USW HRA FUND

SUMMARY PLAN DESCRIPTION

Effective January 1, 2020

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DEAR PARTICIPANT:

We are pleased to provide you with this booklet describing the benefits available under the Health Reimbursement Arrangement ("HRA" or "Plan") provided by the USW HRA Fund ("Fund"). This document is the plan of benefits for the Fund's HRA as of January 1, 2020, and is referred to as the "Summary Plan Description" or "SPD." This SPD is provided to help you understand the benefits to which you and your family, if applicable, are entitled under the HRA.

The Plan is administered by a Board of Trustees made up of representatives of the USW International Union and participating Employers. Administration, record keeping, and claims payment questions should be directed to the Fund Office at 800-251-4107 or 855-450-1875 , hra@uswbenefitfunds.com, or 1101 Kermit Drive, Suite 800, Nashville, TN 37217.

The rules, regulations, and procedures of the Plan in effect at the time a claim for benefits is received by the Fund Office will determine how the claim is processed. The Trustees have the power to interpret, apply, construe, and amend the provisions of the Plan and make factual determinations regarding its construction, interpretation, and application. Any decision made by the Trustees in good faith is binding upon Employers, Participants, Dependents, and all other persons who may be involved with or affected by the Plan.

The Trustees expressly reserve the right, in their sole discretion, at any time and from time to time to amend either the amount or conditions under which any benefits are provided under the Plan. Although termination of the Fund is not anticipated, in the event of termination, the Trustees shall use all remaining Fund assets in a manner that best carries out the purpose for which the Fund was established.

Sincerely,
The Board of Trustees

BOARD OF TRUSTEES

Union Trustees

Mark Rhodes
USW HRA Fund
1101 Kermit Drive, Suite 800
Nashville, TN 37217

Employer Trustees

Terrence Sproule
USW HRA Fund
1101 Kermit Drive, Suite 800
Nashville, TN 37217

FACTS ABOUT THE PLAN

Plan Name
USW HRA Fund.

Plan Sponsor
The Board of Trustees of the USW HRA Fund, 1101 Kermit Drive, Suite 800, Nashville, TN 37217.

Employer Identification Number (EIN)
The tax identification number assigned to the Plan Sponsor by the IRS is 62-1548543.

Plan Number
The Plan Number assigned to this Plan by the Plan Sponsor is 501.

Type of Plan
This is a welfare plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and is designed to provide health care benefits.

Name of Plan Administrator
The Plan Administrator is the Board of Trustees of the USW HRA Fund.

Type of Administration
The Plan is administered by a joint labor/management Board of Trustees. The Board of Trustees, the Plan Administrator, establishes the rules and regulations of the Plan and is otherwise responsible for the operation of the Plan. The Trustees have the discretion and exclusive right to construe the terms of the Plan provisions and to determine all questions, whether legal or factual, of the nature, amount, and duration of benefits. The decisions of the Trustees regarding the terms of the Plan is final and binding. Although the Trustees are legally designated as the "Plan Administrator," the Fund employs an in-house administrative staff.

Agent for Service of Legal Process
The agent for service of legal process is the Board of Trustees of the USW HRA Fund, attention Executive Director. Service of legal process may be made upon a Fund Trustee, at the addresses listed on page 2, or the Plan Administrator at the address listed for the Fund.

Sources of Contribution
Contributions are made to the Fund as required by collective bargaining agreements between Employers and the USW International Union, AFL-CIO or its local unions, or other unions, or as required by written agreement between an Employer and the Fund, that require the Employer to make contributions to the USW HRA Fund on your behalf. You may request in writing to receive a copy of your collective bargaining agreement by contacting the Fund Office.

Funding Medium
The Plan is funded by Employer Contributions that are made to a qualified tax-exempt Fund. This

money is reserved irrevocably for the reimbursement of Eligible Medical Expenses, as defined in the Plan, incurred on behalf of Participants and their Dependents and to pay administrative expenses. Upon the election of the continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") (as explained more fully in Section 6 of the SPD), Participants and their Dependents are allowed to make contributions to the Fund on their own behalf on an after-tax basis. Participants and Dependents also are allowed to make contributions to the Fund under provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") as described in Section 8.

Fiscal Year/Plan Year
The Plan's fiscal year is the calendar year January 1 through December 31.

Plan Interpretation
All determinations made by the Trustees with respect to any matter arising under the Plan documents shall be final, conclusive, and binding on all affected Participants, their Dependents, and all other persons affected by the Plan. Any decision of the Trustees shall only be reversed by a court if such decision is determined to be arbitrary and capricious.

No individual (other than the Trustees) has any authority to interpret the Plan, to apply the terms of the Plan, or to make any promises to you about the Plan.

The Trustees intend that the Plan's terms are legally enforceable. If a provision of this Plan is held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provisions of the Plan, and this Plan will be construed and enforced as if such invalid or unenforceable provision had not been included.

While the Trustees have attempted to make this SPD as easy to understand as possible, the Trustees are aware that some of the terms and concepts discussed may be unfamiliar to you. If you have any questions regarding the Plan, you should feel free to contact the Fund Office in writing at USW HRA Fund, 1101 Kermit Drive, Suite 800, Nashville, TN 37217, by email at hra@uswbenefitfunds.com, or by calling 800-251-4107 or 855-450-1875.

DEFINITIONS

Certain terms in this booklet have specific definitions. Defined terms are capitalized whenever they appear in this booklet and will help you understand your benefits. In all cases, the Trustees have the sole discretion to determine whether a definition applies or is satisfied. Wherever the following terms are used, they are capitalized and have the following meanings:

Active Employee means an Employee who is currently working in Employment.

Alternate Recipient means any child of a Participant who is recognized under a qualified medical child support order as having a right to enrollment in the Plan.

Code means the Internal Revenue Code, as amended.

COBRA means the Consolidated Omnibus Budget Reconciliation Act.

COBRA Beneficiaries under this Plan are Dependents who are either:

1. your spouse, other than a legally separated or divorced spouse;

2. your child from birth until, and including, the date of your child's 26th birthday; or

3. your unmarried dependent child who is incapable of self-sustaining employment by reason of mental or physical handicap, who becomes so incapable on or before the date of your child's 26th birthday.

In addition to your biological child, a child includes your stepchild, and your adopted child, including a child placed with you for adoption during any waiting period prior to the finalization of the adoption.

Continuation Coverage is the coverage provided under the Plan upon a Participant's or Dependent's election of COBRA coverage.

Contributions means amounts paid to the Fund by an Employer for each Employee as required under a collective bargaining agreement between the Union and an Employer or other written agreement between an Employer and the Fund that requires contributions to the Fund on your behalf.

Dependent under this Plan is any individual who is either:

1. your spouse, other than a legally separated or divorced spouse;

2. your child from birth until, and including, the date of your child's 26th birthday;

3. your unmarried dependent child who is incapable of self-sustaining employment by

reason of mental or physical handicap, who becomes so incapable on or before the date of his or her 26th birthday;

4. an individual meeting the definition of "dependent" under Code section 105(b);

5. a former Dependent who continues to be eligible for coverage under COBRA continuation coverage will be a Dependent until that coverage ends.

In addition to your biological child, a child includes your stepchild, and your adopted child, including a child placed with you for adoption during any waiting period prior to the finalization of the adoption. All individuals claiming Dependent status must either be listed on the Participant's properly completed enrollment form or be reported to the Fund Office by the Participant's Employer and be properly substantiated to be eligible for coverage under the Plan.

Furthermore, all individuals claiming Dependent status must be enrolled in a group health plan that provides minimum value as described under the Patient Protection and Affordable Care Act ("Affordable Care Act"), and the Fund must receive an attestation stating that the Dependent is enrolled in a group health plan that provides minimum value.

