Program of Insurance Benefits

Summary Plan Description

For USW Represented Employees for Employee Life and Accidental Death and Dismemberment Insurance, Sickness and Accident, and Prescription Drug

Effective January 1, 2019

INTRODUCTION

This booklet is the Summary Plan Description ("SPD") for employee life and accidental death and dismemberment insurance, sickness and accident benefits, and prescription drug benefits of the ArcelorMittal USA LLC. Program of Insurance Benefits (PIB) (the "Plan") for United Steelworker represented wage employees of ArcelorMittal USA LLC that are covered under bargaining units defined in Exhibit A.

The Plan provides employee life insurance and accidental death and dismemberment insurance and sickness and accident coverage for you only and it provides prescription drug services for you and your eligible family members.

Medical, mental health and alcohol and substance abuse services, dental, and vision benefits for you and your eligible family members are provided from the Steelworkers Health and Welfare Fund (the "Fund"). Please refer to the separate SPD provided by the Fund for a description of the terms and conditions of these benefits.

The eligibility provisions defined in this SPD apply to employees and their eligible dependents for employee life and accidental death and dismemberment insurance, sickness and accident benefits, prescription drug benefits, and medical, dental, mental health and alcohol/substance abuse services and vision benefits provided from the Fund.

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SECTION 1.

ELIGIBILITY, ENROLLMENT AND COST

Eligibility - Employee

1.0 You are eligible for coverage under the Plan if at the time of your employment you are an employee in the designated group to which the Insurance Agreement is applicable as defined in Exhibit A.

Eligibility - Dependents

1.1 You may elect to include your dependents for coverage under the Plan if you are an employee of the Company.

If you and your spouse are both employees of ArcelorMittal USA and you both receive benefits under this Plan or, one of you receives benefits under this Plan and one of you receives benefits under any other ArcelorMittal USA plan or, one of you receives benefits under this Plan as an employee and the other is a former employee covered under any other ArcelorMittal USA plan or program toward the cost of which the Company contributes, you will only be allowed to elect to enroll eligible dependent children separately under one plan. Eligible dependent children may only be enrolled under your plan or under your spouse's plan. You will not both be allowed to enroll your dependent children.

If you and your Spouse are both entitled to benefits under this Active Plan, either of you may elect coverage as a dependent Spouse under the other's plan. In the case of an eligible Spouse who is entitled to coverage under a Plan sponsored by the Company other than this Plan, such Spouse will not be eligible to enroll in this Plan. Where such Spouse is enrolled in the hourly Retiree plan, the Company will reimburse their ArcelorMittal retiree monthly contribution for medical and prescription drug coverage. The $3600 Waiver of Coverage payment in Section 1.7 will not apply.

At the time you elect coverage for your dependents, you must submit verification documentation (e.g., birth certificate, marriage certificate, divorce decree, etc.). These documents must be submitted to the Human Resources Department at your plant location or to the designated eligibility administrator.

Your eligible dependents include:

(a) Your spouse (the person to whom you are legally married);

(b) Your children under 26 years of age, including natural children (a blood descendant of the first degree), stepchildren, legally adopted children (including a child living with the adopting parents during the period of probation), or a child permanently residing in your household of which you are the head and actually being supported solely by you and you have been appointed the child's legal guardian;

NOTE: Please see side letter pg 43.

(c) Your children who are otherwise eligible as dependents, are over the age of 26, who became handicapped (either physically or mentally) before turning 19 years of age, are unable to work and are financially dependent on you for support and maintenance.

To continue a child's coverage under this provision, the Disabled Dependent Certification form must be completed and returned to the Company or designated administrator within 90 days after the end of the year in which your child turns age 19. Once the information is reviewed and if approved, coverage will continue for a specified period of time. Application for

continued coverage as a handicapped dependent may be required from time to time as specified by the Company. If eligibility for continued coverage under the Plan as a disabled dependent child is not approved, all such coverage for that child will end as of the end of the month the child turns age 26 or at the end of the month such dependent child is no longer considered disabled, whichever is later.

There are also some restrictions that may affect the eligibility of your dependents:

(a) No spouse, or dependent child can be covered by more than one employee or retiree at a time; married employees of the Company may choose which parent will cover their eligible natural or legally adopted dependent children;

(b) A dependent who resides outside the United States or Puerto Rico is not covered; and

(c) If the parents of a dependent child are divorced and if there is a court decree that establishes financial responsibility for the health care expenses with respect to the child, eligibility for the Plan will be determined by the court decree.

Change in Family Status

1.2 Written notice of any change in your family status, such as marriage or divorce, birth of a child, or death of any dependent should be sent to the Company or designated eligibility administrator. When sending such notice, include complete information and copies of documents such as marriage certificate, birth certificate, divorce decree, death certificate, etc., and include your full name and social security number.

If you acquire a dependent as a result of marriage, birth, adoption, or step child, you may elect to include your dependent in your coverage. Coverage for an eligible acquired dependent will become effective on the date you acquire the dependent, if you notify and provide all necessary documentation to the Company or designated eligibility administrator. If you do not notify and provide all necessary and required documentation for your dependent to the Company or designated eligibility administrator within **90 days** after the date you acquire the dependent, coverage will not become effective for such dependent until the first of the month following receipt of all required documentation.

When Coverage Begins

1.3 Coverage becomes effective on the day that you actually begin to work for the Company. If you are not at work on the date that you are scheduled to start, coverage will be postponed until you return to work.

Coverage for an eligible dependent spouse or eligible dependent child of a new employee becomes effective on the same day your coverage becomes effective provided that you have submitted all appropriate and required documentation for the dependent within **30 days** of your first day of work. If you provide all appropriate and required documentation for a new dependent more than **30** days after your coverage becomes effective, coverage will not become effective for such dependent until the first of the month following receipt of all required documentation.

If you and your spouse are both employees of ArcelorMittal USA and receive benefits under this Plan, or any other plan or program toward the cost of which the Company contributes, and in the event that the coverage of either you or your spouse is terminated for any reason other than non-payment of required contributions, that individual and the individual's enrolled dependents can be enrolled as dependents of the other covered employee upon application.

When Coverage Ends

1.4 Plan coverage for an employee ends:

(a) On the day that you cease to be eligible for coverage under the Plan;

(b) On the date of termination of employment with the Company. For the purpose of this paragraph only, you will be considered to have terminated your employment if you are absent from work for a period of five or more calendar days for reasons other than disability, layoff, leave of absence, suspension, vacation, jury duty, witness duty or any other specifically authorized absence and all your coverage under the Plan will terminate at the end of the 5th day of such absence. Benefits will not be terminated if an Employee has a Sickness and Accident claim in process;

(c) At the end of the month in which you last worked, if you retire and are otherwise eligible for retiree healthcare from the Company, the Company will take all reasonable steps to eliminate any administrative delays that may exist in the transfer from Active to Retiree coverage**;**

(d) On the date of your death.

Plan coverage for a dependent ends:

(a) On the date that the coverage of the employee ends;

(b) At the end of the sixth month following the month in which the employee dies;

(c) On the date of your divorce from your spouse as pertaining to your spouse's eligibility;

(d) At the end of the month in which a dependent child attains age 26 unless such dependent is totally disabled prior to age 19 and approved for such disabled dependent coverage; or

(e) At the end of the month that you elect to have a dependent removed from coverage.

Continuation of Benefits after Termination of Coverage

1.5 If you or one of your eligible dependents is confined in a hospital, an approved rehabilitative facility or a skilled nursing facility on the date coverage terminates, benefits will continue to be provided subject to all of the provisions described in Section 5 - Health Care Benefits until discharge from such hospital or facility.

Monthly Cost

1.6 There is no cost for you or any of your enrolled dependents for coverage under this Plan.

Waiver of Coverage

1.7 You may elect to waive medical coverage and prescription drug coverage for you and all eligible dependents (if any) and receive an annual payment of $3,600.00 from the Company provided that you show proof of coverage under another group health care plan other than one sponsored by ArcelorMittal USA. An employee that waives medical and prescription drug coverage may elect to continue to be enrolled in dental and vision coverage provided under the Plan.

If you waive medical and prescription drug coverage under this Plan, you will have the ability to re-enroll for this coverage:

(a) Annually during the annual open enrollment period for coverage effective January 1, or

(b) In the event of any change in a qualifying life event defined as:

(1) Termination or loss of spouse coverage,
(2) Marriage,
(3) Divorce or legal separation from spouse,
(4) Death of spouse, or
(5) Birth or adoption of a dependent child.

You may not waive medical and prescription drug coverage for self only and continue to cover eligible dependents under the Plan and you may not waive medical and prescription drug coverage for your eligible dependents only and remain covered under the Plan.

If you provide proof that you are covered under another group health plan other than a plan sponsored by ArcelorMittal USA and elect to waive coverage under this Plan and receive the annual payment of $3,600.00, payment will be prorated and paid to you on a pay period basis.

If you elect the waiver, you will not be eligible for spouse premium reimbursement as described in Section 1.8 below.

Employee life and accidental death and dismemberment insurance and sickness and accident, vision and dental benefits under this Plan and any other provisions of the Plan not specifically related to the coverage being waived will remain in effect and unchanged.

If you elect to waive coverage and you terminate your employment you will not be eligible for COBRA continuation coverage.

Spouse Other Employer Coverage and Premium Reimbursement

1.8 If your spouse is employed, by other than the Company or its affiliates, on a full-time basis (defined as 32 or more hours per week) and is provided or offered health care coverage by this employer or if your spouse is retiring or retired and is not Medicare eligible and is provided or offered health care coverage by this employer, your spouse must enroll for that coverage even if there is a cost to participate in that coverage. A spouse who is required to pay premiums to his/her employer or employer's carrier for primary coverage will be reimbursed by the Company upon proper application by the employee on a form provided by the Company.

If your spouse is Medicare eligible, he/she can elect coverage either through their previous employers or as a dependent under the ArcelorMittal plan. If your Medicare eligible spouse selects coverage through their previous employer, he/she is ineligible for ArcelorMittal premium reimbursement.

