 days provided the Claims Administrator determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 15 day period. If any extension of time is necessary because you did not submit information necessary for the Claims Administrator to make a decision on your Pre-Service Claim, the notice of extension will specifically describe the information you must submit. In this event, you will have at least 45 days from the date the notice of extension is received by you to submit the information before a decision is made on your Pre-Service Claim.

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

(a) Know Your Benefits

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

(b) Get an Itemized Bill

Itemized bills must include:

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

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

(c) Copy Itemized Bills

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

(d) Complete a Claim Form

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

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

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

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

3.98 Your Explanation of Benefits Statement

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

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

3.100 When Post-Service Claims Must Be Filed

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

3.101 Determinations of Post-Service Claims

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

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

3.103 Complaint and Appeal Procedure

The Claims Administrator's customer service representatives are specially trained to answer your questions about your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- your coverage and benefit levels, including Copayment amounts;
- specific claims or services you have received;
- doctors or Hospitals in the Network;
- referral processes or authorizations; and/or
- Provider directories.

A complaint procedure has been established to provide fair, reasonable, and timely review of complaints that you may have concerning the Plan. The Claims Administrator invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by medical Providers in the Claims Administrator's Networks.

The Complaint Procedure

If you have a complaint, problem, or claim concerning benefits or services, please contact the Claims Administrator. Please refer to your Identification Card for the Claims Administrator's address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Claims Administrator of its procedures and contracts. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint. If your complaint involves issues of Covered Services, you may be asked to sign a medical records release form so the Claims Administrator can request medical records for its review.

The Appeals Procedure

As a member of the Plan, you have the right to appeal decisions to deny or limit the Plan benefits. You may also file an appeal to address concerns regarding confidentiality or privacy. Appeals should be filed with the Claims Administrator for review in accordance with the procedures set forth below.

Claims Administrator Appeals

An appeal is a request from you for the Claims Administrator to change a previous determination made. An initial determination by the Claims Administrator can be appealed for further review by the Claims Administrator at two subsequent levels known as "Level 1" and "Level 2" appeals. The Claims Administrator will advise you of your rights to the next level of review if a denial is upheld after a Level 1 appeal or a Level 2 appeal.

You have the right to designate a representative (e.g. your Physician) to file an appeal on your behalf and to represent you in the appeal. If a representative is seeking an appeal on your behalf, the Claims Administrator must obtain a signed Designation of Representation form from you before the Claims Administrator can begin processing your appeal unless a Physician is requesting expedited review of a Level 1 appeal on your behalf. If that occurs, the Physician will be deemed to be your representative for the purpose of filing the expedited Level 1 appeal without receipt of a signed form.

Once an appeal has been filed as described below, the Claims Administrator will accept oral or written comments, documents or other information relating to your appeal from you, your designated representative or your provider by telephone, facsimile or other reasonable means. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to your appeal.

3.104 Level 1 Appeals

Level 1 appeals are reviewed by a person who did not make the initial determination and who is not the subordinate of the initial reviewer. If a clinical issue is involved, the Claims Administrator will use a clinical peer for this review unless your appeal concerns an adverse voluntary predetermination decision or unless the adverse decision can be overturned based upon prescreening by a nurse or other qualified reviewer. A clinical peer is a physician or provider who has the same license as the provider who will perform or has performed the service.

If your Level 1 appeal concerns an adverse Pre-Service decision, your appeal may be initiated by letter or over the phone. The Claims Administrator requires its members to submit all other requests for appeal in writing. Written appeal requests, including a detailed description of the problem and all relevant information, should be sent to the entity listed on page iv of this booklet as the Claims Administrator for Health Benefits to the following address:

Anthem Blue Cross and Blue Shield
Attention: Appeals
P.O. Box 105568
Atlanta, GA 30348

or to the address (or phone number for adverse Pre-Service or Precertification decisions) provided for filing an appeal on any written notice of an adverse decision that you receive from the Claims Administrator.

If you are appealing an adverse Pre-Service decision (i.e., an adverse Precertification, Prospective, Concurrent or Prospective Review decision) or the denial of any prior approval required by the Plan, the Claims Administrator will provide you with a written response indicating the Plan's decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 days of the date the Claims Administrator receives your Level 1 appeal request. If more information is needed to make a decision on your appeal the Claims Administrator will send a written request for the information after receipt of the appeal. No extensions of time for additional information may be taken on these Level 1 appeals without the permission of the claimant. Therefore, the Claims Administrator will make a decision based upon the available information if the additional information requested is not received.

If you are appealing any other type of adverse decision and sufficient information is available to decide the appeal, the Claims Administrator will resolve your Level 1 appeal within a reasonable period of time but not later than 60 days from receipt of the Level 1 appeal request. If more information is needed to make a decision on your appeal, the Claims Administrator shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 days of the Level 1 appeal request, the Claims Administrator shall conduct its review based upon the available information, which review shall be completed within a reasonable period of time but not later than 60 days from receipt of the Level 1 appeal request. After the Level 1 appeal decision is made, you will be notified within 5 business days in writing by the Claims Administrator of the Plan's decision concerning your Level 1 appeal.

If your Level 1 appeal is denied, your written notice of the denial will contain the specific reasons for the denial, a reference to the specific plan provisions on which the determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents relevant to your claim for benefits, a description of the voluntary Level 2 appeal, a statement regarding your right to bring a civil action as described below, and if an internal guideline or protocol was relied on in making the determination, a statement that the guideline or protocol is available upon request free of charge.

3.105 Level 2 Appeals

If you are dissatisfied with the Level 1 appeal decision, you may request a Level 2 appeal. At Level 2, the appeal is reviewed by a panel of the Administrator's staff members. The Claims Administrator may arrange for a hearing at which you may appear. Level 2 appeals concerning adverse Precertification decisions or the denial of any prior approval required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Level 2 appeal request was received by the Administrator. All other Level 2 appeals will be resolved by the panel no later than 45 business days from the date your Level 2 appeal request was received by the Administrator. After the appeal panel makes a decision you will be notified within 5 business days in writing by the Administrator of the Plan's decision concerning your Level 2 appeal.

Expedited Reviews

Any level of appeal can be expedited if:

- The service at issue has not been performed;
- The service at issue has been denied as Experimental/Investigative or as not Medically Necessary; and
- Your physician believes that the standard appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

The Claims Administrator by applying a prudent lay person standard, may also determine that an appeal may be expedited.

The Claims Administrator will complete expedited review of a Level 1 appeal as soon as possible taking into account the medical urgency of the situation but not later than forty-eight hours (48 hours) after the Claims Administrator receives the Level 1 appeal request and will communicate the Plan's decision by telephone to your attending physician or the ordering provider. The Claims Administrator will also provide written notice of the Plan's determination to you, your attending physician or ordering provider, and the facility rendering the service. The Claims Administrator will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and panel administration permits. The Plan's decision will be communicated by telephone to your attending physician or the ordering provider. The Claims Administrator will also provide written notice of the Plan's determination to you, your attending physician or ordering provider, and to the facility rendering the service.

External Appeals

If you are dissatisfied with the Plan's Level 2-appeal decision, an "External Appeal" may be available. External Appeal is available if a service or supply has been denied as Experimental/Investigative. The External Appeal option also extends to services denied as not Medically Necessary if the cost of the medical service is over $10,000 or if the service at issue has

not been received and non-receipt of the medical service would jeopardize the patient's life or health. It is coordinated by the Claims Administrator and involves a review of the case by an independent reviewer. External Appeal is available after all other appeal rights with the Claims Administrator are exhausted. In a case of urgently needed care, the Claims Administrator may elect to bypass some levels of appeal to send a case directly to an External Appeal. An External Appeal is not available for services or supplies that are limited or excluded by contract.

Appeals Filing Time Limit

You are encouraged to file Level 1 appeals on a timely basis. The Claims Administrator will not review a Level 1 appeal if it is received after the end of the calendar year plus 12 months since the incident leading to the Member's appeal. Level 2 appeals must be filed within 60 days of receipt of notice of the Level 1 appeal determination. An External Appeal, must be filed within 60 days from receipt of the Plan's Level 2-appeal decision.

Appeals by Members of ERISA Plans

If you are covered under an Employer plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file a Level 1 appeal prior to bringing a civil action under 29 U.S.C. 1132 §502(a). Level 2 appeals and External Appeals, if available, are voluntary levels of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be temporarily suspended while a Level 2 appeal or External Appeal, if available, is pending. You will be notified of your right to file for a voluntary level of review if the Plan's response to your current appeal level (i.e., Level 1 or Level 2 appeal) is adverse. Upon your request, the Claims Administrator will also provide you with detailed information concerning Level 2 appeals and, if available, External Appeals, including how Level 2 panelists are selected.

3.106 You may further appeal a Claim by filing an insurance grievance in accordance with the Insurance Grievance Procedure outlined in Section 9.

3.107 You must complete the Level 1 appeal described above before taking any other action, except that you may proceed directly to the Grievance Procedure described in Section 9 of this Booklet prior to completing the appeals process described above. You are, however, encouraged to use the appeals process described above prior to using the Grievance Procedure.

3.108 Nurse on Call

From My BlueLink page at www.Anthem.com, click on "Nurse On Call" or dial the 24-hour toll free number, 1-888-596-9473 to speak with a specially trained registered nurse. Your call will be kept strictly confidential.

3.109 Nurse On Call addresses your total health care needs rather than focusing on one specific disease, condition or illness through interaction with both the patient and the physician. Nurse On Call promotes the philosophy of shared decision-making by helping you work with your physicians in the task of choosing treatment options that take into account your values and preferences. Nurse On Call provides you with health care support services, including assistance in the self-management of certain health conditions. You have 24-hour access, seven days a week, to health information and personalized support for health decisions.

3.110 Support services may include:

(a) assessment of your functional and health status, including co-morbidities, risk factors, motivation and confidence in managing your health, and receptivity for change;

(b) assessment of your knowledge of your particular condition and your understanding and adherence to the recommendations and instructions of your health care provider;

(c) education and training on health-related topics that can be helpful in improving your overall health status, such as appropriate diet and nutrition, smoking cessation and exercise; and

(d) ongoing monitoring (coaching) to optimize your health status, ensuring adherence to the physician's treatment plan, identifying and addressing barriers that prevent or hinder adherence to the physician's treatment plan, and assessing the need for case management services.

3.111 You may contact Nurse On Call at the toll-free telephone number listed on your Identification Card.

3.112 Information About Federal Laws
Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Program provides benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following health services, as you determine appropriate with your attending physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such health services (including copayments and any annual deductible) is the same as required for any other covered health service. Limitations on benefits are the same as for any other covered health service.

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Per the Mental Health Parity Act:

Benefits for mental health and substance use disorder must be treated like benefits for regular medical and surgical care. For example, if there is no limitation on the number of days for inpatient and number of visits for outpatient medical care, then there can be no limitation for mental health and substance use disorder treatments. As always, treatments must be medically necessary to qualify for coverage. Plan participants should review their plan's certificate of coverage or benefit document for specific information about coverage, limitations and exclusions for mental health care and substance use disorder treatments.

Statement of Grandfathered Status

Cleveland-Cliffs believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. This plan should remain grandfathered through length of this contract.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at 1-866-583-6288. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SECTION 4. PRESCRIPTION DRUG BENEFITS
(For You and Your Dependents)

4.0 Introduction

You and your eligible dependents are covered by the prescription drug program outlined in this Section 4 (the "Prescription Drug Benefits"). The Prescription Drug Benefits under the Program are administered by the entity listed on page iv as the Claims Administrator for Prescription Drug Benefits.

4.1 Who Is Eligible?

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

4.2 How Does the Program Work?

Whenever you or an eligible dependent requires a prescription drug, you have the following options for getting your prescription filled:

(a) **Mail Order**

You can order up to a 90-day supply of medications prescribed for treatment of chronic or long-term illness (such as arthritis, diabetes, high blood pressure) through the mail.

(b) **Retail Pharmacy**

You can purchase up to a 30-day supply of your prescription medications from any retail pharmacy of your choice. However, there are certain advantages if you obtain your medication from a participating retail pharmacy.

4.3 What Is My Cost?

Prescription drug benefits are provided through an integrated network of national chain and local pharmacies and via mail order from the Claims Administrator's mail pharmacy. Your cost per prescription is displayed below.

	Participating Pharmacy	**Non-Participating Pharmacy**
Retail Prescription Copayments (per Rx)		
Formulary Generic	$10.00	50% copayment
Formulary Brand-Name	$20.00	50% copayment
Non-Formulary Generic or Brand-Name	$30.00	50% copayment
Specialty Drugs – Generic	$0.00	50% copayment
Specialty Drugs – Brand Name	$20.00	50% copayment
Retail, Maximum Supply	Up to 30 days	Up to 30 days
	Participating Pharmacy	**Non-Participating Pharmacy**
Mail Order Prescription Copayment (per Rx)		
Formulary Generic	$20.00	Not Covered
Formulary Brand	$40.00	Not Covered
Non-Formulary Generic or Brand-Name	$60.00	Not Covered
Mail Order, Maximum Supply	Up to 90 days	Not Covered
Specialty Drugs – Generic	$0.00 limited to 30-day supply	50% copayment
Specialty Drugs – Brand Name	$20.00 limited to 30-day supply	50% copayment

Note: *50% copayment for retail prescription drugs at non-participating pharmacies after submission of paper claims and reimbursement.*

4.4 Covered Prescriptions

The Program covers prescriptions written by licensed physicians for medications which require a prescription pursuant to Federal or State law including insulin, disposable insulin syringes (when dispensed with insulin), blood glucose testing agents and strips. Each prescription for a "controlled substance" (including Schedule II drugs) must be written by a licensed physician on a separate prescription blank.

4.5

(a) Prescriptions for smoking cessation drugs such as Zyban, Wellbutrin, and certain nasal sprays are covered when purchased at a local retail pharmacy. Coverage is limited to two courses of treatment per person per lifetime. These medications are not available through the mail service.

(b) Prescription drugs for weight loss are covered for individuals with a BMI >30 without additional risk factors, or BMI >27 with two or more risk factors (such as hypertension, lipid disorders, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and certain cancers).

4.6 What Is a Formulary?

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

4.7 The benefits under this Section include coverage for both formulary and non-formulary drugs. To receive a copy of the formulary, call Member Services at the number on the back of your Identification Card. You can also access the formulary online at the website address listed in the Introduction to this Booklet.

The Company shall provide the Union with the formulary on an annual basis, specifying which drugs have been added, which drugs have been removed, and what comparable alternatives in the formulary might be for drugs that have been removed.

4.8 What Prescriptions Are Not Covered?

Except for insulin, this Program does not cover any drugs or medicines that can be purchased over-the-counter without a prescription, nor does it cover:

- drugs not medically necessary to treat a condition of illness or injury (such as drugs prescribed for cosmetic purposes or nicotine skin patches and nicorette gum), except that the following prescription drugs are covered:
  - (1) FDA approved prescriptions for oral contraceptives, and
  - (2) Smoking cessation drugs (such as Zyban, Wellbutrin and certain nasal sprays) when purchased at a local retail pharmacy (but not through mail order). Coverage is limited to two courses of treatment per person per lifetime;
- experimental drug;
- drugs prescribed for weight loss, except as provided in paragraph 4.5(b);
- growth hormones;
- drugs prescribed for treatment of infertility;
- allergy serums;
- refills of any prescription older than one year; and
- home infusion therapy drugs.

In addition, the following are not available through the mail-order pharmacy:

- drugs for acute, short-term illnesses as determined by the Claims Administrator even though prescribed for 30 days or more; and
- drugs which may not be legally provided through mail service.

4.9 Generic Substitution

A brand-name drug and its generic equivalent must be the same chemically and also have the same therapeutic effect. Generic drugs are also subject to the same rigid FDA standards for quality, strength and purity and are as safe, efficient and effective as brand-name drugs. Although only 30% of all drugs are available generically, generic drugs are usually less costly. Therefore, ask your doctor to authorize generic substitution when an approved generic is available. The Program covers both brand-name and generic equivalent drugs. However, generic equivalents will be substituted where permissible by law.

4.10 If your physician prescribes a brand-name drug that can legally be filled with the generic equivalent and indicates that generic substitution is not permitted, your initial prescription will be filled and the Claims Administrator will send you a form entitled "Explanation for Use of Brand-Name". If your physician determines that a generic equivalent will not be acceptable for your specific need and if you wish to continue using this Program to purchase this particular drug, your physician must complete and return to the Claims Administrator the appropriate form providing the medical reasons a brand-name drug is required. Any subsequent refills and prescriptions authorized by your physician will be filled by the Claims Administrator only if the Claims Administrator determines, on the basis of the physician's explanation, that use of the brand-name drug is required in accordance with accepted standards of medical practice.

4.11 Using the Mail Order Option
Initial Prescriptions

When using the mail service option, it is recommended that you ask your physician to write a prescription for up to a 90-day supply of all needed maintenance drugs, plus the appropriate number of refills, either prescribing the drug in generic form or agreeing to generic substitution where permitted by law.

- If you or your dependents previously used the mail service and you have a new prescription, follow the instructions outlined on the mail service order form.
- If no one in your family previously ordered prescription drugs through the mail service option, complete the mail service order form and Health Assessment questionnaire which you can obtain by the Claims Administrator or visiting its website (see the Introduction of this Booklet or your ID card for the telephone number and website). Answer all questions, making sure you enter your member identification number in the space provided. This form is completed only with your first order; however, if you become aware of an allergy or health condition after completing the Health Assessment questionnaire, be sure to notify the Claims Administrator. Place your original prescription(s), completed order form, check or money order payable to the Claims Administrator (where applicable) and Health Assessment questionnaire in the pre-addressed envelope also provided by the Claims Administrator and mail to the Claims Administrator.

IMPORTANT: Write your name and member identification number on the back of each prescription you enclose.

4.12 Refill Prescriptions

If the label indicates that the prescription may be refilled and the prescription is not for a Schedule II drug, you may follow one of these refill options:

- **Telephone**
  Call Member Services toll-free at the number listed on your I.D. card. Have your member identification number, the prescription number and your card information ready.
- **Mail**
  Use the refill and order form provided with your medication shipment and mail them in the postage-paid envelope along with your copayment.
- **Website**
  Visit the website listed for the Prescription Drug Benefit Claims Administrator on page iv of this Booklet. Have your member identification number, the prescription number and your card information ready. You will need to register first before you can refill a prescription.

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

4.14 If you need medication immediately for a chronic or long-term condition, have your doctor write two prescriptions: one for a two-week supply, that you can have filled at a retail pharmacy, and one for up to a 90-day supply that you can send to the mail service program. Remember, the initial prescription for a drug ordered through the mail-service will be limited to a 30-day supply.

4.15 How Soon Will I Receive My Mail Order Prescription?

Orders are usually processed and mailed within 48 hours of receipt via First Class U.S. Mail or United Parcel Service. However, you should allow from 7 to 11 days from the date you mailed your prescription for normal mail delivery.

4.16 Using the Retail Pharmacy Option

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

4.17 Participating Pharmacies

(a) At a participating retail pharmacy, show your Identification Card and pay the following copayments:

Retail Prescription Copayments (per Rx)	Participating Pharmacy
Formulary Generic	**$10.00**
Formulary Brand-Name	**$20.00**
Non-Formulary (Generic or Brand-Name)	**$30.00**
Specialty Drugs – Generic	**$0.00**
Specialty Drugs – Brand Name	**$20.00**

(b) Participating pharmacies currently include national chains such as Albertsons, CVS, Fagen, Giant Eagle, Rite Aid, Sav-on, Walgreens, Wal-Mart, and Winn Dixie as well as selected local drugstores. To find a participating retail pharmacy nearest you, call Member Services at the number listed on your I.D. card and use the voice-activated pharmacy locator system or visit the website at the address listed for the Prescription Drug Benefits Claims Administrator in the Introduction to this Booklet.