Eligible Medical Expenses means medical expenses that (1) are tax deductible under Code section 213; (2) are expenses for which you have not otherwise been reimbursed from insurance or from some other source; and (3) are not otherwise excluded under Section 5 of this SPD.

Employee means (1) an employee, or former employee, covered by a collective bargaining agreement between an Employer and the Union in a position for which contributions are required to the Fund after the applicable probationary period, if any; or (2) an employee working in a position with an Employer for which contributions are required to be made to the Fund under a written agreement with the Fund.

Employer means an employer that has signed a collective bargaining agreement with the Union or has executed a written agreement with the Fund obligating the employer to make payments to the Fund for coverage of its Employees.

Employment means a position with an Employer for which contributions are required to be made to the Fund.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Fund means the USW HRA Fund.

Fund Office means the USW HRA Fund Office located at 1101 Kermit Drive, Suite 800, Nashville, TN 37217.

Medicare is the Health Insurance for the Aged and Disabled provisions in Title XVIII of the Social Security Act, as amended.

Non-Covered Employee means an employee of an Employer who does not work in a position with the Employer for which contributions are required to be made to the Fund. Under the terms of the Plan, Non-Covered Employees are not considered Employees, as defined herein.

Over the Counter Drugs means nonprescription medications, not including dietary supplements or other products that are merely beneficial to general good health.

Participant is an Employee who meets the eligibility requirements set forth in Section 2. A former Employee who continues to be eligible for coverage under COBRA continuation coverage will be a Participant until the coverage ends. Former Employees, including Retirees, Terminated Employees, and Non-Covered Employees, who do not elect COBRA continuation coverage will no longer accumulate an account balance (except for any allocated investment earnings as described in Section 4 of this SPD), but will remain Participants for purposes of receiving reimbursements until the amount of funds in their accounts reach zero.

Plan means the health reimbursement arrangement provided under the USW HRA Fund.

Plan Year means January 1 through December 31.

Qualified Medical Child Support Order ("QMCSO") means a judgment, decree, or order (including a settlement agreement) that has been issued by a court of competent jurisdiction or is issued through an administrative process established under state law (and has the force and effect of law under applicable state law), and has been determined by the Plan to create the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or beneficiary is eligible under the Plan. Contact the Fund Office to obtain a copy of the Fund's QMCSO procedures.

Retiree means a former Employee of an Employer who has retired from employment, as reported to the Fund by the Employer.

Retiree Program means the plan of benefits provided by the Fund to provide health care coverage for a specific group of retired Employees of the Potlatch Corporation.

Terminated Employee means a former Employee of an Employer who has terminated employment with the Employer but is not a Retiree, as reported to the Fund by the Employer. In addition, if an Employer ceases to be an Employer under the Plan, all current employees of the Employer will be considered Terminated Employees.

Union means the United Steelworkers International Union and any local unions or other unions that require the Employer to make contributions to the USW HRA Fund on your behalf pursuant to a written agreement.

Please note that "you" or "your" refers to the Participant, unless the context clearly indicates otherwise.

SECTION 1. HOW THIS PLAN WORKS

The Plan is a Health Reimbursement Arrangement that reimburses Participants and Dependents for out-of-pocket Eligible Medical Expenses. Employer Contributions made to the Fund will be credited to an individual medical account established in the name of each Participant.

For Employees, each account will be credited with an amount based on the Employer's Contributions as required under the applicable collective bargaining agreement. There is no minimum amount required to be contributed to the Fund to establish an account balance.

When a Participant or Dependent incurs an Eligible Medical Expense (as explained more fully in Section 5) a claim for reimbursement, accompanied by appropriate documents to substantiate the claim, is to be submitted and signed by the Participant or Dependent, in the case where the Participant has died. For Over the Counter Drugs (other than insulin), the Participant or Dependent, as applicable, must submit a prescription from a physician or other authorized medical professional to be eligible for reimbursement. In general, claims for Eligible Medical Expenses with a date of service that is more than 24 months prior to the date the claim is received by the Fund Office will not be reimbursed. There is a limited exception to this rule, described in the subsection "Reimbursement and Substantiation of Expenses," below. Account balances remaining at the end of each calendar year are carried over for use in the next year.

How To Enroll

It is easy to enroll in the Plan. Simply complete the enrollment application available from the Fund Office at 800-251-4107 or 855-450-1875, at 1101 Kermit Drive, Suite 800, Nashville, TN 37217, or available for download on the Fund's website at www.uswbenefitfunds.com. Be sure to return the enrollment information promptly to the Fund Office, as your coverage cannot begin until the enrollment information is received. If you choose Dependent coverage, you must list your Dependents on your enrollment form. Only Dependents who are listed on your enrollment form will be entitled to coverage.

In the event that a Participant dies prior to submitting a properly completed enrollment form, Dependents will have access to the Participant's account (as explained more fully in Section 4) and may submit claims for reimbursements of Eligible Medical Expenses to spend down the account until the account balance is zero, and also may elect to continue coverage under COBRA. The Fund Office may require documentation to verify Dependent status.

Reimbursement and Substantiation of Expenses

Reimbursements will be made for Eligible Medical Expenses that are incurred. Claim forms for reimbursement of Eligible Medical Expenses must be received by the Fund Office no later than 24 months following the date of service. Claims received by the Fund Office more than 24 months following the date of service ("Stale Claims") will not be eligible for reimbursement, except as set forth below.

When a Participant becomes a Retiree, or reaches age 65, whichever occurs first, the Participant may submit one Stale Claim form for reimbursement. To be eligible for reimbursement, the Stale Claim form must be received by the Fund Office within 180 days of the earlier of the date the Participant becomes a Retiree or reaches age 65 (the "Eligibility Period"), and the Stale Claim must otherwise satisfy the requirements for reimbursement set forth in this Section, other than the requirement that a claim be submitted no later than 24 months following the date of service. Only the first Stale Claim form received by the Fund during the Eligibility Period will be eligible for reimbursement.

To receive reimbursement for Eligible Medical Expenses, a signed claim form must be submitted to the Fund Office with the required documentation attached regarding the Eligible Medical Expenses, by one of the following methods:

US Mail:	**USW HRA Fund** **1101 Kermit Drive, Suite 800** **Nashville, TN 37217**
Facsimile:	**615-333-5797**
E-mail:	**hra@uswbenefitfunds.com**
Website:	**www.uswbenefitfunds.com**

In general, claim reimbursement payments will be issued directly to the Participant, not to a provider of services. However, claim reimbursement payments for health insurance or health plan premiums may be issued directly to the applicable health insurer or health plan.

All claims must be submitted in writing and include substantiation that the expenses have been incurred and paid by the Participant or Dependent, and the amount of the charge. The Participant or Dependent, as applicable, also must confirm that the expenses have not been reimbursed and are not reimbursable under any other medical plan that provides the Participant or Dependent with health coverage.

With regard to Over the Counter Drugs, the Participant or Dependent, as applicable, must submit a prescription from a physician or other authorized medical professional for the Over the Counter Drug (other than insulin), a receipt identifying the purchased item, the amount paid, and the date of the purchase. If the receipt does not identify the name of the item, other documentation must be provided, such as a box-top with the name of the item. For items, other than Over the Counter Drugs, that serve a dual purpose (items that can be used for medical and non-medical purposes, such as sunscreen), you may be required to submit additional documentation. For example, you may be required to submit a doctor's note specifying that the treatment is for a specific medical condition.

Please see Section 10 for more information about claims procedures, including limitations on time periods in which you may file an appeal of a claim denial or file suit against the Fund.

SECTION 2. PARTICIPANT ELIGIBILITY

Initial Eligibility and When Coverage Begins

Except as otherwise provided below, coverage begins on the first day of active Employment for which an Employer is required to make a contribution on behalf of the Participant, provided that the Participant is enrolled in a group health plan that provides minimum value as described under the Affordable Care Act, and the Fund has received the Participant's enrollment form (or electronically received the Participant's enrollment information from the Employer) and an attestation form stating that the Participant is enrolled in a group health plan that provides minimum value.