Your spouse is not required to pay premiums for dependent coverage under any other employer group plan or to pay premiums for his/her health care under any other employer group plan if he/she works part-time (defined as less than 32 hours per week). However, if your spouse pays premiums for dependent child(ren) coverage under his/her employer's group plan and that coverage is the primary coverage, the premiums will be eligible for reimbursement as stated above.

SECTION 2.

CIRCUMSTANCES THAT MAY AFFECT YOUR BENEFITS

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

2.0 All your coverage under this Plan terminates for:

(a) Non-Occupational Disability – Six (6) months from the end of the month last worked if you have less than two (2) years of continuous service on the date you cease work, twelve (12) months from the end of the month last worked if you have two (2) but less than twenty (20) years of continuous service on the date you cease work, and twenty-four (24) months from the end of the month last worked if you have twenty (20) or more years of continuous service on the date you cease work.

(b) Occupational Disability – All coverage under the Plan will be continued during absence due to such disability but not beyond one (1) month following the end of the month that statutory compensation payments terminate. Except that sickness and accident coverage will terminate at the end of six (6) months from the end of the month last worked if you have less than two (2) years of continuous service on the date you cease work, twelve (12) months from the end of the month last worked if you have two (2) but less than twenty (20) years of continuous service on the date you cease work, twenty-four (24) months from the end of the month last worked if you have twenty (20) or more years of continuous service on the date you cease work.

(c) Layoff - Your sickness and accident coverage will terminate on your last day worked. Your coverage for employee life and accidental death and dismemberment insurance and health care will continue as indicated below.

(1) If you have not completed your probationary period (1040 hours of actual work) your coverage for employee life and accidental death and dismemberment insurance and health care benefits will be continued until the end of the month that you last worked.

(2) If you have completed your probationary period (1040 hours of actual work) and you have less than two (2) years of continuous service on the date you cease work, your coverage for employee life and accidental death and dismemberment insurance and health care benefits will be continued during the time that you are on layoff for up to a maximum of six (6) months from the end of the month that you last worked.

(3) If you have two (2) or more but less than ten (10) years of continuous service on the date you cease work, your coverage for employee life and accidental death and dismemberment insurance and health care benefits will be continued during the time you are on layoff for up to a maximum of eighteen (18) months from the end of the month that you last worked.

(4) If you have ten (10) or more years of continuous service on the date you cease work, your coverage for employee life and accidental death and dismemberment insurance and health care benefits will be continued during the time you are on layoff for up to a maximum of thirty (30) months from the end of the month that you last worked.

After your Company provided employee life coverage ends as indicated in (1), (2), (3), or (4) above, you may elect to convert all or part of your employee life coverage to an individual life insurance contract. You must apply to convert to this individual contract and pay the first premium by no later than the thirty-first (31st) day after you cease to be covered for this employee life insurance.

(d) Suspension – the provisions described above for an employee that ceases work because of layoff apply except that sickness and accident benefit coverage will continue during a period of suspension that is not converted into discharge.

(e) Leave of Absence – if you cease work because of a leave of absence that is not covered under The Family and Medical Leave Act of 1993, all your coverage under the Plan, except for employee life and accidental death and dismemberment insurance, will terminate at the end of the month in which you last worked. Your employee life and accidental death and dismemberment insurance will continue in effect during such leave of absence for a further period not to exceed 6 months. If earlier termination of coverage is required by federal or state election laws, Plan coverage will terminate earlier.

(f) Military Duty – if you cease work due to authorized military duty, all coverage for you will terminate at the end of the month in which you last worked. However, the medical, dental and vision benefits only provided under this Plan will be continued for your eligible dependents during the period that you are on authorized military duty.

(g) Family Medical Leave – if your leave of absence is due to authorized leave under the Family and Medical Leave Act, all benefits under this plan will terminate upon expiration of the authorized leave unless you return to work at that time.

(h) Additional Negotiated Parental Leave –If your leave of absence is due to authorized leave under the 2015 BLA regarding additional family leave, your benefits will continue during such leave of absence.

After your Company provided health care coverage ends because of a non-occupational disability, occupational disability, layoff, leave of absence, family medical leave, or termination with severance pay, you may continue it under COBRA continuation coverage. See Section 2.5 for information about COBRA coverage.

If you cease work for one of the reasons specified in Section 2.0 and you do not return to active work because of another one of such reasons, your coverage under the Plan 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 (vacation is same as return to work). Notwithstanding the above, if you have 20 or more years of continuous service on the date you cease work due to layoff and do not return to work due to disability, the provisions set forth in the case of an employee who ceases work due to layoff will continue to apply to you.

If you return to work after the first calendar day in any month, no claim shall be made by you or on your behalf for a refund of insurance premiums paid by you for such month.

Reinstatement or Re-employment

2.1 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 Plan shall have terminated and prior to a break in continuous service, all your coverage under the Plan will be reinstated on the day you return to work.

If you return to work after a break in continuous service, you will be enrolled in the Plan as a new employee as specified in Section 1.3.

Continuous Service

2.2 Wherever the term "continuous service" is used in this booklet, it means your continuous service as determined for pension purposes under the non-contributory pension plan, the SPT, or, if neither of those apply, the Basic Labor Agreement.

Health Care Benefits for Eligible Pensioners, Surviving Spouses, and Their Dependents

2.3 If you retire or become a surviving spouse and it is determined that you are eligible for benefits under the Plan, you and your eligible dependents upon your election will be enrolled in the Program of Insurance Benefits for Eligible Retirees and Surviving Spouses Effective for which you will be required to make a contribution. The contribution level will depend upon whether the retiree and/or dependent spouse is eligible for Medicare.

Retirees, spouses and surviving spouses will pay a monthly premium as specified on the following schedule. There is no charge for eligible dependent children.

Year Ending	Not Eligible for Medicare	Eligible for Medicare
2019	$100.00	$50.00
2020	$100.00	$50.00
2021	$100.00	$50.00
2022	$100.00	$50.00

Medicare

2.4 You or a dependent of yours may, upon proper application, be entitled to Medicare Part A and Medicare Part B by reason of attainment of age 65, disability or end-stage renal disease. The Company will consider you or your dependent to be entitled to Medicare coverage on the first day of the month of entitlement whether or not proper application has been made.

If, while you are an active employee, you or your dependent is age 65 or over, the Company will consider you or your dependent to be entitled to Medicare coverage on the first day of the month you retire. The Plan will be considered to be the primary plan if you are an active employee. If Medicare coverage is elected the Company will not reimburse you for any Medicare premiums charged or provide any benefits under the Plan.

Medicare coverage will be considered to be the primary coverage if you or your dependents become eligible for such coverage by reason of end-stage renal disease. Primary benefits under the Plan will continue to be paid for the first 33 months of dialysis treatment and Medicare benefits as secondary to benefits under the Plan will begin with the fourth month of treatment (subject to government mandate). Subsequently, benefits under the Plan will be reduced by benefits that you receive under Medicare.

If you or a dependent of yours becomes eligible for Medicare by reason of end-stage renal disease, you or your dependent should enroll in Medicare Parts A & B. The Company will reimburse you for any Medicare B premiums charged. Timely enrollment will avoid the loss of valuable protection against medical expenses. You must also advise the claims administrator of the effective date of Medicare coverage applicable to you or one of your eligible dependents. Failure to do so could result in an overpayment of benefits that you would have to repay.

Benefits While Traveling Outside the United States or Puerto Rico

2.5 If you incur covered medical expenses/services while traveling outside the United States or Puerto Rico, you will probably be required to pay the provider for such services since providers in foreign countries generally do not accept assignments 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 for reimbursement on the same basis as if the expenses were incurred in the United States. If you are 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 the Plan as if you were not eligible for Medicare. If you or any of your eligible dependents establish permanent residence outside of the United States or Puerto Rico, you and/or they will no longer be covered under the Plan.

COBRA (Consolidated Omnibus Budget Reconciliation Act) Continuation Coverage

2.6 The Plan offers you and your dependents the opportunity to elect a temporary extension of health coverage at group rates in certain instances where coverage would otherwise end. This is called COBRA continuation coverage. You or they must pay the cost of this coverage.

You and/or your eligible dependents have the right to elect COBRA continuation coverage for up to 18 months (29 months if you are disabled at any time during the first 60 days of continued coverage) if you lose your group health coverage under the Plan for any of the following reasons:

- a reduction in your hours of employment; or
- termination of your employment (for reasons other than gross misconduct on your part).

Your covered dependents have the right to choose COBRA continuation coverage for up to 36 months if they lose group health coverage under the Plan for any of the following reasons:

- you die;
- you divorce or legally separate from your spouse; or
- your child ceases to be qualified as an eligible dependent.

Under COBRA continuation coverage you, or your dependent, have the responsibility to inform the medical claims administrator within 60 days of a divorce, legal separation, or a child losing dependent status under the Plan. The Company has the responsibility to notify the medical claims administrator of your death or your loss of eligibility for coverage under the Plan.

When the medical claims administrator is notified that one of these events has happened, they will in turn notify you and your qualified beneficiary, such as your covered dependent or spouse, of their right to elect COBRA continuation coverage. They have at least 60 days from the date coverage is lost because of one of the events described above to inform the medical claims administrator that COBRA continuation coverage is elected.

COBRA Notices will be mailed by Certified Mail to Participants losing coverage under the Plan.

If COBRA continuation coverage is not elected within 60 days of being notified of COBRA eligibility, group health coverage under the Plan will end as described in earlier sections of this Summary Plan Description. If COBRA continuation coverage is elected, the coverage must equal, as of the time coverage is being provided, the coverage provided under the Plan to similarly situated employees and their family members.

If your coverage is continued at the Company's expense, because of a non-occupational disability, occupational disability, layoff, leave of absence, family medical leave, or termination with severance pay, such continuation is used as part of your allowable COBRA coverage. For example, if you are eligible to continue your benefits under COBRA for a maximum of 18 months and the Company pays for the first 2 months of continued coverage, you can continue your coverage, at your own expense, under COBRA for an additional 16 months (27 months if disabled).

