ArcelorMittal USA LLC VEBA Retiree Benefits Plan
Summary Plan Description

Effective: January 1, 2017

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1. INTRODUCTION

The ArcelorMittal USA LLC VEBA Retiree Benefits Plan (the "Plan") and associated trust were established pursuant to the 2002 Labor Agreement between International Steel Group, Inc. ("ISG") and the predecessor to the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union ("USW") to provide benefits for certain eligible retirees (including surviving spouses and their eligible dependents) of steel companies that were subsequently acquired by ISG. The Plan is intended to constitute a voluntary employees' beneficiary association under Section 501(c)(9) of the Internal Revenue Code.

As of January 1, 2017, for members who are age 65 or over or enrolled in Medicare, Parts A and B, the Plan provides Medicare Advantage Plans with prescription drugs OR the option of a Medicare Part B Reimbursement Benefit. The Plan provides a medical plan for those under age 65 which meets the requirements for the federal Health Care Tax Credit program (HCTC).

In addition, as a result of the merger with the Retiree Insurance Plan (Weirton VEBA), the Plan also provides a life insurance benefit for Legacy Weirton Retirees who are not covered by the Medicare Advantage Plan, the Medicare Part B Premium Reimbursement Benefit or the HCTC qualified medical coverage. See Section 8.1 for eligibility requirements.

The Plan is a welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 ("ERISA"). The benefits and eligibility requirements described in the Plan are determined by ArcelorMittal USA LLC ("ArcelorMittal"), the Plan sponsor, as described under the current Labor Agreements with the USW.

This document, together with the benefit booklets and certificates of coverage which describe the medical benefits provided hereunder, summarize the terms and conditions under which benefits are payable under the Plan and constitute the Summary Plan Description ("SPD") for the Plan.

2. DEFINITIONS

When used in this Booklet, unless the context otherwise requires, the following terms shall have the meanings set forth below:

Claim: You or your dependent's request for covered services.

COBRA: The Consolidated Omnibus Budget Reconciliation Act. This Act establishes your rights to continue coverage under the Plan, at your expense, following termination of Plan coverage due to certain COBRA qualifying events.

Contribution: The monthly amount you must pay towards the cost of a benefit.

Copayment: The portion of the cost of a prescription drug or medical service that you must pay.

Enrollment Packet: When you enroll in a plan, the carrier will send you an enrollment packet consisting of identification cards, Certificate of Coverage, Formulary information, and other useful program information.

ERISA: The Employee Retirement Income Security Act of 1974. ERISA establishes various minimum standards, rules and regulations which govern the operation of this Plan, including reporting and disclosure of Plan information, and the conduct of Plan fiduciaries.

HIPAA: Health Insurance Portability and Accountability Act of 1996. HIPAA requires the Plan to comply with rules addressing the privacy of information relating to your health, health care, and payment for health care under this Plan.

Labor Agreement: The Basic Labor Agreements, dated September 1, 2008, September 1, 2012 and September 1, 2015, as well as Memorandums of Understanding between ArcelorMittal and the USW.

Plan: The ArcelorMittal USA LLC VEBA Retiree Benefits Plan.

Plan Administrator: Division Manager, Employees Benefits, ArcelorMittal USA LLC.

Plan Sponsor: ArcelorMittal USA LLC.

Third Party Administrator: Solidarity Health Network, Inc.

3. MEDICAL BENEFITS

3.1 For those 65 or older or enrolled in Medicare.

The Plan offers participants who are 65 or older or enrolled in Medicare the following options for medical-related benefits. Participants may only choose one of these options per benefit year:

- Medicare Advantage Plan with Prescription Drugs (there are three plans available) (described in Section 4 below)
- Medicare Part B Premium Reimbursement Benefit (described in Section 5 below)

3.2 For those under age 65

As described in Section 6 below, the Plan offers a medical plan for those who are at least age 55 and not yet age 65 and not on Medicare. This plan qualifies for the federal Health Coverage Tax Credit (HCTC) program, under which eligible

individuals receive a 72.5% tax credit subsidy from the federal government toward their monthly health care premium.

3.3 Member Inquiries

If you have a general inquiry regarding your eligibility for coverage or Plan benefits, you should call the Third Party Administrator at (877) 474-8322.

You may also call the above number:

- To locate a provider for your health plan
- To ask questions on your billing statements
- To ask questions on your plan benefits

3.4 Eligible Beneficiary

Subject to any additional requirements for a specific benefit, you are eligible to participate in the medical benefits offered under the Plan if you are a Beneficiary as described below:

(A) Certain eligible retirees, and their spouses, who retired on or before the dates specified below from USW-represented bargaining units under a collective bargaining agreement between the USW and the following former employers (or any one of its direct or indirect subsidiaries), and at the time of retirement were eligible for retiree insurance benefits:

- LTV Corporation (other than Copperweld Corp.) - March 31, 2002
- Bethlehem Steel Corporation – May 8, 2003
- Acme Metals, Inc. (other than Acme Packaging Corp.) – June 1, 2002
- Georgetown Steel Corporation LLC - June 22, 2004
- Weirton Steel Corporation LLC – December 21, 2007

(B) Specified retirees, and their spouses, of International Steel Group, Inc. who had been formerly employed by Bethlehem Steel Corporation and who received a benefit under the Transition Assistance Program established under the 2002 Labor Agreement.

(C) As defined by the Memorandum of Understanding between ArcelorMittal USA and the United Steelworkers on behalf of USW Local Union 2911 dated December 12, 2009 and the First Amendment thereto dated March 17, 2010, those Weirton Steel Corporation retirees and surviving spouses who are specifically listed and have executed their participation election forms in a compliant and timely manner.

(D) As defined by the Memorandum of Understanding between ArcelorMittal USA and the United Steelworkers on behalf of USW Local Union

2911 dated December 12, 2009 and the First Amendment thereto dated March 17, 2010, those Weirton Steel Corporation retirees and surviving spouses who are specifically listed and have executed their participation election forms in a compliant and timely manner.