Establishment of Accounts - Employees and Retirees

Accounts were established January 1, 2003, for the following:

1. **Group 1** – Employees who were employed by the Potlatch Corporation on December 31, 1996, and were not eligible for full retiree health benefits from the Potlatch Employee Benefits Organization Hourly Health Benefits Plan;

2. **Group 2** – Employees who were employed by the Potlatch Corporation after December 31, 1996, and who were either (1) employed by the Potlatch Corporation or (2) had retired from employment with the Potlatch Corporation as of December 31, 2002;

3. **Group 3** – Employees receiving benefits from the Fund under the Retiree Program as of December 31, 2002;

4. **Group 4** – Employees of the Potlatch Corporation, covered by a collective bargaining agreement with the Potlatch Corporation that required contributions to the Fund, who worked in any Employment during the calendar year January 1, 2003 through December 31, 2003;

5. **Group 5** – Employees of the Potlatch Corporation, covered by a collective bargaining agreement with the Potlatch Corporation that requires contributions to the Fund, who work in any Employment after December 31, 2003.

Accounts will be established, effective the first day contributions are required pursuant to an applicable collective bargaining agreement or other agreement, for the following:

1. **Group 6** – Employees of any other Employer, covered by a collective bargaining agreement or other written agreement that requires contributions to the Fund. However, if any account is established for an Employee who is not enrolled in a group health plan that provides minimum value as described under the

Affordable Care Act, or the Fund has not received an attestation form stating that the Employee is enrolled in a group health plan that provides minimum value, the account will not be available to the Employee for reimbursement of Eligible Medical Expenses and any Contributions made to the account, and any investment earnings or other credited amounts, will be forfeited.

Continued Eligibility

Once you are initially eligible, you become and remain a Participant for as long as Contributions are made to the Fund on your behalf, or for as long as your coverage is continued pursuant to Section 6. In addition, if you are no longer an Employee and do not elect COBRA continuation coverage under Section 6, you will no longer accumulate an account balance (except for any allocated investment earnings as described in Section 4 of this SPD), but you will remain a Participant for purposes of receiving reimbursements until the amount of funds in your account reaches zero.

Notwithstanding the above, effective January 1, 2014, if you are not enrolled in a group health plan that provides minimum value as described under the Affordable Care Act, or the Fund does not receive an attestation form stating that you are enrolled in a group health plan that provides minimum value, your participation in the Plan will terminate and you will no longer be credited with Contributions for periods worked after that date or accumulate an account balance after that date. Any Contributions made to the Fund on your behalf for periods worked on or after the later of January 1, 2014, or the date you are not enrolled in a group health plan that provides minimum value, and any investment earnings or other credited amounts attributable to those Contributions, will be forfeited. However, you will be permitted to spend down your remaining account balance and will remain a Participant for purposes of receiving reimbursements until the remaining non-forfeited amounts accumulated in your account reach zero. If you are unsure whether your group health plan provides minimum value, please contact that group health plan to confirm.

Loss of Eligibility

An Employee will cease to be eligible to continue to accumulate Contributions in the Fund upon the earliest of the following:

1. termination of Employment;

2. military service, except as provided under the Uniformed Services Employment and Reemployment Rights Act ("USERRA") (See Section 8);

3. leave of absence;

4. the end of the Employer's obligation to make Contributions pursuant to a collective bargaining agreement between the Union and an Employer or other written agreement between an Employer and the Fund that requires Contributions to the Fund;

5. the date the Plan is amended to terminate coverage of the class of Employees in which the Employee is included;

6. the Employee's death;

7. the date the Employee is no longer enrolled in a group health plan that provides minimum value as described under the Affordable Care Act; or

8. the date that an Employer or Employee fails to provide an attestation form stating that the Employee is enrolled in a group health plan that provides minimum value, and the Fund's inability to confirm the Employee's enrollment in such a plan.

A Retiree, Terminated Employee, or Non-Covered Employee will cease to be eligible for benefits once his or her account balance is zero.

If a Participant loses eligibility under the Plan, the Participant may elect to submit claims for reimbursements for Eligible Medical Expenses to spend down the account until the account balance is zero. In the event of a Participant's death, termination of Employment, or retirement, the Participant's Dependents also may spend down the account, and claims will be paid in the order in which the claims are received and processed by the Fund Office, until the account balance is zero. In all other cases, if a Dependent loses eligibility under the Plan, coverage will cease unless the Dependent elects to continue coverage under COBRA. Please refer to Section 6 for information regarding coverage under COBRA.

Notwithstanding the above, effective January 1, 2014, if a Participant is not enrolled in a group health plan that provides minimum value as described under the Affordable Care Act, or the Employer or Employee fails to provide an attestation form stating that the Participant is enrolled in such a group health plan, the Participant will forfeit any Contributions made to the Fund on his or her behalf for periods worked on or after the later of January 1, 2014, or the date the Participant is not enrolled in a group health plan that provides minimum value, and any investment earnings or other credited amounts attributable to such Contributions also will be forfeited. However, such a Participant will be permitted to spend down his or her remaining account balance and will remain a Participant for purposes of receiving reimbursements until the remaining non-forfeited amounts accumulated in his or her account reach zero.

If a Participant loses eligibility to continue to accumulate Contributions in his or her account due to termination of the Participant's coverage in a group health plan that provides minimum value, his or her eligibility to accumulate future Contributions may be reestablished beginning on the first day of the month that is on or after the date that the Participant's coverage in a group health plan that provides minimum value is subsequently reestablished, and the Participant otherwise meets the requirements for Participant Eligibility in this Section 2, provided that the Participant has not permanently opted out of coverage through the Fund.

Except as otherwise provided below, coverage begins on the first day of active Employment for

which an Employer is required to make a Contribution on behalf of the Participant, provided the Participant is enrolled in a group health plan that provides minimum value as described under the Affordable Care Act, and the Fund has received the Participant's enrollment form and an attestation from stating that the Participant is enrolled in a group health plan that provides minimum value.

Opting Out of Coverage and Eligibility

Participants will be provided an opportunity to opt out of participation in the Fund, to the extent required by Federal law, on an annual basis and upon termination of Employment. If a Participant elects to opt out of participation in the Fund, he or she will waive his or her eligibility for future reimbursements from the Plan and forfeit the remaining balance in his or her account.

A Participant may opt out of participation, waive his or her eligibility for future reimbursements, and forfeit the remaining balance in his or her account as follows:

1. A Participant may opt out by providing written notice to the Fund Office, on a form approved by the Fund, of his or her decision to opt out of participation, waive his or her eligibility for future reimbursements, and forfeit the remaining balance in his or her account. Such notice must be provided to the Fund no later than December 15th and will be effective on January 1st of the following calendar year; and

2. A Participant may opt out by providing written notice to the Fund Office, on a form approved by the Fund, of his or her decision to opt out of participation, waive his or her eligibility for future reimbursements, and forfeit the remaining balance in his or her account within 60 days after the date of the Participant's termination of Employment. Such notice will be effective on the later of the date of the Participant's termination of Employment or the date the notice is received and processed by the Fund.

If a Participant opts out of participation in the Fund, the Participant's and his or her Dependents' eligibility for coverage through the Fund will be terminated and the remaining amount accumulated in the Participant's account will be forfeited, to the extent required by Federal law.

SECTION 3. DEPENDENT ELIGIBILITY

If a Participant chooses Dependent coverage and completes the necessary enrollment information, coverage for a Dependent begins the same day that coverage for the Participant begins and the money in the Participant's account may be used to pay the Dependent's Eligible Medical Expenses. Coverage for a Dependent will start on the day the Dependent's enrollment information is received by the Fund Office.