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

4.18 Non-Participating Retail Pharmacies

At a non-participating retail pharmacy, pay the pharmacy its charge for the medication. Then complete your portion of the Claim Form, which may be obtained by visiting the Claims Administrator's website listed in the Introduction to this Booklet or by calling the Claims Administrator at the telephone number on your I.D. card. Have the pharmacist complete the pharmacy portion of the Form (including the NDC number), attach a receipt for each prescription and send to the Claims Administrator at the address shown on the Form within one year from the purchase date. Claims submitted without all required information will be returned for proper completion, which will delay your reimbursement. Claims filed later than one year after purchase are not eligible for reimbursement. A separate Form must be completed for each family member and each pharmacy. You will be reimbursed 50% of the pharmacy's charge for each properly completed claim filed on a timely basis. A new Form will be sent to you with your reimbursement check.

4.19 Before Leaving the Doctor's Office

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

4.20 What Are the Quality Standards?

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

4.21 Who Do I Contact for Express Scripts By Mail and Pharmaceutical Information?

If you have any questions or problems concerning a prescription ordered via the mail service program, call Member Services at the number listed on your I.D. card and use the automated system or visit the website listed for the Prescription Drug Benefit Claims Administrator in the Introduction to this Booklet. If you do not receive your medication in 14 days, call the Claims Administrator and a replacement order will be sent to you at no additional charge if your first order cannot be traced. The toll-free telephone number listed on your I.D. card is also available for any questions about an order, including physician inquiries, and for you to phone in refills.

Deadlines for Initial Determinations

4.22 Post-Service Claims

A Post-Service Claim is any claim for a benefit that is made after the prescription is received. You will receive notice of the decision that has been made on your Post-Service Claim within 30 days of the Claims Administrator's receipt of the claim. A 15 day extension is available. To be eligible for benefits under the Program, your claim must be submitted to the Claims Administrator within one year from the prescription purchase date. Claims other than Post-Service Claims will be decided within the timeframes described beginning in Section 3.94.

4.23 How Do I Appeal a Claim for a Prescription Purchased At a Retail Pharmacy or Through Mail Order?

If you want to appeal the denial of a prescription claim under this Section you may do so by using the following procedures.
The appeal procedure involves the following steps:

(a) Initial Review by the Claims Administrator

(b) Second Review by the Claims Administrator

(c) Insurance Grievance Procedure, including arbitration.

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

4.24 Initial Review by Claims Administrator

(a) If you receive notification that a claim has been denied by the Claims Administrator, in whole or in part, you may appeal the decision to the Claims Administrator at the address listed on the denial notice. Your appeal must be in writing and must be submitted not later than 180 days from the date you received notice of the adverse benefit determination.

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

(c) The Claims Administrator will provide written notification of its decision within a reasonable period of time not to exceed 30 days following receipt of the appeal by the Claims Administrator.

(d) A notification of an adverse benefit determination on your appeal will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file a further appeal as outlined in paragraph 4.25. The following additional information will be included in the notification, if applicable:

(1) Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination will be set forth;

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

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

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

4.25 Second Review by the Claims Administrator

(a) You may further appeal the claim within 60 days of your receipt of an adverse determination by writing to the Claims Administrator at the address listed on the denial notice. Once again, you should supply any information necessary to support your position. You will be advised of the final decision within 30 days of the date that your appeal is received.

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

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

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

4.26 You must complete the appeals process described above before taking any other action, except that you may proceed directly to the Grievance Procedure described in Section 9 of this Booklet prior to completing the appeals process described above. You are, however, encouraged to use the appeals process described above prior to using the Grievance Procedure.

SECTION 5. DENTAL CARE BENEFITS
(For You and Your Dependents)

5.0 Payment of Benefits

If you or one of your eligible dependent while covered for Dental Expense Benefits incurs Covered Dental Expenses, as described in paragraph 5.7 benefits are payable, subject to the deductible, coinsurance and maximums specified in this Section to the extent such charges are reasonable and customary charges. The term “reasonable and customary charge" means the actual fee charged by a dentist for a service rendered or supply furnished but only to the extent that the fee is reasonable, taking into consideration the following:

(a) The usual fee which the individual dentist most frequently charges the majority of their patients for a service rendered or a supply furnished;

(b) The prevailing range of fees charged in the same area by dentists of similar training and experience for the service rendered or supply furnished; and

(c) Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular dental service or procedure.

Area means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of dentists rendering such services of furnishing such supplies.

5.1 Annual Deductible

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

5.2 Maximum Benefits

(a) The Maximum benefit payable for all Covered Dental Expenses incurred during any calendar year, except for services described in paragraphs 5.7(e), shall be $2,500 for you and for each of your dependents.

(b) The Maximum benefit payable for Covered Dental Expenses in connection with orthodontic diagnostic procedures and treatment described in paragraph 5.7(e) shall be $3,000 during the lifetime of each individual.

(c) In applying the calendar year and lifetime maximums referred to in (a) and (b) above, benefits for Covered Dental Expenses paid under any other group insurance plan or program toward the cost of which the Company contributes shall be considered to have been paid under the Program.

5.3 Claims Not Requiring Predetermination of Benefits

When Covered Dental Expenses are incurred by you or one of your dependents for emergency treatment, routine oral examinations, X-rays, prophylaxis, fluoride treatments or a course of treatment, the charge for which is not expected to exceed $150, predetermination of benefits (paragraphs 5.3-5.5) is not required. Metropolitan makes the determination as to the reasonable and customary charge and makes the applicable benefit payment; for these services not payable at 100%, the remaining 20% or 40% of the reasonable and customary charge is your responsibility. If you incur a charge which Metropolitan determines to be in excess of the reasonable and customary charge for a procedure not requiring predetermination of benefits, the Program will not pay such excess charge.

5.4 Claims Requiring Predetermination of Benefits

If a course of treatment for you or one of your dependents can reasonably be expected to involve Covered Dental Expenses of $150 or more, a description of the procedures to be performed and an estimate of the dentist's charges must be filed with Metropolitan prior to the commencement of the course of treatment.

As used herein "course of treatment" means a planned program of one or more services or supplies, whether rendered by one or more dentists for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment commences on the date a dentist first renders a service to correct or treat such diagnosed dental condition.

5.5 Metropolitan will notify you and your dentist of the benefits certified as payable based upon such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services, or courses of treatment that may be performed for such dental condition in order to accomplish the desired result. The amount included as certified dental expenses will be the appropriate amount determined in accordance with the provisions of paragraph 5.5, subject to the maximums set forth in paragraph 5.2 above and the limitations set forth in paragraphs 5.7 and 5.8. If you and your dentist agree to a charge higher than the amount predetermined by the Insurance Company such excess will not be paid by the Program.

If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, Metropolitan reserves the right to make a determination of benefits payable taking into account alternate procedures, services or courses of treatment, based on accepted standards of dental practice.

5.6 Summary of Dental Care Benefits

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

SUMMARY OF DENTAL CARE BENEFITS	
Benefit Provision	**What the Plan Covers**
Annual Deductible (does not apply to Diagnostic or Preventive Services) INDIVIDUAL: $25 FAMILY: $50	
Diagnostic Services > Routine oral examinations > Dental X-rays - Full mouth X-rays - - Bitewing X-rays > Palliative Treatment	100% of the Allowable Charge
Preventive Services > Routine cleanings > Topical fluoride application for dependent children up to age 26 > Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children under 19 years of age > Sealants when provided to children. Coverage is limited to one sealant per tooth in any three-year period	100% of the Allowable Charge
General and Restorative Services > Fillings and restorations > Simple extractions > Endodontics, including pulpotomy and root canal treatment > Inpatient consultations > Repairs of crowns, inlays, onlays, bridges and dentures	80% of the Allowable Charge after Deductible
Periodontal Services > Diagnosis and treatment planning including periodontal examination > Non-surgical periodontal therapy including periodontal scaling and root planing > Surgical periodontal therapy > Maintenance - post treatment preventive periodontal procedures (periodontal cleanings)	80% of the Allowable Charge after Deductible
Oral Surgery > Surgical removal of teeth and certain other procedures listed in paragraph 5.7(e)	80% of the Allowable Charge after Deductible

SUMMARY OF DENTAL CARE BENEFITS	
Benefit Provision	**What the Plan Covers**
Prosthetics > Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays) > Initial insertion of partial or full dentures (including any adjustments during the six-month period following insertion) > Replacement of an existing partial or full denture or bridge by a new denture or bridge	60% of the Allowable Charge after Deductible
Crown, Inlay and Onlay Restorations, Implants > Single unconnected crowns, inlays and onlays > Replacement of crowns, inlays and onlays, but only if satisfactory evidence is presented that at least 5 years have elapsed since the date of insertion of the existing crown, inlay or onlay, and only if the existing crown, inlay or onlay is unserviceable and cannot be made serviceable	60% of the Allowable Charge after Deductible
Orthodontics (Not subject to Annual Maximum, limited to dependent children under age 19) > Diagnosis, including radiographs > Active treatment, including necessary appliances > Retention treatment following active treatment > Lifetime Maximum $3,000	60% of the Allowable Charge
Annual Maximum/Person	$2,500
Balancing billing, the difference between the Allowable Charge and the Provider's Charge, may be possible if using an out-of-network Provider.	

5.7 Covered Dental Expenses

Covered Dental Expenses are those incurred in connection with the following dental services which are performed by (i) a licensed dentist practicing within the scope of their license, or (ii) a licensed physician authorized by their license to perform the particular dental services rendered but only to the extent such charges are for services and supplies customarily employed for treatment of that dental condition and only if rendered in accordance with accepted standards of dental practice:

(a) Benefits for the following Covered Dental Expenses are payable at 100% of the usual, reasonable and customary charge:

(1) Routine oral examinations and prophylaxis scaling and cleaning of teeth), but not more than twice in any period of twelve consecutive months:

(2) Oral examinations performed to determine the need for and, if required, to plan a course of orthodontic treatment. Periodic examinations used to monitor the progress of such treatment are not considered "oral examinations" for the purpose of this paragraph;

(3) Topical application of fluoride (the direct application of fluoride to the exposed surfaces of the teeth to inhibit or retard the incidence of cavities);

(4) Space maintainers (a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost teeth for dependent children under 19 years of age;

(5) Emergency treatment for temporary relief of pain which does not effect a definite cure;

(6) Administration of general anesthetics, intravenous sedation, analgesia, and substances or agents which are administered to minimize fear (except local infiltration anesthetic) if the patient is handicapped by cerebral palsy, mental retardation or spastic disorders; and

(7) Administration of general anesthetics, when medically necessary, and intravenous sedation (except local infiltration anesthetic) provided either in or out of a hospital, and administered in connection with oral or dental surgery, except as provided in paragraph 5.7(b)(7). Benefits are not provided for substances or agents which are administered to minimize fear, or analgesia, except as provided in (a)(6) above;

(8) Full mouth X-rays, (but not more than once in any period of 36 consecutive months), supplementary bitewing X-rays (but not more than twice in any period of twelve consecutive months) and such other dental X-rays as are required in connection with the diagnosis of a specific condition requiring treatment, except X-rays provided in connection with orthodontic diagnostic procedures and treatment; and

(9) Sealants.

(b) Benefits for the following Covered Dental Expenses are also payable at 80% of the usual, reasonable and customary charge and are not subject to the maximum benefit referred to in paragraph 5.2(a);

(1) Surgical removal if impacted teeth if you are admitted as an inpatient to an accredited hospital or an accredited dental hospital; and surgical removal of impacted teeth if partially or completely covered by bone, either in or out of the hospital;

(2) Dental root resection (apicoectomy);

(3) Excision of radicular or dentigerous cyst;

(4) Alveolectomy on an area covering at least six consecutive tooth sockets when performed:

(i) during an inpatient hospital confinement, either as an independent procedure or at the time of extraction of teeth, or

(ii) out of the hospital as an independent procedure (not at time of extraction of teeth); alveolectomies not covered herein are covered under 5.7(c)(3);

(5) Excision of tori;

(6) Frenectomy when performed as an independent procedure; and

(7) Administration of anesthetics in accordance with paragraphs 5.7(a)(6) and 5.7(a)(7) when required in connection with the Covered Dental Expenses referred to in (1) through (6) above;

(c) Benefits for the following Covered Dental Expenses are payable at 80% of the usual, reasonable and customary charge:

(1) Extractions, except those described in (b)(1);

(2) Oral surgery, except as described in (b);

(3) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased teeth;

(4) Treatment of diseases of the gums and other tissues of the mouth;

(5) Endodontic treatment (those procedures usually employed for prevention and treatment of diseases of the dental pulp and the area surrounding the tip of the tooth root), including root canal therapy, except as described in (b)(2);

(6) Injection of antibiotic drugs by the attending dentist;

(7) Repair or re-cementing of crowns, inlays, onlays, bridgework or dentures; or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more that one relining or rebasing in any period of 36 consecutive months; and

(d) Benefits for Covered Dental Expenses incurred for correction of damage caused by an accident occurring while covered for the Dental Expense Benefits of the Program are payable at 80% [100% in case of Covered Dental Expenses described in paragraph 5.7(a)] of the usual, reasonable and customary charge and are not subject to the maximum benefit referred to in paragraph 5.2.

(e) Benefits for the following Covered Dental Expenses are payable at 60% of the usual, reasonable and customary charge:

(1) Initial installation of implants or fixed bridgework to replace missing natural teeth (including inlays and crowns as abutments except periodontal splinting);

(2) Initial installation of partial or full removable dentures (to replace missing natural teeth and adjacent structures (including precision attachments which can be justified as functionally necessary with study models and radiographs) and any adjustments during the six-month period following installation;

(3) Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:

(i) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or

(ii) the existing denture or bridgework that cannot be made serviceable and it was installed at least five years prior to its replacement; or

(iii) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

Normally, dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a Covered Dental Expense.

(4) Inlays, onlays, gold fillings, or crown restorations to restore diseased teeth, but only when the tooth, as a result of extensive care, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filing restoration.

(f) Benefits for the following Covered Dental Expenses are payable at 60% of the usual, reasonable and customary charge:

(1) Orthodontic diagnostic procedures (including X-rays) and treatment consisting of appliance therapy and surgical therapy (the surgical repositioning of the jaw, facial bones and/or teeth to correct malocclusion) for dependent children under 19 years of age. (Related oral examinations, surgery and extractions are covered under paragraphs 5.7(a), 5.7(b), 5.7(c)(2) and (3) and are not considered "orthodontic diagnostic procedures and treatments".)

(2) Orthodontic treatment means preventive and corrective treatment of all those dental irregularities which result from the anomalous growth and development of dentition and its related anatomic structures or as a result of accidental injury and which require repositioning (except for preventive treatment) of teeth.

5.8 Limitations

The following limitations apply:

(a) **Restorative:**

(1) Gold, baked porcelain restorations, crowns and jackets If a tooth can be restored with a material such as amalgam, payment of the applicable percentage of the charge for that procedure will be made toward the charge for another type of restoration which you and your dentist may select. In such case, you are responsible for the balance of the treatment charge.

(2) Reconstruction - Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to alter vertical dimension in restoring occlusion are considered optional and their cost remains your responsibility.

(b) **Prosthodontics:**

(1) Partial Dentures - If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision appliance that you and your dentist may choose to use; the balance of the cost remains your responsibility.

Precision Attachments - Benefits will not be provided for precision attachments when used for cosmetic purposes.

(2) Dentures - If, in the provision of denture services, you and your dentist decide on personalized or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment and the balance of the cost remains your responsibility.

(3) Replacement of Existing Dentures or Fixed Bridgework Replacement of an existing denture or fixed bridgework will be a Covered Dental Expense only if the existing denture or fixed bridgework is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a Covered Dental Expense only if at least five years have elapsed since the date of the initial installation of that appliance.

(c) **Orthodontics:**

(1) If orthodontic treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services shall be resumed to the extent of the remaining maximum lifetime benefit applicable to such individual.

(2) The benefit payment for orthodontic services shall be only for months that coverage is in force.

(d) **Course of Treatment in Progress on Effective Date of Dental Expense Benefits:** Benefits are not provided for treatment received prior to commencement of coverage. Claims for a course of treatment which was started prior to commencement of coverage but completed while coverage is in force will be investigated to determine the amount of the entire fee which should be allocated to the treatment which was actually received while covered. Only that portion of the total fee which can be allocated to treatment received while covered will be included as a Covered Dental Expense.

5.9 Exclusions

The following are not Covered Dental Expenses:

(a) Services other than those specifically covered herein;

(b) Charges for treatment by other than a licensed dentist or licensed physician, except

(1) charges for scaling or cleaning of teeth and topical application of fluoride performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the dentist, and

(2) charges by a dental school if the services are not experimental, the dental school customarily charges for services and the services are performed under the supervision of a licensed dentist;

(c) Charges for veneers (the coating or covering of plastic or porcelain on the outside of and bonded to a crown or false tooth to cause it to blend with the color of surrounding teeth) or similar properties of crowns and pontics placed on or replacing teeth, other than the 10 upper and lower anterior teeth;

(d) Charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;

(e) Charges for prosthetic devices (including bridges), crowns, inlays and onlays, and the fitting thereof which were ordered while the individual was not covered for Dental Expense Benefits, or which were ordered while the individual was covered for Dental Expense Benefits but are finally installed or delivered to such individual more than 60 days after termination of coverage;

As used herein “ordered” means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays and onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.

(f) Charges for the replacement of a lost, missing, or stolen prosthetic device;

(g) Charges for replacement;

(h) Charges for any services which are covered by any worker's compensation laws or employer's liability laws, or services which an employer is required by law to furnish in whole or in part;

(i) Charges for services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer;

(j) Charges for services or supplies, for which no charge is made that you are legally obligated to pay or for which no charge would be made in the absence of dental expense coverage;

(k) Charges for services or supplies which are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;

(l) Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services and supplies which are experimental in nature;

(m) Charges for services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;

(n) Services or supplies which are obtained by you or your dependent from any governmental agency without cost by compliance with laws or regulations enacted by any federal, state, municipal or other governmental body;

(o) Charges for any duplicate prosthetic device or any other duplicate appliance;

(p) Charges for any services to the extent for which benefits are payable under any health insurance program supported in whole or in part by funds of the federal government or any state or political subdivision thereof;

(q) Charges for oral hygiene and dietary instruction;

(r) Charges for a plaque control program (a series of instructions on the care of the teeth); and

(s) Charges for periodontal splinting.

5.10 Date Expenses Are Incurred.

Benefits are provided only for Covered Dental Expenses incurred on a date when coverage by the Dental Expense Benefits provisions in this Section is in effect for you or your dependent who incurs such expenses. Covered Dental Expenses are considered to have been incurred on the date when the applicable dental services, supplies, or treatments are received, except as otherwise provided in paragraph 5.9(e).

5.11 How To File a Claim. If Your Dental Expense Benefits Coverage Has Become Effective:

You should obtain the Metropolitan dental expense claim form, which includes instruction for filing a claim from any Employee Relations Office. Detailed instructions for the filing of the claim will be provided with the claim form.