(E) As defined by the Memorandum of Understanding between ArcelorMittal USA and the United Steelworkers on behalf of USW Local Union 2911 dated December 12, 2009 and the First Amendment thereto dated March 17, 2010, those Weirton Steel Corporation retirees who are specifically listed and have executed their participation in the Weirton Life Insurance Benefit.

(F) An unmarried surviving spouse of a retiree as described in (A) and (B) above who was married to the eligible retiree on or before the date of his/her retirement.

(G) If an eligible participant as defined in (E) above subsequently marries an eligible retiree or surviving spouse, they will remain eligible.

3.5 Eligible Dependents

(A) When you enroll in a medical-related benefit, subject to the terms below, you may enroll any of the following dependents, *provided such individual was eligible for coverage as your dependent at the time you retired* and remains eligible as your dependent at the time you enroll in the Plan:

- For any of the HCTC program, or the Medicare Advantage Plan, or the Medicare Part B Reimbursement Benefit: Your spouse (Note: You may enroll your spouse for coverage even though you do not enroll yourself.)

- For the HCTC program (or if the dependent is Medicare eligible, then the Medicare Advantage Program or the Medicare Part B Reimbursement Program), any of:

  Your unmarried dependent child under 19 years of age, including:

  - your natural child
  - a stepchild who resides in your household
  - a legally adopted child, including a child living with you during a period of probation

- Your unmarried dependent child after attainment of age 19 but not beyond attainment of age 25, provided the child is enrolled in and regularly attending a full-time accredited school, college or university, and is dependent solely upon

you for support. If your dependent is disenrolled from an accredited school, college or university due to illness, your dependent may be eligible for Michelle's Law. Please call the Third Party Administrator for additional information, and see the Michelle's Law Notice below.

- Your unmarried child over age 19 who is not able to support himself or herself due to a physical or mental disability that commenced prior to age 19 and while covered under a health care plan maintained by your former employer.

(B) Certification of Dependent Status

To be eligible for dependent coverage, proof may be required that the dependent meets the requirements stated above. Special certification shall be required to qualify student and disabled dependents. If you believe that a child of yours meets the student or disability criteria above, you should secure from the Third Party Administrator the appropriate Dependent Certification form which must be completed and returned within 90 days from the date your coverage under this Plan becomes effective. That form will be reviewed by the Third Party Administrator to determine the eligibility of such a dependent for benefits under this Plan and you may be required to submit additional information in connection with such eligibility determination.

You will be notified by the Third Party Administrator as to whether or not your dependent is eligible for benefits of this Plan as a disabled child or student. If such eligibility is approved, you will be further required, usually not more frequently than once a year, to furnish satisfactory evidence to substantiate the continued eligibility of such a dependent for benefits under this Plan.

3.6 Spouse and Dependent Coverage

(A) An eligible spouse may be enrolled in the Plan without requiring the retiree to enroll.

(B) An eligible dependent child may not be enrolled in the Plan unless the retiree and/or the eligible spouse are also enrolled.

3.7 Changes in Status

You must inform the Third Party Administrator about any change in your address or change in family status that may affect your coverage. Changes must be reported within 31 days of their occurrence. Failure to timely report a change will result in non-coverage.

You can notify the Third Party Administrator:

- By mail to the following address:

  ArcelorMittal USA LLC VEBA Retiree Benefits Plan
  c/o Solidarity Health Network
  Attention: Eligibility Department
  4853 Galaxy Parkway, Suite K
  Cleveland, OH 44128

- By calling (877) 474-8322

4. MEDICARE ADVANTAGE PLAN BENEFIT

4.1 Eligibility

(A) You are eligible for the Medicare Advantage Plan Benefit offered under the Plan if you meet the definition of "Beneficiary" as detailed above, and you are at least age 65 and enrolled in Medicare Parts A and B (or otherwise enrolled in Medicare).

(B) If you choose to participate in the Medicare Part B Premium Reimbursement Benefit coverage described in Section 5 below, you are not eligible for the Medicare Advantage Plan Benefit described in this Section 4. You can choose the benefit described under this Section 4 (the Medicare Advantage Benefit) or the benefit described in Section 5 (the Medicare Part B Premium Reimbursement) each year during open enrollment.

4.2 Medicare Advantage Choices

The Medicare Advantage Plan Benefit will be comprised of one or more levels of Medicare Advantage with Prescription Drug benefits, as in place from year to year. Each level will have its own mix of monthly premium contributions, medical benefits and prescription benefits. Detailed information regarding each level will be provided annually in the open enrollment materials and at any time upon request. A participant may choose to participate in one level of Medicare Advantage Plan.

4.3 Monthly Contribution

The Plan Sponsor reserves the right, subject to collective bargaining between ArcelorMittal USA LLC and the USW, to require payment of a monthly contribution as a condition for receipt of coverage under the Medicare Advantage Plan.

The monthly contribution is determined based on the plan that a retiree or surviving spouse chooses.

Retiree and spouse do not have to choose the same plan. Each participant may choose a plan and pay the corresponding contributions.

You will be invoiced quarterly or you can opt for monthly deductions from your checking or savings account through Automated Clearing House (ACH).

You should make sure that you pay the required contributions in a timely fashion. If a required contribution is not paid by the due date on the invoice, you will be sent a payment reminder notice. If you do not remit payment by the due date on the payment reminder, your Plan coverage will be terminated effective the last day of the month for which the last payment of required contributions was made. Members who are canceled for non-payment will not be allowed to re-enroll back into the Plan until all required contributions have been paid.

The Plan Sponsor reserves the right, subject to terms of the Labor Agreement, to change the rate of required contributions at any time.

5. MEDICARE PART B PREMIUM REIMBURSEMENT BENEFIT

5.1 Eligibility

(A) You are eligible for the Medicare Part B Premium Reimbursement Benefit offered under the Plan if you meet the definition of "Beneficiary" as detailed above, and you are at least age 65 and enrolled in Medicare Parts A and B (or otherwise enrolled in Medicare).

(B) If you participate in the Medicare Advantage Plan Benefit described above you are no longer eligible for the Medicare Part B Premium Reimbursement Benefit. You can choose the benefit described under Section 4 (the Medicare Advantage Benefit) or the benefit described in this Section 5 (the Medicare Part B Premium Reimbursement) each year during open enrollment.