Coverage of Newborn Children

Eligibility begins at the time of birth for a Participant's newborn child or a newborn child adopted or placed for adoption with a Participant provided that the child has been properly enrolled in the Plan. However, a newborn child must be added as a Dependent and enrollment information must be received by the Fund Office within 24 months of the child's birth in order to be covered as of the child's date of birth. Otherwise, coverage for a newborn child begins on the day the child's enrollment information is received by the Fund Office.

Qualified Medical Child Support Order ("QMCSO")

The Plan will provide Dependent coverage to a child if it is required to do so under the terms of a Qualified Medical Child Support Order ("QMCSO"). The Plan will provide coverage to a child under a QMCSO even if the Participant does not have legal custody of the child, the child is not dependent on the Participant for support, or if the child does not reside with the Participant. If the Plan receives a QMCSO and the Participant does not enroll the affected child, the Plan will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Plan's procedures for determining whether an order is a QMCSO may be obtained, free of charge, from the Fund Office.

When Dependent Coverage Ceases

Coverage for a Dependent will end on the earliest of the following dates:

1. the date a Dependent becomes eligible for coverage under the Plan as an Employee;

2. in the case of a Dependent child, the later of:

   (a) the day following the date of the 26th birthday of the child, unless the child is incapable of self-sustaining employment by reason of mental or physical handicap and becomes so incapable on or before the child's 26th birthday; or

   (b) the date the child ceases to meet the definition of "dependent" under Code section 105(b).

3. in the case of a spouse, the earlier of the date of the Participant's divorce or legal separation from the spouse;

4. in the case of a Dependent who is not a spouse or child of the Participant, the date the Dependent ceases to meet the definition of "dependent" under Code section 105(b);

5. the date the Dependent is no longer enrolled in a group health plan that provides minimum value as described under the Affordable Care Act;

6. the date that an Employer, Employee, or Dependent fails to provide an attestation form stating that the Dependent is enrolled in a group health plan that provides minimum value, and the Fund's inability to confirm the Dependent's enrollment in such a plan; or

7. the date Participant coverage is terminated. However, if a Dependent loses coverage because a Participant ceases to be an Employee, the Dependent will remain eligible to receive reimbursements, provided that funds remain in the applicable Participant's account and the Dependent is not otherwise ineligible under 1 through 6 above.

   In addition, if the Participant is not enrolled in a group health plan that provides minimum value under the Affordable Care Act, or an attestation form stating that the Participant is enrolled in such a group health plan has not been received by the Fund and the Fund is unable to confirm the Participant's enrollment in such a plan, the Dependent's eligibility to receive reimbursements will be limited as follows: the Dependent may only receive reimbursements to the extent that there are Contributions in the Participant's account for periods worked prior to the later of January 1, 2014, or the date that the Participant was not enrolled in a group health plan that provides minimum value, or any investment earnings or other credited amounts attributable to such Contributions.

   If a Dependent loses coverage under the Fund due to the termination of a Participant's or Dependent's coverage in a group health plan that provides minimum value, such coverage under the Fund may be reestablished beginning on the first day of the month that is on or after the date that the Participant's or Dependent's coverage in a group health plan that provides minimum value is subsequently reestablished and the Dependent otherwise meets the requirements for Dependent eligibility in this Section 3.

SECTION 4. ACCOUNT INFORMATION

Accessing Amounts in Accounts

Retirees and their Dependents may access up to 100% of their account balance at any time. For a Participant who is not a Retiree, the amount of his or her account that he or she may access will depend on whether the Participant is in Program A, Program B, or Program C, as described in the "Account Balance Access" chart below. Your eligibility under a particular program is determined based on the terms of the collective bargaining agreement or other written agreement requiring Contributions to the Fund on your behalf. If you are unsure which program you are enrolled in, please see Appendix A or contact the Fund Office at 800-251-4107 or 855-450-1875, or at 1101 Kermit Drive, Suite 800, Nashville, TN 37217, or at hra@uswbenefitfunds.com.

Account Balance Access		
Program A	**Program B**	**Program C**
Full Access Program ALL Participants may access up to 100% of their account balances at any time.	Partial Access Program Active Employees and Non-Covered Employees may access up to 50% of the amount in their accounts as determined on January 1 of each year. Terminated Employees and Retirees may access up to 100% of their account balances at any time.	Retiree Access Program All Participants who are age 65 or older, and Retirees, may access up to 100% of their account balances at any time. Active Employees, Non-Covered Employees, and Terminated Employees who are not age 65 or older may not access their account balance at any time until they reach age 65 or become a Retiree.
All Programs: A Dependent of a deceased Participant may access up to 100% of the Participant's account balance at any time.		

Once a Participant's account is reduced to zero, neither the Participant nor the Dependent is eligible for benefits from the Fund unless an Employer makes additional Contributions on behalf of the Participant, or the Participant or Dependent makes after-tax payments to the Fund to maintain COBRA coverage as described in Section 6. If a Participant dies or retires with a remaining account balance, the account is maintained and is available to reimburse the Participant's spouse or other Dependents for Eligible Medical Expenses until the account is reduced to zero. Access to a Participant's account is subject to the eligibility requirements of Sections 2 and 3.

Account Forfeitures

Amounts remaining in a Participant's account following his or her death may only be used by the Participant's spouse, or other Dependents, to pay for Eligible Medical Expenses. The Participant's estate, through the legal representative of the estate, also may receive reimbursements for Eligible Medical Expenses incurred by the Participant if the claim is received by the Fund Office on or

before the last business day immediately preceding the first anniversary of the Participant's death and otherwise meets the requirements for reimbursement. Except as otherwise provided, no other distribution from the deceased Participant's account may be made. If there are no Dependents upon the Participant's death and no claims are received by the Fund Office from the legal representative of the Participant's estate on or before the last business day immediately preceding the first anniversary of the Participant's death, any remaining amounts in the account will be forfeited. Amounts also will be forfeited in the case of a lost Participant, as described below. Additionally, any amounts remaining in an account are forfeited upon the termination of COBRA continuation coverage.

If a Participant is not enrolled in a group health plan that provides minimum value as described under the Affordable Care Act, or the Fund does not receive an attestation form stating that the Participant is enrolled in a group health plan that provides minimum value and the Fund cannot confirm the Participant's enrollment in such group health plan, the Participant will forfeit any Contribution made to the Fund on his or her behalf for periods worked on or after the later of January 1, 2014, or the date the Participant is not enrolled in a plan that provides minimum value. Any investment earnings or other credited amounts attributable to such forfeited Contributions also will be forfeited. In addition, if a Participant elects to opt out of participation in the Plan and waive his or her eligibility for future reimbursements from the Plan, the amounts accumulated in the Participant's account will be forfeited, to the extent required by Federal law.

Allocation of Administrative Expenses, Fees, and Investment Income

Reasonable administrative expenses of the Fund are paid from the investment income earned on the Fund's assets, forfeited Participant account balances, and fees collected from Participant accounts as described below. To the extent that investment income, forfeitures, and fees are not sufficient to pay the administrative expenses for a calendar year, such expenses will be deducted from each Participant's account, effective December 31st of that calendar year, on a pro-rata basis in proportion to the amount in each Participant's account. If the investment income, forfeitures, and fees collected from Participant accounts exceed the Fund's administrative expenses for a calendar year, such excess shall be allocated to each account, effective December 31st of that calendar year, on a pro-rata basis, in proportion to the amount in each Participant's account.

The Administration Fees, Payment Processing Fees, Denied Claim Processing Fees, and Account Inactivity Fees are determined as indicated below, based on the applicable Program.

Administration Fees

The amount and frequency of the Administration Fees are determined by Program, as indicated in the "Administration Fees" chart below.