5.12 Subrogation

In the event any Dental Benefits are provided under the Program to you or to one of your dependents. Metropolitan shall be subrogated and succeed to your rights of recovery thereof against any person or organization except against insurers on policies of insurance issued to you as an individual. You or your dependent will be notified in the event Metropolitan elects to enforce its rights of subrogation. You or your dependent will be required to execute and deliver such instruments and papers and do whatever else is necessary to secure such rights.

5.13 Proof of Claim

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

5.14 Initial Determination

After you submit a claim for dental benefits to the Claims Administrator, the Claims Administrator will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within 24 days (15 days in the case of a pre-service claim and 72 hours in the case of an urgent care claim) from the date the Claims Administrator received

your completed claim, except for situations requiring an extension of time of up to 15 days because of matters beyond the control of Plan. If the Claims Administrator needs such an extension, the Claims Administrator will notify you prior to the expiration of the initial 24 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of the Claims Administrator's notice requesting further information and an extension until the Claims Administrator receives the requested information does not count toward the time period the Claims Administrator is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from the Claims Administrator.

If the Claims Administrator denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because the Claims Administrator did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge of relevant documents.

Appealing the Initial Determination

If the Claims Administrator denies your claim, you may take two appeals of the initial determination. Upon your written request, the Claims Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to the Claims Administrator at the address indicated on the claim form within 180 days of receiving the Claims Administrator's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why you are appealing the initial determination.

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After the Claims Administrator receives your written request appealing the initial determination or determination on the first appeal, the Claims Administrator will conduct a full and fair review of your claim. Deference will not be given to initial denials, and the Claims Administrator's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim, or a subordinate of such individual. If the initial denial is based in whole or in part on a medical judgment, the Claims Administrator will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination. The Claims Administrator will notify you in writing of its final decision within 30 days (15 days in the case of a pre-service claim and

72 hours in the case of an urgent care claim) after the Claims Administrator's receipt of your written request for review.

If the Claims Administrator denies the claim on appeal, the Claims Administrator will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written, request the Claims Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim.

You must complete the appeals process described above before taking any other action, except that you may proceed directly to the Grievance Procedure described in Section 9 of this Booklet prior to completing the appeals process described above. You are, however, encouraged to use the appeals process described above prior to using the Grievance Procedure.

SECTION 6. VISION CARE BENEFITS
(For You and Your Dependents)

6.0 Introduction

You and your eligible dependents are covered by the Vision Care Benefits outlined in this Section 6 (the "Vision Care Benefits"). Vision Care Benefits under the Program are administered by the entity listed on page iv as the Claims Administrator for Vision Benefits. This Program provides you with flat dollar payment for vision care services and supplies. In addition, it provides you with certain discounted prices when you utilize the services of Participating Providers.

6.1 Summary of Vision Care Benefits

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

.

SUMMARY OF VISION CARE BENEFITS
(Effective as of January 1, 2023)

Service/ Product	Allowance	Patient Responsibility	Frequency
Eye Exam and Refraction	$48	In-Network: $0 Out-of-Network: Provider Charge	Once per 12 months
Single Vision Lenses (standard)	$72	In-Network: $0 Out-of-Network: Provider Charge	Once per 12 months
Bifocal Lenses (standard)	$108	In-Network: $0 Out-of-Network: Provider Charge	Once per 12 months
Trifocal Lenses (standard)	$138	In-Network: $0 Out-of-Network: Provider Charge	Once per 12 months
Aphakic/ Lenticular Lenses	$216	In-Network: $0 Out-of-Network: Provider Charge	Once per 12 months
Non-Standard Lenses (excluding photochromatic, polycarbonate and anti-reflective coating)	Same Allowances as standard	In-Network: Difference between charge and Allowance with a 10% discount Out-of-Network: Provider Charge	Once per 12 months
Non-Standard Lenses (photochromatic, polycarbonate, anti-reflective coating)	Same Allowances as standard, plus up to $60 for each option	In-Network: Difference between charge and Allowance with a 10% discount Out-of-Network: Provider Charge	Once per 12 months
Progressive Lenses	$150	In-Network: Difference between charge and Allowance with a 10% discount Out-of-Network: Provider Charge	Once per 12 months
Frames	$150	In-Network: $0 – up to $150 retail; Over $150 retail – patient pays the difference between $150 and charge Out-of-Network: Provider Charge	Once per 12 months
Contact Lens Fitting and Prescription	$30 – Daily $45 – Extended	In-Network: $0 Out-of-Network: Provider Charge	Once per 12 months

SUMMARY OF VISION CARE BENEFITS (Effective as of January 1, 2023)			
Standard Contact Lenses (see paragraph 6.4(b))	$150	In-Network: $0 Out-of-Network: Provider Charge	Once per 12 months
Specialty Contact Lenses (see paragraph 6.4(b))	$150	In-Network: $0 – up to $150 retail; Over $150 retail – patient pays the difference between $150 and charge Out-of-Network: Provider Charge	Once per 12 months
Disposable Contacts Unlimited	$150	In-Network: $0 up to $150. Patient pays difference, if any, between $150 and provider's charge Out-of-Network: Provider Charge	Once per 12 months
Additional Services or Products – LASIK and PRK Vision Correction Procedures	15% off Retail price or 5% off promotional pricing	N/A	As needed
Vision Care Options Additional Pairs	40% off Complete pair eyeglass purchases and 15% off conventional contact lens once the funded benefit has been used.	N/A	As needed

6.2 Eligible Providers of Service

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

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

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

6.3 Payment For Professional Services

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

6.4 Payment For Post-Refractive Services and Supplies

(a) **Eyeglasses**

- **Frames:** Contracting suppliers and Participating Providers agree to accept the lower of the Allowance or the amount charged as payment-in-full for frames which have a charge of $150 or less. If you choose frames with a charge over $150, you are responsible at the point of purchase for the difference between $150 and the charge.
- **Lenses:** Contracting suppliers and Participating Providers agree to accept the lower of the Allowance or the amount charged as payment-in-full for standard lenses. If you choose nonstandard lenses, you are responsible for the difference between the charge for standard lenses (plus up to a $60 Allowance for each photochromatic, polycarbonate, anti-reflective coating option) and the charge for nonstandard lens options. This differential payment must be made at the point of purchase. Contracting suppliers and Participating Providers agree to accept these payments — the Allowance plus the differential payment — as payment-in-full for nonstandard lenses. Nonstandard lenses are those that have, as a part of their manufacturing process, been provided with features that enhance their desirability to consumers. Such lenses include, but are not limited to, polycarbonate lenses and progressive "no-line" bifocals. At your option, plastic lenses, tints equal to tints #1 or #2, or contact lenses may be substituted for glass lenses. Leases should meet the Z80.1 or Z80.2 standards of the American National Standards Institute.

(b) **Contact Lenses**

- Contracting suppliers and Participating Providers agree to accept the lower of the Allowance or the amount charged as payment-in-full for standard contact lenses valued at $150 or less.
- If you choose standard contact lenses valued in excess of $150, you are responsible at the point of purchase for the difference between $150 and 85% of the remaining balance of the charge for the standard lenses.
- If you choose disposable contact lenses, the contracting supplier or Participating Provider agrees to accept the Allowance as payment-in-full for lenses that have a charge of $150 or less. You are responsible at the point of purchase for the difference between $150 and the charge for the disposable lenses. Contracting suppliers and Participating Providers agree to accept the amount charged as payment in full for Specialty (Medically Necessary) contact lenses.
- Participating Providers and contracting suppliers will accept the Allowances described in the Summary of Vision Care Benefits as payment for their services and supplies and charge you only the copayments described in the Summary of Vision Care Benefits. If you use a Participating Provider or contracting supplier for eyeglasses and contact lenses, you will not have to file a claim. However if you use a Non-Participating Provider, you will have to pay the provider's charge and then file a claim for the amount of the Allowance to be paid to you directly. You will not receive any payment for the difference between the Allowance and the amount of the Non-Participating Provider's charge.

6.5 Provider/Supplier Sale Items

You may not obtain eyeglasses and contact lenses at the prices set forth above and also take advantage of special sale pricing. You have the choice of paying the sale price and not using the

above pricing arrangements or using the above pricing arrangements. You may choose the best deal for you. In all circumstances, however, you will be credited with the Allowances set forth in the Summary of Vision Care Benefits against whatever pricing arrangement you utilize.

Note: This does not affect the discounts on vision care options described below.

6.6 Vision Care Options

Contracting suppliers and Participating Providers agree to sell all other post-refractive supplies and related services at a charge of $15 to $45. Such items include, but are not limited to: special lens treatment applied at your option, such as ultraviolet coating, or scratch-resistant treatment; tints (including tints #1 and #2); gradient tints. See Summary of Vision Care Benefits above for exact amounts. Polarized lenses and other add ons are offered at 20% off retail price.

This 20% discount is in addition to, and not in lieu of, any other special promotions and/or sale prices which affect the charge at the time you purchase post-refractive products and related services. You must pay the contracting supplier or Participating Provider at the point of purchase to receive the discounted price. The Claims Administrator is not responsible for payment of, or reimbursement for, vision care options. Such payment is your responsibility.

6.7 Non-contracting suppliers and Non-Participating Providers do not agree to offer a 10% discount off the charge for vision care options.

6.8 Professional Services

(a) **Eye Examination and Refractive Services**
Such services shall include, but are not necessarily limited to, the following:

(1) Case history;

(2) Visual acuity, near and far;

(3) External examination, including biomicroscopy or other magnified evaluation of the anterior chamber;

(4) Objective, subjective and ophthalmoscopic examinations;

(5) Binocular measure; and

(6) Summary, findings, and recommendations.

(b) **Contact Lens Prescription and Fitting Services**
Such services shall include, but are not necessarily limited to, the following:

(1) Keratometry, or "K" reading, through the use of a keratometer to determine measurements of the eyes, curvature and base curve;

(2) Proper fitting of appropriate contact lenses, including the application of trial contact lenses to the patient's corneas; and

(3) Post-dispensing contact lens follow-up care, including the correction of any ill-fitting or unsuitable lenses.

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

6.9 Post-Refractive Services

Post-refractive services consist of:

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

(b) cost of the materials;

(c) verification of the completed prescription;

(d) adjustment of the completed glasses; and

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

6.10 Limitations

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

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

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

(c) Payment is limited to one set of frames in any 12-month period. Eligibility will be determined from the date of the last previous refraction.

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

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

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

6.11 Additional Savings

In circumstances where the services or products are covered, but exceed the frequency limitations outlined in paragraph 6.12, contracting suppliers and Participating Providers agree to furnish services or products at the Allowance shown in the Summary of Vision Care Benefits, provided you make payment at the point of purchase. You will be solely responsible for the payment of this Allowance.

6.12 Exclusions

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

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

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

(c) for industrial safety glasses and safety goggles;

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

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

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

(g) for drugs or any other medications;

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

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

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

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

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

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

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

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

(p) for temporary devices, appliances, and services;

(q) for which you incur no charge;

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

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

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

(u) treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance.

6.13 How To File A Claim for Services from a Non-Participating Provider or Non-Contracting Supplier

(a) **Authorized Representatives**
You have the right to designate an authorized representative to file or pursue a Claim on your behalf. If you wish to do so, you must notify the Claims Administrator in writing of your choice of an authorized representative. Your notice must include the representative's name, address, telephone number and a statement indicating the extent to which the individual is authorized to pursue the Claim or appeal on your behalf. A consent form that you may use for this purpose will be provided to you by the Claims Administrator upon request. For purposes of this Section, a Claim is a request for payment or reimbursement of the charges or costs associated with Covered Services or supplies.

(b) You may obtain a claim form at the employee benefits office at the plant or location where you are employed. In addition, you may obtain a claim form by calling the Claims Administrator at the telephone number listed on your I.D. card and requesting one. Once you obtain the claim form, you should complete and mail it, along with the required proof of purchase, to the Claims Administrator at the address listed for the Vision Benefits Claims Administrator in the Introduction to this Booklet. To be eligible for payment or reimbursement under the Program, your Claim must be submitted to the Claims Administrator no later than one year from the date of service.

(c) The Claims Administrator will notify you in writing of its determination on your Claim within a reasonable period of time following receipt of your Claim. That period of time will not exceed 30 days (72 hours in the case of an urgent care claim or 15 days in the case of a pre-service claim) from the date your Claim is received by the Claims Administrator. However, this 30 day period of time may be extended one time by the Claims Administrator for an additional 15 days, provided that the Claims Administrator determines the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 30 day determination period. If an extension of time is necessary because you failed to submit information necessary for the Claims Administrator to make a decision on your Claim, the notice of extension sent to you will specifically describe the information you must submit. In this event, you will have at least 45 days from the date such notice is received to submit the information before a decision is made on your Claim.

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

6.14 Complaint and Appeal Process

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

I. Complaint and Appeal Process Definitions

Acknowledgement Letter - A letter sent by a Quality Assurance Specialist to a claimant no later than three (3) business days from receipt of a Complaint or Appeal acknowledging the date of receipt and describing the applicable procedure and timeframe as described in this policy. An Acknowledgement Letter for a verbal Complaint must be accompanied by a Complaint Form. If a Complaint is resolved within three (3) business days of the receipt of the Complaint, the Acknowledgement Letter shall also include the resolution and a description of the Appeal procedure and timeframe.

Appeal (Level Two) - A claimant who is dissatisfied with the resolution of their Complaint may file an Appeal for a second level review of the Complaint by the Grievance Sub-Committee.

Complaint - Any dissatisfaction expressed by a complainant verbally or in writing to the Claims Administrator including, but not limited to, dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction or termination of a service for reasons related to medical necessity; the way a service is provided; or disenrollment decisions expressed by claimant.

Complaint and Appeal Log - All Complaints and Appeals received are logged in the Complaint and Appeal Log in accordance with Section IV of this Policy.

Complaint Sub-Committee - The Complaint Sub-Committee is comprised of the Claims Administrator Medical Director, the Sr. Director of Professional Operations, the Quality Assurance Specialists, Sr. Manager of Call Center Operations, and the Claims Administrator's Paralegal. The Complaint Sub-Committee meets on a monthly basis, with additional meetings called as warranted. If specialty care is involved, the Claims Administrator's Medical Director will review and make the decision. The Panel includes a specialist in the field relating to the Appeal.

Complaint File - A Complaint File is kept for each Claimant Complaint and Appeal received by the Claims Administrator. All information and documentation, including copies of all correspondence regarding a Complaint and/or Appeal shall be kept in the File. Files are maintained for a period of seven (7) years from the date of receipt of the Complaint or Appeal.

Complaint Form - A one-page Complaint Form is included with the Complaint Acknowledgement Letter for each verbal Complaint received from a claimant. The Complaint Form must be completed and returned by the claimant for prompt resolution.

Grievance Sub-Committee - A review panel comprised of an Ophthalmologist, Optician, and three (3) Optometrists. The committee will review all appeals concerning quality of care and any appeal from a claimant who disagrees with the resolution of his/her complaint from the Complaint Sub-Committee. The Panel shall not include anyone involved in the resolution of the Complaint (Level One).

Inquiry - questions received by the Customer Service Representative from claimant which the Customer Service Representative is able to resolve the issue within 48 hours of receipt and do not involve quality of care issues.

Resolution Letter - A letter sent to the claimant by the Quality Assurance Specialist that details the outcome of the Complaint or Appeal. A Resolution Letter includes the specific medical determination, clinical basis and/or contractual criteria used to determine the outcome of the Complaint or Appeal and the specialization of any physician or other provider consulted. In addition, a Complaint Resolution Letter includes a description of the Appeal procedure and timeframe, and an Appeal Resolution Letter includes the toll-free telephone number and address of any specific state requirement.

II. Inquiry

A. Customer Service Representative reviews the inquiry and contacts the Professional to obtain information concerning the claimant's complaint. The Customer Service Representative attempts to resolve the complaint between the claimant and the Professional.

B. If the Customer Service Representative is unable to reach a resolution that is acceptable to the parties involved, or if the issues outlined in the complaint question the quality of care delivered to the claimant, the Customer Service Representative forwards the inquiry to the Resource Team.

C. If the Resource Team is unable to reach a resolution within 48 hours that is acceptable to the parties involved the claimant is asked to formally submit the complaint in writing, and, if applicable, furnish copies of any relevant paperwork, such as receipts, prescriptions, etc., to the attention of the Quality Assurance Department of the Claims Administrator by mail or fax to the following address:

4000 Luxottica Place
Mason, OH 45040
1-513-765-3024

If the claimant wants to submit a verbal complaint the Resource Team must collect all information and submit it to the Quality Assurance Department on behalf of the claimant.

III. Complaint Procedure

A. Standard Complaint Procedure

1. Upon receipt of a Complaint, the Quality Assurance Specialist logs the Complaint on the Complaint and Appeal Log and creates a claimant Complaint File. All information and documentation, including copies of all correspondence, shall be kept in the File.

2. The Quality Assurance Specialist sends a Complaint Acknowledgement Letter to the claimant no later than three (3) business days from receipt of the Complaint. If a Complaint is resolved within three (3) business days of receipt of the Complaint, the Complaint Acknowledgement Letter shall

contain the resolution, along with a description of the Appeal process and timeframe.

3. For verbal Complaints, the Complaint Acknowledgement Letter is accompanied by a Complaint Form. The Complaint Form must be completed and returned by the claimant for resolution of the claimant's Complaint. If a completed Complaint Form is not received within fifteen (15) business days of the date of the Complaint Acknowledgement Letter, the Quality Assurance Specialist shall perform one (1) follow-up telephone call to the claimant. Notwithstanding the foregoing, the Quality Assurance Specialist will resolve the Complaint to the best of the Quality Assurance Specialist's ability based upon the information received.

4. The Quality Assurance Specialist researches the Complaint and obtains all relevant information regarding the issue(s) involved. This includes sending a summary of the complaint via certified mail to the Provider requesting copies of the claimant's file and an explanation regarding the complaint. The Provider is asked to respond in writing to the complaint, to the Claims Administrator within ten (10) business days of receipt. If the Provider fails to respond within ten (10) business days, the Provider is contacted by telephone by the Quality Assurance Specialist to verify that a response is forthcoming. If the response is still not received within five (5) business days of the telephone inquiry, the claimant's complaint is forwarded to the Complaint Sub-Committee without the Provider's response and a notation is made in the Provider's file that the Professional failed to respond to the request for information and the provider will begin the disciplinary process.

5. The Quality Assurance Specialist forwards all information regarding the Complaint to the Complaint Sub-Committee. If the Complaint involves a medical issue, the Quality Assurance Specialist shall consult with the Medical Director who shall make a decision regarding the Complaint.

6. Upon resolution of the Complaint, the Quality Assurance Specialist records the decision on the Complaint and Appeal Log and sends a Resolution Letter to the claimant. The Resolution Letter includes a statement of the specific medical determination, clinical basis and/or contractual criteria used to make the decision and the specialization of any physician or other provider consulted, along with a description of the Appeal process and timeframe.

7. The Claims Administrator acknowledges, investigates and resolves all claimant Complaints no later than thirty (30) calendar days from receipt of a written Complaint or completed Complaint Form from the claimant.

IV. Grievance Procedure (First Level of Appeal)

A. If a claimant disagrees with the resolution of their Complaint, they may file a request for an Appeal with the Claims Administrator.

B. Upon receipt of a claimant's request for Appeal, the Quality Assurance Specialist logs the Appeal on the Complaint and Appeal Log and pulls the original claimant Complaint File. All documentation regarding the Appeal, including copies of all correspondence, shall be kept in the claimant's original Complaint File.

