May 18, 2017

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 January 1, 2015 ("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.

If you have any questions about these changes, please contact the USW HRA Fund Office at 800-251-4107 or 855-450-1875, or at 1101 Kermit Dr, Ste 800, Nashville, TN 37217.

Sincerely,

Board of Trustees
USW HRA Fund

USW HRA FUND
SUMMARY OF MATERIAL MODIFICATIONS
December 2016

1. Effective January 1, 2017, the definition of Dependent beginning on page 5 is amended by adding the following language to the end of the definition:

   Furthermore, all individuals claiming Dependent status must be enrolled in a group health plan that provides minimum value as described under the 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.

2. Effective January 1, 2017, the subsection "When Dependent Coverage Ceases" beginning on page 14 is deleted and replaced in its entirety with the following:

   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 HRA 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 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.

3. Effective January 1, 2017, the Account Balance Access chart on page 16 is deleted and replaced with the following:

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, Non-Covered Employees, and 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.		