Administration Fees			
Participant	**Program A Fee Amount**	**Program B Fee Amount**	**Program C Fee Amount**
Active Employee	$5.00 per month	$5.00, each month in which a claim is paid	None
Non-Covered Employee	$5.00 per month	$5.00, each month in which a claim is paid	None
Terminated Employee, under age 65	$5.00 per month	$5.00, each month in which a claim is paid	None
Terminated Employee, age 65 and older	None	None	None
Retiree	None	None	None
Dependent of Deceased Participant	None	None	None

Payment Processing Fees

The Fund Office will issue a reimbursement payment only in the form of an Automated Clearing House ("ACH") credit transfer for all Eligible Medical Expenses submitted on a claim form that meets the requirements of Section 1. Payment Processing Fees are assessed on the accounts of Participants or Dependents receiving reimbursement payments, as indicated in the "Payment Processing Fees" chart below.

Payment Processing Fees		
Participant	**Programs A and B Fee Amount**	**Program C Fee Amount**
	Paid by ACH	**Paid by ACH**
Active Employee	$5.00 per payment	Not Applicable
Non-Covered Employee	$5.00 per payment	Not Applicable
Terminated Employee, under age 65	$5.00 per payment	Not Applicable
Terminated Employee, age 65 and older	None	None
Retiree	None	None
Dependent of a Deceased Participant	None	None

Account Inactivity Fees

For all Programs, an annual $50.00 Account Inactivity Fee will be applied to a Participant's account if the account balance is less than $100.00 and the account has been inactive for the past two years. The Account Inactivity Fee will be assessed on the last day of each Plan Year in which all of the following requirements are met, determined as of the last day of the Plan Year:

1. The balance of the Participant's account is less than $100.00, as determined before crediting of any applicable investment income or the deduction of any applicable administrative expenses (other than Administration Fees or Processing Fees) for the Plan Year;

2. The Participant is not an Active Employee or Non-Covered Employee;

3. No amounts derived from Contributions or COBRA premiums have been credited to the Participant's account during the current Plan Year or immediately prior Plan Year;

4. No reimbursements for Eligible Medical Expenses have been made from the Participant's account during the current Plan Year or immediately prior Plan Year; and

5. No claims for reimbursement from the Participant's account have been received by the Fund Office during the current Plan Year or immediately prior Plan Year.

If an Account Inactivity Fee exceeds the balance remaining in a Participant's account, the Participant's account will be reduced to zero. The Participant will not be required to pay the Fund for any portion of the Account Inactivity Fee that exceeds the balance in the Participant's account.

Lost Participants

Accounts will only be forfeited if a Participant dies with no Dependents or if all three of the following criteria are met: 1) it is the account of a Participant who is no longer actively employed; 2) no distributions from the account have been made for three calendar years; and 3) regular mail from the Plan to the Participant has been returned with no forwarding information. In such an event, the Fund Office will search for the Participant, or the Participant's Dependents in the event of a Participant's death. The Fund Office will contact both the Employer and the Union, and will avail itself of government programs, if any, provided through the Social Security Administration, the Department of Labor, or other entities to attempt to obtain information regarding the Participant, including the Participant's last known mailing address. The cost of such efforts shall be deducted from the account.

If, after following the above procedures, the Fund Office is unable to locate any Participant or Dependent, upon approval by the Board of Trustees, the applicable Participant accounts will be forfeited. If, at any time later, the Participant or a Dependent contacts the Fund Office, the Participant's account will be reconstituted and the cost of such shall be treated as an Administrative Expense. The reconstituted account will reflect a proportionate share of income earned, and will be

reduced by a proportionate share of administrative expenses incurred by the Fund and allocated to all Participants' accounts for the period up to the date the account is reconstituted.

Reporting of Account Balance

Account balances will be reported to Participants in statements mailed to Participants twice a year. In addition, a Participant may view his or her account balance at www.uswbenefitfunds.com.

Overpayments

If a Participant, or his or her Dependent, is overpaid for a claim, the Participant, or his or her Dependent, must return the overpayment. The Fund has the right to recover any payments made that were based on false or fraudulent information, as well as any payments made in error. Amounts recovered may include interest, costs, and attorneys' fees. If repayment is not made by the date specified by the Fund, the Fund may deduct the overpayment amount from any future benefits from this Fund that the Participant, or his or her Dependent, would otherwise receive, or a lawsuit may be initiated to recover the overpayment.

SECTION 5. BENEFITS

The Plan will reimburse a Participant or his or her Dependent for Eligible Medical Expenses, as described below, that are tax deductible under Code section 213 and are expenses that may be reimbursed by an HRA. Eligible Medical Expenses are expenses that have not otherwise been reimbursed by insurance or from some other source such as an employer sponsored flexible spending account and that are not otherwise excluded from coverage by this Section. Eligible Medical Expenses are limited to generally recognized health care expenses, which are defined as (a) expenses incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body; and (b) for transportation primarily for and essential to such medical care. No Participant or Dependent can elect to receive cash or other taxable or non- taxable benefits under the Plan other than the reimbursement of Eligible Medical Expenses.

Eligible Medical Expenses include:

- Health insurance premiums
- COBRA premiums
- Medicare Part B premiums
- Long term care insurance premiums

Subject to appropriate substantiation as detailed in Section 1, Eligible Medical Expenses that the Plan would reimburse also include:

1. amounts paid for operations;

2. Over the Counter Drugs, with a prescription from a physician or other authorized medical professional;

3. obstetrical expenses;

4. artificial teeth and limbs, eye glasses, hearing aids;

5. cosmetic surgery following an operation that causes disfigurement or that is needed to correct a defect caused by a disease or that interferes with the normal functioning of the body;

6. physical therapy expenses;

7. x-ray treatments;

8. hospital services;

9. nursing services;

10. medical, laboratory, surgical, dental and diagnostic services;

11. prescription drugs and insulin;

12. ambulance services;

13. institutionalized care (including meals and lodging);

14. transportation expenses used primarily for medical care;

15. expenses that are covered under another medical plan that are not paid at 100%;

16. insurance deductibles and co-payments.

Some expenses that are not covered as Eligible Medical Expenses include:

1. travel expenses, including the cost of lodging, for the general improvement of a Participant's or Dependent's health (for example, vacation expenses);

2. expenses paid for cosmetic surgery that is not medically necessary such as hair transplants, electrolysis, liposuction, teeth whitening, and face lift operations, or is not described above under the covered expense provisions;

3. long-term disability insurance coverage;

4. special foods or dietary supplements;

5. hot tubs and home spas and any expenses incurred for the maintenance of hot tubs and home spas;

6. swimming pools and any expenses incurred for the maintenance of swimming pools;

7. Over the Counter Drugs (other than insulin), unless prescribed by a physician or other authorized medical professional.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any length of hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a

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

Women's Health and Cancer Rights Act

Notwithstanding any other provisions, the Plan provides reimbursements for the following if performed in connection with a mastectomy that is an Eligible Medical Expense under the Plan:

1. reconstruction of the breast on which the mastectomy was performed;

2. surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. prostheses; and

4. treatment for physical complications at all stage of mastectomy, including lymphedemas.

These benefits will be provided under the Plan subject to the same rules applicable to all other Eligible Medical Expenses. If you would like more information on benefits under the Women's Health and Cancer Rights Act, please contact the Fund Office.

Mental Health Parity Act

Subject to applicable limits, to the extent claims incurred for the treatment of mental health are Eligible Medical Expenses under the Plan, the reimbursement for such claims will not be lower than any other limits for other, non-mental health Eligible Medical Expenses covered under the Plan.

SECTION 6. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT ("COBRA")

The Consolidated Omnibus Budget Reconciliation Act, more commonly known as COBRA, generally requires that group health plans offer Participants and their COBRA Beneficiaries the opportunity to temporarily continue their health coverage when coverage under the Plan would otherwise end. This extended coverage is called "COBRA coverage." If you and your COBRA Beneficiaries are covered under the Plan, you and your COBRA Beneficiaries can continue coverage for a time if coverage ends for one of the several reasons (called Qualifying Events), even if you or they are already covered by another group health plan or Medicare.

