Program of Insurance Benefits

Summary Plan Description

For Eligible Retirees and Surviving Spouses for Life Insurance, and Prescription Drug

Effective January 1, 2019

INTRODUCTION

This booklet is the Summary Plan Description ("SPD") for retiree and surviving spouse life, , and prescription drug services of the ArcelorMittal USA LLC Retiree Program of Insurance Benefits (PIB) (the "Plan") for United Steelworker Retirees of ArcelorMittal USA LLC who retired from locations listed in Exhibit A and who were hired prior to ratification of the 2015 BLA.

The Plan provides retiree life insurance for you only and it provides prescription drugs for you and your eligible family members.

Medical, mental health and alcohol/substance abuse, and vision services 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 retirees and surviving spouses and their eligible dependents for life insurance, prescription drug benefits, and medical, mental health and alcohol/substance abuse services, and vision services benefits provided from the Fund.

Dental services and treatments are not covered under this ArcelorMittal USA retiree plan.

The Plan provides a Medicare Advantage Plan ("MAPD") with Drug Coverage for Medicare eligible participants. The MAPD plan provides comprehensive medical coverage with covered medical expenses payable at 90% of the Allowed Fee, Prescription Drugs, and Vision Care.

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SECTION 1.

ELIGIBILITY, ENROLLMENT AND COST

Eligibility for Employees hired or rehired after June 23, 2016

Employees hired or rehired after 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) are entitled ONLY to Retiree Health Care Account Contributions while active as outlined in Section 6 of this RPIB.

Eligibility for Former Ispat Inland Locations

The following Eligibility criteria apply to Retirees and Surviving Spouses of retirees who worked at former Ispat Inland Locations (including USW Locals 1010, 1010-06, 1010-23, 1010-27– Indiana Harbor Works, East Chicago, Indiana, USW Local 4302 – Ispat Inland Lime and Stone Company, Gulliver, Michigan, USW Local 6115, ArcelorMittal Mining Company, Virginia, Minnesota, Inland Steel Container Company, Jackson County Iron Company, Inland Steel Coal Company, Vessel Department, INRYCO, IRMC, Inland Steel Magnetics); these eligibility provisions shall also apply to Retirees and Surviving Spouses from I/N Tek and I/N Kote:

Eligibility - Retiree

1.0 You are eligible for coverage under the Plan if you are a resident of the United States or Puerto Rico and,

(a) You were hired on or before November 13, 2005 and retired from ArcelorMittal, or designated predecessor unit, under the Company non-contributory pension plan for certain hourly and bargaining unit employees in the designated group to which the Insurance Agreement is applicable, as defined in Exhibit A,

1) On or after August 1, 1974 and prior to January 1, 1990 on other than a deferred vested pension and at the time of retirement had 15 or more years of continuous service, or
2) On or after January 1, 1990 and prior to September 1, 2008 on other than a deferred vested pension and at the time of retirement had 10 or more years of continuous service, or
3) On or after September 1, 2008 on other than a deferred vested pension and at the time of retirement have 15 or more years of continuous service, or
4) Before August 1, 1974 on other than a deferred vested pension and at the time of retirement had 15 or more years of service

(b) You were hired on or after November 14, 2005 and hired or rehired before June 23, 2016, participated in the Steelworkers Pension Trust, retired from one of the designated bargaining units to which the Insurance Agreement is applicable as defined in Exhibit A, accrued at least fifteen (15) years of continuous service, and qualify as an eligible individual by satisfying one of the following requirements:

1) Eligible and have applied for a normal or unreduced early retirement benefit from the Steelworkers Pension Trust; or

2) Eligibility for a severance allowance due to a permanent closure in accordance with Article Eight, Section C – Severance Allowance of the Basic Labor Agreement with age and continuous service being the sum of sixty-five (65) or greater and with at least (20) years of continuous service; or
3) Eligible and have applied for a disability benefit from the Steelworkers Pension Trust; or

(c) You are a former LTV Employee and;
1) You retired from ArcelorMittal, were hired into Minorca Mine prior to 2008,, and have accrued at least the following years of Continuous Service at the Minorca Mine:
i. If your age was 62 or older at retirement, 2 years of Continuous Service at the Minorca Mine, or
ii. If your age was 60 up to 62 at retirement, 3 years of Continuous Service at the Minorca Mine, or
iii. If your age was less than 60 at the time of retirement, 5 years of Continuous Service at the Minorca Mine; or
2) You became eligible for a Severance Allowance in accordance with the Basic Labor Agreement and the sum of your age and Continuous Service totals at least 65; or
3) You became eligible for and receive a pension under the Company's defined benefit pension plan by reason of a disability.