COBRA continuation coverage may be cut short for any of the following reasons:

- the Company no longer provides group health coverage to any of its employees;
- the premium for COBRA continuation coverage is not paid within the COBRA time limits;
- the covered individual becomes covered under another group health plan which does not contain an exclusion or limitation with respect to any pre-existing condition of the person receiving COBRA continuation coverage; or
- the covered individual first becomes entitled to Medicare.

In the unlikely event the Company files for Chapter 11 Bankruptcy reorganization, covered employees and their eligible dependents will be offered COBRA continuation if they are not eligible for Medicare.

Your qualified beneficiaries do not have to show proof of insurability to choose COBRA continuation coverage. They or you will have to pay the entire cost for COBRA continuation coverage.

More specific information will be provided, upon eligibility for COBRA coverage.

SECTION 3.

EMPLOYEE LIFE and ACCIDENTAL DEATH and DISMEMBERMENT INSURANCE

Excluded Groups

The benefits as provided in this Section are not applicable to the following bargaining unit locations. Benefits for these groups are described in separate PIBs.

- Columbus, Ohio (Local 9309)
- East Chicago, Indiana (Office & Technical USW Local 1010-06)
- East Chicago, Indiana (Research USW Local 1010-23)
- East Chicago, Indiana (Process Automation USW Local 1010-27)
- New Carlisle, Indiana (I/N Tek & I/N Kote USW Local 9231)
- New Carlisle, Indiana (I/N Tek & I/N Kote USW Local 9231-01)
- Obetz, Ohio (Local 2342-1)

Coverage and Benefit Amount

3.0 In the event of your death, employee life insurance in the amount of $50,000 will be payable to any person(s) you designate as beneficiary when the Company or designated life insurance carrier receives written proof of death.

You will also be covered for accidental death and dismemberment insurance in the amount of $50,000. This coverage pays a benefit, to you or your designated beneficiary, for loss of life and certain injuries resulting from a covered accident. Benefits for accidental loss are paid at certain percentages of your coverage amount for specific accidental losses and only if certain conditions are met. Not all such losses are covered.

You have the right to change your beneficiary at any time by completing and returning the proper beneficiary change form by mail or email to the Employee Benefits Office. A change in beneficiary will take effect when the form is signed and dated by you. The participant will receive a confirmation of changes via regular US mail.

If there is more than one beneficiary but the beneficiary form does not specify their shares, they will share equally. If a beneficiary dies before you, that beneficiary's interest will end. It will be shared equally by any remaining beneficiaries, unless the beneficiary form states otherwise.

Life Insurance after Retirement

3.1 If you retire with eligibility for employee life insurance coverage, the amount of your coverage will be $25,000 and will be continued until the end of the month in which you attain 62. On the first of the month after the month in which you attain age 62, the amount of your life insurance will be reduced to $20,000.

If you retire and are not eligible for employee life insurance, you will have the right to convert to an individual policy as explained in section 3.2 below.

Your coverage for accidental death and dismemberment insurance as indicated in section 3.0 above ends on the date you retire.

Conversion Privilege

3.2 If your employee life insurance is reduced due to retirement or terminated as a result of layoff, leave of absence, or termination of employment, you will have the right to convert to an individual

policy as explained below. At the time of retirement, the Company will inform you of the life insurance conversion privileges for Employee life insurance.

Upon application to the life insurance carrier within 31 days after your employee life insurance coverage is reduced as provided in section 3.1 or terminates as provided in section 1.4 and 2.0, you may arrange to continue your employee life insurance under an individual policy for an amount not greater than the amount of the reduction or for an amount not greater than the amount you have under the Plan at the time of such termination, without having to provide medical evidence of insurability. Such individual policy may be on any one of the forms of policy then customarily issued by the carrier 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 your employee life insurance coverage terminates under the Plan 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 employee life insurance which you may continue under an individual policy as referred to above shall in no event exceed the amount of employee life insurance terminated under the Plan less the amount of life insurance for which you become eligible under such other plan.

Any such individual employee life insurance policy referred to in this Section 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 employee life insurance in force under the Plan immediately prior to termination or reduction, less any amount of term life insurance for which you became insured under any other Company provided group life insurance plan, will be payable to your beneficiary.

Accidental death and dismemberment insurance as indicated in Section 3.0 above cannot be converted to an individual policy.

Claiming Benefits

3.3 Your designated beneficiary must contact the ArcelorMittal USA Employee Benefits Office or the designated life insurance administrator to file a claim and will be provided the necessary forms for claiming the life insurance proceeds when your death occurs.

How to Appeal a Claim

3.4 If your designated beneficiary has any questions concerning a denial of employee life insurance benefits, in whole or in part, your beneficiary should write within 60 days from the date the claim was denied to the insurance carrier 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. 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 Manager of Employee Benefits, ArcelorMittal USA LLC, 3210 Watling Street, East Chicago, IN 46312. Your beneficiary will be advised by that office of the final decision within 60 days.

SECTION 4.

SICKNESS AND ACCIDENT BENEFITS

Excluded Groups

The benefits as provided in this Section are not applicable to the following bargaining unit locations. Benefits for these groups are described in separate PIBs.

- Columbus, Ohio (Local 9309)
- East Chicago, Indiana (Office & Technical USW Local 1010-06)
- East Chicago, Indiana (Research USW Local 1010-23)
- East Chicago, Indiana (Process Automation USW Local 1010-27)
- New Carlisle, Indiana (I/N Tek & I/N Kote USW Local 9231)
- New Carlisle, Indiana (I/N Tek & I/N Kote USW Local 9231-01)
- Obetz, Ohio (Local 2342-1)

Eligibility

4.0 If you **have six (6) months of continuous service and** become totally disabled as a result of an illness, injury, or accident so as to be prevented from performing the duties of your employment and an authorized provider certifies thereto, you will be eligible to receive sickness and accident benefits. An "authorized provider," as defined under this plan, is limited to a licensed medical doctor (M.D.), **a Nurse Practitioner, a Physician's Assistant (P.A.)**, a licensed doctor of osteopathy (D.O.), a licensed doctor of podiatric medicine (D.P.M.), or any provider authorized by the mental health/substance abuse managed care administrator to provide treatment, and operating within the scope of their license(s). Benefits will not be payable for any period during which you are not under the care of an authorized provider.

If an employee after consultation with the Company's physician or other clinical staff is required to see a treating physician prior to returning to work, and does so within three days excluding Saturday, Sunday, and holidays, the seven-day waiting period referred to in Section 4.2 will begin on the day after his or her consultation with the Company's physician or staff.

Filing a Sickness and Accident Benefit Claim

4.1 You, or someone on your behalf, will be required to file your sickness and accident benefit claim with the Company, or appropriately designated sickness and accident benefits claim administrator, and provide information concerning your medical condition including the name, address, and telephone number of your authorized provider and the expected duration of absence. You will also be required to complete and return an authorization for the release of medical information regarding the disability for which you are claiming sickness and accident benefits. Attending Physician Statement forms (whether the plan is administered by the Company or an outside Claims Administrator) and Medical Release forms will be available at each Plant and local Union office upon request.

You are encouraged to provide prompt notice of your claim for sickness and accident benefits so that the evaluation of the claim, including any necessary investigation of medical and other factual aspects of it, can be made in an expeditious manner. This provision shall not be used to deny a claim for Sickness and Accident Benefits.

When Benefits Begin

4.2 Sickness and accident benefits begin:

(a) On the first (1st) day of disability as a result of an accident,
(b) On the first day of inpatient hospitalization or outpatient surgery regardless of cause, or
(c) On the eight (8th) day of disability resulting from an illness or injury when not hospitalized.

Duration of Benefits

4.3 Sickness and accident benefits are payable according to the following schedule:

Years of Continuous Service When Absence Begins	**Weeks of Benefit**
6 months but less than 2	26
2 but less than 20	52
20 or more	52 (and up to an additional 52 weeks)

Successive periods of disability separated by a period of continuous active employment with the Company of less than two (2) weeks will be considered to be one continuous period of disability, unless it is clear that they arise from unrelated causes.

If you complete (a) six (6) months, (b) two (2) years, or (c) 20 years of continuous service after the start of one continuous period of disability and before the start of a succeeding period of disability which is considered to be part of such continuous period of disability under the foregoing provision, your benefits are payable for a period not to exceed 26 or 52 or 104 weeks, respectively, for such continuous period of disability.

If you have 20 or more years of continuous service as of your last day worked and have received benefit payments under this Section 4 for a period of 52 weeks, you will be entitled to up to an additional 52 weeks of benefit payments if an Authorized Provider certifies that you are expected to return to active work within 12 months of the 52nd week of benefit payments (regardless of whether you have qualified for disability benefits under Social Security).

Amount of Benefits

4.4 The amount of weekly sickness and accident benefits for which you are eligible is equal to 70% of your base rate of pay for up to a maximum of 40 hours per week.

The per day benefit amount is:

Pay Grade	**9/2/2018**	9/1/2019	8/30/2020	9/5/2021
1	$ 85.08	$ 88.40	$ 91.12	$ 93.88
2	$ 93.16	$ 96.40	$ 99.76	$102.76
3	$102.40	$106.00	$109.72	$113.00
4	$107.80	$111.56	$115.48	$118.92
5	$114.48	$118.48	$122.64	$126.32

Reduction of Benefits and Workers Compensation

4.5 If you become totally disabled due to illness, injury, 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. The amount of sickness and accident benefits will be reduced according to the following schedule:

Eligibility for Benefits	Reduction Amount
Weeks 1 – 6	100% of weekly workers compensation benefit
Weeks 7 – 26	75% of weekly workers compensation benefit
Weeks beyond 26	85% of weekly workers compensation benefit

If you were disabled due to illness, injury, or accident arising out of or in the course of your employment and subsequently released to work by an authorized provider on or after the seventh (7^{th}) compensable week following the illness, injury, or accident with a restriction(s) requiring "light duty" work and such work is not available, sickness and accident benefits will not be offset by workers compensation benefit payments.

No benefits are payable in the event of total disability due to illness, injury, or accident arising out of or in the course of employment by other than the Company. Payments under any such law for hospitalization or medical expense or specific 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, sickness and accident benefits will be paid in full if satisfactory arrangements (which includes executing the necessary documents) 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.