Administrative duties relating to the day-to-day operation of the Plan, including the administration of COBRA continuation coverage, are done by the Fund Office.

Qualifying Events

If any of the following events result in a loss of Plan coverage, you and your COBRA Beneficiaries can elect COBRA coverage under the Plan. If you and/or your COBRA Beneficiaries do not elect COBRA coverage, you and/or your Dependents' coverage under the Plan will end when one of these Qualifying Events occurs. Qualifying Events are:

1. your termination of Employment (for reasons other than gross misconduct) or retirement;

2. reduction in your hours of Employment to fewer than the number required for participation in the Plan;

3. your entitlement to Medicare;

4. your death;

5. termination or substantial reduction of your coverage as a Retiree (or Retiree's spouse or child) within one year before or after your Employer files bankruptcy proceedings under Title 11 of the United States Bankruptcy Code;

6. your divorce or legal separation;

7. loss of status as a Dependent.

Coverage may be continued for any eligible COBRA Beneficiary who is properly enrolled on the day before the event resulting in loss of eligibility (listed above). Each eligible COBRA Beneficiary has the independent right to elect or reject COBRA continuation coverage. The Participant may elect coverage on behalf of his or her spouse and family members. An election on behalf of a COBRA Beneficiary child can be made by the child's parent or legal guardian.

If one of the Qualifying Events listed above occurs and you and/or your COBRA Beneficiary(s) do not elect COBRA coverage, you and/or your COBRA Beneficiary's health coverage under the Plan will end.

Reporting Requirements

The Fund will offer COBRA coverage to qualified beneficiaries only after the Fund has been timely notified of the occurrence of a Qualifying Event.

Employer Notices and Procedures

An Employer must notify the Fund, in writing, within 30 days of the Participant's death, termination of the Participant's employment, reduction in working hours, the Participant's entitlement to Medicare, or the Employer's initiation of bankruptcy proceedings.

Participant and COBRA Beneficiary Notices and Procedures

The Participant or eligible COBRA Beneficiary must inform the Fund Office, in writing, within 60 days of the following Qualifying Events in order to maintain the right to COBRA Coverage: divorce or legal separation of a Participant, or a child's loss of Dependent status as defined by the Fund. Both the Participant and the affected COBRA Beneficiary are jointly responsible for this notice. If you or your COBRA Beneficiary fail to give written notice to the Fund Office within the required 60 days, the affected person will lose the right to COBRA Coverage.

All notifications under COBRA must comply with these provisions. Notice should be mailed or hand delivered to the USW HRA Fund, 1101 Kermit Drive, Suite 800, Nashville, TN 37217.

The written notice of a Qualifying Event must include the following information: name and address of affected Participant and/or beneficiary, Participant's Social Security number, date of occurrence of the Qualifying Event, and the nature of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example, a copy of a divorce decree, separation agreement, death certificate, Dependent's birth certificate). Once the Fund Office receives timely notification that a Qualifying Event has occurred, COBRA coverage will be offered to the Participant and COBRA Beneficiaries, as applicable.

Notice of Second Qualifying Event or Disability

Participants and beneficiaries covered under COBRA continuation coverage must provide notice of a second Qualifying Event or disability to the Fund Office within 60 days of the date of occurrence of the second Qualifying Event or the date of disability determination, and before the end of the 18-month COBRA continuation coverage period.

The written notice must conform to the requirements for providing notices in the subsection titled "Participant and COBRA Beneficiary Notices." The notice must include evidence of the second Qualifying Event or disability (for example, a copy of a divorce decree, separation agreement, death certificate, Medicare eligible / enrollment, COBRA Beneficiary's birth certificate, SSA

disability determination).

Failure to provide the Fund Office notice of a disability or second qualifying event within 60 days will result in the loss of the right to extend coverage.

Financial Responsibility for Failure to Give Notice

If a Participant or COBRA Beneficiary does not give written notice within 60 days of the date of the Qualifying Event, or an Employer within 30 days of the Qualifying Event, and as a result, the Plan pays a claim for a person whose coverage terminated due to a Qualifying Event, then that person or the Employer, as applicable, must reimburse the Plan for any claims that should not have been paid. If the person fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the person was his or her COBRA Beneficiary.

In addition, you or your eligible COBRA Beneficiary must notify the Fund Office immediately if you become covered by any other plan of group health benefits whether through your employment or your spouse's employment or otherwise. You must repay the Fund for any claims paid in error as a result of your failure to notify the Fund Office of any other health coverage.

Notice and Election Form

Within 30 days of receiving notice of any of these events, the Fund Office will notify the Participant or eligible COBRA Beneficiary of the right to continue coverage. The Participant or eligible COBRA Beneficiary must elect COBRA continuation coverage within 60 days of the date that coverage would otherwise end, or if later, within 60 days from the date that Fund Office first sent notice of the right to elect COBRA continuation coverage to the Participant or eligible COBRA Beneficiary. This election must be made in writing and returned to the Fund Office within the 60-day election period. Failure to notify the Fund Office on time will result in forfeiture of COBRA rights.

Details of Continuation Coverage

Coverage provided under the Plan to Participants and COBRA Beneficiaries electing COBRA is the same as the coverage provided to similarly situated Participants or COBRA Beneficiaries who have not elected COBRA, regardless of account balances. If the coverage provided under the Plan is modified after a COBRA election is made, coverage for Participants and COBRA Beneficiaries who elected COBRA also will be modified.

If you have a child born, or if a child is placed for adoption with you, during a period of COBRA coverage, you may elect COBRA continuation coverage for that child for the remainder of your COBRA coverage period provided that you enroll the child in accordance with the Fund's rules. Coverage for the newborn or adopted child will continue for the same time as coverage for COBRA Beneficiary children who were properly enrolled in the Fund on the day before the Qualifying Event. Newborn or adopted children added to your COBRA coverage also become

COBRA Beneficiaries.

Participant Election of COBRA and Spend Down Option

Upon the occurrence of a Qualifying Event, a Participant may spend down the amount in the account until it reaches zero and also may elect COBRA which will allow the Participant to make monthly contributions to the account in the form of a COBRA premium.

COBRA Beneficiary Election of COBRA in the Event of the Participant's Death or Retirement and Spend Down Option

In the event that a COBRA Beneficiary loses coverage under the Plan as a result of the Participant's death or retirement, the COBRA Beneficiary may spend down the amount in the Participant's account and may elect COBRA, which will allow the COBRA Beneficiary to make monthly contributions to the account in the form of a COBRA premium.

COBRA Beneficiary Election of COBRA in the Event of a Qualifying Event Other than the Participant's Death or Retirement

In the event that a COBRA Beneficiary loses coverage under the Plan due to a Qualifying Event other than the Participant's death or retirement, the COBRA Beneficiary is not entitled to spend down the account, but may elect to continue coverage under COBRA. Upon the election of COBRA, the COBRA Beneficiary is allowed the following options:

1. the COBRA Beneficiary may immediately fund a separate account using post-tax dollars in an amount equal to the value of the Participant's account on the date of the COBRA Qualifying Event. Under this option, the COBRA Beneficiary also is required to make monthly COBRA premium payments; or

2. the COBRA Beneficiary may elect not to fund a separate account in the amount equal to the value of the Participant's account on the date of the COBRA Qualifying Event, but instead can choose to make only monthly COBRA premium payments.

Payment Provisions

Under COBRA, timely monthly payments must be made. The payment due date is the first day of the month in which COBRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of COBRA coverage must include payment for the period of time dating back to the date that coverage terminated. If the full payment is not paid by each due date (or within the 30-day grace period for payments other than your initial payment) coverage under COBRA will cease.