Eligibility – Surviving Spouse

1.1 You are eligible for coverage under the Plan as a surviving spouse if you are,

(a) The unmarried surviving spouse of a retiree described in (a) (1), (2), or (3) above, and
1) You receive a surviving spouse's benefit under the Company non-contributory pension plan as the surviving spouse of a retiree, and
2) You were married to the retiree on the date of retirement and on his/her date of death, or
3) You were married to an employee who died on or after August 1, 1974 and at a time when the employee was accruing Continuous Service in a group of employees designated by the Company as covered by the Plan after he or she had completed 15 years of Continuous Service; or

(b) The unmarried surviving spouse of a retiree described in (b) (1), (2), or (3) above, and
1) You were married to the retiree on the date of his/her retirement or eligibility for severance allowance as described in (b) (2) above and on his/her date of death, or
2) You were married to an employee who completed 15 years of continuous service and who dies while accruing continuous service under the Steelworkers Pension Trust, or

(c) The unmarried surviving spouse of a retiree described in (c) (1), (2), or (3) above, and
1) You were married to the retiree on the date of retirement and on his/her date of death, or
2) You were married to an employee who died at a time when the employee was accruing Continuous Service in a group of employees designated by the Company as

covered by the Plan after he or she had met the eligibility requirements described in (c) (1), (2), or (3) above.

(d) You are the unmarried surviving spouse of an employee that was hired or rehired before June 23, 2016 and that died as a direct result of an on-the-job accident or injury.

Eligibility – Dependents

1.2 You may elect to include your dependents for coverage under the Plan if you are an eligible retiree or eligible surviving spouse.

If you and your spouse are both retirees 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. You or your spouse will not be allowed to enroll as a dependent spouse on each other's ArcelorMittal USA plan.

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 eligibility administrator for the Plan.

Your eligible dependents include:

(a) The spouse of a retiree (the person to whom you are legally married);

(b) The retiree's or surviving spouse's unmarried children under 19 years of age, including natural children (a blood descendant 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 have been appointed the child's legal guardian;

(c) Your unmarried children between 19 and 25 years of age who:
   i. Are enrolled as active full-time students attending an accredited college, university or high school, or are enrolled as active, full-time students attending a vocational school supported or operated by state or local governments or by the federal government, or a licensed technical school, nurse's training school, beautician school, automotive school or similar training school; and
   ii. Are not employed on a regular full-time basis; and
   iii. Are not covered under any other group plan maintained by an employer.

Self-study or at-home study programs do not support eligibility under the full-time student requirements.

To be eligible for coverage as a full-time student dependent under this provision, the child must have been eligible for coverage as a dependent prior to attainment of age 19.

Your dependent that qualifies as a full-time student will remain eligible during regularly scheduled vacation periods or between semesters or terms as established by the school. If he or she elects to work during this vacation period, that employment will not be considered employment on a full-time basis. In the case of an absence from class due to a medically necessary leave of absence, eligibility will continue for up to one (1) year after the first day of the medically necessary leave of absence. A medically necessary leave of absence is that as defined under ERISA Subpart B part 7 of title I as amended ("Michelle's Law") and commences while such child is suffering from a serious illness or injury, is medically necessary, and causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

Full-time student status is defined as carrying 12 or more credit hours per semester or term or as designated and certified as full-time by the institution. Verification of full-time student status must be submitted each semester or term by completing and mailing the Student Dependent Certification form to the medical claims administrator. Forms are available from the medical claims administrator.

Students will be covered until the earlier of 1) the end of the month school ends if they do not re-enroll for the next semester, 2) the end of the month of graduation or completion of the course, 3) termination of full-time attendance at the institution, or 4) the end of the year in which a student attains age 25. Upon such termination, the student may elect to continue coverage under COBRA.

(d) Your unmarried children who are otherwise eligible as dependents, 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 medical claims administrator within 90 days after your child turns 20. 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 Plan Administrator. 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 19 or at the end of the month such dependent child is no longer considered disabled.

(e) The unmarried eligible dependent children of an employee that died as a result of an on-the-job accident or injury regardless of whether there is a Surviving Spouse. Such a dependent child's coverage shall be extended to age 19 and continued if an eligible full time student up to age 25 under the same terms as other dependent children above.

(f) The unmarried eligible dependent children of a Retiree who would otherwise lose coverage in the absence of a Surviving Spouse after the death of such Retiree and/or Surviving Spouse. Such a dependent child's coverage shall be extended to age 19 and continued if an eligible full time student up to age 25 under the same terms as other dependent children above.

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

(a) A dependent who is a member of the military is not eligible under the Plan during any period of active duty;
(b) No retiree, spouse, or dependent child can be covered by more than one retiree at a time; married employees or retirees of the Company may choose which parent will cover their eligible natural or legally adopted dependent children;
(c) A dependent who resides outside the United States or Puerto Rico is not covered; and
(d) 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.