Social Security and Railroad Retirement

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

If your absence from work due to illness, injury, or accident is expected to continue beyond week 15, you are required to apply for disability benefits under the Social Security Act or Railroad Retirement Act prior to week 15 and provide proof that you have filed for such benefit with the Company or sickness and accident benefit claim administrator. If you do not provide evidence of your filing for Social Security or Railroad Retirement disability benefits, the Company or sickness and accident benefit claim administrator will assume that you are receiving a benefit under the Social Security Act or Railroad Retirement Act, in an estimated amount, and your sickness and accident benefits will be reduced by the estimated Social Security or Railroad Retirement disability benefit beginning at week 26 until the Company or sickness and accident benefit claim administrator is furnished a copy of your Social Security or Railroad Retirement 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 or sickness and accident benefit claim administrator written proof within the initial 15 weeks of disability that you have applied for disability benefits under the Social Security Act or Railroad Retirement 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 or Railroad Retirement disability benefits commence, or

(b) The date 34 weeks of weekly benefits have been paid, provided you make satisfactory arrangements with the Company or sickness and accident benefit claim administrator to assure that any overpayment of weekly benefits which may result by reason of receipt of Social Security or Railroad Retirement benefits will be repaid by you 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 or Railroad Retirement 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 or Railroad Retirement Administration to release relevant information to the Company or sickness and accident benefit claim administrator.

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:

(a) You furnish satisfactory evidence that in the judgment of an authorized provider 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 or Railroad Retirement disability benefits, or

(c) You inform the Company or sickness and accident benefit claim administrator that your application for Social Security or Railroad Retirement disability benefits has been denied; however, weekly sickness and accident benefits will be paid beyond 34 weeks only if within four (4) weeks of the date of the denial letter you request reconsideration of such denial.

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 or Railroad Retirement disability benefits have been awarded or your request for reconsideration has been denied. The Company or sickness and accident benefit claim administrator will notify you of your responsibility to apply for Social Security or Railroad Retirement disability benefits and to request reconsideration of any denial of such application on a timely basis.

The applicable Social Security or Railroad Retirement monthly disability benefit will be converted to its equivalent weekly (or daily) rate. If the Social Security or Railroad Retirement disability benefit ultimately determined is more or less than the amount of reduction (or Social Security or Railroad Retirement 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.

You may obtain the services of an attorney to assist you in seeking reconsideration of, or appeal of denial of, Social Security or Railroad Retirement disability benefits. If you are subsequently awarded Social Security or Railroad Retirement disability benefits, any sickness and accident benefit overpayment that results will be reduced by the attorney's fees incurred in pursuing the appeal, but only by the amount of attorney's fees approved for payment by the Social Security or Railroad Retirement Administration.

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

Transplant Donor Benefits

4.7 If you are a donor of a human organ or tissue transplant requiring surgical removal of the donated part from the donor, disability resulting in the surgical removal of such transplant will be deemed to be a disability due to illness. In no event, however, will disability be considered to have

commenced prior to the date of hospital confinement.

Disability during Suspension

4.8 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) You promptly notify the Company of your disability; and

(b) If requested to do so, report for examination to the medical department of the plant or office where you work or to such other physician as may be designated by the Company or the sickness and accident benefits claim administrator (unless you are unable to do so for good and sufficient reason);

weekly sickness and accident benefits will be payable in accordance with Section 4.3, except that benefits will not be paid for any days during the period of suspension.

Administration of Benefits

4.9 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 in accordance with a policy with an insurance company. The Company performs important administrative functions in connection with the handling of claims, including the issuance of benefit checks. In the typical case, such handling is routine and a claim is paid within two weeks after it is reviewed 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 Company and/or the insurance company. If you have a claim which does not meet these standards, the sickness and accident benefits administrator or the insurance company may take reasonable steps to investigate the medical and other factual aspects of the claim.

SECTION 5.

PRESCRIPTION DRUG BENEFITS

Introduction

5.0 Coverage for medically necessary and appropriate prescription drugs requiring a prescription written by a licensed physician and dispensed by a licensed pharmacist pursuant to Federal or State law is provided under the Prescription Drug Benefit plan. The Prescription Drug Benefit plan also provides coverage for insulin, disposable insulin syringes, and blood glucose testing agents/strips.

Prescription drug benefit coverage will be administered by a prescription drug benefit manager who will be responsible for developing and maintaining a network of retail pharmacies, offering a mail service option for the purchase of maintenance medications for chronic or long-term conditions, managing drug utilization, and making payments for covered prescription drugs.

The prescription drug plan is a 3-tier formulary plan. A formulary is a list of preferred drug products developed by a committee of physicians and pharmacists. Your copay/coinsurance will be based on whether the drug your doctor prescribes is a generic, formulary brand, or non-formulary brand prescription drug.

Per the 2012 Settlement Agreement between the Parties, the Plans cannot be altered without written Agreement from the Union. Recommendations from the PBM shall be mutually agreed upon with the Union (such agreement shall not be unreasonably withheld). In the event agreement cannot be reached, all Plan benefits shall remain the same.

There are specific coinsurance, copayment and out-of-pocket maximums that apply only to prescription drugs (as defined below). These do not reduce or satisfy any other deductible, coinsurance, copayment, or out-of-pocket maximums elsewhere in the Plan.

Prescription Drug Costs and Benefit Payments

5.1 Your coinsurance or copayment for covered prescription drugs, by drug type and where purchased is as follow (but in no case more than the actual cost of the drug):

5.2 PPO Plan – Cost and Benefit Payments

In-Network

Retail Prescriptions (up to a 30-day supply)	Copayment
Generic	$10
Formulary Brand	$20
Non-Formulary Brand	$30

Out-of-Network

Retail Prescriptions (up to a 30-day supply)	Coinsurance
Generic	50% of the cost of drug
Formulary Brand	50% of the cost of drug
Non-Formulary Brand	50% of the cost of drug

Mail Service Prescriptions (up to a 90-day supply)	Copayment
Generic	$15
Formulary Brand	$30
Non-Formulary Brand	$60

5.3 CDHP Option – Cost and Benefit Payments

Preventive medications (as defined in the CVS Caremark Preventive Therapy Drug List) are covered by the Plan at 100% with no deductible.

In-Network

Retail Prescriptions (up to a 30-day supply)	Employee Coinsurance
Generic	20%
Formulary Brand	20%
Non-Formulary Brand	20%

Out-of-Network

Retail Prescriptions (up to a 30-day supply)	Coinsurance
Generic	50% of the cost of drug
Formulary Brand	50% of the cost of drug
Non-Formulary Brand	50% of the cost of drug

Mail Service Prescriptions (up to a 90-day supply)	Employee Coinsurance
Generic	20%
Formulary Brand	20%
Non-Formulary Brand	20%

Specialty drug cost sharing will be determined by the days supply dispensed and according to whether the drug is generic, formulary brand or non-formulary brand. Participants will pay the retail copay for a 30 day or less supply of medication. Participants will pay the mail service copay for a 31-90 day supply of medication. Specialty Drugs that are part of the Specialty Guideline Management Program are dispensed only through the prescription drug benefits manager's specialty mail order pharmacy.

Prescriptions written after the effective date of this PIB which are for Brand name drugs with generic equivalents (not including generic alternatives within a therapeutic class) will be covered provided the prescribing physician submits satisfactory clinical evidence to the prescription drug benefit manager that there is a specific pharmacological or medical reason why a brand must be dispensed. Based on satisfactory clinical evidence, the PBM will authorize the brand name drug and authorization shall not be withheld unreasonably. Brand name drug authorizations, once approved, will be good for the life of the Participant. If approved, by the prescription drug benefit manager, the copayment will follow the above table for Formulary or Non-Formulary Brand.

If authorization for a brand name drug with generic equivalents available is not obtained, the brand name drug will not be covered by the plan.

Synthroid and similar brand thyroid medications will be covered at the Tier 1 Generic copayment.

Prescription Drug Out-of-Pocket Limits

5.4 PPO Plan Out-of-Pocket Limits

An out-of-pocket maximum of $1,500 individual and $3,000 family is applied to your prescription drug purchases**.** When your individual out-of-pocket expense totals $1,500, or $3,000 for a family, for the year, drugs will then be covered at 100% by the Plan. All prescription drug coinsurance and copayments accumulate toward the prescription drug out-of-pocket limit.

5.5 CDHP Option – Out of Pocket Limit

An in-network out-of-pocket maximum of $3,000 individual and $6,000 family is applied to your medical and prescription drug purchases**.** When your individual in-network medical and prescription drug out-of-pocket expense totals $3,000, or $6,000 for a family, for the year, drugs will then be covered at 100% by the Plan. All covered services and covered prescription drug coinsurance accumulate toward the prescription drug out-of-pocket limit.

Cost of Coverage

5.6 There is no additional cost (premium) for coverage under the prescription drug benefit plan.

How the Prescription Drug Benefit Plan Works

5.7 Retail Pharmacy

You can purchase up to a 30-day supply of medication. If the drug is purchased at a network pharmacy, the pharmacist will charge you your copayment amount only. No claim forms are required and you do not file the claim with the prescription drug benefit manager for payment. If the drug is purchased at an out-of-network pharmacy, the pharmacist will charge you the entire amount of your prescription purchase. You must then complete a prescription drug claim form and submit it along with your receipt to the prescription drug benefit manager. The prescription drug benefit manager will pay you the benefit for your drug purchase.

Mail Service

You can order a 14-90 day supply of medication through the mail from the prescription drug benefit manager. Medications that are used and required to treat chronic long term conditions will be limited to two (2) 30 day prescription fills at a retail pharmacy. After two (2) fills, you must use the mail service to obtain your medication. When you purchase prescription drugs through the mail service, include the appropriate copayment amount along with your prescription and a completed mail order form in a mail order envelope. If you are not sure of the copayment amount, submit the maximum copayment with your order. Your mail order account will be credited or a credit will be issued for you if the copayment is less.

Participants will pay the copay according to the days supply dispensed. Participants will pay the retail copay for a 30 day or less supply of medication. Participants will pay the mail service copay for a 31-90 day supply of medication.