There is an initial grace period of 45 days to pay the first amounts due starting with the date

COBRA coverage was elected. There is then a grace period of 30 days to pay any subsequent amounts due. If payment of the amounts due is not received by the end of the applicable grace period, the COBRA coverage will terminate.

Once a timely election of COBRA coverage has been made, it is the responsibility of the Participant or COBRA Beneficiary seeking COBRA coverage to make timely payment of all payments. The Fund will NOT send notice that a payment is due or that it is late, or that COBRA coverage is about to be or has been terminated due to the untimely payment of a required payment.

COBRA Premiums

The cost of COBRA coverage for all Participants and COBRA Beneficiaries is based on 102% of the monthly contributions made to the Plan on behalf of the Participant as calculated in accordance with the formulas described below. If any individual or family coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits (described below), the cost of COBRA coverage is based on 150% of the contributions made to the Plan on behalf of the Participant as calculated in accordance with the formulas described below and due during the 11-month extension of COBRA coverage.

COBRA premiums for Participants and COBRA Beneficiaries will be determined by evaluating the average contributions received by the Plan on behalf of the Participant for the 12 months immediately preceding the Qualifying Event. Administrative fees will also be included in the determination of COBRA premiums.

Maximum Periods of COBRA Coverage for Each Qualifying Event

COBRA coverage continues subject to a maximum time period as set forth in the chart below:

		Dependents	
	Participant	**Spouse**	**Child(ren)**
Participant terminated (for other than gross misconduct) or retirees	18 months	18 months	18 months
Participant's reduction in hours of Employment	18 months	18 months	18 months
Participant dies	N/A	36 months	36 months
Participant becomes divorced or legally separated	N/A	36 months	36 months
Participant becomes entitled to Medicare	N/A	36 months	36 months
Dependent child ceases to have Dependent status	N/A	N/A	36 months
Termination or substantial reduction of your coverage as a Retiree (or Retiree's spouse or child) within one year before or after your Employer files bankruptcy proceedings under Title 11 of the United States Bankruptcy Code	Lifetime COBRA coverage	For the life of the Retiree plus 36 months following the death of the Retiree	For the life of the Retiree plus 36 months following the death of the Retiree

If a Participant becomes entitled to Medicare, and within 18 months of becoming entitled to Medicare, he/she becomes entitled to COBRA due to termination of employment (other than for gross misconduct) or reduction in work hours, coverage for the Participant's Dependent may be continued for up to 36 months from the date the Participant became entitled to Medicare.

If you become eligible for COBRA continuation coverage, the 18-month coverage period may be extended for your spouse or beneficiaries for an additional 18 months if a second qualifying event occurs within the 18-month period of COBRA continuation coverage. However, in no event will COBRA continuation coverage extend beyond 36 months. Such second qualifying events include the death of the Participant, divorce or separation from the Participant, the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a COBRA Beneficiary child's ceasing to be eligible for coverage as a Dependent under the Fund. However, these events are second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Fund if the first qualifying event had not occurred. You must notify the Fund Office in writing and in accordance with the notification procedures described below in order to extend the period of continuing coverage.

Entitlement to Social Security Disability Income Benefits

If you become eligible for COBRA continuation coverage, the 18-month COBRA continuation coverage period may be extended an additional 11 months if you or your COBRA Beneficiary are determined to be disabled by the Social Security Administration ("SSA") as of or during the first 60 days of COBRA continuation coverage. The extended COBRA continuation coverage period applies to you and your COBRA Beneficiaries, regardless of which of you is disabled. You must notify the Fund Office in writing and in accordance with the notification procedures described in this Section in order to extend the period of continuing coverage. If, during the initial 18-month period, the Social Security Administration determines that the person is no longer disabled, the 11-month extension does not apply. If the Social Security Administration determines that the person is no longer disabled after the initial 18-month period, the period of continuation coverage ends with the first month that begins more than 30 days after the date of the Social Security Administration's determination, provided the period of continuation coverage does not extend 29 months.

Termination of COBRA Coverage

If you and/or your COBRA Beneficiaries elect COBRA coverage, the COBRA coverage will end upon the occurrence of the earliest of the following events:

1. the date the Plan terminates or the Plan no longer provides coverage to similarly situated Participants or COBRA Beneficiaries;

2. the date a COBRA payment is due and unpaid after the applicable grace period;

3. the date you and/or your COBRA Beneficiary first become covered under another group health plan as long as it is after the Qualifying Event. Contact the Fund Office for additional information when you and/or your COBRA Beneficiaries become covered under another group plan;

4. the date you or your COBRA Beneficiaries first become eligible for Medicare, as long as it is after the Qualifying Event;

5. the date the applicable period of COBRA coverage ends;

6. the first month that begins more than 30 days after the date of the Social Security Administration's determination that you or your COBRA Beneficiaries are no longer disabled in situations where coverage was being extended for 11 months, so long as the period of continuation coverage does not exceed 29 months;

7. if your Employer ceases to maintain any group health plan for its Employees through the Fund, the date your Employer makes health coverage available to a class of Employees formerly covered under the Plan.

Notice of Change of Participant's and COBRA Beneficiary's Address

It is crucial that Participants and beneficiaries keep the Fund informed of their current addresses. If you or a covered family member experiences a change of address, immediately inform the Fund Office.

Other Rights

This section describes your rights under COBRA. It is not intended to describe all of the rights available under ERISA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws.

Contact for Additional Information

If you have questions or wish to request additional information about COBRA coverage or the Plan, please contact:

USW HRA Fund
1101 Kermit Drive, Suite 800
Nashville, TN 37217

SECTION 7. FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The Family and Medical Leave Act of 1993 ("FMLA") requires certain employers to provide employees with unpaid leave for certain kinds of family or medical situations. You should contact your Employer for details about FMLA.

To comply with the FMLA, your Employer is required to maintain your existing coverage under the Plan during your period of leave under the FMLA just as if you were in Employment. Your coverage under the Plan will end once the Plan is notified or otherwise determines that you have terminated Employment, exhausted your 12-week or 26-week FMLA leave entitlement, or you inform the Plan of your intent not to return from FMLA leave.

Once the Plan is notified or otherwise determines that you are not returning to Employment following a period of FMLA leave, you may elect continued coverage under the COBRA coverage rules. The date of the Qualifying Event entitling you to COBRA coverage is the last day of your FMLA leave.

If you fail to return to Employment following your FMLA leave, or if you choose not to elect COBRA coverage, your account will be forfeited.

SECTION 8. THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 ("USERRA")

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and the regulations thereunder require that the Plan provide to Participants and their Dependents the right to elect continuous health coverage for up to 24 months, beginning on the date in which the Participant's absence from Employment begins due to military service, including Reserve and National Guard Duty under federal authority, as described below.

Coverage Under USERRA

If you are absent from Employment by reason of military service, you can elect to continue coverage for yourself and your Dependents under the provisions of USERRA. This coverage will include the same benefits offered under COBRA coverage. Your coverage also will include any other benefits that you would be entitled to if you were on leave of absence. The right to elect USERRA coverage does not apply to Dependents who enter military service. Further, USERRA rights do not apply to service in a state national guard under authority of state law.

The period of coverage begins on the date on which your absence begins and ends on the earlier of:

1. The end of the 24-month period beginning on the date on which the absence begins; or

2. The day after the date on which you are required to, but fail to apply under USERRA for or return to a position of Employment covered under the Plan. (For example, for periods of service over 180 days, generally you must reapply for employment within 90 days of discharge.)

In addition to the right to continued coverage under USERRA, you or your Dependents also may have rights to elect continuation coverage under COBRA. Please refer to the COBRA Section of this SPD (Section 6) for more information.

If you meet the Plan's eligibility requirements at the time you entered the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan upon return from uniformed service, as required under USERRA.