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

Eligibility for Former ISG Locations

The following Eligibility criteria apply to Retirees and Surviving Spouses of retirees from former ISG locations (including Burns Harbor, Indiana, Cleveland, Ohio, Coatesville, Pennsylvania, Conshohocken, Pennsylvania, East Chicago, Indiana (Indiana Harbor West), Georgetown, South Carolina, Hennepin, Illinois, Lackawanna, New York, Riverdale, Illinois, Sparrows Point, Maryland (prior to 1/1/09), Steelton, Pennsylvania, Warren, Ohio, Weirton, West Virginia, Columbus, Ohio (Columbus Coatings):

Eligibility - Retiree

1.3 You are eligible for coverage under the Plan if you are an employee in the designated group to which the Insurance Agreement is applicable, as defined in Exhibit A, you were hired or rehired before June 23, 2016,and you retired from ArcelorMittal from one of the bargaining units in Exhibit A and accrued at least fifteen (15) years of continuous service including any predecessor company service (as specifically defined in Article Five, Section E – Seniority of the Basic Labor Agreement) and qualify as an eligible individual by satisfying one of the following requirements:

(a) Eligible and have applied for a normal or unreduced early retirement benefit from the Steelworkers Pension Trust; or

(b) Eligibility for a severance allowance due to a permanent closure in accordance with Article Eight, Section C – Severance Allowance of the Basic Labor Agreement with age and continuous service being the sum of sixty-five (65) or greater and with at least twenty (20) years of continuous service; or

(c) Eligible and have applied for a disability benefit from the Steelworkers Pension Trust; or

(d) Retired from ArcelorMittal Weirton with at least 15 years of continuous service with ArcelorMittal Weirton and any predecessor company, with the sum of age and continuous service equal to eighty-five (85) or more or after attaining age sixty-five (65) and after having accrued at least two (2) years of continuous service as an employee of ArcelorMittal Weirton (measured from January 1, 2008 without reference to service with any predecessor company).

Eligibility – Surviving Spouse

1.4 You are eligible for coverage under the Plan as a surviving spouse if,

(a) You are the unmarried surviving spouse of a retiree described above and you were married to the retiree on the date of his/her retirement or eligibility for severance allowance as described in section (b) above and on his/her date of death, or

(b) You were married to an employee who was hired or rehired before June 23, 2016 and who completed 15 years of continuous service and who died while accruing continuous service under the Steelworkers Pension Trust and remain unmarried, or

(c) You are an unmarried individual who is a surviving spouse of an ArcelorMittal Weirton employee who was hired or rehired before June 23, 2016 and was in the ArcelorMittal USA LLC Hourly 401(k) Plan who died on or after January 1, 2008 and who had accrued at least fifteen (15) years of continuous service with ArcelorMittal Weirton and any predecessor company; or

(d) You are the unmarried surviving spouse of an employee who was hired or rehired before June 23, 2016 that died as a direct result of an on-the-job accident or injury.

Eligibility - Dependents

1.5 You may elect to include your dependents for coverage under the Plan if you are an eligible retiree or eligible surviving spouse.

If you and your spouse are both retirees 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. You or your spouse will not be allowed to enroll as a dependent spouse on each other's ArcelorMittal USA plan.

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 eligibility administrator for the Plan.

Your eligible dependents include:

(a) The spouse of a retiree (the person to whom you are legally married);

(b) The retiree's or surviving spouse's unmarried children until the end of the year in which they turn age 19, including natural children (a blood descendant 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 have been appointed the child's legal guardian;

(c) Your unmarried children between 19 and 25 years of age who:

- Are enrolled as active full-time students attending an accredited college, university or high school, or are enrolled as active, full-time students attending a vocational school

supported or operated by state or local governments or by the federal government, or a licensed technical school, nurse's training school, beautician school, automotive school or similar training school; and

- Are not employed on a regular full-time basis; and
- Are not covered under any other group plan maintained by an employer.

Self-study or at-home study programs do not support eligibility under the full-time student requirements.

Your dependent that qualifies as a full-time student will remain eligible during regularly scheduled vacation periods or between semesters or terms as established by the school. If he or she elects to work during this vacation period, that employment will not be considered employment on a full-time basis. In the case of an absence from class due to a medically necessary leave of absence, eligibility will continue for up to one (1) year after the first day of the medically necessary leave of absence. A medically necessary leave of absence is that as defined under ERISA Subpart B part 7 of title I as amended ("Michelle's Law) and commences while such child is suffering from a serious illness or injury, is medically necessary, and causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

Full-time student status is defined as carrying 12 or more credit hours per semester or term or as designated and certified as full-time by the institution. Verification of full-time student status must be submitted each semester or term by completing and mailing the Student Dependent Certification form to the designated eligibility administrator. Forms are available from the designated eligibility administrator.

Students will be covered until the earlier of 1) the end of the month school ends if they do not re-enroll for the next semester, 2) the end of the month of graduation or completion of the course, 3) termination of full-time attendance at the institution, or 4) the end of the year in which a student attains age 25. Upon such termination, the student may elect to continue coverage under COBRA.