The Prescription Drug Benefit Plan as Secondary Payer

5.8 If the prescription drug benefit plan is a covered dependent's secondary plan and prescription drugs are covered in their primary plan (other than Medicare):

(a) Benefits for retail pharmacy purchases of drugs will be coordinated through the Prescription Drug Benefit plan. Benefits otherwise payable will be reduced by benefits paid by the primary plan.
(b) Mail order copays paid under an eligible dependent's primary plan may be coordinated through the Prescription Drug Benefit plan. However, participants can submit for reimbursement of the difference (if any) they paid out of pocket under their primary plan and the cost they would have paid under the ArcelorMittal plan if it were primary for any prescription filled after 1/1/17. Proof of payment must be provided for reimbursement.

Benefits will be coordinated through the medical plan for 1) retail pharmacy purchases of Medicare Part B covered drug products for a Medicare-primary member and 2) drugs dispensed or administered and billed by a physician or clinic. Benefits otherwise payable will be reduced by benefits paid by the primary plan or by Medicare.

Prescription Drug Coverage Limitations and Exclusions

5.9 The following drugs are subject to limitations:

(a) Smoking cessation products that can be obtained only with a physician's prescription (non over-the-counter) are covered at the generic coinsurance/copayment level;
(b) Drugs prescribed for the treatment of infertility are limited to $5,000 in plan expense per lifetime;
(c) Drugs prescribed for erectile dysfunction are subject to prior authorization approval and limited to eight (8) pills maximum per month. Low dose daily erectile dysfunction drugs shall be dispensed according to FDA limits;
(d) Certain drugs may require step therapy;
(e) Certain drugs may be limited in quantities covered;
(f) Certain drugs may require prior authorization;
(g) Anti-obesity or diet pills prescribed for obesity are subject to prior authorization approval; and
(h) Shingles shots for participants over age 60, or for those age 50 to 60 if medically necessary, at participating pharmacies at 0% coinsurance.
(i) There will be no Quantity Limits on Proton Pump Inhibitor medications

Prescription drug benefits are not payable for:

(a) Drugs that can be purchased over-the-counter without a prescription (except for insulin);
(b) Experimental, investigational, or drugs not approved by the FDA;
(c) Anti-obesity or diet pills without a physician's diagnosis of obesity and prior authorization approval;
(d) Vitamins (obtained over-the-counter or by prescription), minerals, or supplements;
(e) Food and food or nutritional supplements;
(f) Refills of prescriptions older than one year;
(h) Drugs prescribed for cosmetic purposes (including, anti-wrinkle agents, dermatologicals, and hair growth stimulants when prescribed solely for cosmetic purposes);
(i) Drugs prescribed in amounts greater than the manufacturer's recommended dosing or for diagnoses for which the drug is not FDA approved;
(j) Replacement of lost or stolen prescription drugs; or
(k) Alcohol swabs, therapeutic devices, or appliances (except as provided in Section 7.8

below).

Prior Authorization

5.10 Some prescription drugs require review by the prescription drug benefit manager before certain quantities or an extended duration of therapy will be covered under the Prescription Drug Benefit Plan. Prescription drugs that are subject to review and prior authorization are those that cause potentially serious side effects, are costly, or have a high potential for inappropriate use or fraud. A listing of drugs that require prior authorization is available on the ArcelorMittal website at http://benefits.arcelormittalusa.com. Select "USW Represented Employees and Retirees", then "Prescription Drug Benefits", then select "Prescription Drug Reference List." Or call the prescription drug benefit manager for a copy of the Drug Reference List.

Compound drugs: Compounded drugs are drugs that have been mixed together that are typically not approved by the Food and Drug Administration. Any compounded drug prescription using proprietary bulk powders and bases and/or costing $300 or more shall be subject to prior authorization.

Contraceptives

5.11 The Plan covers contraceptive prescription drugs and devices with no cost sharing.

SECTION 6.

RESTRICTED RETIREE HEALTH CARE ACCOUNT

The following provisions apply to Employees hired into a bargaining unit covered by the Basic Labor Agreement, or the specific Collective Bargaining Agreements for I/N Tek and I/N Kote, Columbus Coating, IH O&T, IH Process Automation, or IH Research and Development.

Employees hired prior to the ratification date of the 2015 BLA (June 23, 2016) and who meet the eligibility requirements for retiree health insurance and life insurance benefits, will continue to be eligible for Non-Medicare (i.e. pre-65) retiree health insurance and life insurance coverage and Medicare Eligible (i.e. post-65) retiree health insurance and life insurance coverage and shall remain participants under the Retiree PIB and the Retiree Insurance Agreement.

An Employee whose original date of hire occurred before the ratification date of the 2015 BLA (June 23, 2016) and who breaks pension continuous service due to a layoff from the Company after the ratification date of the 2015 BLA and is rehired, shall regain eligibility to become a participant under the Retirees' and Surviving Spouses' Health Insurance Agreement if such rehire is within 5 years of the last day worked during a prior period of employment.

Employees hired or rehired on or after the ratification date of 2015 BLA (June 23, 2016) (and who are not entitled to regain eligibility to become a participant under the Retirees' and Surviving Spouses' Health Insurance Agreement if such rehire is within 5 years of the last day worked during a prior period of employment) and who complete their probationary period will receive a 401(k) contribution of $0.50 per hour worked and for lost time from scheduled work due to union business hours (union business hours capped at a maximum 40 hours per week) to a Restricted retiree health Care Account for eligible hours during the period September 1, 2015 to 11:59 p.m. September 1, 2018. Hourly contributions are $0.60 per hour for eligible hours for the period after September 1, 2018. Contributions to the Retiree health Care Account are in lieu of retiree health insurance and life insurance benefits.

The Retiree Health Care Account portion of the employee's 401(k) balance will not be eligible for loans, hardship withdrawals or early distributions.

If a participant has not made an investment election. Contributions will be initially invested in an age appropriate target date fund.

Where a participant has made investment elections, contributions will be invested as directed by the participant.

All such contributions to the Retiree Health Care Account will be immediately vested.

Contributions will begin after an Employee completes their probationary period. For the sole purpose of determining when the Company starts making the 401(k) contributions that are in lieu of Company-provided retiree health care, the probationary period will end six months from their Date of Hire.

SECTION 7.

COORDINATION OF BENEFITS

Coordination of Benefits

7.0 The Plan is coordinated with other plans to which you or your covered dependents belong. This is designed to prevent duplication of payments when you or a dependent can collect benefits from another plan. The coordination of benefits (COB) provision operates on a primary/secondary basis. The plan that pays first is considered the primary plan. The plan that pays second is the secondary plan. The following types of plan benefits will be coordinated with benefits from the Plan:

- governmental benefit programs provided or required by law (other than Medicaid, and other than any plan which, by law, has benefits in excess of those of any private insurance program); and

- other group health care plans to which you or your covered dependents belong.

The coordination of benefits provision does not apply to individual insurance plans.

The procedure used to determine which plan is primary or secondary is as follows:

(a) Primary coverage for the employee is under the Plan; primary coverage for a working or retired spouse is under his or her employer's plan. Should an employee have two primary plans, the plan which has covered the employee the longest is considered primary.

(b) When dependent children are eligible for coverage under both parents' plans who are not divorced from each other, the plan of the parent whose birthday occurs first in the year will be the primary plan, if both parents have the same birthday, the plan which covered the parent longer will be the primary plan.

If both parents are covered under any group insurance plan toward the cost of which the Company contributes, the parents may elect to cover their dependent children under either parent's plan, but not both.

(c) Where both plans cover the patient as a dependent child of divorced parents, benefit determination will be as follows:

(1) If there is a court decree which establishes financial responsibility for the medical, dental, vision or other health care expenses of such child, the plan which covers the child as a dependent of the parent with such financial responsibility will be primary and the benefits there under will be determined before the benefits of any other plan which covers the child as a dependent; or

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

(3) If there is no court decree and the parent with custody of the child has remarried, the plan which covers the child as a dependent of the parent with custody will be primary and the benefits there under will be determined before the benefits of a plan which covers the child as a dependent of the stepparent, but the benefits of a plan which covers the 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.

(d) Where the determination cannot be made in accordance with (a), (b), or (c) above, the plan that has covered the patient for the longer period of time is the primary plan.

Benefits are not coordinated between married Company employees or retirees.

If it is determined that benefits under the Plan should have been reduced because the benefits provided are available 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 Plan have been provided under another group plan, the claims administrator or carrier may make reimbursement direct to the insurance company or other organization providing benefits under the other plan.

For the purpose of this provision, the claims administrator or carrier 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.

Any person claiming benefits under the Plan must furnish the claims administrator or carrier such information as may be necessary or the purpose of administering this provision.

SECTION 8.

CLAIM PROCEDURES

Claim Procedures

8.0 The following definitions have special meaning when used in this Plan in accordance with claim procedures.

A **"**Claim**"** is any request for a Plan benefit or benefits made by you or your authorized representative in accordance with the Plan's procedures for filing benefit claims.

A **"**Pre-Service Claim**"** means any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A **"**Post-Service Claim**"** is a claim for a benefit that is not a pre-service claim within the meaning of the language quoted in the pre-service definition, above.

An **"**Urgent Care Claim**"** is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Requests for determinations of eligibility or general inquiries to the availability of particular Plan benefits or the circumstances under which benefits might be paid under the terms of the Plan will not be treated as a claim for benefits for the purposes of the Claim Procedures.

1. Initial Benefit Determination

If you file a Claim in accordance with the provisions of the Plan, you will receive an Explanation of Benefits (EOB) from the third party administrator that will tell you if your Claim has been paid or denied, or if additional information is needed to process your Claim. If additional information is requested, it is your responsibility to provide it, along with a copy of the EOB, to the third party administrator, so that your Claim can be processed with the additional information. If your Claim is denied, the EOB will tell you the reason for the denial and how you can have the decision reviewed.