C. The Quality Assurance Specialist sends an Appeal Acknowledgement Letter to the claimant no later than three (3) business days from receipt of the claimant's request for an Appeal.

D. The claimant has the right to appear before the Grievance Sub-Committee where the claimant normally receives their health care or at another site agreeable to the parties. The Quality Assurance Specialist shall contact the claimant and provide written confirmation of the date and time of the claimant's scheduled Panel Meeting.

1. No Grievance Sub-Committee claimant shall have previously been involved in the disputed decision.

2. The Grievance Sub-Committee is comprised of an ophthalmologist, optician, and three (3) optometrists.

E. The claimant may bring a friend or family member; however, the friend or family member may not be present for the Panel discussion or voting. Neither side will utilize legal counsel during the proceeding.

F. The claimant has the right to request the presence of and question any person responsible for the Complaint resolution.

G. The claimant has the right to present alternative expert testimony.

H. The claimant has the right to address a written Appeal and/or submit written information to the Grievance Sub-Committee.

I. No later than five (5) business days before the scheduled Grievance Sub-Committee meeting, the Claims Administrator shall provide the claimant all documentation to be presented to the Grievance Sub-Committee by the Claims Administrator; the specialization of any physician or other provider consulted during the investigation; and, the name and affiliation of the Grievance Sub-Committee claimants.

J. Following the decision of the Grievance Sub-Committee, the Quality Assurance Specialist documents the resolution in the claimant Complaint File and the Complaint and Appeal Log and sends the claimant a Resolution Letter. The Letter includes the following:

1. A statement of the specific medical determination, clinical basis and contractual criteria used to make the decision.

2. The specialization of any physician or other provider consulted.

K. The Claims Administrator acknowledges, investigates and resolves all claimant Appeals no later than thirty (30) calendar days from receipt of a request for an Appeal.

V. Claim Appeal Process (Second Level of Appeal)

The claimant may request that the Claims Administrator review a claim that was denied. To make this request, the claimant must send the Claims Administrator a written letter of appeal no more than 180 calendar days after the date of the denied claim. The written letter of appeal should include the following:

- The claim number, a copy of the Claims Administrator denial information, or a copy of the Claims Administrator Explanation of Benefits.
- The item of vision coverage that you feel was misinterpreted or inaccurately applied.
- Additional information from your eye care provider that will assist the Claims Administrator in completing its review of your appeal, such as documents, records, questions or comments.

The written letter of appeal should be mailed to the attention of the Quality Assurance Department of the Claims Administrator at the following address:

4000 Luxottica Place
Mason, OH 45040

Time Frames for Appealed Claims

Activity	Time Frame
Claimant - Appeal of Adverse Determination	180 calendar days after the denial
Plan - Decision on Appeal	30 calendar days

The Claims Administrator will review the appeal for benefits and notify the claimant in writing within thirty (30) calendar days of receipt of the appeal. If the appeal is denied, the written decision includes the reasons for the denial along with reference to the plan or insurance policy provisions on which the denial is based; a statement that the claimant may receive free of charge reasonable access to or copies of any voluntary procedure for an additional appeal, if applicable, and the right to file a civil action.

VI. Complaint and Appeal Documentation and Record Retention

A. The Claims Administrator maintains a Complaint and Appeal Log regarding each Complaint and Appeal. The Log identifies those Complaints relating to delegated entities.

1. At a minimum, the following information is recorded on the Complaint and Appeal Log regarding all Complaints and Appeals received by the Claims Administrator;

a. Date Received;

b. Claimant Name;
c. Claimant ID;
d. Plan Sponsor;
e. Plan ID;
f. Provider ID (if applicable);
g. Summary of Complaint;
h. Complaint Status;
i. Summary of Resolution;
j. Resolved in Favor of Claimant (Y/N);
k. Date Closed;
l. Complaint Category; and
m. Complaint against Delegated Entity (Mark "x").

2. A Claimant Complaint and/or Appeal is reflected on the Complaint and Appeal Log in one (1) of the following categories;

a. Plan Administration (e.g. marketing, policyholder service, billing, underwriting or similar administrative functions) (NOT APPLICABLE TO PLAN);

b. Benefit Denial or Limitation (e.g. denial of a benefit, refusal to refer or provide requested service) (NOT APPLICABLE TO PLAN);

c. Quality of Provider Care (subcategorized for tracking and tending purposes as Exam, Ancillary Services and Lack of Courteous Treatment); and

d. Claimant Services (subcategorized for tracking and trending purposes as Appointments, Network Accessibility, Claims Issues, Eligibility Issues, Materials Issues and Miscellaneous).

B. The Claims Administrator maintains a complete record of each Complaint and Appeal and any Complaint or Appeal proceeding and any actions taken on a Complaint or Appeal, including Complaints and Appeals.

6.15 You must complete the appeals process described above before taking any other action, except that you may proceed directly to the Grievance Procedure described in Section 9 of this Booklet prior to completing the appeals process described above. You are, however, encouraged to use the appeals process described above prior to using the Grievance Procedure.

SECTION 7. GENERAL PROVISIONS RELATING TO HEALTH CARE BENEFITS

7.0 Coordination of Benefits

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

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

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

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

(2) Where both plans cover the patient as a dependent child, and the parents are not legally separated or divorced, the plan of the parent whose birthday falls earlier in the year will be the primary plan. However, if both parents have the same birthday, the plan of the parent who has been covered for the longer period of time will be primary. If the spouse's plan does not determine the order of benefits by the birthday rule, the plan covering the patient as a dependent child of a male will be the primary plan. In any event, if the parents are separated or divorced, benefit determination will be as follows:

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

(B) if there is no court decree and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody;

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

(3) Where the determination cannot be made in accordance with (1) or (2) above, the plan which has covered the patient for the longer period of time will be the primary plan.

Note: In any case where this Program is determined to be secondary pursuant to (a) or (b) above, benefits otherwise payable under this Program are reduced by benefits paid by the other plan, except medical benefits are calculated by reducing covered medical expenses under this Program by the other plan payment.

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

(d) If it is determined that benefits under this Program should have been reduced because of benefits provided under another group plan, the Claims Administrator will have the right to recover any payment already made which is in excess of its liability. Similarly, whenever benefits which are payable under the Program have been provided under another group plan, the Claims Administrator may make reimbursement direct to the insurance company or other organization providing benefits under the other plan.

(e) For the purpose of this provision, the Claims Administrator may, without the consent of, or notice to, any person, release to, or obtain from, any insurance company or other organization or person any information which may be necessary regarding coverage, expenses and benefits.

(f) Any person claiming benefits under this Program must furnish the Claims Administrator such information as may be necessary for the purpose of administering this provision.

7.1 Medical Necessity

Health Care Benefits under the Program are payable only if the services rendered are medically necessary. Medically necessary means that the services and supplies in question are medically reasonable and necessary for the diagnosis or treatment of an illness or accidental injury and are given at the appropriate level of care. The fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary. In determining questions of reasonableness and necessity, due consideration shall be given to the customary practices of physicians in the community where the service is performed. Services which are not reasonable and necessary shall include, but are not limited to the following:

(a) procedures which are experimental or of unproven or questionable current usefulness;

(b) procedures which tend to be redundant when performed in combination with other procedures;

(c) diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly;

(d) procedures which are not ordered by a physician or which are not documented in timely fashion in the patient's medical record; and

(e) procedures performed in an inpatient setting which could be performed with equal safety and effectiveness in an outpatient setting or treatment which can be performed with equal efficiency and quality at a lower level of care.

7.2 Subrogation

In the event any health care benefits are provided under the Program to you or to one of your dependents, the Claims Administrators and/or any other Company-sponsored health care provider shall be subrogated and succeed to your rights of recovery thereof against any person or organization except against insurers on policies of insurance issued to you as an individual. You or your dependent will be required to execute and deliver such instruments and papers and do whatever else is necessary to secure such rights. You and your dependent will be notified in the event the Claims Administrator elects to enforce its right of subrogation.

7.3 Definition of Dependents

The term "dependents" includes only:

(a) Your spouse,

(b) Your children under 26 years of age. Such children include (1) natural born children, (2) step children, (3) legally adopted children (including children who have been placed with you for adoption), or (4) dependents who become eligible due to a Qualified Medical Child Support Order (QMCSO) and (5) children for whom you have a court-appointed guardianship.

7.4 To be eligible for dependent coverage, proof is required (i.e. birth certificate, court order, etc.) that the dependent meets the requirement stated above.

7.5 If you become divorced or separated, a Qualified Medical Child Support Order ("QMCSO") may require that your child(ren) be enrolled under this Program. You may obtain without charge a copy of the Program's QMCSO Procedures from the Plan Administrator.

7.6 The term dependents does not include a person who is covered under any other group insurance plan or program toward the cost of which the Company contributes or who is covered as an employee under this Program.

7.7 Change in Family Status

It is important that you give prompt written notice on the prescribed form of any change in your family status, such as marriage or divorce, birth of a child, marriage of any of your dependent children, or death of any dependent. Proof of the change will be required (i.e. birth certificate, marriage certificate, divorce decree, etc).

7.8 If you are enrolled for personal coverage only and thereafter marry or otherwise acquire a dependent, dependent coverage will become effective on the date you acquire the dependent, if you notify the Company promptly. If you do not notify the Company within 30 days after the date you acquire the dependent, you will be required to submit proof of such date.

MEDICARE

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

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

(a) Payment under this Program shall be the benefit which would otherwise be payable under this Program reduced by the amount of benefits you or your dependent receive, or would upon application receive, under Part A (Hospital Insurance Benefits) or Part B (Supplementary Medical Insurance Benefits) of Medicare.

Note: In calculating benefits in Section 3, Covered Services will be reduced by Medicare benefits before applying the Deductible, if any, imposed by this Program.

(b) For any month for which you or a dependent of yours is covered under Section 3 of this Program, the Company will reimburse you for the Medicare Part B premium, except where the Part B charge for a dependent is deducted from Social Security or Railroad Retirement benefits.

7.10 Active Employees and Their Spouses Age 65 or Older

If you continue to work after age 65 or if your spouse becomes age 65 while you are still actively employed, you and your spouse, as applicable, will continue to be covered under this Program on the same basis as any other Employee and Dependent under age 65. However, you and your spouse can elect Medicare as your primary coverage for medical care expenses instead of this Program. If you make the election you must notify the Company, in writing that you no longer wish to be covered by this Program.

The above choice to elect Medicare as primary coverage applies independently to you and your eligible spouse.

If you choose to continue the regular coverage under this Program on the same basis as an Employee under age 65, you will not be reimbursed for the premium you pay for Part B of Medicare. If you elect Medicare as primary payor, you should contact your Human Resources Department to determine if you will be reimbursed for the Part B premium.

Even though you may elect Medicare as your primary payor, you will still be covered under the other programs (e.g., dental care, etc.) not related to Medicare.

7.11 Disabled Employees and Dependents

If you or your Dependent become eligible for Medicare due solely to disability, you or your Dependent, as applicable will continue to be covered under this Program on the same basis as any other Employee or Dependent under age 65. Unless required otherwise by law, benefits under Medicare will be primary for disabled dependents who are eligible for Medicare.

If you or your Dependent are eligible for Medicare solely due to end stage renal disease, the benefits for Covered Expenses due to that disease are payable under this Plan first during the first thirty (30)

months in which renal dialysis treatment starts for that person, or for kidney transplants, with the first month the Employee or Dependent is enrolled for Medicare.

7.12 When to Enroll for Medicare

It is important that you or your Dependent enroll for Medicare Part A (if Medicare Part A is available without charge) and Medicare Part B during the three month period before becoming eligible for Medicare.

Additionally, if you or your Dependent becomes eligible for Medicare Part B by reason of disability, you should accept enrollment in Medicare Part B following notification by the government of your automatic enrollment in Medicare Part A and your eligibility for Medicare Part B.

You may continue in the Program and decline Medicare Part B coverage. If you do not enroll for Medicare B on a timely basis (i.e., not later than the end of the third month following the month in which that person attains age 65 or within the seven calendar month period following your retirement, if later), you can subsequently enroll for Medicare B coverage only during the months of January, February, and March of any year with Part B coverage becoming effective the following July 1. It is important for you to enroll for Medicare B immediately upon your retirement, since any delay in the effective date of Medicare B coverage will result in a gap in health care coverage because the Company's retiree medical plan provides that benefits payable under the Program will be reduced by benefits payable under Medicare, whether or not the person is enrolled for Medicare coverage. There is no penalty surcharge added to the Medicare Part B premium for late enrollment if this Plan is primary.

7.13 Benefits While Traveling Outside the United States or Puerto Rico

If you or a dependent of yours is hospitalized and/or treated by a physician while traveling outside the United States or Puerto Rico, you will probably be required to pay the provider for such services since hospitals and physicians in foreign countries generally do not honor coverage through the Claims Administrator or Medicare identification cards. Be sure to obtain itemized receipts detailing the dates and types of services performed and the charges incurred. Such receipts are then to be submitted to the Claims Administrator for reimbursement on the same basis as if the expenses were incurred in the United States. If the person incurring the expenses is covered under this Program and eligible for Medicare but Medicare benefits are not payable because Medicare does not cover care outside the United States (except for certain services incurred in Canada or Mexico), benefits will be provided under this Program as if such person were not eligible for Medicare. However, no benefits will be provided under this Program if you elected to terminate your medical coverage under this Program pursuant to paragraph 7.10.

7.14 Other Provisions

Notwithstanding any contrary provision of the Program, the following will apply:

(a) Regardless of medical necessity, sterilization procedures will be covered under Section 3 of the Program.

(b) The maternity and obstetrical benefits of the Program are provided for elective abortions where permitted by law.

(c) For any type of human organ or tissue transplant requiring surgical removal of the donated part from a living donor to a transplant recipient, benefits under Section 3 of the Program are payable as follows:

(1) When the transplant recipient and donor are both covered under the Program, payment for covered services will be provided for both.

(2) When the transplant recipient is covered under the Program but the donor is not, payment for covered services will be provided for both the recipient and the donor to the extent that charges for such services are not payable under any other insurance. Benefits payable on behalf of the donor are charged to the recipient's claim.

(3) When the transplant donor is covered under the Program but the recipient is not, payment for covered services attributable to the donor will be provided to the extent that charges for such services are not payable under any other insurance. Payment will not be provided for services attributable to the recipient.

7.15 Benefit Coverage for Surviving Spouse and Eligible Dependents

In the unfortunate event an employee dies as the result of a work-related accident, the surviving spouse (if any) and eligible dependents of the deceased employee shall be eligible to participate in health care coverage, including dental and vision, under the terms of this Agreement, at no cost, until he/she either remarries or becomes eligible for Medicare.

In the unfortunate event an employee dies while on active payroll, but not as the result of a work-related accident, the surviving spouse (if any) and eligible dependents of the deceased employee shall receive Company-paid COBRA coverage for six (6) months following the death of the employee.

SECTION 8. GENERAL

8.0 Eligibility

You will be eligible to participate in the Program if you are actively at work on or after the date the Program becomes effective, in the regular service of the Company in a group of employees designated by the Company as covered by the Program. If you are enrolled in the Program more than once because you are in more than one of such groups, you will be deemed to have only that coverage which provides you the highest benefits.

8.1 Part-Time Employees

If you are a part-time employee (an employee who for the mutual convenience of the employee and the Company is regularly scheduled to work fewer hours than the straight-time schedule of full-time employees), the following applies to you:

(a) The amount of your life insurance and the amount of your sickness and accident weekly benefit, as determined from the schedules set out in paragraphs 1.0 and 2.4, will be reduced to amounts equitably related to the hours worked by you in comparison to hours worked by full-time employees.

(b) Your dependents will not be eligible for health care benefits of the Program.

(c) In applying the provisions of paragraph 7.0 concerning coordination of benefits, any other group plan providing you benefits will be deemed to be the primary plan as compared to this Program.

If at any time you become a full-time employee, the provisions applicable to full-time employees will apply to you.

8.2 The determination as to the amount of your life insurance and sickness and accident weekly benefit will be made when you first become covered under the Program and will be reviewed and adjusted each year at the time of the annual review of insurance classification as described in paragraph 8.7. In making such review the requirement that you be paid for 240 hours in the applicable pay periods will be appropriately modified.

8.3 Enrollment and Effective Date of Coverage

If you are a new employee, you will be enrolled in the Program at the time of your employment with coverage becoming effective as of the dates specified below.

8.4 If you have dependents you will be enrolled for dependent coverage, except that if both man and wife are eligible for enrollment under the Program, each will be enrolled for personal coverage only unless there are dependent children, in which case the husband will be enrolled for dependent coverage except as the man and wife elect otherwise; provided, however, that such an election may not be revoked within the first twelve calendar months following the month in which such election is made.

In the event that the coverage of either the husband or wife is terminated for any reason, that individual and that individual's enrolled dependents will automatically be enrolled as dependents of the other covered employee.

8.5 All of your coverage under the Program will become effective 60 calendar days from your date of hire, whichever comes first. The effective date of your medical, dental and vision benefits will not

be delayed if you are absent from work due to a health-related factor. If you are a student hired on or after May 1 for summer employment, however, you will not be covered for the Dental Benefits of the Program unless such employment extends beyond September 30, in which case you will then be covered for Dental Benefits as provided above. Dependent coverage becomes effective on the same date as your coverage.

If you enroll for optional life insurance at the time you are enrolled for basic life insurance, you will be covered for optional life insurance on the date you become covered for basic life insurance. If you do not enroll for optional life insurance within 31 days after that date you will be required to submit evidence of good health satisfactory to the insurance company in order to obtain optional life insurance.

8.6 Determination of Insurance Classification

If you were covered under the Program of Insurance Benefits in effect prior to this Program, your insurance classification will remain the same, subject to paragraph 8.7. If you were not covered under the Prior Program, the job classification for the job to which you are assigned at the time of enrollment will be used as the basis for determining your insurance classification.

8.7 Change of Insurance Classification

There will be a review of your insurance classification each calendar year. Your classification will be changed upward on each August 1 if, in the last six biweekly pay periods ended prior to July 1 in that year, your average job classification for the hours for which you were paid in those periods entitles you to a higher insurance classification and you were paid for at least 240 hours in those periods. (If during those periods you did not work some hours solely because of a compensable disability incurred during the course of employment by the Company, such hours shall be deemed to be hours for which you were paid for the purpose of determining whether you were paid for 240 hours during those periods.) If, on such August 1 you are absent from work, such change will take effect as of the first day of the calendar month following your return to work.

8.8 A general and uniform change in wage rates will not affect the amount of your insurance.

8.9 Provisions Applicable to Coverage if You Cease Active Work Because of Certain Specified Reasons

If you cease work because of non-occupational disability the following provisions will be applicable to your coverage other than optional life insurance under the Program:

(a) If you have 10 or more years of continuous service on the date you cease work, all your coverage will be continued during absence due to such disability up to a maximum of 18 months from the end of the month in which you last worked, subject to the provisions relating to total disability as described in paragraph 1.2.

(b) If your disability continues beyond that period, you may elect, on or before the 15th day of the 19th month of such disability, to continue your medical benefits, dental and vision care coverage as an optional additional benefit for not more than the next 6 months of disability, provided you make payments in the same manner as outlined in paragraph 8.15. However, if you have 15 or more years of continuous service on the date you cease work, all coverage will be continued until the end of the last month during which you are eligible for sickness and accident benefits.