(d) Your unmarried children who are otherwise eligible as dependents, 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 year the child turns age 19 or at the end of the month such dependent child is no longer considered disabled.

(e) The unmarried eligible dependent children of an employee that died as a result of an on-the-job accident or injury regardless of whether there is a Surviving Spouse. Such a dependent child's coverage shall be extended to age 19 and continued if an eligible full time student up to age 25 under the same terms as other dependent children above.

(f) The unmarried eligible dependent children of a Retiree who would otherwise lose coverage in the absence of a surviving spouse after the death of such Retiree and/or Surviving Spouse. Such a dependent child's coverage shall be extended to age 19 and continued if an eligible full time student up to age 25 under the same terms as other dependent children above.

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

(a) A dependent who is a member of the military is not eligible under the Plan during any period of active duty;

(b) No retiree, 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;

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

(d) 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.

The following eligibility provisions apply to all Participants

Change in Family Status

1.6 Written notice of any change in your family status, such as marriage or divorce, birth of a child, marriage of any of your dependent children or death of any dependent 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

1.7 Coverage for an eligible retiree becomes effective on the first day of the month for which a pension benefit from the Steelworkers Pension Trust or Company defined benefit pension plan or severance allowance as indicated above is payable.

You may elect to defer enrollment in retiree health care coverage only if you or your dependent spouse is eligible for and enrolled in health care coverage under another employer's insurance program and enroll at a later time, provided you notify the Company within ninety (90) days of the termination of the other coverage. You must provide proof of your enrollment in the other employer provided coverage to be able to defer your enrollment and reenroll at a later time. You may elect to defer retiree health care coverage for you and all eligible dependents or for an eligible dependent only. You may not elect to defer coverage for you only and continue to cover your eligible dependents only.

Coverage for an established eligible dependent spouse or eligible dependent child becomes effective on the same day your coverage becomes effective. 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 promptly. 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.

If you and your spouse are both retirees 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 retiree upon application.

When Coverage Ends

1.8 Plan coverage of a retiree ends:

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

(b) At the end of the month that you last paid the required monthly premium;

(c) On the date of your death;

(d) At the end of the month that you request termination of coverage; or

(e) At the end of the month that you provide notice of your election to voluntarily terminate coverage because you were eligible for medical and prescription drug coverage under another employer's insurance program and you have provided proof of such coverage to the designated eligibility administrator.

Plan coverage of an eligible surviving spouse ends:

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

(b) The day immediately preceding the date such eligible surviving spouse remarries;

(c) At the end of the month that you last paid the required monthly premium;

(d) At the end of the month that you request termination of coverage; or

(e) At the end of the month that you provide notice of your election to voluntarily terminate coverage because you were eligible for medical and prescription drug coverage under another employer's insurance program and you have provided proof of such coverage to the designated eligibility administrator.

Plan coverage for a dependent of a retiree or eligible surviving spouse ends:

(a) The day that such person ceases to be an eligible dependent;

(b) At the end of the month in which a dependent child attains age 19 unless such dependent qualifies as a full-time student or is totally disabled and approved for such disabled dependent coverage;

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

(d) On the date coverage terminates for the retiree or eligible surviving spouse;

(e) The end of the month that the retiree or eligible surviving spouse dies, except in the case of an eligible dependent child of a deceased retiree where there is no surviving spouse and in the case of an eligible dependent child of an active employee who died as a result of an on the job injury regardless of whether there is a surviving spouse; or

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

Continuation of Benefits after Termination of Coverage

1.9 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

1.10 Eligible retirees, eligible spouses, and surviving spouses will pay a monthly premium to participate in the Plan. The required monthly premium depends on whether the retiree, eligible spouse, or surviving spouse is eligible for Medicare or not. The premium for benefit coverage includes coverage for any eligible dependent children. Eligible dependent children who do not have a surviving parent in the plan will not be charged a premium.

The monthly premiums are:

Year	Medicare Eligible	Non-Medicare Eligible
2019-	$50.00	$100.00
2020	$50.00	$100.00
2021	$50.00	$100.00
2022	$50.00	$100.00

If you receive a pension from the Company's defined benefit pension plan, your monthly premium for coverage under the Plan will be deducted from your pension or surviving spouse's benefit, or in the event your pension or surviving spouse benefit is insufficient to cover the premium, you will be required to send a check or money order payable to ArcelorMittal in the care of the pension administrator each quarter in an amount equal to three times the monthly amount applicable to you. Such payment is to be mailed to the pension administrator and must be received not later than the 10th day of the calendar quarter for which payment is due (Jan. 10, April 10, July 10, Oct. 10).

If you receive a pension or surviving spouse benefit under the Steelworkers Pension Trust, you will be billed for your monthly premium for coverage under the Plan. The monthly premium payment will be due prior to or on the first of each month for that month. For example, April premium is due on or before April 1, May premium is due on or before May 1.