Under normal circumstances a decision on your Claim for benefits will be made within 30 days after receipt of your properly filed Claim with the appropriate third party administrator. However, if your Claim for benefits is for one involving Urgent Care, a decision on such Claim will be rendered within 24 hours after receipt. Or, if your Claim is for a Pre-Service Claim, a decision will be provided within 15 days after receipt. These periods may be extended, however, one time by the third party administrator for up to 24 hours for Urgent Care Claims and 15 days for all others, provided that the administrator determines that such an extension is necessary due to matters beyond their control and notifies you, prior to the expiration of the initial notification periods, of the circumstances requiring the extension of time and the date by which the administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 48 hours for Urgent Claims and 45 days for all others

from receipt of the notice within which to provide the specified information.

In the event you or your authorized representative does not follow the Plan's filing procedures for a Pre-Service Claim, the Plan will provide notification to you or your authorized representative accordingly. For all Pre-Service Claims, the Plan must notify you or your authorized representative, of failure to follow filing procedures within 5 calendar days (24 hours in the case of a failure to follow filing procedures for an Urgent Care Claim). Notification by the Plan may be oral unless written notification is requested by you or your authorized representative. The notification of failure to follow filing procedures for Pre-Service Claims will apply only when a communication is received from you or the health care professional representing you that specifies the identity of the Covered Person, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, and the communication is received by the third party administrator.

If your Claim for benefits is wholly or partially denied, the appropriate third party administrator will notify you in writing. This written notice will tell you the reason for the denial, the provisions of the Plan on which the denial is based, and what additional information is needed, if any, that could change the decision. If a standard claim processing protocol was followed, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to you free of charge upon written request. If the determination is based on medical necessity or similar exclusion or limit, then the notice will state that an explanation of the clinical judgement used and how the terms of the Plan were applied to your medical circumstances will be provided free of charge upon written request. The notice will also tell you how you can have the decision reviewed.

Any decision by the Plan to terminate or reduce benefits that have already been granted with the potential of causing disruption to ongoing care, course of treatment, number of treatments or treatments provided as a covered health service before the end of such treatments shall constitute a denied claim. The Plan will provide you with notice of the denial at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated. The written notice of denial will contain the information outlined above.

Any Urgent Care Claim requesting to extend a course of treatment beyond the initially prescribed period of time, or number of treatments, must be decided within 24 hours provided that the Claim is made at least 24 hours prior to the expiration of the initially prescribed period. Notification will be provided in accordance with the Urgent Care Claim notice requirements.

2. Claim Review Process

If you receive a written notice denying your Claim for benefits, in whole or in-part, and you do not agree with such determination, you can have your Claim reviewed. If you want your Claim reviewed, you, or your authorized representative, must file a written request for review with the appropriate party within 180 days after you received the written notice of denial of your Claim for benefits.

This review provision will allow you to request from the Plan a review of any Claim for benefits. Such request must include the employee/retiree name and social security number or alternate ID, and name of the patient. The request for review must be in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the Claim. Submit written comments, documents, records, and other information relating to the Claim. This review provision will also allow you to request, free of charge, reasonable access to documents, records, and other information relevant to your Claim. A document, record or other information is

considered relevant if it was relied on in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination; demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In the case of Urgent Care Claims, a request for an expedited review may be submitted orally and all necessary information, including the Plan's benefit determination upon review, may be transmitted between the Plan and you via telephone, facsimile, or other available similarly expeditious methods. If the benefit determination is transmitted orally, a written notification will be furnished within 3 days after the oral notification.

The review of the denial will be made by an appropriate named fiduciary that is neither the party who made the initial Claim determination nor the subordinate of such party. The review will not defer to the initial Claim determination and will take into account all comments, documents, records and other information submitted by you without regard to whether such information was previously submitted or relied upon in the initial determination. In upholding any denied Claim that is appealed, which denial is based in whole or in part on a medical judgment, an appropriately qualified health care professional who is neither an individual who was consulted in connection with the denied Claim that is the subject of the appeal nor the subordinate of any such individual shall be consulted.

Under normal circumstances, you will be notified of a decision on your request for review within 30 days after receipt. However, if your request for review is for a Claim involving Urgent Care, a decision on your request for review will be rendered within 72 hours after receipt of your request. Or, if your request for review is for a Pre-Service Claim, a decision on your request for such a review will be provided within 15 days after receipt of your request. In all cases, you will be provided with written notification of the determination on review. If your Claim is denied, you will be told the reason for the denial, the provisions of the Plan on which the denial is based, the documents and information you can receive upon request, and what additional information is needed, if any, that could change the decision. If a standard claim processing protocol was followed, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to you free of charge upon request. If the determination is based on medical necessity or similar exclusion or limit, then the notice will state that an explanation of the clinical judgment and how the terms of the plan were applied to your medical circumstances will be provided free of charge upon written request. The notice will tell you of your right to bring a civil action under section 502(a) of the Act following a final adverse benefit determination on review. The notice will also tell you how you can appeal the decision to the Plan Administrator.

3. Appeal Process

If you want to appeal (in whole or in part) the decision made on your request for review, you, or your authorized representative, must file a written appeal with the Plan Administrator within 180 days after you received the written notice of denial of your request for review of your Claim. This review provision will allow you to request from the Plan a review of any Claim for benefits. Such request must include the employee/retiree name and social security number, and name of the patient. The request for review must be in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the Claim. Submit written comments, documents, records, and other information relating to the Claim. This appeal provision will also allow you to request, free of charge, reasonable access to documents, records, and other information relevant to your Claim. A document, record or other information is

considered relevant if it was relied on in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination; demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In the case of Urgent Care Claims, a request for an expedited review may be submitted orally and all necessary information, including the Plan's benefit determination upon review, may be transmitted between the Plan and you via telephone, facsimile, or other available similarly expeditious methods. If the Plan Administrator's determination is transmitted orally, a written notification will be furnished within 3 days after the oral notification.

The Plan Administrator will make the appeal determination. The appeal determination will not defer to the initial Claim determination or the determination on review and will take into account all comments, documents, records and other information submitted by you without regard to whether such information was previously submitted or relied upon in the initial determination or the request for review. In upholding any denied request for review that is appealed, which denial is based in whole or in part on a medical judgment, an appropriately qualified health care professional who is neither an individual who was consulted in connection with the denied request for review that is the subject of the appeal nor the subordinate of any such individual shall be consulted.

Under normal circumstances, the Plan Administrator will render a decision on your appeal within 30 days after receipt of your appeal. However, if your request for appeal is for a Claim involving Urgent Care, the Plan Administrator will render a decision on your request for appeal within 72 hours after receipt of your appeal.

Or, if your request for appeal is for a Pre-Service Claim, a decision on your request for such appeal will be provided within 15 days after receipt of your appeal. In all cases, the Plan Administrator will provide you with written notification of the determination on appeal. If your appeal is denied in whole or in part, you will be told the reason for the denial, the provisions of the Plan on which the denial is based, the documents and information you can receive upon request. If a standard claim processing protocol was followed, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to you free of charge upon request. If the determination is based on medical necessity or similar exclusion or limit, then the notice will state that an explanation of the clinical judgment and how the terms of the plan were applied to the claimant's medical circumstances will be provided free of charge upon written request, including the names of any medical professionals consulted during the review process. The notice will also tell you of your right to bring a civil action under section 502(a) of the Act following a final adverse benefit determination on review.

If you feel the Plan has not complied with the established Plan Claim Procedures, there are steps you can take to enforce your rights. For additional information, please refer to the ERISA Section of this Plan.

4. External Review

If the outcome of the appeal determination is adverse to you and it was based on medical judgement, or if it pertained to a recission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Plan Administrator within four (4) months of the notice of your final internal adverse determination.

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

For Urgent Care Claims, you may proceed with an expedited External Review while simultaneously pursuing an expedited appeal through the Plan Administrator's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the decision related to your request, can be sent between the Plan Administrator and you by telephone, facsimile or other similar method. To proceed with an expedited External Review, you or your authorized representative must contact the Plan Administrator. Such request must include the employee name and social security number, name of patient, the service or supply for which approval of benefits is sought, and any reasons why the review should be processed on a more expedited basis.

All other requests for External review should be submitted in writing unless the Plan Administrator determines that it is not reasonable to require a written statement.

Such request must include the employee name and social security number, name of the patient and state in clear and concise terms the reason or reasons for this disagreement with the handling of the Claim.

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

5. Limitation

No action at law or in equity can be brought to recover on this Plan until the appeals procedure has been exhausted as described in this Plan.

No action at law or in equity can be brought to recover after the expiration of two (2) years after the time when written proof of loss is required to be furnished to the Plan Administrator.

SECTION 9.

OTHER INFORMATION

Official Plan Documents

9.0 This Summary Plan Description (SPD) is the official Plan document that has been established pursuant to the Insurance Agreement dated September 1, 2018, and subsequent amendments as agreed to between ArcelorMittal USA LLC (the "Company") and the United Steelworkers (the "Union"). It is provided for informational purposes only and is not a contract of employment between the Company and you. If there is a conflict between this document and any other description of the Plan, the text of this Plan and/or Agreement controls. The Company intends that the terms of the Plan, including those relating to coverage and benefits, be legally enforceable. The Plan is maintained for the exclusive benefit of the bargaining unit employees of the Company.

ERISA Information (Employee Retirement Income Security Act of 1974, as Amended)

9.1 The Plan is part of a single welfare benefit plan called the ArcelorMittal USA LLC. Program of Insurance Benefits for USW Represented Employees.

The Employer Identification Number is 71-0871875.

The Plan Number is 506.

The Plan Sponsor is:

Program of Insurance Benefits – Plan Administrator
ArcelorMittal USA LLC
3210 Watling Street
East Chicago, IN 46312

The Agent for Service of Legal Process is:

ArcelorMittal USA LLC
c/o CT Corporation System
251 E. Ohio Street
Suite 1100
Indianapolis, IN 46204

The Plan Administrator for employee life and accidental death and dismemberment insurance, medical, sickness and accident, dental, vision, and prescription drug benefits is the ArcelorMittal USA LLC Manager, Employee Benefits. The day-to-day operation of the Plan is handled by the claims administrators.

