UNITED STEELWORKERS
USW
UNITY AND STRENGTH FOR WORKERS
BENEFIT FUNDS

USW HRA FUND
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Administrative Officer
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Dear Participant:

The Board of Trustees of the USW HRA Fund ("Fund") has adopted the following changes to the Health Reimbursement Arrangement ("HRA" or "Plan") provided by the Fund. This letter summarizes the changes.

All page numbers refer to the Summary Plan Description, effective July 1, 2010 ("SPD"), which serves as the plan of benefits for the Fund's HRA. Please keep this document with your SPD, so that you always know the benefits that you are eligible for and the rules that apply.

SUMMARY OF MATERIAL MODIFICATIONS

1. Effective May 28, 2013, the BOARD OF TRUSTEES Section on page 2, which lists the names and addresses of the Fund's Trustees, is deleted and replaced with the following:

BOARD OF TRUSTEES

Union Trustees

James Kidder
USW Local 0712
1618 Idaho Street

Employer Trustees

Terrence Sproule
Corporate Benefits Analyst
Clearwater Paper Corporation
Lewiston, ID 83501
601 West Riverside Ave., Suite 1100
Spokane, WA 99201

2. Effective January 1, 2014, the Fund does not require any minimum dollar value for submitted claims and will accept claims for Eligible Medical Expenses regardless of whether they total at least $150. To reflect this change, effective January 1, 2014, the last two sentences of the first paragraph on page 10 are deleted.

3. Effective January 1, 2014, the subsection "Initial Eligibility and When Coverage Begins" on page 10 is deleted and replaced with the following:

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 the Participant is enrolled in a group health plan that provides coverage that is "minimum value" as described under the Patient Protection and Affordable Care Act, as amended ("Affordable Care Act"), and the Fund has received the Participant's enrollment form and an attestation from the Participant that he or she is enrolled in a group health plan that provides such minimum value.

4. Effective January 1, 2014, the last paragraph of the subsection "Establishment of Accounts – Employees and Retirees" on page 11 is deleted and replaced with the following:

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 Contributing 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 coverage that is "minimum value" as described under the Affordable Care Act or the Fund has not received an attestation from the Employee that he or she is enrolled in a group health plan that provides such 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.

5. Effective January 1, 2014, the following new paragraph is added to the end of the subsection "Continued Eligibility" on page 11:

Notwithstanding the above, effective January 1, 2014, if you are not enrolled in a group health plan that provides coverage that is "minimum value" as described under the Affordable Care Act or the Fund does not receive an attestation from you that you are enrolled in a group health plan that provides such 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 plan to confirm.

6. Effective January 1, 2014, the following is added to the list of circumstances that will result in a loss of an Employee's eligibility to accumulate Contributions in the subsection "Loss of Eligibility" on page 12:

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

8. the Employee's failure to provide an attestation required by the Fund that the Employee is enrolled in a group health plan that provides minimum value, and the Fund's inability to confirm that Employee's enrollment in such a plan.

7. Effective January 1, 2014, the following paragraph is added to the end of the subsection "Loss of Eligibility" on page 12:

Notwithstanding the above, effective January 1, 2014, if a Participant is not enrolled in a group health plan that provides coverage that is "minimum value" as described under the Affordable Care Act, or fails to provide an attestation required by the Fund that he or she is enrolled in such a group health plan, he or she 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 will also 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 HRA account due to the 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 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 coverage that is "minimum value" as described under the Patient Protection and Affordable Care Act, as amended ("Affordable Care Act"), and the Fund has received the Participant's enrollment form and an attestation from the Participant that he or she is enrolled in a group health plan that provides such minimum value.

8. Effective January 1, 2014, the following new subsection "Opting Out of Coverage and Eligibility" is added to the end of Section 2, "PARTICIPANT ELIGIBILITY," on page 12:

Opting Out of Coverage and Eligibility

Participants will be provided an opportunity to permanently opt out of participation in the Fund 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 permanently 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 permanently opts out of participation in the Fund, the Participant 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.

9. Effective January 1, 2014, under the subsection "When Dependent Coverage Ceases" on page 13, which lists the dates on which a Dependent's coverage under the Plan will cease, paragraph 5 is deleted and replaced with the following:

5. 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, 2, 3, or 4 above.

In addition, if the Participant is not enrolled in a group health plan that provides minimum value under the Affordable Care Act or fails to provide an attestation required by the Fund that the Participant is enrolled in such a group health plan 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 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 through the Fund due to the termination of the Participant's coverage in a group health plan that provides minimum value, such coverage through the Fund may be reestablished beginning on the first day of the month that is on or after the date the Participant'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.

10. Effective January 1, 2014, the following sentence is added to the end of the subsection "Accessing Amounts in Accounts" on page 14:

Access to a Participant's account is subject to the eligibility requirements of Sections 2 and 3.

11. Effective January 1, 2014, the following paragraph is added to the end of the subsection "Account Forfeitures" on page 15:

If a Participant is not enrolled in a group health plan that provides coverage that is "minimum value" as described under the Affordable Care Act or the Fund does not receive an attestation from the Participant that he or she is enrolled in a group health plan that provides minimum value and cannot confirm that Participant's enrollment in such a group health plan, he or she will forfeit any Contributions made to the Fund on his or her behalf for periods worked on or after 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 will also 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.

12. Effective November 13, 2013, the last paragraph of SECTION 11. BENEFIT CLAIMS AND APPEALS PROCEDURES on page 34 is deleted and replaced with the following:

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 the Employee Retirement Income Security Act ("ERISA") on the claim for benefits, however, the claimant 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 2 years of the date the Trustees denied the appeal. For all other actions, a claimant must file suit within 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.