Notice and Election of USERRA Coverage

You must notify your Employer and the Fund Office that you will be absent from Employment due to military service, unless giving notice is precluded by military necessity or unless, under all the relevant circumstances, notice is impossible or unreasonable. If you wish to elect USERRA coverage, you also must notify the Fund Office within 60 days of the last day of Employment unless you are excused from giving advance notice of service under the provisions of USERRA. While an employee may notify an employer of service orally, the Fund requires that you elect

USERRA coverage in writing. The Fund will provide you with the necessary forms.

Paying for USERRA Coverage

You may be required to pay all or a portion of the cost of these benefits. If the period of military service is less than 31 days, there is no charge for this coverage. If the military service extends more than 31 days, the participant must pay 102% of the cost of the coverage unless the Employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the costs for COBRA continuation coverage. Participants should contact the Fund Office for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if the Participant had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If the Participant timely elects and pays for USERRA coverage, coverage will be provided retroactive to the date of the Participant's departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If the Participant fails to pay the full payment by each due date (or within the 30-day grace period), the Participant will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is the responsibility of the Participant to make timely payment of all required payments. The Fund will <u>not</u> send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to the untimely payment of a required payment.

SECTION 9. COORDINATION OF BENEFITS WITH MEDICARE AND OTHER PROGRAMS

Active Employees Age 65 and Over and Their Dependents

Generally, the Fund will be primary for any Active Employee over the age of 65 and spouses over age 65 of Active Employees of any age. An Active Employee or Dependent may decline coverage under the Plan and elect Medicare as primary. In that instance, the Fund will not pay benefits secondary to Medicare for Medicare covered services. Absent an election, the Fund will continue to be primary. In the event Medicare seeks reimbursement from the Fund for amounts for which the Fund should have paid primary, but did not, such amounts will be deducted from the Participant's account. In the event such an account no longer exists, the individuals to whom the claims apply shall be responsible for reimbursement to Medicare, not the Fund.

Disabled Employees or Disabled Dependents Under 65

If the Plan is a Large Group Health Plan as defined under applicable federal law, the Plan will be Primary, to the extent required by law, for Active Employees and their Dependents who are under age 65 and who are entitled to Medicare benefits due to disability (other than End Stage Renal Disease).

End Stage Renal Disease

The Plan will be primary for Employees or their Dependents who are under age 65 and who are entitled to Medicare benefits due to End Stage Renal Disease for the first 30 months of such entitlement, to the extent required by law.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan is primary and Medicaid pays secondary.

Other Coverage Provided by State or Federal Law

If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

SECTION 10. BENEFIT CLAIMS AND APPEALS PROCEDURES

Claims for reimbursement from the Plan should be filed with the Fund Office. All claims must be accompanied by appropriate substantiation of the expense incurred as described in Section 1.

Claim Procedure

The claimant may name a representative to act on his or her behalf during the claims procedure. To do so, the claimant must notify the Fund Office in writing of the representative's name, address, and telephone number and authorize the Fund Office to release information to the representative. The Plan will not impose any charges or costs to review a claim or appeal; however, regardless of the outcome of an appeal, neither the Trustees nor the Plan shall be responsible for paying any expenses that might be incurred during the course of an appeal.

The Fund Office, in making decisions on claims and appeals, will apply the terms of the Plan document and any applicable guidelines, rules, and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, are applied consistently with respect to similarly situated claimants. The Fund Office may request that the claimant voluntarily extend the period of time in which to make a decision on claims or appeals.

If the Fund Office denies the claim, in whole or in part, it will send the claimant a notice of the claim denial within a reasonable period of time, but not later than 30 days after the claim is received by the Fund Office. The Fund Office may extend the period for a decision for up to 15 additional days due to matters beyond its control, provided that it gives the claimant written notice of such extension before the end of the initial 30-day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the Fund Office expects to make a decision. If an extension is necessary due to the claimant's failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be given at least 45 days from receipt of the notice to provide the requested information. If the information requested is not provided, the Fund Office will decide the claim based on the information it has available.

If the Fund Office denies a claim for reimbursement, in whole or in part, the Fund Office will send a written notice of the denial. The notice will provide (a) the specific reason or reasons for denial; (b) reference to specific Plan provisions on which the denial is based; (c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (d) an explanation of the Plan's claims review procedures and the time limits applicable to such procedures; (e) a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of the appeal; (f) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (g) if the denial is based on a determination of medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon

request.

Appeal Procedure

The claimant shall have the right to appeal a denial of a benefit claim to the Trustees. The appeal must be in writing and must be sent to the Trustees at USW HRA Fund, 1101 Kermit Drive, Suite 800, Nashville, TN 37217.

If a claim for reimbursement has been wholly or partially denied, the claimant will have 180 days from receipt of the denial notice to file an appeal with the Trustees.

The claimant has the right to (a) submit written comments, documents, records, and other information relating to a claim for benefits; and (b) upon request, reasonable access to, and free copies of, all documents, records, and other information relevant to the claim for benefits. In making a decision on review, the Trustees will review and consider all comments, documents, records, and all other information submitted by the claimant or the claimant's duly authorized representative, without regard to whether such information was submitted or considered in the initial claim determination. In reviewing the claim, the Trustees will not automatically presume that the Plan's initial decision was correct, but will independently review the appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Trustees will consult with a healthcare professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice to the Plan on the initial claim.

The Trustees will provide the claimant with notice of a determination regarding the appeal within sixty (60) days of the receipt of the appeal.

If the Trustees have denied the appeal, the notice will provide (a) the specific reason or reasons for the denial; (b) references to specific Plan provisions on which the denial is based; (c) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and (d) a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

In addition, the notice will state that (a) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (b) if the denial of the appeal was based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation will be provided free of charge upon request.

The Trustees retain the power and sole discretion to interpret, apply, construe, and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation, and application of the Plan. The decision of the Trustees is final and binding.

If the claim is denied, in whole or in part, the claimant is not required to appeal the decision. If a

claimant disputes a decision on a claim for benefits, the claimant has a right to file suit under Section 502(a) of ERISA on the claim for benefits, however, the claimant first must exhaust the Plan's administrative remedies by appealing the denial to the Trustees before the claimant has a right to file suit. Failure to exhaust the Plan's administrative remedies will result in the loss of the claimant's right to file suit. **If the claimant wishes to file suit for a denial of a benefit claim, the claimant must do so within two (2) years of the date the Trustees denied the appeal. For all other actions, a claimant must file suit within two (2) years of the date on which the violation of Plan terms is alleged to have occurred.** These rules apply to you, your spouse, Dependent, or beneficiary, and any provider who provided services to you or your spouse, Dependent, or beneficiary. This Section applies to all litigation against the Fund, including litigation in which the Fund is named as a third party defendant.

SECTION 11. YOUR RIGHTS UNDER ERISA

As a Participant in the Plan you are entitled to certain rights and protections under ERISA. The Trustees comply fully with this law and encourage you to first seek assistance from the Fund Office when you have questions or problems that involve the Plan.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, if any, and 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 Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, if any, 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.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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. Please read Section 10 for more

information about the claims procedures, including limitations on time periods in which you may file an appeal of a claim denial or file suit against the Fund.

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 thirty (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, provided that you have exhausted the Plan's administrative remedies, which are described in Section 10, by appealing the denial to the Trustees before you file suit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court, also provided that you have exhausted the Plan's administrative remedies, which are described in Section 10. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

SECTION 12. GRANDFATHER STATUS

The notice below is required by the U.S. Department of Labor:

> This group health plan believes this plan or coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
>
> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the USW HRA Fund at 855-450-1875. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

12/2019

APPENDIX A

Program Enrollment by Employer as of January 1, 2020	
Employer	**Program**
Clearwater Paper Corporation	B
PIUMPF	C
Steelworkers Charitable and Educational Organization	B