5.2 Amount of Benefit

The amount of the Medicare Part B Premium Reimbursement Benefit is determined each year. There is no guarantee that a reimbursement benefit will be payable every year.

5.3 Application for Benefit

An eligible Beneficiary must submit an application for the Medicare Part B Premium Reimbursement Benefit each year, in accordance with procedures established by the Third Party Administrator.

6. HCTC SUBSIDY BENEFIT

6.1 Eligibility

(A) A retiree is eligible for the HCTC subsidy benefit offered under the Plan if the retiree meets the definition of "Beneficiary" as detailed above and meets the following criteria:

(1) Less than age 65 but at least age 55; and

(2) Not eligible for Medicare, Medicaid, the U.S. Military Health System (Tricare) or the Federal Employees Health Benefits Program (FEHBP).

(B) An eligible spouse may also be enrolled in the HCTC subsidy benefit offered under the Plan, if they meet the following criteria:

(1) Less than age 65; and

(2) Not eligible for Medicare, Medicaid, the U.S. Military Health System (Tricare) or the Federal Employees Health Benefits Program (FEHBP).

Note: A spouse may continue to receive the HCTC subsidy benefit for up to 24 months after any of the following events: the retiree becomes eligible for Medicare, the retiree and the spouse divorce, or the retiree dies.

(C) An eligible dependent may also be enrolled in the HCTC subsidy benefit offered under the Plan if they meet the following criteria:

(1) Not eligible for Medicare, Medicaid, the U.S. Military Health System (Tricare), the Federal Employees Health Benefits Program (FEHBP) or the State Children's Health Insurance Program (CHIP).

Note: A dependent may continue to receive the HCTC subsidy benefit for up to 24 months after any of the following events: the retiree becomes eligible for Medicare, the retiree and the spouse divorce, or the retiree dies.

6.2 The HCTC subsidy benefit will provide a mix of monthly premium contributions, medical benefits and prescription benefits, as in place from year to year. Detailed information regarding the benefit will be provided annually in the open enrollment materials and at any time upon request.

6.3 Provided you qualify for the HCTC subsidy benefit and that you elect such coverage, you will be eligible for a tax credit subsidy equal to 72.5% of the monthly premium cost. Due to this subsidy, you will be billed 27.5% of the total monthly premium cost. In addition, the 27.5% cost to you will be reduced by $100 per month in 2017 and 2018.

6.4 The Plan Sponsor reserves the right, subject to collective bargaining between ArcelorMittal USA LLC and the USW, to require payment of a different monthly contribution as a condition for receipt of coverage under the Plan.

7. MEDICAL BENEFITS – GENERAL TERMS

7.1 Qualified Medical Child Support Orders

If the Third Party Administrator determines that your separated or divorced spouse or any state Medicaid or child support agency has obtained a legal Qualified Medical Child Support Order ("QMCSO"), you will be required to provide coverage for any child named in the QMCSO. If a QMCSO requires that you provide health coverage for your child and you do not enroll the child, the Third Party Administrator must enroll the child upon application from your separated/divorced spouse, the state Medicaid or child support agency, and must collect any additional monthly contribution required from you for covering such child. You may not drop coverage for the child unless you submit written evidence to the Third Party Administrator that the child support order is no longer in effect. You or your beneficiary may obtain, without charge, a copy of the procedures governing QMCSO determinations by the Plan by contacting the Third Party Administrator.

7.2 Effective Date of Coverage

Your coverage will become effective on the latest of the following dates:

- the date you become a Beneficiary, or
- the first day of the calendar month following a qualifying event.

Coverage of your dependent will become effective on the same date your coverage becomes effective, or the date he/she becomes your dependent, if later.

7.3 Termination of Coverage

Coverage under this Plan will terminate on the earliest of:

- the date on which you cease to be an eligible Plan Beneficiary,
- the last day of the month for which the last payment of required monthly contributions was made,
- the last day of the month in which your death occurs,
- the date on which the Plan is terminated, or
- the last day of the month in which the surviving spouse remarries, UNLESS, the surviving spouse marries another eligible Plan Beneficiary

Coverage for your dependent will terminate on the earliest of:

- the date such person ceases to be an eligible dependent,
- the date on which your coverage terminates,
- the last day of the month for which the last payment of required contributions was made,
- the last day of the month in which the dependent's death occurs, or

- the date on which the Plan is terminated.

7.4 Eligibility Appeals

(A) Scope

The procedures in this Section 7.4 govern eligibility determinations and other matters not covered under the claims procedure of any medical benefit provided under the Plan. For example, as provided in Section 7.5 below, if a claim for benefits of a retiree enrolled in the Medicare Advantage Plan Benefit is denied because the treatment is not covered under the terms of the Medicare Advantage Plan Benefit, the claims procedures described in the benefits booklet or certificate of coverage for the Medicare Advantage Plan Benefit will govern. In contrast, if a retiree believes that his or her eligibility for medical benefits under the Plan has not been correctly determined, the claims procedure described here will govern.

(B) Initial Inquiry

If you have questions about your eligibility status, call or write the Third Party Administrator Office. The Third Party Administrator will attempt to either confirm your eligibility for participation in the Plan or explain why you are not eligible. If the Third Party Administrator cannot determine your eligibility status, you will be advised as to what additional information may be required to resolve your eligibility status.

(C) Level One Appeal

If you wish to file an appeal regarding your eligibility for participation in the Plan, you must submit your appeal in writing to the Third Party Administrator at the following address:

ArcelorMittal USA LLC VEBA Retiree Benefits Plan
c/o Solidarity Health Network
Attention: Appeals Department
4853 Galaxy Parkway, Suite K
Cleveland, OH 44128

You will be notified of the Third Party Administrator's decision within a reasonable period of time, but no later than 90 days after receipt of the appeal, or 180 days after receipt of the appeal if the Third Party Administrator determines that such extension is necessary due to matters beyond control of the Plan. In this circumstance, the Third Party Administrator will, within the initial 90 day period, notify you of the special circumstances requiring an extension of time and the date by which the Third Party Administrator expects to make a decision.