The Plan Administrator has the responsibility to the Plan to make and enforce any necessary rules for the Plan, and to interpret the Plan provisions uniformly for all employees. If it is necessary for you to communicate with the Plan Administrator or appeal a claim, you should submit your written comments or requests to the Plan Administrator, in care of ArcelorMittal USA LLC at the following address:

Manager, Employee Benefits
3210 Watling Street
East Chicago, Indiana 46312

The records of the Plan are kept on the basis of a plan year which is the 12-consecutive-month

period beginning each January 1.

Statement of ERISA Rights

9.2 As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

(a) Receive information about your Plan and benefits and;
   (1) Examine without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
   (2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operations 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;
   (3) Receive a summary of this Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

(b) Continue group health plan 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;

(c) 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. 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;

(d) 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 interests of you and other Plan participants and beneficiaries. No one, including your employer, a union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare 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. 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.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this summary 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Women's Health and Cancer Rights Act of 1998

9.3 In compliance with Title IX, the Women's Health and Cancer Rights Act, added to ERISA by the 1998 Omnibus Budget Bill, requires plans that provide medical and surgical benefits with respect to mastectomies also cover reconstructive surgery. A group health plan generally must, under federal law, make available the following services complementing medical and surgical benefits for a mastectomy that is covered under the Plan:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of mastectomy.

The extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. All relevant Plan provisions regarding annual deductibles and coinsurance apply to these services.

Mental Health Parity Act (MHPA)

9.4 Through the MHPA, the United States Department of Labor mandated that lifetime and annual dollar limits for mental health benefits be the same as other health care benefits. Effective January 1, 1998, there are no separate dollar limits for mental health. Mental health benefits are now subject to the lifetime benefit dollar maximum of the Plan.

The requirements of this Act do not apply to the treatment of substance abuse and chemical dependency.

Newborns' and Mothers' Health Protection Act (NMHPA)

9.5 The NMHPA requires that a mother and newborn can remain in the hospital for at least 48 hours following a vaginal delivery and 96 hours following a cesarean delivery. In addition, a medical plan may not require that a provider provide authorization for a stay not in excess of 48 hours or 96 hours if a cesarean delivery. However, the mother can choose early discharge if approved by the attending physician.

Provider Directories

9.6 Each employee, including former employees enrolled in COBRA, and each alternate payee under a Qualified Medical Child Support Order may request a directory listing preferred providers,

without charge. Spouses and dependent children may request a directory, which may be provided at a reasonable fee.

QMCSOs

9.7 This plan processes Medical Child Support Orders (MCSOs) and National Medical Support Notices (NMSNs) in compliance with applicable Federal and State law. Information on the Plan's procedures regarding MCSOs and NMSNs is available without charge from the Plan Administrator.

Funding Information

9.8 Contributions for this Plan are provided by the Plan Sponsor.

Medical Necessity

9.9 Health care benefits under the Plan are payable only if the services rendered are medically necessary and appropriate. Medically necessary and appropriate 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 that 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 that are not ordered by a physician or that 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.

Experimental or Investigational Services or Supplies

9.10 Any medical, surgical, mental health, dental, diagnostic intervention, or drug treatment that is done or given unless it is generally accepted by the medical community in the United States and, as compared to accepted alternative treatments for that condition, can reasonably be expected to: (1) result in similar or improved survival, health or function, or (2) alleviate symptoms of or stabilize the condition. Generally accepted by the medical community in the United States means that the clinical efficacy of the treatment has been documented in credible published medical literature which demonstrates that the results of the treatment have been measured for a five-year period or other period generally regarded as valid. Clinical efficacy means that the treatment can reasonably be expected to improve survival, health, or function or to alleviate symptoms of or stabilize that condition, and its use outweighs any potential harm. However, the following are not considered experimental or investigative:

Transplants - any human solid organ or bone marrow/stem cell provided that:

1. the condition is life-threatening; and
2. such transplant for that condition is the subject of an ongoing phase III clinical trial; and
3. such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise.

Drugs - any drug or biologic that has been approved by the Food and Drug Administration (FDA) provided that it:

1. conforms to FDA approved use guidelines; or
2. conforms to usage listed in a Recognized National Compendia such as the American Hospital Formulary Service, the American Medical Association Drug Evaluations, or the U.S. Pharmacopeia Drug Information for the Health Care Professional.

Medical Devices - any medical device provided that it:

1. has been approved by the FDA; and
2. conforms to FDA approved use guidelines.

The Plan will cover approved clinical trials as required by 10103(c) of the PPACA.

Coverage for New Drugs, Tests, Devices, and Procedures

9.11 The entries in this Plan, as it may be amended from time to time, describe the drugs, medical tests, devices, and procedures that are covered under the Plan, and the circumstances under which they are covered.

All determinations as to whether or not a new or existing drug, medical test, device, or procedure is covered or not covered under the Plan are made by the Plan Administrator, at his or her sole discretion.

Additional information concerning whether or not a specific new or existing drug, medical test, device or procedure is covered, and if covered, the circumstances under which it is covered, may be obtained free of charge by contacting the Plan Administrator or third party administrator.

A designation of an expense as a covered charge does not guarantee benefits under the Plan. Determination as to any expense's eligibility for benefits under the Plan cannot be made until such expense is incurred, and a written claim for such expense submitted to the third party administrator.

Laws Affecting Plan Benefits

9.12 Employees in certain states are subject to state laws regarding disability benefits. The Plan is modified, as described in this booklet, to reflect the provisions of such laws. The Plan 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 Plan. If, under any such state or federal law, any benefits are now or in the future provided which are in excess of the Plan's benefits, any contribution required for such excess benefits shall be paid entirely by the employees covered for such benefits.

The benefits otherwise payable under the Plan will be offset by similar benefits payable for wage

loss or medical expenses or which would be payable upon timely and proper submission of claim (unless good and sufficient reason is shown for your inability to submit such claim or to have such claim submitted by someone else on your behalf), under any insurance policy, bond, fund, or other arrangement required by any motor vehicle insurance law requiring the provision of benefits for personal injury without regard to fault. The benefits of the Plan 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 Plan.

Right to Recovery

9.13 Individuals receiving benefits under Section 5 are required to subrogate their rights to payment or any reimbursements received as a result of an action against a third party.

Any individual receiving benefits under Section 5 agrees that his or her rights to any recovery or payment personally or for the account of such individual (including any covered dependent) arising out of any legal action or settlement (other than claims against the employee's or dependent's personal coverage for which he/she pays premiums) thereof (including any settlement prior to the institution of legal action) are subrogated to the rights of the Plan as provided hereunder. By filing a claim, he/she acknowledges and agrees (for themselves and any covered dependents) that the right to subrogation of the Plan is the right to be fully reimbursed for all payments paid by or on behalf of the Plan, from the first dollar paid after legal fees are deducted, by any source or sources of any recovery (whether deemed for personal injury or reimbursement of medical payments for any other reason) up to and including the full extent of payments made or benefits provided by or on behalf of the Plan, irrespective of whether any covered dependent has recovered for all or any part of his or her claim for personal injury or other damages and expenses arising therefrom or related thereto. He/she has the responsibility of (i) notifying the Plan promptly upon making claim against any party for any personal injuries, damages or expenses related in any way to the subrogation rights provided hereunder or receiving any settlement, court decision or payment related to such claim and (ii) cooperating with the Plan (including (a) promptly providing any information reasonably requested related to any such claim and (b) assisting the Plan in perfecting its subrogation rights).

SECTION 10.

INSURANCE GRIEVANCES

10.0 If a difference relating to the Plan 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 directly into Step 3 of the provisions of the Basic Labor Agreement applicable to the adjustment of grievances. Such provisions do not apply to a beneficiary's claim for employee life and accidental death and dismemberment insurance (see Section 3.3).

10.1 Insurance grievances will be scheduled for arbitration at the earliest practical date and not later than 45 days from the date the grievance was filed. Costs of arbitration to be divided equally between the Company and the Union.

SECTION 11.

SIDE LETTERS

September 1, 2015

David McCall
Director, USW District 1
United Steelworkers
777 Dearborn Park Lane - J
Columbus, OH 43085

RE: Dental Allowed Charges for Minorca and I/N Tek and I/N Kote

Dear Mr. McCall:

The Parties have agreed that in the event there is no adequate dental network established for either Minorca or I/N Tek and I/N Kote, then the allowed charge for Out of Network providers for those locations will be determined based upon the Usual and Customary charge as reported as of the time of service by the 99th percentile as published by FAIR Health, which collects and reports charges by procedure code, date of service, and zip code. In the event an Adequate Dental Network is agreed upon, the general plan terms will apply to the group(s) with an Adequate Dental Network.
Adequate Dental Network shall be defined as 95% of Employees shall have access to at least 2 In-Network dental practices that are accepting new patients within 20 miles of their home.

In the event a network is established that does not meet the definition of "Adequate Dental Network", the general plan terms will apply when an In-Network dentist is utilized and the 99th percentile will apply when an Out of Network provider is utilized.

Sincerely,

_____
Patrick David Parker
Vice President-Labor Relations

Confirmed:

_____
David McCall
Director-District 1

September 1, 2015

David McCall
Director, USW District 1
United Steelworkers
777 Dearborn Park Lane - J
Columbus, OH 43085

RE: Dependent eligibility for former Inland Employees

Dear Mr. McCall:

Active Employees

Existing USW Represented Employees who were covered under the Ispat Inland Program of Insurance Benefits prior to ratification of the 2015 Basic Labor Agreement 06/23/2016, shall continue to be subject to the Dependent Eligibility language in the "Program of Insurance Benefits, Summary Plan Description, For Wage Employees (former Ispat Inland) for Employee Life and Accidental Death and Dismemberment Insurance, Sickness and Accident, Medical, Prescription Drug, Mental Health and Alcohol/Substance Abuse Treatment, Dental, and Vision Care, Effective January 1, 2013", Section 1.1(b).

That language is as follows for Active Employees:
Your eligible dependents include:
(b) Your children under 26 years of age, including natural children (a blood descendent of the first degree), stepchildren, legally adopted children (including a child living with the adopting parents during the period of probation), or a child permanently residing in your household of which you are the head and actually being supported solely by you and you are related to the child by blood or marriage **or** are the child's legal guardian [emphasis added].