(c) If you have two or more but less than 10 years of continuous service on the date you cease work, all your coverage will be continued during absence due to such disability up to a

maximum of 12 months from the end of the month in which you last worked, subject to the provisions relating to total disability as described in paragraph 1.2.

(d) If you have less than two years of continuous service on the date you cease work, all your coverage will be continued during absence due to such disability up to a maximum of six months from the end of the month in which you last worked. If you continue to be disabled beyond such period and your life insurance is not being continued in accordance with the provisions relating to total disability described in paragraph 1.2, your life insurance will continue in effect for an additional period not to exceed six months. Also, during such continued disability you may elect, on or before the 15th day of the seventh month of disability, to continue your medical benefits, dental and vision care coverage as an optional additional benefit for not more than the next six months of disability, provided you make payments in the same manner as outlined in paragraph 8.15.

8.10 If you cease work because of occupational disability, all your coverage under the Program other than optional life insurance will be continued during absence due to such disability, but not beyond one month following the end of the month from which statutory compensation payments terminate, except that sickness and accident coverage will terminate:

(a) at the end of the last month during which you are eligible for sickness and accident benefits pursuant to paragraph 2.2, if you have 10 or more years of continuous service on the date you cease work, or

(b) at the end of 12 months following the month in which you last worked, if you have two but less than 10 years of continuous service on the date you cease work, or

(c) at the end of six months following the month in which you last worked, if you have less than two years of continuous service on the date you cease work.

8.11 If you cease work because of layoff or leave of absence under the Family and Medical Leave Act, the following provisions will be applicable to your coverage other than optional life insurance under the Program:

(a) Your sickness and accident coverage will terminate on the date you cease work.

(b) If you have 20 or more years of continuous service on the date you cease work, your remaining coverage will be continued during such layoff up to the later of (i) 12 months from the end of the month in which you last worked or (ii) the number of weeks from your date last worked equal to the number of your credit units under the Supplemental Unemployment Benefit Plan as of the date you cease work provided, however, that if your remaining coverage will terminate pursuant to (ii) above on a date other than the last day of the month, such remaining coverage will be continued through the end of that month. Notwithstanding the above, if you become disqualified from receiving Weekly Benefits under paragraph 3.6 of the Supplemental Unemployment Benefit Plan, your remaining coverage will terminate as of the later of (i) 12 months from the end of the month in which you last worked or (ii) the date you first become so disqualified. In addition, if you receive a Weekly Benefit as a result of an additional SUB credit unit granted pursuant to Section IV of Appendix A of the Company's pension plan applicable to you, your remaining coverage will be continued during a week for which such Weekly Benefit is paid. You may elect, on or before the 15th day of the month next following the month in which your coverage otherwise terminates, to continue your life insurance until the end of the month

in which you incur a break in continuous service provided you make payments of $.60 per month per $1,000 of life insurance. Failure to make your life insurance payments on or before the 15th day of any month will terminate such insurance at the end of the last month for which payment has been made.

(c) If you have 10 but less than 20 years of continuous service on the date you cease work, your remaining coverage will be continued during such layoff up to a maximum of 12 months from the end of the month in which you last worked. If your layoff continues beyond that period, you may elect, on or before the 15th day of the 13th month of layoff, to continue your life insurance for not more than the next 12 months of layoff, provided you make payments in the same manner and amount as outlined in (b) above.

(d) If you have two but less than 10 years of continuous service on the date you cease work, your remaining coverage will be continued during such layoff up to a maximum of six months from the end of the month in which you last worked. If your layoff continues beyond that period, you may elect, on or before the 15th day of the seventh month of layoff, to continue your life insurance for not more than the next 18 months of layoff, provided you make payments in the same manner and amount as outlined in (b) above. Also, during such continued layoff you may elect, on or before the 15th day of the seventh month of layoff to continue your medical benefits, dental and vision care coverage as an optional benefit for not more than the next six months of layoff, provided you make payments in the same manner as outlined in paragraph 8.15.

(e) If you have less than two years of continuous service on the date you cease work, your basic life insurance will be continued on the same basis as in (c) above, but your health care benefits coverage will terminate at the end of the month following the month in which you last worked.

(f) If you have exhausted insurance and benefit continuation and are then recalled, additional months of insurance continuation will be provided at the time of your next layoff on the basis of one month's continuation for each full or partial month worked during the recall period, up to the limits provided under the Program.

(g) If you are recalled prior to having exhausted insurance and benefit continuation and are subsequently laid off, you will have added to the remaining months of insurance and benefit continuation at time of recall an additional month for each full or partial month worked during the recall period, up to the limits provided under the Program.

(h) In either event, upon recall you will receive the full insurance and benefit continuation level to which you would otherwise be entitled by reason of seniority after having actually worked a cumulative total of 3 months. In calculating the three (3) cumulative months, a month shall be defined as a calendar month or a portion thereof. It is also understood that in no event will the total of any continuation of coverage provided by the above provisions exceed the limits set forth under the Program.

8.12 If you cease work because of suspension, the provisions set forth in the case of an employee who ceases work because of layoff are applicable, except that sickness and accident coverage will be continued during a period of suspension which is not converted into discharge.

8.13 If you cease work for one of the reasons specified in paragraphs 8.9, 8.10, 8.11, or 8.12 and you do not return to active work because of another one of such reasons, your coverage other than the

optional life insurance under the Program will be continued for the unexpired portion, if any, of the period which would have been applicable if the reason for not returning to active work had been the original reason for cessation of work. However, in no event will any coverage which has terminated for any reason during your absence be reinstated until you return to work. Notwithstanding the above, if you have 20 or more years of continuous service on the date you cease work due to layoff and do not return to work due to disability, the provisions set forth in the case of an employee who ceases to work due to layoff will continue to apply to you.

8.14 If you cease work because of a leave of absence, all your coverage under the Program, except for life insurance, will cease at the end of the month in which you last worked. Your life insurance will continue in effect during such leave of absence for a further period not to exceed six months. However, if your leave of absence continues beyond the end of the month in which you last worked you may elect, on or before the 15th day of the following month of leave of absence, to continue your medical benefits, dental and vision expense coverage as an optional additional benefit for not more than the next six months of leave of absence, provided you make the payments in the same manner as outlined in paragraph 8.15. If earlier termination of coverage is required by federal or state election laws, Program coverage will terminate earlier.

8.15 Payments for Optional Additional Benefits

If, on or before the 15th day of the month following the month in which your hospital, physicians' services, major medical, dental and vision coverage would otherwise cease under the Program, you elect to continue such coverage in force as an optional additional benefit under paragraphs 8.9, 8.10, 8.11, 8.12, or 8.14, you will be required to pay the full premium amount for such coverage. Consequently, except in the case where such premium is being deducted from sickness and accident benefits payable to you, you should arrange to remit the necessary premium payment to the Company each month. Failure to make such payment on or before the 15th day of any month will terminate the insurance at the end of the last month for which payment has been made.

8.16 Optional Life Insurance During Absence From Work

If you cease work because of disability (other than total disability as provided under section 1.2), layoff or leave of absence, you may elect to continue your optional life insurance for the respective periods referred to in paragraphs 8.6 through 8.11 for continuation of basic life insurance, provided you make the regular monthly payments for such optional life insurance. Failure to make such payments on or before the 15th day of any month will terminate such insurance at the end of the last month for which payment has been made.

8.17 Termination of Coverage

If your employment is terminated, by other than retirement all your coverage under the Program will end on the date of such termination. In addition, for the purpose of this paragraph only, you will be considered to have terminated your employment if you are absent from work for a period of five or more calendar days for reasons other than disability, layoff, leave of absence, suspension, vacation, jury duty, witness duty or any other specifically authorized absence and all your coverage under this Program will terminate at the end of the fifth day of such absence.

8.18 Dependent coverage under the Program terminates on the earlier of:

(a) the date your coverage terminates, except that dependent coverage will be continued until the end of the month in which you die; or

(b) the end of the day immediately preceding the date any individual ceases to be an eligible dependent, except that coverage for a dependent child will be continued until the end of

the month in which such person (i) attains age 26 nor disabled, (ii) ceases to meet the disabled dependent criteria.

8.19 Retirement

If you retire under the Company pension plan and, at the time of such retirement, have at least 10 years of continuous service, your life insurance will be continued as set forth in paragraphs 1.3 and 1.5. Any other coverage then in effect under the Program terminates at the end of the month in which employment terminates due to such retirement. See paragraph 8.26 with respect to medical benefits coverage following retirement.

8.20 Life Insurance Conversion Privilege

Upon application to the Claims Administrator within 31 days after your life insurance coverage terminates as provided in paragraphs 8.9 through 8.17, you may arrange to continue your life insurance protection under an individual policy, for an amount not greater than the amount of life insurance you have under the Program at the time of such termination, without medical examination. Such individual policy may be on any one of the forms of policy then customarily issued by the Claims Administrator other than a policy of term insurance or one which provides disability benefits or special benefits in the event of accidental death, and will be issued at the rate applicable to your age and class of risk at that time.

If the Group Insurance Policy is discontinued five years or more after the effective date of the Employee's Life Insurance thereunder, an individual policy of Life Insurance may be obtained subject to the terms and conditions specified in this paragraph, except that the amount of such individual policy shall not exceed the lesser of (a) the amount of the Employee's Life Insurance under the Policy on the date of cessation of such insurance, reduced by any amount of Life Insurance for which the Employee may be or may become eligible under any Group Policy issued or reinstated by the Insurance Company or by any other insurer within thirty-one days after such cessation, and (b) $2,000.

8.21 If your life insurance coverage terminates under the Program as a result of your transfer to other employment which makes you eligible for life insurance under another group insurance plan toward the cost of which the Company or one of its subsidiaries contributes, the amount of life insurance which you may continue under an individual policy as referred to in paragraph 8.20 shall in no event exceed the amount of life insurance terminated under this Program less the amount of life insurance for which you become eligible under such other plan.

8.22 Furthermore, whenever your life insurance under the Program is reduced, you may apply for an individual policy, in accordance with paragraph 8.20, in an amount not greater than the amount of the reduction. Such application must be made within the 31-day period commencing with the effective date of the reduction.

8.23 Any such individual life insurance policy referred to in paragraphs 8.20, 8.21, or 8.22 will become effective at the end of the 31-day conversion period. If you should die during such period, whether or not you have applied for such a policy, an amount equal to the amount of life insurance in force under the Program immediately prior to termination or reduction, less any amount of life insurance for which you became insured under any other group insurance plan as referred to in paragraph 8.21 will be payable to your beneficiary. If any such amount is payable, no life insurance will be payable under paragraph 8.19.

8.24 Medical Benefits Conversion Privilege

Upon application to the health benefits Claims Administrator within 31 days after your medical benefits, dental and vision care coverage under the Program terminates as provided in paragraphs 8.9 through 8.17, you may obtain an individual policy. The converted policy may be obtained by making application to the Claims Administrator and will provide the benefits, call for the premiums and include the provisions applicable to such forms of policy then being issued by the Claims Administrator. In the event of your death, your dependents have the same privilege of continuing protection unless, such dependents are eligible for Hospital and Medical Coverage for Pensioners and Surviving Spouses (see paragraph 8.27) in which event conversion is not available.

The Conversion Privilege described in this paragraph is also available to (1) a Dependent child on cessation of insurance because of attainment of the maximum age of Dependent children, and (2) the divorced spouse of the Employee, or the former spouse of the Employee in the event of annulment of the marriage of the Employee, upon the divorce or annulment of the marriage while the spouse is covered as a Dependent under the Group Policy.

8.25 Maternity and obstetrical benefits will be provided after termination of your group coverage, only if you apply for a converted policy of hospital and surgical insurance. If you convert, you and your dependents will be eligible for the maternity and obstetrical benefits provided by the converted policy, while such converted policy is in effect.

8.26 Medical Benefits for Pensioners and Surviving Spouses

If you retire under the Company pension plan on other than a deferred vested pension and at the time of such retirement have 15 or more years of continuous service, you and your eligible dependents will be enrolled under the Program of Medical Benefits for Eligible Pensioners and Surviving Spouses unless you elect otherwise. You may obtain a copy of the booklet describing the above Program from the Human Resources Department at your place of employment. At the time of your retirement, you will be advised of the required premium which will be deducted from your pension check. If you are thinking of retiring, you should ask for a copy of such booklet. In any event, you will be given a copy of the booklet shortly before you retire.

8.27 A person who becomes eligible to receive a Surviving Spouse's benefit under the Company pension plan is also eligible for medical benefits described in paragraph 8.26. A copy of the booklet describing the Program of Medical Benefits together with descriptive material and contribution rates will be given to such person at the time the person becomes eligible for the Surviving Spouse's benefit under the Company pension plan.

8.28 Reinstatement or Re-employment

If you return to work following an absence on account of layoff, leave of absence or disability during which some or all of your coverage under the Program shall have terminated and prior to a break in continuous service, all your coverage under the Program will be reinstated on the day you return to work.

8.29 If you return to work after a break in continuous service, you will be enrolled in the Program as a new employee and, except as otherwise specified below, you will not be covered by the Program until you complete 60 calendar days from your date of reemployment, whichever comes first. However, (a) if you sustained a break in continuous service and at such time you were eligible for an immediate or deferred vested pension under the Company pension plan, (b) if your break in continuous service was removed at the time of your reemployment, or (c) if you sustained your

break in continuous service prior to completing 60 calendar days because of lack of work and you are rehired at the same plant within one year from the date of termination and given credit for prior service for purposes of completing your probationary period, day of work completed by you prior to your break in service will be counted toward the 60 calendar days of work which you must complete under paragraph 8.5 prior to becoming covered under the Program.

8.30 Continuous Service

Wherever the term "continuous service" is used in this booklet, it means your continuous service as determined for pension purposes under the Company pension plan, regardless of whether you are a participant in such pension plan.

8.31 Laws Affecting Program Benefits

Employees are subject to state laws regarding disability benefits. The Program is modified, as described in this booklet, to reflect the provisions of such laws. The Program has also been modified, as described in this booklet, because of the provisions of federal law concerning Medicare. If any such law shall be amended, or if any other state or federal legislation shall be enacted to provide benefits similar to those described in this booklet, appropriate adjustments will be made in the provisions of the Program. If, under any such state or federal law, any benefits are now or in the future provided which are in excess of the Program's benefits, any contribution required for such excess benefits shall be paid entirely by the employees covered for such benefits.

8.32 The benefits otherwise payable under the Program will be offset by similar benefits payable for wage loss or medical expenses or which would be payable upon timely and proper submission of claim (unless good and sufficient reason is shown for your inability to submit a claim or to have such claim submitted by someone else on your behalf), under any insurance policy, bond, fund, or other arrangement required by any motor vehicle insurance law requiring the provision of benefits for personal injury without regard to fault. The benefits of the Program will not be offset if the provisions of such law require that other insurance benefits be utilized before benefits are available pursuant to such law or you have obtained no-fault insurance at a lower cost because of your coverage under the Program.

8.33 Disabled Children

In order for a dependent child to be eligible for health care benefits of the Program as a disabled child after attainment of age 26, the child:

(a) Must otherwise meet the Program definition of a dependent child and;

(b) Must be incapable of self-support because of a continuously disabling illness or injury which commenced prior to age 26; and

(c) Must be principally supported by you.

If you believe that a dependent of yours meets the disability criteria above, you should secure from the Human Resources office at your place of employment the Disabled Dependent Certification form which must be completed by you and the attending physician and returned to that office within 90 days of the date such dependent attains age 26. That form will be reviewed by the Claims Administrator to determine the eligibility of such a dependent for benefits under the Program and you may be required to submit additional information in connection with such eligibility determination. You will be notified as to whether or not the dependent is eligible for benefits of the Program as a disabled child. If such eligibility is approved, you will be further required, usually

not more frequently than once a year, to furnish the Claims Administrator satisfactory evidence to substantiate the continued eligibility of such a dependent for benefits under the Program.

SECTION 9. INSURANCE GRIEVANCES

9.0 Grievance Procedure

If a difference relating to the Program arises between you and the Company and such difference is not resolved by discussion with a representative of the Company at the location where it arises, the difference may be processed as an insurance grievance under the provisions of the basic labor agreement applicable to insurance grievances. The International Union will have the right to file a grievance on behalf of a deceased employee with respect to eligibility for and amounts of benefits payable under the Program.

SECTION 10. FLEXIBLE SPENDING ACCOUNTS (FSA)

The Plan is called a "flexible" spending account plan because you determine the amount of unreimbursed eligible medical and/or dependent day care expenses that you (and where applicable, your eligible family members) will likely incur during the Plan Year and you elect to have the Employer withhold equal amounts from your pay (subject to Plan limitations) on a pre-tax basis for reimbursement of such expenses. Any amounts that you elect to have withheld for reimbursement of eligible medical expenses will be credited to the Health FSA and any amounts that you elect to have withheld for reimbursement of dependent day care expenses will be credited to the Dependent Care FSA. You must elect wisely because any amounts allocated to a flexible spending account that are not used for expenses incurred during the Plan Year will generally be forfeited.

The Plan is beneficial to you because amounts that you elect to have withheld from your pay for reimbursement of eligible medical and/or dependent day care expenses are withheld before any federal income and employment taxes (e.g., FICA and FUTA) are applied, and in most cases, before any applicable state taxes are applied. If you have unreimbursed medical and/or dependent day care expenses, participation in this Plan will actually increase your take home pay over what your net take home would be if you paid for such expenses with after-tax dollars.

Who can participate in the Plan?

Each Eligible Employee of the Employer who satisfies the Plan's eligibility requirements (see section 8.5) will be eligible to begin participating in this Plan on the applicable Entry Date.

When does my participation in the Plan end?

You continue to participate in the Plan until the earlier of the date that (i) you elect not to participate in this Plan; (ii) you no longer satisfy the eligibility requirements (e.g., you terminate employment); or (iii) the Plan is terminated or amended to exclude you or the class of employees of which you are a member.

If you cease to satisfy the eligibility requirements during the Plan Year but become eligible for the Plan again during the same Plan Year and more than 30 days after ceasing to satisfy the eligibility requirements, you may make new elections under the Plan. If you cease to satisfy the eligibility requirements during the Plan Year but become eligible for the Plan again during the Plan Year and within 30 days or less after ceasing to satisfy the eligibility requirements, your prior elections will be reinstated and will remain in effect for the remainder of the Plan Year.

What are the enrollment periods under the Plan?

When you are first hired, you must enroll during the "Initial Enrollment Period" if you want to participate. The enrollment material provided by the Employer (or the Third Party Administrator identified in the Plan Information Appendix) will identify the beginning and end dates of the Initial Enrollment Period. If you make an election during the Initial Enrollment Period, your participation in the spending account(s) that you elect will begin on the later of your Entry Date or the date that your election is received and processed by the entity processing your election form. The election that you make during the Initial Enrollment Period is effective for the remainder of the Plan Year and generally cannot be revoked during the Plan Year unless you experience a specified event that will allow a mid-year election change (see below for more details on mid-year election changes).

If you do not make an affirmative election to participate in either of the spending accounts during the Initial Enrollment Period, you will be deemed to have elected not to participate in this Plan for the remainder of the Plan Year unless you experience an event that allows you to change that election during the Plan Year.