If your appeal is denied, the notification to you will include:

(a) The specific reason(s) for the denial;

(b) Reference to the specific provisions of the Plan, Trust Agreement, Labor Agreement, or other document on which the decision is based;

(c) A description of any additional material or information necessary for you to perfect your appeal and an explanation of why such material or information is necessary; and

(d) A description of the Plan's Level Two Appeal procedure and the time limits applicable to such procedure, including a statement of your right to bring a civil action under section 502(a) of ERISA following a denial of a timely-filed Level Two appeal.

(D) Level Two Appeal

If your Level One appeal is denied, you may appeal the denial by filing a written Level Two appeal with the Plan Administrator within 120 days of receipt of notification of a denial at the following address:

ArcelorMittal USA LLC VEBA Retiree Benefits Plan
c/o Solidarity Health Network
Attention: Level Two Appeals
4853 Galaxy Parkway, Suite K
Cleveland, OH 44128

The following procedures will apply to the Level Two appeal:

(a) In support of the appeal, you may submit written comments, documents, records and other information relating to the claim, and the Plan Administrator will provide you upon request, and at no charge, with reasonable access to, and copies of, all documents, records, or other information relevant (as defined in Treas. Reg. 2560.503-1(m)(8)) to the claim.

(b) In reviewing the appeal, the Plan Administrator will take into account all materials and information submitted by you relating to the claim (even if not submitted or considered in connection with the initial claim).

The Plan Administrator will make a decision no later than 60 days following receipt of the Level Two appeal. Notwithstanding the

foregoing, if special circumstances require a further extension of time for processing, the decision will be made no later than 120 days following receipt of the Level Two appeal, and the Plan Administrator will provide written notice of the extension to you before the commencement of the extension, describing the special circumstances and the date by which the decision will be made. In no event shall such extension exceed a period of 60 days from the end of the initial 60-day period. The Plan Administrator will notify you of its decision no later than five days after the decision is made.

The decision of the Plan Administrator will be in writing and will include, in the case of an adverse decision:

(a) The specific reason(s) for the adverse decision;

(b) Reference to the specific provisions of the Plan, Trust Agreement, Labor Agreement, or other document on which the decision is based;

(c) A statement that you are entitled to receive, upon request and at no charge, reasonable access to, and copies of, all documents, records or other information relevant (as defined in Treas. Reg. 2560.503-1(m)(8)) to your claim; and

(d) A statement of your right to bring a civil action under section 502(a) of ERISA.

No legal action concerning a denial of participation in the Plan may be commenced against the Plan, the Plan Administrator, or any representative of the Plan until you have exhausted all of the administrative remedies set forth under the foregoing appeal procedure.

7.5 Medical Benefit Appeals

(A) Scope

Your claims for medical benefits under the Plan will be processed in accordance with the insurers' or claim administrators' claims procedures, including all time limitations thereunder, as set forth in the benefits booklets, certificates of coverage or similar documents for each relevant medical benefit, to the extent that such procedures are consistent with applicable law and regulations. For more detailed information, you should review the insurance carriers' or claims administrators' benefit booklets, certificates of coverage or similar documents, or you may contact the insurance carriers or claims administrators directly to obtain specific claim/appeal processes. If no such procedure governs the disposition of a claim for medical benefits,

or if such procedure is legally deficient, then the claims procedure described in this Section 7.5 shall apply. The claims procedure described in this Section 7.5 shall be interpreted and applied in a manner consistent with applicable law and regulations.

(B) Level One Appeal

If you or your physician receives notification that a claim has been denied in whole or in part, the decision may be appealed by submitting a request in writing, which may be accompanied by a letter from the physician, no later than 180 days from the date the benefit or related item was denied. The appeal must be submitted in writing to:

ArcelorMittal USA LLC VEBA Retiree Benefits Plan
c/o Solidarity Health Network
Attention: Appeals Department
4853 Galaxy Parkway, Suite K
Cleveland, OH 44128

In preparing the appeal, you may ask to review any documents, records or other information relevant to the appeal (as defined in Treasury Regulation 2560.503-1(m)(8)) free of charge.

The Third Party Administrator will complete its review and issue a written response to you or your authorized representative as follows:

(1) Post-Service Claims - Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Third Party Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Third Party Administrator will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe and the claim is denied, the Third Party Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

(2) Pre-Service Claims - Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Third Party Administrator within 15 days of receipt of the claim. The Third Party Administrator will notify you within this 15-

day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Third Party Administrator will notify you of the determination within 15 days after the information is received. If you do not provide the needed information within the 45-day period, your claim will be denied. In the event that you fail to follow the Plan's procedures for filing a Pre-Service Claim, you will be notified of the failure and the proper procedures to be followed. This notification shall be provided to you not later than 5 days (24 hours in the case of a failure to file a claim involving Urgent Care) following the failure. This notification may be oral, unless you request written notice.

(3) Urgent Care Claims that Require Immediate Action - Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations you will receive notice of the benefit determination in writing or electronically within 72 hours after the Third Party Administrator receives all necessary information, taking into account the seriousness of your condition. Notice of denial may be oral with a written or electronic confirmation to follow within 3 days. If you filed an Urgent Care Claim improperly, the Third Party Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Third Party Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information. You will be notified of a determination no later than 48 hours after: (1) the Third Party Administrator's receipt of the requested information; or (2) the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

(4) Concurrent Care Claims - If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the time frames described above. If an ongoing course of treatment

was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies. Any reduction or termination by the Plan of your previously approved course of treatment (other than by plan amendment or termination) before the end of the approved period of time or number of treatments shall constitute an adverse benefit determination. The Third Party Administrator will notify you of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a Level Two Appeal determination before the benefit is reduced or terminated.

If the Level One Appeal is denied, you will receive a written notification letter, including:

(a) The specific reason(s) for the denial;

(b) Reference to the specific Plan provisions on which the denial is based;

(c) A description of any additional material or information necessary for you to perfect your claim, and an explanation of why such material or information is necessary;

(d) A description of the Plan's Level Two Appeal procedure, and the time limits applicable to such procedure, including a statement of your right to bring a civil action under section 502(a) of ERISA following the denial of a timely-filed Level Two Appeal;

(e) The internal rule, guideline, protocol, or other similar criterion (collectively, the "Rule") relied upon in making the decision;

(f) If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision; and

(g) In the case of a denial concerning a claim involving Urgent Care, a description of the expedited Level Two Appeal procedure applicable to such claim.