Retirees

Existing USW Represented Employees at former Inland facilities who are employed prior to ratification of the 2015 Basic Labor Agreement (upon their retirement) and existing Retirees who were employed at former Inland facilities prior to ratification of the 2015 Basic Labor Agreement, shall continue to be subject to the Dependent Eligibility language in the "Program of Insurance Benefits, Summary Plan Description, For Eligible Retirees (former Ispat Inland) and Surviving Spouses for Life Insurance, Medical, Prescription Drug, Mental Health, and Alcohol/Substance Abuse Treatment, and Vision Care, Effective January 1, 2011," Section 1 Eligibility-Dependents (b).

That language is as follows for Retirees:
Your eligible dependents include:
(b) The retiree's or surviving spouse's unmarried children under 19 years of age, including natural children (a blood descendent of the first degree), stepchildren living in your household and depending on you for support, legally adopted children (including a child living with the adopting parents during the period of probation), or a child permanently residing in your household of which you are the head and actually being supported solely by you and you are related to the child by blood or marriage **or** are the child's legal guardian.

Any USW Represented Employee from a former Inland facility hired after the ratification of the 2015 Labor Agreement will be subject to the dependent eligibility requirements of the current PIB.

Sincerely,

_____
Patrick David Parker
Vice President-Labor Relations

Confirmed:

_____
David McCall
Director-District 1

September 1, 2015

David McCall
Director, USW District 1
United Steelworkers
777 Dearborn Park Lane - J
Columbus, OH 43085

RE: Vision Allowed Charges for Minorca and I/N Tek and I/N Kote

Dear Mr. McCall:

This is to confirm our understanding that the negotiated vision care benefit is based on the existence of a network of vision care providers who have contracted with the Company to provide services at the negotiated rates. If no adequate network can be established for employees at the Minorca mine location or the I/N Tek and I/N Kote locations, when Participants utilize an Out of Network provider, the Company will provide a temporary increase in the Out of Network Reimbursement Schedule of $10 per item.

The out of network reimbursement schedule will be as follows (ONLY for Minorca or I/N Tek and I/N Kote and only in the event an Adequate Vision Network cannot be established):

Eye examinations, up to	$60
Contact lens evaluation and fitting:	
Daily wear, up to	$30
Extended wear, up to	$40
Spectacle Lenses (per lens):	
Single, up to	$60
Bifocal, up to	$65
Trifocal, up to	$70
Lenticular, up to	$75
Frame, up to	$85
Contact Lenses:	
Non-disposables, up to	$70
Disposables, up to	$85
Medically Necessary, up to	$235

In the event an Adequate Vision Network is agreed upon, the general plan terms will apply to the group(s) with an adequate network.

Adequate Vision Network shall be defined as 80% of Employees shall have access to at least 1 In-Network vision practices that are accepting new patients within 20 miles of their home.

In the event a network is established that does not meet the definition of "Adequate Vision Network", the general plan terms will apply when an In-Network vision provider is utilized and the above schedule will apply at Out of Network Providers.

Sincerely,

_____
Patrick David Parker
Vice President-Labor Relations

Confirmed:

_____
David McCall
Director-District 1

INSURANCE AGREEMENT

Agreement
Between
ArcelorMittal USA LLC
and the
United Steelworkers

Effective September 1, 2018

AGREEMENT dated September 1, 2018 between ArcelorMittal USA (the "Company") and the United Steelworkers (the "Union").

1. Definitions

Wherever used herein
(a) "Employee" means an employee in one of the bargaining units in Exhibit A attached hereto;
(b) "Program" means the program of insurance benefits effective January 1, 2019 established by this Agreement and described in the Summary Plan Description ("SPD") adopted by the parties and constituting part of this Agreement as though incorporated herein;
(c) "Prior Programs" means the programs of insurance benefits in effect as of January 1, 2017 for the plants listed in Exhibit A.

2. Program of Insurance Benefits

The Program shall be applicable to Employees while this Agreement is in effect (the period beginning January 1, 2019), in accordance with the provisions of this Agreement, subject to the following provisions:

(a) Any coverage which was in effect as of January 1, 2017 will be continued in accordance with the provisions of the Prior Programs. Any Employee absent from work on December 31, 2018 shall have his/her coverage under the applicable Prior Programs continue in accordance with such Prior Programs until the Employee returns to active work. Any such coverage which was terminated under the Prior Programs prior to January 1, 2019 shall be reinstated under the Program as of the date the Employee returns to active work.

(b) The benefits of the Prior Programs shall be applicable to any occurrence prior to January 1, 2019, subject to all of the provisions of the Prior Programs, except that to the extent Medical, Prescription Drug, Dental , Vision Care, and Sickness and Accident benefits related to such occurrence are payable for a period extending beyond January 1, 2019, the benefits otherwise payable shall be conformed to the benefits provided under the Program, and will be payable for the period provided under the Program reduced by the amount of or the period for which benefits were paid prior to January 1, 2019.

(c) Benefit provisions of the Program not contained in the Prior Programs shall not be applicable to any period prior to January 1, 2019 except that the Sickness and Accident rate of pay established in the Program will be applied to all claims incurred or in force on or after the ratification date.

3. Cost of Benefits

The cost of the benefits under the Program (or Prior Programs) shall be paid by the Company, except as provided below in this paragraph 3(a) and paragraph 6 hereof:

(a) In the event of a strike or lockout 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 (and the Prior Programs), with the exception of Sickness and Accident coverage will be continued for 150 days, which premium will be paid by the Company.

4. Participation by Employees

Each Employee shall be a participant in the Program (and the Prior Programs if eligible) and the amount, if any, which the Employee shall be required to contribute to the cost thereof shall be deducted by the Company from his or her pay. Each Employee shall furnish to the Company any such written authorization or assignment (in a form agreed to by the Company and the Union) as shall be necessary to authorize the deduction from his or her pay of the amount of any contributions.

5. Requirements of Law

It is intended that the provision for the insurance benefits which shall be included in the Program (or Prior Programs) 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 (or Prior Programs) are provided under law rather than under the Program (or Prior Programs), the Company will pay the amount required to be paid therefor, including any Employee contribution required by law on account of such benefits. The Company shall, after consultation with the Union, reduce the benefits of the Program (or Prior Programs) to the extent that benefits provided under any law would otherwise duplicate any of the Program (or Prior Programs) benefits.

6. Additional and Alternate Benefits

(a) The Program (and the Prior Programs where applicable) 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 services 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.

7. Administration of the Program

(a) The Program (and the Prior Programs) shall be administered by the Company or through arrangements provided by it. Except as may otherwise be provided in the Agreement, the Company will arrange to have benefits (Medical, Prescription Drug, Dental, Vision, Life Insurance, and Sickness and Accident benefits) provided through contracts with carriers and/or administrators mutually agreed to by the Company and the Union. Any contracts entered into by the Company with respect to the benefits of the Program (and the Prior Programs) shall be consistent with this Agreement and shall provide benefits and conditions conforming to those set forth in the booklets. Any elective change in carriers/vendors by the Company or the USW Health and Welfare Fund will be discussed in advance by both parties.

Any potential disputes arising from these discussions will be referred to the Joint Benefits Committee for resolution. Neither party will unreasonably withhold its agreement on proposals. Barring resolution, no changes will be made.

(b) At any time within six months prior to the expiration of the BLA, either party may initiate a joint RFP process for a program(s) to provide benefits provided through contracts with carriers and/or administrators and/or other arrangements previously agreed to by the Company and the Union. Any proposed change in carriers, vendors, or administrators will be mutually agreed to by the parties.

8. Life Insurance after Retirement

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 basic life insurance terminated or reduced (except as provided in such booklet) so long as he or she remains retired from the Company, notwithstanding the expiration of such agreement or booklet or of this Agreement, except as the Company and the Union may agree otherwise.

9. Extent of Company Obligation

The failure of any carriers and/or administrators to provide for benefits under the Program (or Prior Programs) 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/administrator fails to pay, the Company will provide such benefits.

10. Insurance Reports

The Union shall be furnished annually a report regarding the Program. From time to time during the term of this Agreement, the Union and Company shall be furnished such additional information as shall be reasonably required for purpose of enabling it to be properly informed concerning the operation of the Program (and the Prior Programs). Any accounting under the Program (and the Prior Programs) 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 (or the Prior Programs) 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 (or the Prior Programs), be deemed to be a cost of such programs.

11. Continuation of Benefits after Expiration

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 the layoff or absence commenced shall receive such benefits for the duration specified in such Agreement or Program, notwithstanding the expiration or termination of this Agreement or the Program or the collective bargaining agreement between the Company and the Union.

12. Term of Agreement

This Agreement shall become effective September 1, 2018 and shall remain in effect until September 1, 2022 and thereafter remain in effect for an additional 150 days beyond the expiration date.

Patrick Parker	David McCall
Vice President, Labor Relations	Director, District 1
ArcelorMittal USA LLC	United Steelworkers

EXHIBIT A

Bargaining Units Covered By Insurance Agreement

Following are the groups of employees, and their locations, in bargaining units to which the Insurance Agreement is applicable.

Burns Harbor, Indiana (Local 6787)
Cleveland, Ohio (Local 979)
Coatesville, Pennsylvania (Local 1165)
Columbus, Ohio (Local 9309)
Conshohocken, Pennsylvania (Local 9462)
East Chicago, Indiana (Indiana Harbor West Local 1011)
East Chicago, Indiana (Indiana Harbor East Local 1010)
East Chicago, Indiana (Office & Technical USW Local 1010-06)
East Chicago, Indiana (Research USW Local 1010-23)
East Chicago, Indiana (Process Automation USW Local 1010-27)

New Carlisle, Indiana (I/N Tek & I/N Kote USW Local 9231)
New Carlisle, Indiana (I/N Tek & I/N Kote USW Local 9231-01)
Obetz, Ohio (Local 2342-1)
Riverdale, Illinois (Local 1010)
Steelton, Pennsylvania (Local 1688)
Virginia, Minnesota (Local 6115)
Warren, Ohio (Local 1375)
Weirton, West Virginia (Local 2911)