The Plan also has an "Annual Enrollment Period" during which you may enroll (if you did not enroll during the Initial Election Period), continue your previous election or change your previous elections for the next Plan Year. You will be notified each year of the beginning and end dates of the Annual Enrollment Period. You must make an affirmative election to participate, change your election, or continue your current election for the next Plan Year. The election that you make during the Annual Enrollment Period is effective the first day of the following Plan Year and is irrevocable for the entire Plan Year unless you have experienced an event that allows a mid-year election change.

If you are a current Participant in the Plan and you fail to complete and submit an election form during the Annual Enrollment Period, you will be deemed to have elected not to participate during the next Plan Year.

The Plan Year is a 12-month period, January 1 – December 31 (except during the initial or last Plan Year of the Plan).

Can I ever change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the Pre-tax Contribution that you have elected to allocate to the Health FSA and/or the Dependent Care FSA. That being said, your election to participate in the Plan will automatically terminate if you cease to satisfy the applicable eligibility requirements. Otherwise, you may change your Pre-tax Contribution elections only during the Annual Enrollment Period, and then, only for the coming Plan Year.

There is an important exception to this general rule that you cannot revoke your elections during the Plan Year: You may change or revoke your elections during the Plan Year if you submit a written request (or where applicable, an electronic request) for an election change with the Plan Administrator (or the Third Party Administrator identified in the Plan Information Appendix) within 30 days of experiencing one of the following events. Note that not all of the events apply to Health FSA elections.

1. **Change in Status**. If one or more of the following "Changes in Status" occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator determines are permitted under subsequent IRS regulations:

    - A change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse);
    - A change in the number of your dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent);
    - Any of the following events that change the employment status of you, your spouse, or your dependent that affect benefit eligibility under a cafeteria plan (including this Plan and the plan of another employer) or other employee benefit plan of an employer of you, your spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change

which makes the individual become (or cease to be) eligible for a particular employee benefit;

- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, or ceasing to be a student; and
- A change in your, your spouse's or your dependent's place of residence.

The election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator. With the exception of an election change to the Health FSA resulting from birth, placement for adoption or adoption, all election changes are prospective. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility for coverage under the Plan. A Change in Status affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the Plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Gain of Coverage Eligibility under Another Employer's Plan*. For a Change in Status in which you, your spouse, or your dependent gain eligibility for coverage under another employer's cafeteria plan (or benefit plan) as a result of a change in your marital status or a change in your, your spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan. You may be required to provide proof that coverage will become effective.
- *Dependent Care Reimbursement Plan Benefits*. With respect to the Dependent Care Reimbursement Plan benefit, you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; or (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

  Example: employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

2. **Special Enrollment Rights (NOTE: This applies only to Health FSA elections and only to the extent that the Health FSA is not an "excepted benefit" as defined by the Health Insurance Portability and Accountability Act of 1996)**. If you, your spouse and/or a dependent are entitled to special enrollment rights under Health FSA as set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment for yourself or your eligible dependents because of other medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (e.g., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect Health FSA coverage for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request

enrollment within the 30-day election change period. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child identified in the order. If the order requires that another individual (such as your former spouse) cover the dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the dependent child.

4. **Entitlement to Medicare or Medicaid**. If you, your spouse, or a dependent becomes entitled to Medicare or Medicaid, you may cancel that person's Health FSA coverage. Similarly, if you, your spouse, or a dependent that has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's Health FSA coverage.

5. **Change in Cost (applies only to Dependent Care FSA elections)**. If you are notified that the cost of your Dependent Care FSA coverage under the Plan has *significantly* increased or decreased or will *significantly* increase or decrease during the Plan Year, you may make certain prospective election changes. If the cost significantly increases, you may choose either to make an increase in your contributions, revoke your election and choose another day care provider, or drop coverage altogether if you are unable to find another provider. If the cost significantly decreases, you may revoke your election and make a new election to correspond with the decrease in cost. For *insignificant* increases or decreases in the cost of Dependent Care FSA coverage, however, your Pre-tax Contributions will change automatically to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

6. **Change in Coverage (applies only to Dependent Care FSA elections)**. If your coverage under the Dependent Care FSA is significantly curtailed, you may revoke your election and either choose another day care provider or drop coverage altogether. Further, if you change day care providers, you may revise your elections to correspond to the new provider. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (i) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (ii) the plan year for this Plan is different from the plan year of the other employer plan.

   Additionally, your election(s) may be modified downward during the plan year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

7. **Approved Leave of Absence**. If you take an approved leave of absence, your elections are subject to the following terms (depending, in part, on the type of leave you take):

   - If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Health FSA coverage on the same terms and conditions as though you were still active.
   - Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage).

If so, you will pay your share of the contributions with Pre-tax Contributions withheld from pay you receive while on leave.

- In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your Health FSA, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave (not to exceed the end of the Plan Year) with Pre-tax Contributions from your pre-leave compensation by making a special election to that effect before the date such compensation would normally be made available to you, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with IRS Code Section 125, FMLA and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Plan Administrator.
- If your Health FSA coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Health FSA upon return from such leave on the same basis as you were participating in the Health FSA prior to the leave, or as otherwise required by the FMLA. Your Health FSA coverage may be automatically reinstated provided that coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.
- The Employer may, on a uniform and consistent basis, continue your Health FSA coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and Employer.

If you are commencing or returning from unpaid FMLA leave, your Dependent Care FSA election under this Plan shall be treated in the same manner that elections for non-health plans are treated with respect to Participants commencing and returning from unpaid non-FMLA leave Health Care Flexible Spending Account.

10.0 The Health Flexible Spending Account ("Health FSA")

Health FSA is the portion of the Plan that provides for reimbursement of Eligible Medical Expenses incurred by the Participant and his/her Eligible Dependents. If you elect benefits under this portion of the Plan, a non-interest bearing bookkeeping account will be set up to keep a record of Pre-tax Contributions (and where applicable, any non-elective Employer contributions) allocated to the account and the reimbursements for Eligible Medical Expenses to which you are entitled during the Plan Year. No actual account is established; it is merely a bookkeeping account.

What is the maximum annual reimbursement amount that I may elect under the Health Flexible Spending Account?

$3,050 annual maximum as of January 1, 2023

What amounts will be available for reimbursement of Eligible Medical Expenses at any particular time during the Plan Year?

The full annual amount of reimbursement you have elected under the Health FSA (reduced by prior reimbursements made during the Plan Year) will be available at any time during the Plan Year without regard to how much you have contributed to the Health FSA.

What happens to unclaimed Health Care FSA reimbursements?

Any Health Care FSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Health Care Expense was incurred shall be forfeited.

What is an "Eligible Medical Expense"?

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your Eligible Dependents that satisfies the following conditions:

- The expense is for "medical care" as defined by IRS Code Section 213(d). Whether an expense is for "medical care" is within the sole discretion of the Plan Administrator; and
- The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

An "Eligible Dependent" is your legal spouse (in accordance with federal law) and any other individual who is a "dependent" as defined in IRS Code Section 105(b) (i.e., a dependent who is eligible to receive tax-free health coverage under the IRS Code). Coverage for an individual covered as an Eligible Dependent under the Health FSA ends on the date that the individual ceases to meet the requirements to be an Eligible Dependent.

The IRS Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and prescribed over-the-counter drugs (and over-the-counter products and devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care," as that term is defined by the IRS Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Third Party Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Over-the-counter drugs and medicines (other than insulin) that are for “medical care” will not constitute an Eligible Medical Expense unless you or your eligible dependents have obtained a prescription from a provider authorized by state law (e.g., a physician). Insulin and over-the-counter products and devices other than drugs or medicines will still constitute an Eligible Medical Expense even if not prescribed by a physician to the extent that they are for medical care.

In addition, certain other expenses that might otherwise constitute "medical care" as defined by the IRS Code are not reimbursable under any Health FSA (per IRS regulations):

- Health insurance premiums;
- Expenses incurred for qualified long term care services; and
- Any other expenses that are specifically excluded by the Employer as set forth in the Plan Information Appendix and/or enrollment material.

When must the expenses be incurred in order to receive reimbursement?

Eligible Medical Expenses must be incurred ***during*** the Plan Year and while a Participant. An expense is incurred when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the Health FSA becomes effective, before your Health FSA election becomes effective, or after a separation from service (except for expenses incurred during an applicable COBRA continuation period).

For more detailed information, you may request a copy of a full FSA SPD from your local Human Resources Department.

10.1 Dependent Care Flexible Spending Account

The Dependent Care FSA is the portion of the Plan that provides for reimbursement of Eligible Day Care Expenses incurred by the Participant. If you elect benefits under this portion of the Plan, a non-interest bearing bookkeeping account will be set up to keep a record of Pre-tax Contributions (and where applicable, any non-elective Employer contributions) allocated to the account and the reimbursements for Eligible Day Care Expenses to which you are entitled during the Plan Year. No actual account is established; it is merely a bookkeeping account.

What is the maximum reimbursement amount that I may elect under the Dependent Care FSA?

$5,000 annually if married and filing jointly, $2,500 if single or married and filing a separate tax return.

What amounts will be available for reimbursement of Eligible Day Care Expenses at any particular time during the Plan Year?

Under the Dependent Care FSA, you may be reimbursed only up to the amount of your Dependent Care FSA sub-account balance at the time the request for reimbursement is processed.

What are "Eligible Day Care Expenses"?

You may be reimbursed for work-related dependent day care expenses ("Eligible Day Care Expenses"). In other words, the expenses have to be incurred in order for you and your spouse (if applicable) to work or look for work. Generally, an expense must meet all of the following conditions for it to be an Eligible Day Care Expense:

1. The expense is incurred for services rendered after the date of your election to receive Dependent Care Reimbursement benefits and during the calendar year to which it applies.

2. Each individual for whom you incur the expense is a "Qualifying Individual." A "Qualifying Individual" is:

   - An individual that you can claim on your federal income tax return as a "Qualifying Child" (as defined in IRS Code Section 152(a)(1)) and who is age 12 or under, or
   - A spouse or other tax "Dependent" (as defined generally in IRS Code Section 21) who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as you for more than half of the year. For purposes of this Dependent Care FSA only, a "Dependent" under IRS Code Section 21 means an individual who is your tax dependent as defined in IRS Code Section 152 or any individual who would otherwise qualify as your tax dependent under Code Section 152 but for the fact that (i) the individual has income in excess of the exemption amount set forth in IRS Code Section 151(d); (ii) the individual is a child of a Participant who is a tax dependent of another taxpayer under IRS Code Section 152; or (iii) the individual is married and files a joint return with his/her spouse. In addition, a child to whom Section 152(e) applies (a child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents) may only be the qualifying individual of the "custodial parent" (as defined in IRS Code Section 152(e)(3)) without regard to which parent claims the child as a dependent on their tax return.

3. The expense is incurred for the custodial care of a Qualifying Individual (as described above), or for related household services, and is incurred to enable you (and your spouse, if applicable) to be gainfully employed or look for work. Whether the expense enables you (and your spouse if applicable) to work or look for work is determined on a daily basis. Normally, an allocation must be made for all days for which you (and your spouse, if applicable) are not working or looking for work; however, an allocation is not required for temporary absences beginning and ending within the period of time for which the day care center requires you to pay for day care. Expenses for overnight stays or overnight camp are not Eligible Day Care Expenses. Expenses that are primarily for education, food and/or clothing are not considered to be for "custodial" care. Consequently, tuition expenses for kindergarten (or its equivalent) and above do not qualify as custodial care. However, summer day camps are considered to be for custodial care even if they provide primarily educational activities.

4. If the expense is incurred for services outside your household and such expenses are incurred for the care of a Qualifying Individual who is age 13 or older, such dependent regularly spends at least 8 hours per day in your home.

5. If the expense is incurred for services provided by a dependent care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The day care is not provided by a "child" (as defined in IRS Code Section 152(f)(1)) of yours who is under age 19 the entire year in which the expense is incurred or an individual for whom you or your Spouse is entitled to a personal tax exemption as a Dependent. Moreover, the day care cannot be provided by the Participant's Spouse or the parent of the Qualifying Individual.

7. You must supply the taxpayer identification number for each dependent care service provider to the IRS with your annual tax return by completing IRS Form 2441.

You are encouraged to consult your personal tax advisor or IRS Publication 503 for further guidance as to what is or is not an Eligible Day Care Expense if you have any doubts. In order to exclude from income the amounts you receive as reimbursement for Eligible Day Care Expenses, you are generally required to provide the name, address and taxpayer identification number of the dependent care service provider on your federal income tax return.

When must the expenses be incurred in order to receive reimbursement?

Eligible Day Care Expenses must be incurred during the Plan Year and while a Participant. An expense is "incurred" when the service or treatment giving rise to the expense has been performed and not in advance of the services. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective, before your Dependent Care FSA election becomes effective, or after a separation from service.

What happens to unclaimed Dependent Care FSA reimbursements?

Any Dependent Care FSA reimbursements that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the Eligible Day Care Expense was incurred shall be forfeited.

If I participate in the Dependent Care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA, although the balance of your Eligible Day Care Expenses not reimbursed under this Dependent Care FSA may be eligible for the dependent care credit.

10.2 Plan Provisions
Claim and Appeals Procedures

If you are denied a benefit under this Plan, you should proceed in accordance with the following claims review procedures.

Step 1: *Notice is received from Third Party Administrator.* If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;

- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an appeal.* If you do not agree with the decision of the Third Party Administrator, you may file a written appeal. You should file your appeal with the Third Party Administrator no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Third Party Administrator.

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal).
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.
- The Plan Administrator is required to give the Participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination.
- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision.
- Each Participant has the right to request and obtain documents, records and other information as it pertains to their Benefit Plan(s).

Run Period

You may submit for reimbursement for claims incurred in the previous plan year until March 31 of the following year.

For more detailed information, you may request a copy of a full FSA SPD from your local Human Resources Department.

INSURANCE AGREEMENT

AGREEMENT dated January 1, 2023 between Empire Iron Mining Partnership and Tilden Mining Company L.C., Cliffs Mining Company, Managing Agent (the "Company") and The United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (the "Union").

Definitions

1. Wherever used herein
   (a) "Employee" means an employee in one of the bargaining units at the Company;
   (b) "Program" means the program of insurance benefits effective January 1, 2023 established by this Agreement and described in the booklets adopted by the parties, each booklet being applicable to the Employees referred to in its title, such booklets constituting a part of this Agreement as though incorporated herein;
   (c) "Prior Program" means the program of insurance benefits in effect as of December 31, 2022.

Program of Insurance Benefits

2. The Program shall be applicable to Employees while this Agreement is in effect (the period starting January 1, 2023), in accordance with the provisions of this Agreement, subject to the following provisions:

   (a) Any coverage which as of January 1, 2023 is being continued in accordance with the provisions of the Prior Program during an Employee's absence because of layoff, leave of absence or disability shall be continued after December 31, 2022 for the maximum period provided by the Program, reduced by the period such coverage was continued prior to January 1, 2023. Any such coverage which was terminated under the Prior Program prior to January 1, 2023 shall be reinstated under the Program as of the date the Employee returns to active work.

   (b) The benefits of the Prior Program shall be applicable to any occurrence prior to January 1, 2023, subject to all of the provisions of the Prior Program, except that to the extent hospital, physicians' services, major medical, dental and vision care benefits related to such occurrence are payable for a period extending beyond December 31, 2022, the benefits otherwise payable shall be conformed to the benefits provided under the Program, and will be payable for the period provided under the Program reduced by the amount of or the period for the which benefits were paid prior to January 1, 2023.

   (c) Benefit provisions of the Program not contained in the Prior Program shall not be applicable to any period prior to January 1, 2023, unless otherwise specified therein.

Cost of Benefits

3. The cost of benefits under the Program shall be paid by the Company, except as provided below in this paragraph 3 and in paragraph 6 hereof:

   (a) Any Employee on layoff who elects to continue life insurance after the last month of layoff for which such life insurance is continued without Employee contribution will be required to pay $.60 per month per $1,000 of life insurance for each month as to which they are eligible in order to continue such insurance.
   (b) The amounts required to be paid for benefits provided under law in excess of Program benefits shall be paid entirely by the Employees.
   (c) In the event of a strike resulting from failure of the parties to reach an agreement following proper notice given by either party under the provisions of any collective bargaining agreement,

the Program, with the exception of sickness and accident coverage, will be continued for 30 days. The Company will advance the premiums for coverage during such 30 days, which premiums will be repaid by the Employees. During such 30 days, the parties will discuss procedures and arrangements with respect to further continuation of insurance coverage and the repayment of premiums advanced.

(d) The amount of the premiums for any optional life insurance coverage shall be paid entirely by the employee.

Participation of Employees

4. Each Employee shall be a participant in the Program and the amount, if any, which the Employee shall be required to contribute to the cost thereof shall be deducted by the Company from their pay. Each Employee shall furnish to the Company any such written authorization or assignment (in a form agreed to by the Company and the Union) as shall be necessary to authorize the deduction from their pay of the amount of any contributions.

Requirements of Law

5. It is intended that the provisions for the insurance benefits which shall be included in the Program shall comply with and be in substitution for the provisions for similar benefits which are or shall be made by any applicable law or laws. Where, by agreement, certain basic benefits under the Program are provided under law rather than under the Program, the Company will pay the amount required to be paid therefore, including any Employee contribution required by law on account of such benefits. The Company shall, after consultation with the Union, reduce the benefits of the Program to the extent that benefits provided under any law would otherwise duplicate any of the Program benefits.

Additional and Alternate Benefits:

6. (a) The Program shall be in substitution for any and all insurance benefits or payments to or on behalf of Employees for death, sickness or accident, hospitalization, (including less acute care alternatives and outpatient services), dental, medical, surgical or vision care service provided by the Company in whole or in part, except as the Company and the Union have agreed or may agree in writing.

(b) The Union and the Company may agree that benefits may be provided in addition to those which are to be financed by the arrangements set forth in paragraph 3, provided that the full cost of such additional benefits shall be paid by the Employees covered for such additional benefits and provision may be made by agreement between the Company and the Union to deduct the cost of such additional benefits from the pay of such Employees

Administration of the Program

7. The Program shall be administered by the Company or through arrangements provided by it. Except as may otherwise be provided in this Agreement, the Company will arrange to have the medical benefits under the Program provided through contracts with carriers mutually agreed to by the Company and the Union. Sickness and accident benefits, life insurance, prescription drug benefits, dental and vision care benefits shall be provided by such method and through such carriers, if any, as the Company in its sole discretion shall determine. Any contracts entered into by the Company with respect to the benefits of the Program shall be consistent with this Agreement and shall provide benefits and conditions conforming to those set forth in the booklets.

Life Insurance After Retirement

8. Any Employee who shall have retired and who shall have become entitled to life insurance after retirement pursuant to the provisions of the insurance agreement and booklet applicable to such Employee at the time of retirement shall not have such life insurance terminated or reduced (except as provided in such booklet) so long as they remain retired from the Company, notwithstanding the expiration of such agreement or booklet or of this Agreement, except as the Company and the Union may agree otherwise.

Extent of Company Obligation

9. The failure of any carrier to provide for benefits under the Program shall not result in any liability to the Company, nor shall such failure be considered a breach by the Company of any of the obligations which it has undertaken by this or any other agreement with the Union. In the event of any such failure, the Company and the Union shall immediately take action to provide substitute coverage in accordance with the provisions of this Agreement. Notwithstanding the foregoing, any decision reached with respect to a grievance processed under the provisions of the basic labor agreement applicable to insurance grievances shall be binding on the Company, and, to the extent such decision requires the provision of benefits which the carrier fails to pay, the Company will provide such benefits.