For all retirements after July 1, 2019, Non Medicare eligible Retirees, Spouses, and Surviving Spouses will pay premiums on a monthly basis through mandatory ACH (unless they are

participants in the Defined Benefit Pension Plan and pay their premiums through pension deduction).

Beginning July 1, 2019, all Retiree healthcare premium payments for Medicare eligible Retirees, Spouses, and Surviving Spouses will be billed on a monthly basis through ACH or on a quarterly basis if they choose to pay by check (unless they are participants in the Defined Benefit Pension Plan and pay their premiums through pension deduction).

If you retire and you are married to an ArcelorMittal USA employee, you may not be enrolled as their dependent for any coverage that is available and provided under the retiree plan. However, for all months that your spouse is an active employee covered under the ArcelorMittal USA Program of Insurance Benefits for Wage Employees only, the Company will waive the monthly premium that you are required to pay. You will be able to be enrolled in dental and vision coverage if they are not available under your retiree plan.

Spouse Other Employer Coverage and Premium Reimbursement

1.11 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 retiree 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

Medicare

2.0 All Medicare eligible participants will be enrolled in the Medicare Advantage Plan described in Section 5.

Continuous Service

2.1 Wherever the term "continuous service" is used in this booklet, it means your continuous service as determined for pension purposes in accordance with the Basic Labor Agreement.

Benefits While Traveling Outside the United States or Puerto Rico

2.2 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

2.3 The Plan offers an eligible surviving spouse, spouse, or dependent 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.

Your eligible dependents have the right to elect 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.

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.

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 retirees or surviving spouses;
- 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.

COBRA continuation coverage also will end if the Company stops providing health care benefits to all retirees except in the unlikely event that the Company files for Chapter 11 bankruptcy reorganization. In that case, 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.

RETIREE LIFE INSURANCE

Excluded Groups

3.0 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,
- 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)

Coverage and Benefit Amount

3.1 In the event of your death, life insurance in the amount specified, will be payable to any person(s) you designate as beneficiary provided you retired with eligibility for life insurance and when the Company or designated life insurance carrier receives written proof of death.

	Coverage Amount	
Retirement Date	Prior to age 62	At age 62 and After
Prior to 8/1/1989	$15,000	$3,500
On and after 8/1/1989 and prior to 8/1/1999	$20,000	$5,000
On and after 8/1/1999 and prior to 1/1/2009	$25,000	$7,500
On and after 1/1/2009 and prior to 1/1/2016	$25,000	$15,000
On and after 1/1/2016	$25,000	$20,000

You have the right to change your beneficiary at any time by completing and returning the proper beneficiary change form to the Employee Benefits Office. A change in beneficiary will take effect on the date the form is signed and dated by you.

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.

How to File a Claim

3.2 Your designated beneficiary must contact the Employee Benefits Office 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

3.3 If your designated beneficiary has any questions concerning a denial of retiree 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.

PRESCRIPTION DRUG BENEFITS

The prescription drug benefits as provided in this Section are only applicable to non-Medicare eligible plan participants.

Introduction

4.0 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

4.1 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):

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

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 name thyroid medications will be covered at the Tier 1 Generic copayment.

Cost of Coverage

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

How the Prescription Drug Benefit Plan Works

4.3 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

4.4 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

4.5 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

4.6 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

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

SECTION 5.

MEDICARE ADVANTAGE PLAN
WITH DRUG

MEDICAL AND PRESCRIPTION DRUG BENEFITS for Medicare Eligible Participants

Introduction

5.0 Plan will include a Non Part D Rider (to ensure coverage of ED drugs, folic acid, etc.) in addition to covering all Part D designated medications.

The MAPD Plan will offer an Incentive Formulary.

Incorporate P1 Pharmacy Network – This network allows members to obtain a generic prescription at a preferred pharmacy for a copayment of $8, while generic prescriptions at non-preferred pharmacies are available for a copayment of $10.

The company will not prevent Participants in the MAPD plan to obtain a 90-day prescription at a retail store for 2x retail copayments, provided the MAPD plan carrier is willing to offer that benefit at no additional cost. It is understood that this is not a negotiated benefit, nor will it be considered a negotiated benefit.