If the Level One Appeal is approved, the written notice will include the reason why the appeal was approved, the corrective action to be taken by the Third Party Administrator to remedy the situation, and a time frame for resolution.

The decision of the Level One Appeal by the Third Party Administrator is final unless a Level Two Appeal is submitted to the Plan Administrator.

(C) Level Two Appeal

If you or your physician receives notification that the Level One Appeal has been denied by the Third Party Administrator, in whole or in part, the decision may be appealed by submitting a Level Two appeal in writing no later than 180 days from the date of the notification of the Level One Appeal denial. The appeal must be submitted in writing to:

ArcelorMittal USA LLC VEBA Retiree Benefits Plan
c/o Solidarity Health Network
Attention: Level Two Appeals
4853 Galaxy Parkway, Suite K
Cleveland, OH 44128

In preparing your appeal, you may ask to review any documents, records or other information relevant to the appeal (as defined in Treasury Regulation 2560.503-1(m)(8)) free of charge.

In reviewing your appeal, the Plan Administrator will: (i) take into account all materials and information submitted by you relating to your claim, even if not submitted or considered in connection with your Level One Appeal, (ii) consider the claim de novo, without any deference to the initial claim or Level One Appeal denial, (iii) ensure that the review is not conducted by any individual (or subordinate) who participated in the initial claim or Level One Appeal denial, and (iv) with regard to whether a particular treatment is experimental or not medically necessary, will consult with a health care professional who has appropriate training and experience in the field of medicine involved who was not consulted in connection with the Level One Appeal denial.

The plan Administrator will, upon your request, identify any medical experts whose advice was obtained in connection with the Level One Appeal denial.

The Plan Administrator will complete its review and issue a written response to you or your authorized representative as follows:

(1) Pre-Service Appeals - You will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the Level One Appeal decision.

(2) Post-Service Claims - You will be notified by the insurer or claims administrator of the decision within 30 days from receipt of a request for review of the Level One Appeal decision.

(3) Urgent Claim Appeals That Require Immediate Action - Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible, and may provide all necessary information by telephone, facsimile, or other similarly expeditious method. The Plan Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

If the Level Two Appeal reply is denied, the notification letter will include:

(a) The specific reason(s) for the denial;

(b) Reference to the specific Plan provisions on which the denial is based;

(c) A statement that you are entitled to receive, upon request and at no charge, reasonable access to copies of all documents, records and other information relevant (as defined in Treasury Regulation 2560.503-1(m)(8)) to your claim for benefits;

(d) A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures and a statement of your right to bring an action under Section 502(a) of ERISA;

(e) The internal rule, guideline, protocol or similar criterion (collectively, the "Rule") relied upon in making the decision; and

(f) If the denial was based on medical necessity or experimental treatment or similar decision or limit, an explanation of the scientific or clinical judgment for the decision; and

(g) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If the Level Two Appeal decision is approved, the written notice will include the reason why the appeal was approved, the corrective action to be taken by the Plan Administrator to remedy the situation, and a time frame for resolution.

The decision of the Plan Administrator shall be final and binding. No legal action concerning a denial of a claims may be commenced against the Plan, the Plan Administrator, or any representative of the Plan until you have exhausted all of the administrative remedies set forth under the foregoing appeal procedure.

7.6 Continuation of Coverage under COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires the Plan to extend coverage under this Plan to certain Beneficiaries and dependents following the termination of Plan coverage as a result of specified "qualifying events".

If coverage under this Plan terminates for one of the reasons set forth below, the person whose coverage terminates may elect to continue coverage under this Plan without evidence of insurability for up to 36 months, subject to the timely payment of the required monthly contribution, as determined by the Plan Sponsor.

Qualifying Events:

- Termination of coverage for an eligible spouse because of divorce or legal separation from the Beneficiary.

- Termination of coverage for an eligible dependent child of a Beneficiary for any of the following reasons:

  (a) Death of the enrolled parent;
  (b) Parent's divorce or legal separation;
  (c) Remarriage of the surviving spouse;
  (d) The person ceases to qualify as an eligible dependent as defined in the Plan

- Termination of coverage of a Beneficiary who is a Surviving Spouse because of remarriage.

In order to elect continuation of Plan coverage you, your spouse and/or dependent child must notify the Third Party Administrator within 60 days of the date of the qualifying event. Upon such notification, the Third Party Administrator will notify you, your spouse and/or dependent child as to eligibility for continuation of coverage under this Plan and the applicable monthly contribution. If you, your spouse and/or your dependent child wish to continue coverage, an election to do so must be received by the Third Party Administrator within 60 days from the later

of (i) the date coverage terminated or (ii) the date of notification by the Third Party Administrator of eligibility for continuation of coverage. The first payment must be received by the later of the due date shown on the initial bill or within 45 days after the election form is signed. Contributions are payable either monthly or quarterly in advance and subsequent contributions are due 30 days after the due date shown on each invoice.

The 36-month period referred to in the paragraph above may be shortened for any of the following reasons:

(a) The Plan no longer provides coverage to any group of Plan Beneficiaries;

(b) Failure to pay the contribution within the prescribed time limits for continuing coverage;

(c) The person who is continuing coverage (i) first becomes entitled to Medicare benefits or becomes covered under any other group health plan (if the group health plan does not contain any preexisting condition exclusion or limitation) after the date of the qualifying event, or (ii) requests cancellation in writing.