Insurance Reports

10. The Union shall be furnished annually a report regarding the Program. From time to time during the term of this Agreement, the Union shall be furnished such additional information as shall be reasonably required for the purpose of enabling it to be properly informed concerning the operation of the Program. Any accounting under the Program shall make no distinction between the experience with respect to Employees and other employees who may be covered, except that experience of employees who participate in the Program on a different basis or are entitled to different benefits from those provided for Employees represented by the Union shall be included in such accounting only to the extent that the Company and the Union agree to such inclusion. The Company will continue the present arrangements under which it undertakes the keeping of insurance records of individual employees, the recording of changes in insurance classifications and a major portion of the investigation and payment of claims. The cost to the Company of performing such work will not, for any accounting under the Program, be deemed to be a cost of the Program.

Continuation of Benefits After Expiration

11. Any Employee who is on layoff or absent from work due to disability and entitled to benefits under the provisions of the Insurance Agreement and Program applicable at the time layoff or absence commenced shall receive such benefits for the duration specified in such Agreement or Program, notwithstanding the expiration or treatment of this Agreement or the Program or the collective bargaining agreement between the Company and the Union.

Term of Agreement

12. This Agreement shall become effective as of January 1, 2023, and shall remain in effect until February 1, 2027 and thereafter subject to the right of either party on 120 days' written notice served on or after September 1, 2026 to terminate this Agreement.

UNITED STEELWORKERS	**EMPIRE IRON MINING PARTNERSHIP AND TILDEN MINING COMPANY L.C. The Cleveland-Cliffs Iron Company Managing Agent**
/s/ Tom Conway	/s/Rob Fischer
/s/ Emil Ramirez	
/s/ Donnie Blatt	

APPENDIX A. Continuation of Health Coverage (COBRA)

Continuation of Health Coverage

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) you (or your spouse or covered dependents) may elect to continue Plan coverage for yourself and your covered dependents for up to 18 months if your coverage ends because:

- your employment terminates (except if you are terminated for gross misconduct), or
- you are no longer eligible due to a layoff or reduction in your hours of work.

If you are disabled under Title II or XVI of the Social Security Act at the time of your termination of employment or reduction in hours, you may elect coverages for up to 29 months if you notify the Company of your disability determination within 60 days of the determination and before the end of the normal 18 months.

Plan coverage may be continued by a covered dependent for up to 36 months if their coverage ends due to one of the following events occurring while you are actively employed:

- your death,
- your divorce or legal separation,
- your becoming entitled to Medicare, or
- your child ceases to qualify for dependent coverage under the terms of the Plan.

The indicated time periods will be reduced by any period of Company-paid continuation coverage. The Company will provide an election form and more information about the cost of coverage and payment method at the time of a qualifying event. Coverage must be elected within 60 days after coverage under the Plan ends or the election form is received, whichever is later.

You are allowed an additional 45 days from the date continued coverage was elected to make your first premium payment and to pay the back premium necessary to avoid a gap in pre-election coverage. It is the responsibility of you or your covered dependent to notify the Company within 60 days of divorce, legal separation or if your child ceases to qualify for dependent coverage.

If continued coverage is elected, you and/or your covered dependent must pay the full applicable cost of the coverage. Coverage will be the same as that provided to similarly situated participants and dependents, including future changes to the plan coverages. Continuation of coverage will stop before the end of the indicated time period if:

- You or your dependent become covered under another group health plan that does not contain any applicable preexisting condition clause or Medicare,
- You or your dependent cease to be disabled while receiving continued coverage because of the disability;
- The required premiums are not timely paid. For this purpose, payment is timely if made within 30 days after the premium due date; or

- The Company terminates all group health plans.

If you and/or your dependents do not elect continued coverage, your plan coverage will end. You may convert your coverage to an individual policy. If continued coverage is elected, you and/or your dependents may arrange for an individual conversion policy during the 180-day period before you and/or your dependent's continued coverage ends.

A premium for continued coverage may be required for periods of continuation except that the premium may not exceed 102% of the "applicable premium" for this period. Applicable premium means, with respect to any period of coverage continuation of qualified beneficiaries, the cost to the plan for the period for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether the cost is paid by the employer or employee). Also, the premium may be paid in monthly installments, at the election of the payer. The determination of any applicable premium shall be made for a period of twelve months and shall be made before the beginning of such period.

Note that a second COBRA election period may apply to employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a Federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after their coverage ended.

APPENDIX B. Joint Health Care Cost Containment Committee

January 1, 2023

Mr. Emil Ramirez,
Director District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Dear Mr. Ramirez:

As a condition of the Insurance Agreement effective January 1, 2023, it is understood that:

1. In making the annual review of average job classification, for the purpose of determining insurance classifications under the Program, the following shall apply:

   For an employee who fails to meet the requirement that they be paid for 240 hours in the applicable six biweekly pay periods because of having served as a member of the Grievance Committee, Safety Committee or Job Classification Committee (not to exceed the number specified in the Basic Agreement at any time at any Company) or as a President, Vice President, Recording Secretary, Financial Secretary and/or Treasurer of a local of the Union, or shall have been absent from work because of a leave of absence granted upon the request of the Union to any employee who shall be appointed or elected to any other office in the Union at the Company at which they shall then have been employed, the employee's average job classification will be determined in a manner which will fairly reflect their normal job classification had they not been so absent.

2. Pursuant to paragraph 7 of the Insurance Agreement, the medical benefits set forth in the booklets adopted by the parties pursuant to said Agreement will, during the term of the Program, be provided by a contract with Anthem Blue Cross/Blue Shield, unless another insurance carrier is jointly selected and the Union is so advised prior to the effective date of the change in carriers.

3. The arrangement contained in the Program with respect to Medicare has been developed by the parties in the light of the specific provisions of the Medicare Program, and shall not be regarded as any precedent with respect to the adjustment of the Program required by the Insurance Agreement because of benefits provided by law. The limitation previously included in paragraph 8.6(d) of an earlier PIB booklet as to the Company payment for charges for Medicare Part B coverage has been eliminated in the light of the current provisions and operation of the Medicare Law. Should the charge for such Part B coverage be increased, the Company may notify the Union that it does not desire to pay such increase and the parties shall thereupon promptly meet to agree upon the extent to which benefits under such Part B coverage shall not be deducted from benefits which would otherwise be provided under the Program. If the parties fail to agree on this matter, the question shall be decided by arbitration arranged by the Union and the Company.

4. The arrangement contained in the Program with respect to no-fault insurance has been developed by the parties in the light of the specific provisions of the no-fault insurance laws and shall not be regarded as any precedent with respect to the adjustment of the Program required by the Insurance Agreement because of benefits provided by law.

5. In the case of an employee who while actively at work receives benefits under a workers' compensation or occupational disease law or other similar applicable law because of a partial disability and who subsequently suffers a temporary total disability resulting from the same or a related cause, the payments received under such law for the period of temporary total disability shall not reduce the total benefits for partial disability the employee would receive if they had continued actively at work without recurrence of total disability.

6. An employee's rights and the Company's right to discharge them shall not be enlarged or affected by reason of any provision of this Agreement.

7. In order to address the problem of rising health care costs, the parties hereby establish a joint Company-Union Health Care Cost Containment Committee ("Committee"), effective July 1, 1986. The Committee will consist of three (3) Union representatives, a co-chairman and two members who may be Local Union representatives, and a Company co-chairman and two (2) Company members. The principal goal of the Committee is to study health care cost containment on a continuing basis and to recommend effective cost containment alternatives.

   The Committee will review health care cost and utilization data in order to permit the parties to approach health care providers with the goal of achieving cost savings while maintaining the quality of care. These cost containment efforts should help to slow the rapid escalation of insurance benefit costs. The Committee will enable the parties to jointly explore opportunities for cost containment and new ways to provide health care services in a cost-effective manner.

   Other potential committee objectives include:

   - Consideration of whether a benefit provision applicable to a given employment location should be modified on an experimental or permanent basis to determine if a given modification will enhance more efficient utilization of health care resources or to take into account particular circumstances at a given location.

   - Consideration of a new approach to more effectively address the problem of drug and alcohol abuse and more effectively utilize the expenditures being made for drug and alcohol abuse treatment.

   - Consideration of alternatives to avoid hospital confinements by providing coverage for services that can be performed at a reduced cost regardless of where performed.

   - Consideration of a pilot wellness program at a given location to attempt to decrease health care utilization and, therefore, costs.

   - Consideration of methods in addition to the mail order drug program by which employees can obtain prescription drugs through local pharmacies on a cost-effective basis.

   The Committee will meet at least quarterly, and its recommendations shall become effective upon written agreement between the Union and Company. The Company will pay up to sixteen hours lost time quarterly for Local Union members of the Committee.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations
The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership
and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
Director, District 11
United Steelworkers

APPENDIX C. Determining Financial Dependence of a Disabled Child

October 1, 2022

Mr. Emil Ramirez,
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Dear Mr. Ramirez:

Paragraph 7.3(d) of the Program of Insurance Benefits for the hourly employees of Empire Iron Mining Partnership and Tilden Mining Company L.C., who are represented by the United Steelworkers, sets forth the eligibility requirements for disabled dependent children over age 26 for entitlement to health care coverage.

This will confirm our understanding that in determining whether the disabled child is principally supported by the employee, nominal earnings received by such child as a result of participating in the rehabilitation program will not be taken into consideration.

Furthermore, if earnings received are of such an amount that would render the child ineligible for such coverage, the child will again become eligible for coverage if, upon completion of the program, the child continues to be principally supported by the employee.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations
The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership
and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
Director, District 11

APPENDIX D. Life Insurance Certificate

MetLife®

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	Cliffs Natural Resources Inc.
Group Policy Number:	6014092-G
Type of Insurance:	Term Life & Accidental Death and Dismemberment Insurance
MetLife Toll Free Number(s): For Claim Information	FOR LIFE CLAIMS: 1-800-638-6420

THIS CERTIFICATE ONLY DESCRIBES LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOU COVERAGE ARE GOVERNED PRIMARILY BY THE LAWS OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

APPENDIX E. Managed Health Care Protocols

Letter of Understanding Regarding
Proposal on Managed Health Care Protocols

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Managed Health Care Protocols

Dear Mr. Ramirez:

The USW and the Company seek protection against the uncontrolled escalation in medical costs, while at the same time preserving and improving the quality of health care services utilized by employees and their families.

Certain medical benefits under the Program of Insurance Benefits (PIB) and Program of Hospital-Medical Benefits (PHMB) are delivered to active employees and non-Medicare retirees/spouses through a Preferred Provider Organization (PPO). The USW and the Company agree that the PPO will comply with the following Health Care Protocols:

I. **JOINT MANAGED CARE OVERSIGHT COMMITTEE**

A. USW and the Company recognize the importance of joint Union-Management participation in the implementation of Managed Care Networks.

B. USW and the Company propose to establish a joint Managed Care Oversight Committee comprised of an equal number of representatives of each party to direct the implementation of the PPO Program. The Joint Managed Care Oversight Committee will be charged with the following responsibilities.

1. Ensure that the Network Manager(s) maintains substantial compliance with the standards and criteria set forth in Section II below.

2. Ensuring successful implementation of the PPO Program, monitoring the Program to determine its cost-effectiveness and its ability to provide improved high quality health care.

3. Promptly resolving issues concerning the ongoing compliance of a network with the proposed standards and criteria.

4. In addition to the aforementioned responsibilities of the Joint Managed Care Oversight Committee, a number of protocols will be utilized to guide the Committee and serve as ground rules concerning the maintaining of Managed Care. These protocols are included in Section II below.

5. In recognition of the importance of the Program, the Company will pay for expenses of the Joint Committee, including the reasonable use of outside sources experienced in

Managed Care and/or Health Care Cost Containment to assist the Joint Committee with their efforts.

C. The Company and the Union shall establish a Joint Managed Care Oversight Committee to:

1. ensure the successful implementation of the Managed Care Program
2. provide input to the Network Manager(s) to develop the provider network
3. develop appropriate communication material or participants
4. monitor the program to determine cost-effectiveness and ability to provide high-quality health care.

D. The Joint Managed Care Oversight Committee shall be responsible for the following:

1. perform oversight of the Managed Care Program operation
2. hold monthly meetings with the Network Manager's customer service manager
3. develop procedures for discussion and resolution of problems relating to local network organization issues
4. resolve disputes regarding participant complaints
5. nominate hospitals and individual physicians for inclusion in the network.

E. The parties agree that the following minimum requirements shall be met prior to participant enrollment in the network:

1. The Network Manager(s) shall establish a toll-free telephone number at least 30 days prior to enrollment.
2. The Company shall schedule employee meetings (with the opportunity for participation of the spouse) to explain the Managed Care Program.
3. In order to assure satisfaction with the Managed Care Program, the parties agree to the following satisfaction requirements:
    a. The Network Manager(s) shall make professionals available to participants by telephone to answer medical inquiries (patient advocacy).
    b. There shall be a timely turnaround of complaints with the initial response within 48 hours.
    c. A written procedure shall be established for documentation and resolution of participant complaints.
    d. If practical, the Managed Care program shall be serviced by a dedicated customer service unit of the Network Manager.
    e. A member satisfaction survey shall be conducted at appropriate intervals following enrollment. The results of the survey will be made available to the joint committee.
4. In-network benefits will be paid if:
    a. the participant is referred to an out-of-network provider by the PCP or a network specialist, or
    b. a network specialist is not available.
5. In the event a network no longer remains in compliance with the attached standards and criteria, the issue will be immediately referred to the Joint Managed Care Oversight

Committee for resolution. Steps to resolve this issue will entail remedial actions by the Network Manager to bring the network into compliance with the established standards and criteria. During this interim period for individuals covered by the concerned network, benefits will be provided on the same basis as in-network services under the Program of Insurance Benefits (PIB), and the Joint Managed Care Oversight Committee will take steps to encourage employees to receive medical care from network providers whenever feasible. In the event the issue, as to whether the network is in compliance with the standards and criteria, cannot be resolved by the Joint Committee it may be referred by either party to the Chairman of the Negotiating Committee.

II. MANAGED CARE PROGRAM EVALUATION CRITERIA

A. Network Manager

1. Financially strong organization.
2. Managed care is a profitable line of business.
3. Experience in operating managed care programs.
4. Commitment to the managed care product:
    a. significant part of carrier's revenues.
    b. involvement of managed care personnel in top levels of the organization.
5. Strong client references.
6. Adequate resources to sustain growth of existing networks or to develop new networks in key areas.

B. Network Organization

1. Clear delineation of accountability between corporate management and local management.
2. Functioning Peer Review Committee and Quality Assurance Committee at local level.
3. Network size large enough to include virtually all members who work at plant locations in the geographic area.
4. Sufficient number of PCP's:
    a. at least one PCP per 250-300 participants
    b. at least three PCP's located within easy access of each member (e.g. less than 20 minutes travel time.)
5. Sufficient number of specialists:
    a. all specialties included in network
    b. at least 4-5 physicians to chose from in each major specialty
    c. if a specialty is not included in the network, service is deemed to be covered at "in-network" benefit level
6. Access to care:
    a. emergency: anytime at nearby facilities
    b. urgent care: on same day, walk-in basis

c. routine care by PCP: appointments within 5 days.

7. Sufficient number of hospitals:

   a. must provide full range of acute care services

   b. must include high volume hospitals, unless clearly not qualified

   c. if specialized services are not available, member should be referred outside the network with "in-network" benefits.

8. Network should have contacts with "centers of excellence." Transportation to centers should be paid for, with lodging for family member.

9. Network Manager(s) must utilize rigorous objective criteria, based on quality of care, to select hospitals and physicians. Process should include:

   a. review of physician and facility credentials

   b. on site office visits

   c. review of medical records

   d. reference checks.

10. Network provider availability criteria in rural areas will be developed by the Joint Committee.

C. Quality of Care

1. Well documented and rigorous standards for credentials of network providers.

2. Formal Peer Review process for assessment of individual provider performance, with procedures for removal of individual providers.

3. Strong oversight of medical practice by a qualified Medical Director, residing locally.

4. Use of a written Quality Assurance plan to monitor performance, resolve problems and implement improvements in program operation. Also, all Q/A activities should be routinely and fully documented.

5. Regular recredentialling of all providers, at least every three years.

D. Member Satisfaction

1. Written procedures for documentation and resolution of member complaints.

2. Adequately staffed Member Services function.

3. Medical professionals (e.g. Registered Nurse) available by telephone to answer general medical inquiries.

4. Timely turnaround of complaints (limited response within 48 hours; final resolution within 30 days.)

5. Twenty-four hour toll free telephone service for member inquiries.

6. Routine surveys of membership to assess satisfaction level.

7. Regular procedure for review of complaints, including appeals procedure.

E. Claims Administration

1. System integration of utilization review and claims processing functions - for example, claims system will automatically know, while processing a hospital bill, that pre-admission approval has been given.
2. On line, real time claim processing - Customer service personnel will have direct access to claims history files which speeds up problem resolution.
3. Well designed, easy to read Explanation of Benefits (EOB) statements.
4. Dedicated (client specific) claims examiners and customer service personnel.
5. Managed Care Manager's system has demonstrated experience and reliability in adjudicating claims in managed care environment.
6. All network and non-network claims stored in single database.
7. Paperless claims system for in-network provider encounters.
8. Timely claim processing: 95% paid in 30 days: 99% in 60 days; 100% in 90 days. Payment requirements commence upon the receipt of complete and accurate information. The requirements outlined above will not apply to those claims where payment is delayed due to an audit of the provider's records or the investigation of inappropriate billing practices, e.g. fraud.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations

The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership
and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
United Steelworkers

APPENDIX F. Group Medical Cost Neutrality in the Event of National Healthcare

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Group Medical Cost Neutrality in the Event of National Health Care

Dear Mr. Ramirez:

In the event that National Health Care program is enacted, and such program provides insurance benefits which had been provided by the Programs of Insurance Benefits for both active employees and Eligible Pensioners and Surviving Spouses (PIBs) and/or the Programs of Hospital Medical Benefits for Eligible Pensioners and Surviving Spouses (PHMBs) in effect at the time enactment, the parties will meet to discuss the impact the legislation and any modifications to the insurance programs which may be necessary or desirable.

Where, by agreement, certain benefits under the insurance programs are provided under law rather than under the PIBs or PHMBs, the Company will pay the amount required to be paid to insure that participant's coverage is no less than their coverage under the PIBs and PHMBs in which they were enrolled that are in effect at the time of enactment. Except as specifically excluded under the PIBs or PHMBs (for example, Medicare Part B premiums, for a Medicare-eligible retiree), this shall not result in persons covered by the PIBs or PHMBs having to pay additional deductibles, copayments, or contributions in excess of the amounts provided for in the PIBs or PHMBs. Any resulting personal tax liability is the responsibility of the employee, retiree or surviving spouse; however, the Company and Union will meet thereafter to explore methods of reducing this liability.

If the Company is required under the law to provide benefits to participants in excess of the benefits provided under the PIBs and PHMBs in which they are enrolled or as required by law at the time of enactment, the amounts required to be paid for these benefits shall be paid entirely by employees or retirees/surviving spouses.

As soon as practicable following enactment, an actuary selected by the Company will perform a calculation using reasonable actuarial assumptions and methods to determine the amount of savings realized. These savings will be reduced by any premiums, taxes or contributions specifically designated for the purpose of financing the national program which are required of the Company by law. The resulting net savings, if any, will be used to offset the increased employee and retiree/surviving spouse costs referenced in the preceding paragraphs via methods mutually agreed to by the Company and the Union. Any net savings in excess of the offset amount will be shared equally between the Company and the employees and retirees/surviving spouses.