Schedule of Benefits

5.1

	Non-Differential
Description	**In-Network/Out-of-Network Services**
Annual Medical Deductible	None
Is Annual Medical Deductible combined for IN and OUT of network?	N/A
Annual Medical Out-of-Pocket Maximum	$1,250
Is Annual Medical Out-of-Pocket Maximum combined for IN and OUT of network?	Yes
PHYSICIAN SERVICES Primary Care Physician Office Visit (includes Non-MD office visits)	$20 copay
Specialist Office Visit	$20 copay
INPATIENT SERVICES Inpatient Hospital Stay Benefit Period in days. (A "benefit period" begins the first day of admission and ends when the member hasn't received any hospital care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins and the copay cycle starts over.)	Unlimited
Inpatient Hospital Stay	10% Per Admit
Skilled Nursing Facility Care - prior hospital stay requirement waived?	Yes
Skilled Nursing Facility Care - Benefit Period (In days)	Unlimited
Skilled Nursing Facility Care	$0 days 1-20, 10% after*
Inpatient Mental Health Lifetime Maximum number of days	190 Days

Inpatient Mental Health in a Psychiatric Hospital	10% Per Admit
OUTPATIENT SERVICES Outpatient Surgery	10%
Outpatient Hospital Services	10%
Outpatient Mental Health/Substance Abuse (Individual Visit)	$20 copay
Outpatient Mental Health/Substance Abuse (Group Visit)	$20 copay
Partial Hospitalization (Mental Health Day Treatment) per day	5%
Comprehensive Outpatient Rehabilitation Facility (CORF)	$20 copay
Occupational Therapy	$20 copay
Physical Therapy and Speech/Language Therapy	$20 copay
Cardiac/Pulmonary Rehabilitation	$20 copay
Kidney Dialysis	10%
MEDICARE-COVERED SPECIALIST VISITS Chiropractic Visit (Medicare-covered)	$20 copay
Podiatry Visit (Medicare-covered)	$20 copay
Eye Exam (Medicare-covered)	$20 copay
Hearing Exam (Medicare-covered)	$20 copay
Dental Services (Medicare-covered)	$20 copay
AMBULANCE/EMERGENCY ROOM/URGENT CARE Ambulance Services	10%
Ambulance Copay Waived if Admitted?	No
Emergency Room (Includes Worldwide Coverage)	$40 copay
Emergency Room Copay Waived if Admitted within 24 hours?	Yes
Urgently Needed Care (Includes Worldwide Coverage)	$40 copay
Urgent Care Copay Waived if Admitted within 24 hours?	Yes
PART B DRUGS AND BLOOD Part B Drugs - Immunosuppressives, Anti-nausea, Inhalation Solutions, Hemophilia Clotting Factors, Antigens, Outpatient Injectable Medications Administered in a Physician's Office	10%
Chemotherapy Drugs	10%
Blood	$0
Blood 3 pint deductible waived?	Yes
DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES Durable Medical Equipment	10%
Prosthetics	10%
Orthotics	10%
Diabetic Shoes and Inserts	10%
Medical Supplies	10%
Diabetes Monitoring Supplies	$0
HOME HEALTHCARE AGENCY & HOSPICE Home Health Services	10%
Hospice (Medicare-covered)	$0
PROCEDURES Clinical Laboratory Services	10%
Outpatient X-ray Services	10%
Diagnostic Procedure/Test (includes non-radiological diagnostic services)	10%
Diagnostic Radiology Service	10%

Therapeutic Radiology Service	10%
PREVENTIVE SERVICES (MEDICARE-COVERED)	
Cardiovascular Screenings	$0
Immunizations (Flu, Pneumococcal, Hepatitis B Vaccines)	$0
Pap Smears and Pelvic Exams	$0
Prostate Cancer Screening	$0
Colorectal Cancer Screenings	$0
Bone Mass Measurement (Bone Density)	$0
Mammography	$0
Diabetes - Self-Management Training	$0
Medical Nutrition Therapy and Counseling	$0
Annual Wellness Exam and One-time Welcome-to-Medicare Exam	$0
Smoking Cessation Visit	$0
Abdominal Aortic Aneurysm (AAA) Screenings	$0
Diabetes Screening	$0
HIV Screening	$0
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	$0
Screening for Depression in Adults	$0
Screening for Sexually Transmitted Infections	$0
High Intensity Behavioral Counseling to Prevents STIs and Intensive Behavioral Therapy for Cardiovascular Disease	$0
Screening and Counseling for Obesity	$0
Glaucoma Screening	$0
Kidney Disease Education	$0
Dialysis Training	$0
Hepatitis C Screening	$0
ADDITIONAL BENEFITS/PROGRAMS (Non Medicare-covered)	
Routine Podiatry	$20 copay
Routine Podiatry – Number of visits per year	6
Routine Eye Exam Refraction - every 12 months	$0
Routine Vision Eyewear (Eyeglasses or contact lenses)	$0 copay for standard eyeglass frames, lenses or contact lenses, every 2 years. $100 allowance for specialty frames and $100 allowance for contact lenses
Routine Hearing Exam for Hearing Aids - every 12 months	$0
Hearing Aid Allowance - includes Digital Hearing Aids	$1,700
Benefit per ear or combined	Per ear
Number of Hearing Aids	Unlimited
Hearing Aid period in months	36
Annual Routine Physical Exam	$0
WELLNESS/CLINICAL PROGRAMS	Included
NurseLine	
Access Support	Included
Fitness	SilverSneakers
Disease Management - Chronic Heart Failure (CHF)	Included
Disease Management - Coronary Artery Disease (CAD)/Diabetes	Included