7.7 ArcelorMittal USA LLC VEBA Retiree Benefits Plan Privacy Policy and Compliance with HIPAA

It is the policy of the Plan to protect the privacy of information relating to your health, health care and payment for that care. This Protected Health Information ("PHI") is protected from improper use or disclosure under State and/or Federal laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Regulations promulgated thereunder by the U.S. Department of Health and Human Services ("Privacy Regulations"). The Plan has adopted policies and procedures to safeguard any PHI it receives or creates. Service providers to the Plan have entered into Confidentiality Agreements concerning the use and disclosure of PHI. PHI is not released outside the Plan without your written consent, except as may be necessary for treatment, payment, plan administration, and health care operations, including utilization review, determinations of medical necessity and appeals, research, public health and law enforcement, and other uses permitted by law or regulation. The Plan is permitted to use PHI only to the extent necessary to perform Plan administrative functions, including appeals, and use of summary health information to establish contribution rates, obtain contribution bids, and to assess, modify, amend, or terminate the Plan. For uses and disclosures of PHI that are not permitted or required by the Privacy Regulations or law, the individual's authorization must be obtained. Certain medical information will not be released without the individual's specific written permission, such as mental health records, genetic testing results, and HIV information.

(A) Your Right to Privacy

You have the right to receive a notice describing how medical information about you may be used and disclosed, and how you can get access to this information. You also have the right to inspect and copy your own Protected Health Information ("PHI") and to request that your information be released to a third party or specific address by signing a written release. You also have the right to request restrictions on certain uses and disclosures of PHI; however, the Plan is not required to agree to a requested restriction. You also have the right to amend or correct your PHI, and the right to receive an accounting of certain disclosures of PHI. Your written permission is not required for the Plan to disclose PHI to a current care giver, such as a family member, unless you object to such disclosure. Nor is your permission required for uses and disclosures of PHI for treatment, payment, health care operations, public health purposes, law enforcement purposes, other purposes as provided by the Plan's policies and the HIPAA Privacy Regulations, or for purposes for which you have signed an authorization.

(B) Proof of Claims

As a condition of receiving benefits from the Plan, any covered person may be required to submit necessary proof of claims as determined by the Third Party Administrator. Failure on the part of a claimant to comply with such request promptly, accurately, and in good faith shall be sufficient grounds for denying, postponing, or discontinuing benefits from the Plan to such person. If a claimant makes a willfully false statement material to his or her claim or furnishes fraudulent information or proof material to his or her claim, any benefits may be denied, suspended or discontinued. The Third Party Administrator shall have the right to recover any payments made by mistake or in reliance on any false or fraudulent statements, information or proof submitted by any claimant (including the withholding of a material fact), including by recovery through offset of future benefit payments.

(C) Right to Receive and Release Necessary Information

The Plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement Plan provisions. When you request benefits, you must furnish all the information required to implement Plan provisions.

7.8 Alternate Payee Provision

Benefits are generally payable to you and can only be paid to another party upon signed authorization from you and if legally allowable. However, if conditions exist under which a valid release or assignment cannot be obtained, and if legally

allowed, the Plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. With the exclusion of Medicare Part B reimbursement payments, the Plan must make payments to your separated/divorced spouse, state child support agencies or Medicaid agencies if required by a Qualified Medical Child Support Order (QMCSO) or state Medicaid law. The Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plan.

7.9 Terms of Coverage

In accordance with the Labor Agreement between the United Steelworkers and ArcelorMittal USA the Plan Sponsor (including any organization designated to act on its behalf) shall have the complete discretion, right and authority to interpret, construe, and apply any and all terms or provisions of this Summary Plan Description whether or not such terms or provisions are considered vague, ambiguous, or unclear. The Plan Sponsor shall have the authority, right and discretion to make any and all findings of fact or other determinations which are necessary or appropriate to any eligibility determination, benefit determination, or application of the Summary Plan Description or other documents of the Plan. The Plan Sponsor's interpretation, construction, and application of terms and provisions, as well as its findings and determinations shall be final and binding with respect to all Plan Beneficiaries and dependents, any party claiming under or on behalf of any participant, and any other interested individuals or entities.

7.10 NOTICE OF PRIVACY PRACTICES OF THE ARCELORMITTAL USA LLC VEBA RETIREE BENEFITS PLAN

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

(1) The ArcelorMittal VEBA Retiree Benefits Plan is referred to in this notice as "the Plan". The Plan provides certain benefits to you, as applicable, as described in your summary plan description. ArcelorMittal USA LLC, the Plan Sponsor, is required by law to provide you with this Notice, which tells you how the Plan may use your personal information, advise you of your rights in insuring that your personal information is protected, and tells you about the Plan's policies, safeguards and practices. The Plan uses health and other personal information about you for purposes of processing claims and benefit determinations under the Plan, providing payment of benefits, and administering and operating the Plan. The Plan recognizes that the information the Plan uses is personal, and is committed to protecting this information. In addition, the Plan is required by federal and state law to protect the privacy of your personal health information and other personal information. You may also receive privacy notices from

other organizations. Those notices will apply to any information held by them.

The Plan reserves the right to revise this Notice at any time. Any changes in the Plan's privacy procedures will apply to all your personal information, including any created before the change in procedure. Any updated Notice will be provided to you through regular mail communications. The Plan is bound by the terms of this Notice or any revised notice in effect at that time.

(2) YOUR PRIVACY – USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

The Plan will not disclose personal health information without your authorization unless it is necessary to provide your health benefits and administer the Plan, to support the Plan programs or services, or as otherwise required or permitted by law, as described in more detail below. When the Plan needs to disclose individually identifiable information, it will follow the policies described in this Notice to protect your confidentiality.

The Plan may collect information:

- directly from you in conversation or in a written or electronic application for coverage or benefits
- from VEBA records
- from the third party administrator of any portion of the Plan (e.g., Solidarity Health Network, etc.)

The Plan is permitted to use and disclose this information without your permission for certain purposes described below, but must obtain your permission for any other uses.

(3) Use and Disclosure without Your Permission

- Treatment, Payment and Operations. The Plan is permitted to use and disclose your personal health information without your permission for a number of reasons, the broadest of which is "treatment, payment and operations." Of course, the Plan does not provide "treatment", but it may use and disclose your personal information to process and pay claims for prescription services you receive. For example, the Plan will use billing and other information received from providers about prescription services you received to pay the provider in accordance with the Plan terms, to determine if services provided were medically necessary, and to justify charges submitted. The Plan also may disclose your personal health information to another health plan or a health care provider

for its payment activities or to coordinate payment with the other plan.