If any differences shall arise between the Company and the Union regarding the implementation of the matters described above, such matters shall be referred to the Chairperson of the Union's Negotiating Committee and the Chairperson of the Company's Negotiating Committee for resolution. If the Chairpersons are unable to resolve the disputes, the disputes shall be referred to a mutually agreeable third party for binding arbitration.

Furthermore, the parties agreed that during the negotiations for a successor Labor Agreement to the 2022 Labor Agreement they shall attempt to reach agreement regarding the application of any cost savings to the Company resulting from benefits being provided under law which would otherwise duplicate any of the benefits provided under the PIBs and PHMBs in effect at the time of enactment.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations

The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership
and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
Director, District 11

APPENDIX G. Access to Centers of Excellence

LETTER OF UNDERSTANDING REGARDING ACCESS TO CENTERS OF EXCELLENCE UNDER THE PPO PROGRAM

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Centers of Excellence

Dear Mr. Ramirez:

This is to confirm our understanding that participants in the Program of Insurance Benefits (PIB) and Program of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses (PHMB) will continue to have access to centers of excellence in accordance with the negotiated Managed Health Care protocols.

In addition, participants in the PIB and PHMB will have access to enhanced transplant services through the Blue Cross and Blue Shield Blue Quality Centers for Transplant.

Managed care participants may elect to utilize "Centers of Excellence" for medical services or procedures that are difficult, costly or specialized and where such treatment would be likely to reduce costs or improve the outcome. Centers of Excellence are health care institutions that have gained professional recognition through specialized clinical expertise and equipment acquisitions, and are able to provide major resource-intensive procedures in a more effective and efficient manner than may be possible elsewhere in the region.

Coverage for medical services received at a Center of Excellence may vary depending on whether or not prior authorization has been obtained and whether the Center of Excellence is a participating provider in the BCBS PPO network.

Coverage for medical services at a Center of Excellence which is a participating provider in the BCBS PPO network will be provided at the in-network benefit level. If prior authorization is obtained or a denial is successfully appealed, transportation for the participant and a family member to the Center of Excellence will also be paid for, including lodging for the family member.

If authorization is not obtained for medical services at a Center of Excellence which is a participating provider in the BCBS PPO network or the appeal regarding the status of the provider as a Center of Excellence is denied, coverage will still be provided at the in-network benefit level, but transportation expenses will not be covered

Coverage for medical services at a Center of Excellence which is not a participating provider in the BCBS PPO network requires pre-authorization. If authorization is obtained, coverage will provided at the in-network benefit level and transportation expenses will be covered. To qualify for this benefit, the member must reside more than 150 miles from the Center of Excellence. If authorization is not obtained or an

appeal regarding the status of the provider is denied, coverage will provided at the lower out-of-network benefit level and travel expenses will not be covered.

Authorization of medical services at a Center of Excellence and the determination that a provider is a Center of Excellence, as described above, will be made on a case by case basis after consultation with the participant or family, physician(s) and Anthem BCBS. In the event of a dispute over whether a facility is a "Center of Excellence," the matter will be referred to representatives of the Company and Union for resolution.

Examples of such Centers of Excellence are attached, however these are only examples. Participants should consult with their physician and Anthem BCBS for other hospitals and specialties.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations

The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
United Steelworkers

Exhibit A

Centers of Excellence

Note: The following is a partial list of Centers of Excellence and is only for illustrative purposes. Participants should consult with their physician and Anthem BCBS for other hospitals and specialties.

Cancer
Mayo Clinic
University of Chicago Hospital
Johns Hopkins Hospital, Baltimore
Cleveland Clinic
William Beaumont Hospital, Royal Oak, Michigan

Digestive Disorders
Mayo Clinic
Johns Hopkins Hospital, Baltimore
Cleveland Clinic
University of Chicago Hospital
William Beaumont Hospital, Royal Oak, Michigan

Ear, Nose & Throat
Mayo Clinic
Johns Hopkins Hospital, Baltimore
University of Iowa Hospitals and Clinics, Iowa City
Henry Ford Hospital, Detroit
Cleveland Clinic

Eyes
Mayo Clinic
Johns Hopkins Hospital (Wilmer Eye Institute), Baltimore
University of Iowa Hospitals and Clinics, Iowa City
Cleveland Clinic
University of Illinois Hospitals and Clinics, Chicago

Gynecology
Mayo Clinic
Johns Hopkins Hospital, Baltimore
Cleveland Clinic
Northwestern Memorial Hospital, Chicago
William Beaumont Hospital, Royal Oak, Michigan

Heart and Heart Surgery
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
Henry Ford Hospital, Detroit
William Beaumont Hospital, Royal Oak, Michigan

Kidney Disease
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
University of Chicago Hospitals
Henry Ford Hospital, Detroit

Neurology and Neurosurgery
Mayo Clinic
Johns Hopkins Hospital, Baltimore
Cleveland Clinic
Henry Ford Hospital, Detroit
University of Chicago Hospital

Orthopedics
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
University of Iowa Hospitals and Clinics, Iowa City
University of Chicago Hospital
Henry Ford Hospital, Detroit

Pediatrics
Mayo Clinic
Johns Hopkins Hospital, Baltimore
Children's Hospital of Pittsburgh
University Hospitals of Cleveland (Rainbow Babies & Children's Hospital)
Children's Memorial Hospital, Chicago

Respiratory Disorders
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
University of Chicago Hospitals
Henry Ford Hospital, Detroit Henry Ford Hospital, Detroit

Rheumatology
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
University of Chicago Hospitals
University of Iowa Hospitals and Clinics, Iowa City

Urology
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
Henry Ford Hospital, Detroit Henry Ford Hospital, Detroit
University of Chicago Hospitals

APPENDIX H. Joint Committee to Monitor Health Benefits Claims Administration

Letter of Understanding

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Letter of Understanding on Joint Committee to Monitor Health Benefits Claims Administration and Establish Periodic Sessions for Bargaining Unit Employees and Retirees

Dear Mr. Ramirez:

A senior claims representative of Anthem Blue Cross/Blue Shield (and Express Scripts at least annually) shall be available in the areas of Ishpeming-Negaunee, Michigan for at least two full days each calendar quarter for the purpose of meeting with employees, retirees or dependents to review on an individual basis medical and prescription drug care claim adjudication issues or problems. Upon the request of the Local Unions at Empire and Tilden, meetings with claims representative of Anthem Blue Cross/Blue Shield and Express Scripts may be held in the Ishpeming-Negaunee, Michigan

The meetings shall be held at a centrally convenient location within the area. Notices regarding the dates, times and place of such meetings shall be mailed by the Company to all employees and retirees no later than two weeks prior to such meetings. One of the two days of meetings will be held at the union hall if so requested by the local unions.

Additionally, three local union representatives (one from each Local Union and the applicable USW Contract Coordinator) and three Company representatives (one of whom shall include a Corporate Benefits Department representative) shall form a sub-committee which shall meet annually (or more frequently if necessary) to provide guidance and direction on general claim administration issues. There shall be one sub-committee for Empire and Tilden and a separate sub-committee for Hibbing and United Taconite. The Company will arrange and provide HIPAA training for the applicable Union-designated Contract Coordinators.

Responsibilities of the sub-committee shall be:

- To examine all general claim administrative problem areas and recommend appropriate corrective action.
- The sub-committee shall jointly travel to the Claims Administrator's office up to twice a year, if necessary, to resolve claims administration issues within the responsibility of this sub-committee.
- To examine suspended claim logs and make recommendations to expedite such matters.
- To oversee the effectiveness of meetings with employees, retirees and dependents and recommend appropriate changes to improve their effectiveness.

For purposes of this sub-committee, claim administrative issues shall be deemed to include life insurance and sickness and accident benefits in addition to health care benefits (which includes medical, dental, vision care and prescription drugs).

The formation of the sub-committee shall not replace or eliminate the claim appeal provisions of the Program of Insurance Benefits for active employees or the Program of Hospital-Medical Benefits for retirees. The sub-committee shall not have the authority to modify any plan benefit limitation, exclusion or provision.

In the event that the sub-committee cannot reach mutual agreement on subjects within their scope of responsibility, such open subjects shall be referred to the Managed Care Oversight Committee, and then the USW District 11 Director or respective designee and the Senior Vice President of Human Resources or respective designee for review and resolution.

The Company shall agree to pay lost wages and travel expenses for union members of the sub-committee which participate in the joint meetings set forth herein.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations

The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership
and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
United Steelworkers

APPENDIX I. Printing and Distribution of Benefit Agreements

Letter of Understanding

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Printing and Distribution of Benefit Agreements

Dear Mr. Ramirez:

This is to confirm our understanding that the Program of Insurance Benefits will be printed and distributed by January 1, 2023, subject to timely review and approval of both USW and Company.

The parties will make best efforts to update, print and distribute the Program of Hospital-Medical Benefits, Pension Agreements and Supplemental Unemployment Benefit Plan and other summary plan descriptions by January 1, 2023, subject to timely review and approval of both USW and Company.

In the event of disagreement between the parties regarding the drafting of updated Pension, Insurance Agreements or other Summary Plan Descriptions, the Chairs of the Union and Company Negotiating Committees shall attempt to resolve the matter.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations

The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership
and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
United Steelworkers

APPENDIX J. Development of Wellness Program

Letter of Understanding

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Development of Wellness Program

Dear Mr. Ramirez:

This is to confirm our understanding that the parties have agreed to establish a Wellness Program to provide participants with resources and incentives to encourage improved health and well-being, including, for example, tobacco cessation, nutrition and weight management, fitness and other incentives.

The Company agrees to implement the components of the Wellness Program only after reviewing the details and communication materials with the USW Joint Health Care Committee.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations

The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership
and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
United Steelworkers

APPENDIX K. VEBA Funding (Empire)

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: VEBA Funding, Empire Iron Mining Partnership

Dear Mr. Ramirez:

This letter will confirm understandings reached in connection with the 2022 collective bargaining agreement ("CBA") entered into between the USW and Empire Iron Mining Partnership ("EIMP"), concerning future payments by EIMP of health care and insurance benefits for retirees of EIMP. The parties hereto have agreed in 1993 collective bargaining to the establishment of a dedicated trust for the retirees of EIMP to be in the form of Voluntary Employee Beneficiary Associations ("VEBA"), effective as of August 1, 1993.

The funding arrangements will be in accordance with the terms set out in the attached Exhibit A which is a part of this letter agreement. The funding will embody the concept that payment of current liabilities for retiree health and life insurance benefits will continue to be paid directly by EIMP until the VEBA is funded to the level of 70% of the FAS ASC 715-60 (f.k.a. FAS 106) liability of EIMP as detailed in Exhibit A.

These undertakings by EIMP shall be contingent upon continued favorable tax rulings for the VEBA. In the event: the VEBA, either (i) loses its tax-exempt status or (ii) the tax treatment of the VEBA by the Internal Revenue Service (IRS) under the tax code or other applicable law is such that it would be more prudent for EIMP to fund for retiree health care and life insurance in a different way, then, upon the occurrence of any such event and at the sole option of EIMP, EIMP and the USW will meet in good faith for the purpose of agreeing to an alternative mechanism for providing a regular method of funding for retiree health care and life insurance benefits with any dispute to be resolved by final and binding last offer arbitration under which the arbitrator shall be empowered to choose the offer which is most consistent with the purpose and intent of the VEBA to be established pursuant to this agreement.

If the foregoing accurately reflects our agreement, please confirm by signing below.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations

Empire Iron Mining Partnership
The Cleveland-Cliffs Iron Company, Managing Agent

Confirmed:
Emil Ramirez
United Steelworkers

EXHIBIT A

VEBA FUNDING

Empire Iron Mining Partnership

1. Annually funded by February 15 of each year an amount equal to $7.1 million**.** The Local and International Union shall be furnished annually with a written certification from the Chief Financial or Chief Executive officer of Empire's managing partner as to the production of pellets and the funding of the VEBA.

2. At such time of Empire's share of VEBA funding equals 70 percent or more of Empire's FAS ASC 715-60 (f.k.a. FAS 106) obligation, the employer may pay current benefit claims from the VEBA. (The FAS ASC 715-60 obligation is the Accrued Post-Retirement Obligation (APRO) for persons covered by the VEBA). However, before such payments from the VEBA shall be allowed, the employer and the Union must each agree (in their sole and absolute discretion) to an appropriate adjustment to the level of funding for the VEBA to take into account such payments and the projected FAS ASC 715-60 obligation.

3. The funding obligation will be suspended when Empire's share of the value of the assets in the VEBA reaches 90 percent of Empire's FAS ASC 715-60 obligation.

4. The costs of establishing and maintaining the VEBA (including administrative expenses) will, to the extent permitted by ERISA, be borne by the VEBA trusts.

5. Union to have same administrative review rights that the union currently has with the respect to the pension plan. In connection therewith, the Local and International Union shall be furnished with reports annually (including an audited financial statement and list of assets) regarding the operation of the VEBA, and an actuarial valuation report as of December 31st of each year. From time to time, the Union shall be furnished with additional information as shall be reasonably required for the purpose of enabling it to be properly informed concerning the operation of the benefits in so far as they affect the participants. To the extent amounts contributed by the employer are insufficient to pay benefits due to employees of that employer or their dependents, the USW may direct the Claims Administrator as to the payment of such benefits, subject to the requirements of ERISA.

6. In the event that a National Health Care Program is enacted which provides insurance benefits which had been provided under the Program of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses as of October 1, 2022, the employer and the Union will meet to discuss the impact of the legislation and any modifications to the funding of the VEBA that would be appropriate so as to avoid a duplication of funding by the employer under the National Health Care Program and under the VEBA. In the event that the employer and the Union cannot agree on whether modifications to funding are necessary or on the appropriate modifications, the matter shall be settled by arbitration conducted in accordance with (the collective bargaining agreement) and no modifications shall be made unless ordered pursuant to such arbitration.

APPENDIX L. VEBA Funding (Tilden)

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: VEBA Funding, Tilden Mining Company L.C.

Dear Mr. Ramirez:

This letter will confirm understandings reached in connection with the 2022 collective bargaining agreement ("CBA") entered into between the USW and Tilden Mining Company L.C. ("TMC"), concerning future payments by TMC of health care and insurance benefits for retirees of TMC. The parties hereto have agreed to the establishment of a dedicated trust for the retirees of TMC to be in the form of Voluntary Employee Beneficiary Associations ("VEBA"), effective as of August 1, 1993.

The funding arrangements will be in accordance with the terms set out in the attached Exhibit A which is a part of this letter agreement. The funding will embody the concept that payment of current liabilities for retiree health and life insurance benefits will continue to be paid directly by TMC until the VEBA is funded to the level of 70% of the FAS ASC 715-60 (f.k.a. FAS 106) liability of TMC as detailed in Exhibit A.

These undertakings by TMC shall be contingent upon continued favorable tax rulings for the VEBA. In the event: the VEBA, once established, either (i) loses its tax-exempt status or (ii) the tax treatment of the VEBA by the Internal Revenue Service ("IRS") under the tax code or other applicable law is such that it would be more prudent for TMC to fund for retiree health care and life insurance in a different way, then, upon the occurrence of any such event and at the sole option of TMC, TMC and the USW will meet in good faith for the purpose of agreeing to an alternative mechanism for providing a regular method of funding for retiree health care and life insurance benefits with any dispute to be resolved by final and binding last offer arbitration under which the arbitrator shall be empowered to choose the offer which is most consistent with the purpose and intent of the VEBA to be established pursuant to this agreement.
If the foregoing accurately reflects our agreement, please confirm by signing below.

If the foregoing accurately reflects our agreement, please confirm by signing below.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations

Tilden Mining Company L.C.
The Cleveland-Cliffs Iron Company, Managing Agent

Confirmed:
Emil Ramirez
United Steelworkers

EXHIBIT A

VEBA FUNDING

Tilden Mining Company L.C.

1. Annually funded by February 15 of each year an amount equal to $7.0 million. The Local and International Union shall be furnished annually with a written certification from the Chief Financial or Chief Executive officer of Tilden's managing partner as to the production of pellets and the funding of the VEBA.

2. At such time of Tilden's share of VEBA funding equals 70 percent or more of Tilden's FAS ASC 715-60 (f.k.a. FAS 106) obligation, the employer may pay current benefit claims from the VEBA. (The FAS ASC 715-60 obligation is the Accrued Post-Retirement Obligation (APRO) for persons covered by the VEBA). However, before such payments from the VEBA shall be allowed, the employer and the Union must each agree (in their sole and absolute discretion) to an appropriate adjustment to the level of funding for the VEBA to take into account such payments and the projected FAS ASC 715-60 obligation.

3. The funding obligation will be suspended when Tilden's share of the value of the assets in the VEBA reaches 90 percent of Hibbing's FAS ASC 715-60 obligation.

4. The costs of establishing and maintaining the VEBA (including administrative expenses) will, to the extent permitted by ERISA, be borne by the VEBA trusts.

5. Union to have same administrative review rights that the union currently has with the respect to the pension plan. In connection therewith, the Local and International Union shall be furnished with reports annually (including an audited financial statement and list of assets) regarding the operation of the VEBA, and an actuarial valuation report as of December 31st of each year. From time to time, the Union shall be furnished with additional information as shall be reasonably required for the purpose of enabling it to be properly informed concerning the operation of the benefits in so far as they affect the participants. To the extent amounts contributed by the employer are insufficient to pay benefits due to employees of that employer or their dependents, the USW may direct the Claims Administrator as to the payment of such benefits, subject to the requirements of ERISA.

6. In the event that a National Health Care Program is enacted which provides insurance benefits which had been provided under the Program of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses as of October 1, 2022, the employer and the Union will meet to discuss the impact of the legislation and any modifications to the funding of the VEBA that would be appropriate so as to avoid a duplication of funding by the employer under the National Health Care Program and under the VEBA. In the event that the employer and the Union cannot agree on whether modifications to funding are necessary or on the appropriate modifications, the matter shall be settled by arbitration conducted in accordance with (the collective bargaining agreement) and no modifications shall be made unless ordered pursuant to such arbitration.

APPENDIX M. Burn Center Travel Expenses

Letter of Understanding

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Burn Center Travel Expenses

Dear Mr. Ramirez:

The Company shall reimburse an employee or their eligible dependent for no more than three (3) weeks for their reasonable travel and lodging expenses associated with a trip by their immediate family (spouse and dependent children) to stay with an employee or eligible dependent who is receiving treatment at a regional burn center upon the provision of appropriate supporting documentation.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations

The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership
and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
United Steelworkers

APPENDIX N. Preserving Eligibility for Same-Sex Marriages

Letter of Understanding

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Preserving Eligibility for Same-Sex Marriages

Dear Mr. Ramirez:

In the event changes in federal law affect the continued legal recognition of same-sex marriages under federal law, the Company agrees to maintain the eligibility status of employees' same-sex spouses participating in the Company's health and welfare and retirement plans.

The intent of this Agreement is to preserve the status quo of benefits eligibility for employees and their spouses whose marriages are currently legally recognized under any state law and the Program, regardless of any future change in legal status due to a change in the law. In addition, the Company will continue to recognize new dependent spouses whose marriage is recognized under any U.S. jurisdiction and the current Program.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations

The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership
and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
United Steelworkers