Disease Management - End Stage Renal Disease (ESRD)	Included
Group Retiree Case Management	Included
Advanced Illness Care Management	Included
Preferred Diabetic Supply Program	Included
Hi Health Discount Program	Included
Housecalls Program	Included
Outpatient Prescription Drug Coverage	
Prescription Drug Plan	Custom Plan
Part D Gap Coverage	Full Gap Coverage
Formulary	Standard Formulary H
Bonus Drug List	Standard List U with 8 ED per 30 day period
Formulary Edits (step therapy, quantity limits, prior authorization)	Standard: Edits On
Rx Deductible	None
Part D Retail Copay (up to a 30 day supply)	
Tier 1: Generic	$10
Tier 2: Preferred Brand	$15
Tier 3: Non-Preferred Brand	$45
Tier 4: Specialty Tier	$50
Part D Preferred Mail Order Copay (up to a 90 day supply)	
Tier 1: Generic	$20
Tier 2: Preferred Brand	$30
Tier 3: Non-Preferred Brand	$90
Tier 4: Specialty Tier	$100
Initial Coverage Limit	$3,310
TrOOP Threshold	$4,850
Catastrophic Coverage over TrOOP (greater amount of)	Custom
Copay for generics	$10
Copay for all other drugs	$10
OR Coinsurance	N/A

**2016 SNF coinsurance amount capped at $40 a day, days 1-20, $160 a day days 21+, per CMS. Professional fees covered at 100%*

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 eligible retiree or eligible surviving spouse is under the Plan; primary coverage for a working or retired spouse is under his or her employer's plan. Should an eligible retiree or eligible surviving spouse have two primary plans, the plan which has covered the eligible retiree or eligible surviving spouse 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, except if the other plan has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan shall determine the order of benefits. 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, 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. 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"). 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 Retirees 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 Eligible Retirees and Surviving Spouses.

The Employer Identification Number is 71-0871875.

The Plan Number is 516.

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 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 retirees and Surviving Spouses. 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 retiree, 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 partially by contributions of the Plan Sponsor and partially by contributions of covered retirees, eligible spouses, and eligible surviving spouses and potentially from the ArcelorMittal VEBA.

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, 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:

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.

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 this Plan 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 this Plan 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 of settlement (other than claims against the Retiree'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.

SIDE LETTERS

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 1September 1, 2015

September 1, 2018

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

RE: Retiree Health Insurance and Retiree Life Insurance Eligibility for Current and Future Employees

Dear Mr. McCall:

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 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 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 the 2015 BLA (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 $0.60 per hour worked and for lost time from scheduled work due to union business hours (union business hours capped at a maximum of 40 hours per week) to a restricted Retiree Health Care Account. 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. Contributions will be initially invested in an 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.

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

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, 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 2016 PIB.

Sincerely,

_____
Patrick David Parker
Vice President-Labor Relations

Confirmed:

_____
David McCall
Director-District 1

February 27, 2019

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

Re: Retiree Healthcare Premium Billing

Dear Mr. McCall:

For all retirements after July 1, 2019, Non Medicare eligible Retirees, Spouses, and Surviving Spouses will pay premiums on a monthly basis through mandatory ACH (unless they are participants in the Defined Benefit Pension Plan and pay their premiums through pension deduction).

Beginning July 1, 2019, all Retiree healthcare premium payments for Medicare eligible Retirees, Spouses, and Surviving Spouses will be billed on a monthly basis through ACH or on a quarterly basis if they choose to pay by check (unless they are participants in the Defined Benefit Pension Plan and pay their premiums through pension deduction).

Sincerely,

_____
Patrick David Parker
Vice President – Labor Relations

_____
David McCall
Director – District 1

RETIREE INSURANCE AGREEMENT
Agreement
Between
ArcelorMittal USA LLC
and the
United Steelworkers

Effective September 1, 2019

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

1. Definitions

Wherever used herein:

a. "Pensioner" See Eligibility –Retiree Section in PIB.
b. "Surviving Spouse" See Eligibility-Surviving Spouse Section in PIB.
c. "Program" means the program of retiree insurance benefits effective January 1, 2019 established by this Agreement and described in the Summary Plan Descriptions ("SPDs") adopted by the parties and constituting part of this Agreement as though incorporated herein;

d. "Prior Programs" means the programs of insurance benefits in effect as of December 31, 2018;

e. "Covered Adult" means Pensioners, Spouses and Surviving Spouses.

2. Program of Retiree Insurance Benefits

The Program shall be applicable to Pensioners and Surviving Spouses in accordance with the provisions of this Agreement, subject to the following provisions:

a. Except as provided in (b) below in no event shall any benefit provisions of the Program be applicable, (i) to any period prior to January 1, 2019, or (ii) to any part of a period of continuous hospitalization or skilled nursing facility care which commenced prior to the later of January 1, 2019 or the effective date of coverage under the Program.