The Plan may use and disclose your personal health information for our prescription benefit operations. For example, it may be used to provide customer service, or to review plan design or pharmacy network use. Other prescription benefit operations may include sending you information about treatment alternatives or other related benefits and services. The Plan also may disclose your personal health information to another health plan or a provider who has a relationship with you for care coordination or referral for care.

- Disclosure to Plan Sponsor. The Plan may disclose your health information to the Plan Sponsor for certain administrative functions that the Plan Sponsor performs. The Plan Sponsor has agreed to ensure the continuing confidentiality and security of your health information.

- Disclosure to Business Associates. The Plan may disclose your personal health information to business associates the Plan retains to provide a service on behalf of the Plan. The Plan may disclose your personal health information to certain employees of the Company or to a company acting on the Company's behalf, so that it can monitor, audit and otherwise administer the Plan. For example, your personal health information may be disclosed to or used by specified persons within the Company's Benefits department, including the customer service representatives in the Benefits Service Center, to help resolve claims issues such as questions about how a claim was paid or why it was not paid. We have developed procedures under the Plan to identify by position those employees who are authorized to receive and use your personal health information. The Company may not use the personal health information received from the Plan for any purpose other than administration of the Plan.

- Disclosures to Plan Suppliers. The Plan may disclose your personal health information to companies with contracts on behalf of the Plan, if they need it to perform the services requested. For example, the Plan may disclose information to suppliers who help provide important information and guidance to members with chronic conditions like diabetes and asthma. The Plan also may disclose personal health information to accreditation organizations such as the National Committee for Quality Assurance (NCQA) when the NCQA auditors collect Health Plan Employer Data and Information Set (HEDISCII) data for quality measurement

purposes. When the Plan enters into these types of arrangements, a written agreement is obtained to protect your personal health information.

- Public Health Activities; Averting Serious Threat to Safety. The Plan may disclose your personal health information for certain public health activities and purposes, such as: reporting health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; reporting information about a product or activity to the U.S. Food and Drug Administration (FDA) for purposes of monitoring quality of consumer products; and to alert a person who may have been exposed to a communicable disease, if the Plan is authorized by law to give this notice. In addition, the Plan may disclose your personal health information to prevent or lessen a serious and imminent threat to your health or safety or the health or safety of the general public. Of course, your doctor and other medical care providers are much more likely than the Plan to have information that might be disclosed under these rules.

- Health Oversight Activities. The Plan may disclose your personal health information for government health oversight activities such as ensuring compliance with the rules of programs such as Medicare or Medicaid.

- To Comply with the Law. The Plan may use and disclose your personal health information to comply with the law. For example, the Plan may disclose your personal health information in a judicial or administrative proceeding or in response to a legal order, to the police or other law enforcement officials as required by law or in compliance with a court order or other process authorized by law, or to report child abuse or neglect to a government authority that is authorized by law to receive such reports.

- Government Functions. The Plan may disclose your personal health information to various departments of the government such as the U.S. military or the U.S. Department of State.

- Workers' Compensation. The Plan may use or disclose your personal health information when necessary to comply with workers' compensation laws.

(4) Uses and Disclosures with Your Written Permission

The Plan will not use or disclose your personal health information other than as described in this Notice without your signed authorization. You may revoke an authorization you have given previously, but not with respect to any actions the Plan has already taken. An authorization or revocation of an authorization must be in writing.

(5) YOUR RIGHTS

- Right to Inspect and Copy your Personal Health Information. You may ask to inspect or to obtain a copy of your personal health information that is included in certain records the Plan maintains. For the most part, these records are maintained by the Benefits Administrators who administer different portions of the Plan. To obtain your personal health information created by the plan, you will need to contact the following entities. **Please note that if any part of your benefits program is not administered by one of the parties listed below, you should contact your plan representative for information about how to request your personal information:**

For information about the VEBA Retiree Benefits Plan:	Solidarity Health Network, Inc. 4853 Galaxy Parkway, Suite K Cleveland, OH 44128 (877) 474-8322

If you have a question about how to obtain your personal health information, you may call the Third Party Administrator at (877) 474-8322.

Under extremely limited circumstances, the Plan may deny you access to a portion of your records. If this happens, you will be told the reason for the denial.

If you request copies of your personal health information, you may be charged reasonable costs for copying (including labor and supplies) and mailing costs.

- Right to Request Additional Restrictions. You may request restrictions on the Plan's use and disclosure of your personal health information for the treatment, payment and health care operations purposes explained in this Notice. While the Plan will consider all requests for restrictions, it is not required to agree to a requested restriction.

- Right to Receive Confidential Communications. You may ask to receive communications of your personal health information by alternative means of communication or at alternative locations. While all reasonable requests will be considered carefully, the Plan is not required to agree to a request.

- Right to Amend your Records. You have the right to ask the Plan to amend your personal health information that is contained in Plan records. If it is determined that the record is inaccurate, and the law permits the Plan to amend it, it will be corrected. **PLEASE NOTE: IF YOUR DOCTOR OR ANOTHER PERSON CREATED THE INFORMATION THAT YOU WANT TO CHANGE, YOU SHOULD ASK THAT PERSON TO AMEND THE INFORMATION – THE PLAN CANNOT AMEND THAT INFORMATION.**

- Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of disclosures the Plan has made of your personal health information. The accounting will not include disclosures made before April 14, 2003, disclosures made for treatment, payment or health care operations, disclosures made more than six years before the date of your request, disclosures made with your authorization, and certain other disclosures for which the Plan is permitted by law not to account. If you request an accounting more than once during any 12-month period, you may be charged a reasonable fee for each accounting statement after the first one.

- Right to Receive Paper Copy of this Notice. If you have received this Notice electronically, you may call the Benefits Service Center at (877) 474-8322 to obtain a paper copy of the Notice, even if you previously agreed to receive this Notice electronically.

If you want more information about your privacy rights, do not understand your privacy rights, are concerned that privacy rights have been violated, or disagree with a decision that was made about access to your personal health information, you may contact the VEBA Service Center at (877) 474-8322. You may also file written complaints with VEBA's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services. Please call the Privacy Officer to obtain the correct address for the Secretary. VEBA will not take any action against you if you file a complaint with the Secretary or us.