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 Program benefits related to such occurrence are payable for a period extending beyond December 31, 2018, 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.

3. Cost of Benefits

a. The cost of the benefits under the Program (or Prior Program) shall be paid by the Company, except as provided below.
b. During the term of this Agreement the ArcelorMittal Retiree premiums will be as follows effective as of January 1, 2019:

The following monthly premiums per covered adult for eligible retirees and Surviving Spouses:

Year	Medicare Eligible	Non-Medicare Eligible
2019	$50.00	$100.00
2020	$50.00	$100.00
2021	$50.00	$100.00
2022	$50.00	$100.00

c. Effective January 1, 2010, the amount of Company contributions for the Program will be limited to the Per Covered Adult Maximum. The Per Covered Adult Maximum (Cap) shall be the separate Pre-Medicare and Medicare-eligible per Covered Adult Company Costs that were paid for calendar year 2008. Covered Adult Company Cost for the Pre-Medicare group will be determined using the actual paid 2008 Medical, Vision, Prescription Drug claims history and administrative fees, less any formulary rebates and retiree premiums, divided by the average number of Pre-Medicare Covered Adults. The Covered Adult Company Cost for the Medicare group will be determined using the actual paid 2008 Medical, Vision, Prescription Drug claims history and administrative fees, less any formulary rebates, and retiree premiums, and Medicare Part D Subsidy divided by the average number of Medicare eligible Covered Adults. Effective for plan year 2009 and each year thereafter, the Company will treat the funds it projects it will receive under the RDS for the immediately preceding plan year as a reduction in plan costs for the current plan year for purposes of determining the amount over the Cap for Medicare-eligible Covered Adults. After data for the year becomes available, the Company will provide reconcilement between the actual and projected RDS funds for the Program. Using the above described methodology, the Caps were calculated as follows:

Non-Medicare eligible Cap amount: $9,056 annual per Covered Adult Maximum
Medicare eligible Cap amount: $1,913 annual per Covered Adult Maximum

All costs of the Program in excess of the Cap will be borne by the participants, unless offset by the Benefit Trust in accordance with the provisions of the Benefit Trust and any side letters pertaining thereto.

d. The Company and Union agree that in negotiations over the successor agreement to the 2008 Agreement any proposal regarding the Cap shall be treated as a mandatory subject of bargaining, and neither side shall directly or indirectly take any action or position or make any statement to the contrary during the term of this Retiree Insurance Agreement.

With respect to any aspect of the Cap, if the parties are unable to agree on a successor agreement, either side may resort to strike or lockout as the case may be, in support of its position.

4. Requirements of Law

It is intended that the provisions for the insurance benefits which shall be included in the Program shall comply with and be in substitution for the provisions for similar benefits which are or shall be made by any applicable law or laws. Where, by agreement, certain basic benefits under the Program are provided under law rather than under the Program, the Company will pay any direct contribution required of any Pensioner or Surviving Spouse by law on account of such benefits, except as otherwise provided in the Program with respect to the Medicare Part B premiums. The Company shall, after consultation with the Union, reduce the benefits of the Program to the extent that benefits provided under any law would otherwise duplicate any of the Program benefits.

5. 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 Program 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 Steelworkers 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. Nothing in this Agreement shall preclude the parties from mutually agreeing to changes in the Program.

c. 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.

6. 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 Union may agree otherwise.

7. Continuation of Benefits after Expiration

Any Pensioner or Surviving Spouse who shall become covered by the Program established by this Agreement shall not have such coverage terminated or reduced (except as provided in the Program) so long as the individual remains retired from the Company or receives a Surviving Spouse's benefit, notwithstanding the expiration of this Agreement, except as the Company and the Union may agree otherwise.

8. Enforcement

Notwithstanding any provision of the Agreement to the contrary, this Agreement shall be enforceable in any court of competent jurisdiction without resorting to any grievance and/or arbitration procedure.

9. Terms 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 Retiree Insurance Agreement

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

Burns Harbor, Indiana
Cleveland, Ohio
Coatesville, Pennsylvania
Columbus, Ohio
Conshohocken, Pennsylvania
East Chicago, Indiana (Indiana Harbor West)
East Chicago, Indiana (Indiana Harbor East)
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)
Georgetown, South Carolina (Prior to 12-12-2017)
Hennepin, Illinois
Lackawanna, New York
Riverdale, Illinois
Sparrows Point, Maryland (Prior to 1-1-2009)
Steelton, Pennsylvania
Virginia, Minnesota
Warren, Ohio
Weirton, West Virginia
Local 4302 – USW – Ispat Inland Lime and Stone Company, Gulliver, Michigan
Inland Steel Container Company
Jackson County Iron Company
Inland Steel Coal Company
Vessel Department
INRYCO
IRMC
Inland Steel Magnetics