You may contact the Privacy Officer at:
ArcelorMittal USA LLC VEBA Retiree Benefits Plan
Privacy Officer (Legal)
4853 Galaxy Parkway, Suite K
Cleveland, OH 44128
Telephone Number: (877) 474-8322
Fax Number: (216) 504-9561

7.11 MICHELLE'S LAW NOTICE

Michelle's Law prohibits group health plans from terminating coverage for a dependent student who takes a medically necessary leave of absence who otherwise would lose coverage for failing to maintain full-time enrollment in school. Under Michelle's Law, the coverage must continue during the duration of the leave of absence for up to one year after the first day of the medically necessary leave, or until coverage would otherwise terminate under the plan.

To continue coverage under a medically necessary leave of absence: (1) the leave of absence must begin while the Child is suffering from a serious illness or injury; (2) the leave of absence must be medically necessary; (3) the leave of absence must cause the Child to no longer be considered a full-time student for purposes of coverage under the Plan; and (4) the Child must otherwise qualify for coverage under the Plan.

As a result, if your Child is no longer a full-time student as defined in the Plan because he or she is on a medically necessary leave of absence, your Child may continue to be covered under the Plan for up to one year beginning with the first day after the medically necessary leave begins. This continued coverage applies if, immediately before the first day of the leave of absence, your Child was covered under the Plan, was unmarried, and was enrolled as a full-time student at an accredited high school, trade school, vocational school, junior college, college or university. The coverage will end upon the occurrence of the earlier of: (1) the expiration of the one year period; (2) the conditions for a medically necessary leave of absence are no longer satisfied; or (3) the Child is no longer eligible for coverage under the Plan. Once lost, coverage under the Plan may only be reinstated if the Child becomes a full-time student and otherwise qualifies for coverage under the Plan.

If you believe your Child is eligible for this continued coverage, you must provide to the Plan written certification by a treating physician of the Child which states that the Child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. This information should be provided on a form available from the Plan.

Coordination with COBRA Continuation Coverage

If your Child is eligible for continued coverage under Michelle's Law and loses coverage at the end of the continued coverage period, COBRA continuation coverage may apply. You will receive a COBRA notice with further information at that time.

Further Information

If you have any questions regarding the information in this notice or your Child's right to continued health benefits coverage under Michelle's Law, please call 1-877-474-8322, or write to ArcelorMittal USA LLC VEBA Retiree Benefits Plan, Third Party Administrator, 25111 Miles Road, Suite B, Cleveland, OH 44128. Please furnish your member identification number that appears on your benefits card.

8. LIFE INSURANCE BENEFIT

8.1 Eligibility

You are eligible for a term life insurance benefit from the Prudential Insurance Company of America ("Prudential") if you are a "Legacy Weirton Retiree". This means you retired prior to May 17, 2004. This is a closed group and no new retirees can become eligible. Furthermore, you are not eligible if you elected to enroll in any medical-related benefit and are covered by that part of this Plan.

8.2 Amount of Benefit

If you are eligible, you have a $10,000 term life insurance benefit at no cost to you. In addition, the option to purchase an additional $5,000 of term coverage was provided, which will be payable only if you have paid all applicable premiums at the time of your death.

8.3 Beneficiary

If you die while coverage is in effect, your beneficiary will receive the amount of your benefit. You must complete the beneficiary form to designate a beneficiary. If you do not have a valid designation in effect at your death, the benefit will be paid to the first of your (a) spouse, (b) surviving children, (c) surviving parents, (d) surviving siblings or (e) estate.

You may change your beneficiary at any time by completing a new designation form, without the consent of any current beneficiary.

8.4 Claim for Benefits

Your beneficiary should file the claim with Prudential without delay, following the instructions on the claim form. The claim form is available from Prudential by calling them directly toll free at (800) 778-3827. If your beneficiary calls Prudential

they must also call Solidarity Health Network at (877) 474-8322 and inform them of the claim.

8.5 Form of Payment

The benefit will normally be paid as a lump sum, but other options may be available.

8.6 Certificate of Coverage

The payment of the life insurance benefit is subject to all of the terms and conditions of the Certificate of Coverage issued by Prudential. Please refer to your Certificate for additional information, including information regarding conversion privileges.

8.7 Claim Procedures

(A) Determination of Benefits

Prudential shall notify the claimant of the claim determination within 45 days of receipt of a claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide the claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide the claim, shall be furnished within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to a claimant's failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent until the date on which a response is made to the request for additional information.

If your claim for benefits is denied, in whole or in part, the claimant or the claimant's authorized representative will receive a written notice from Prudential of the denial. The notice will be written in a manner calculated to be understood and shall include:

(a) the specific reason(s) for the denial,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary to perfect a claim and an explanation of why such information is necessary,

(d) a description of Prudential's appeals procedures and applicable time limits, including a statement of the right to bring a civil action under Section 502(a) of ERISA following your appeals, and

(e) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

(B) Appeals of Adverse Determination

If the claim for benefits is denied or if the claimant does not receive a response within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), the claimant or the claimant's representative may appeal the denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. The claimant may submit with the appeal any written comments, documents, records and any other information relating to the claim. Upon request, the claimant will also have access to, and the right to obtain copies of, all documents, records and information relevant to the claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on the claim appeal within 45 days of the receipt of the appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished within the initial 45-day period. However, if the period of time is extended due to failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent until the date on which a response is made to the request for additional information.

If the claim on appeal is denied in whole or in part, Prudential will send a written notification of the denial. The notice will be written

in a manner calculated to be understood by the claimant and shall include:

(a) the specific reason(s) for the adverse determination,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that the claimant is entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to the benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that the claimant has the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and

(f) a statement describing any appeals procedures offered by the plan, and the right to bring a civil suit under ERISA.

If a decision on appeal is not furnished within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of the benefit claim is denied or if claimant does not receive a response to the appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), claimant or claimant's representative may make a second, voluntary appeal of the denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Claimant may submit with the second appeal any written comments, documents, records and any other information relating to the claim.

Upon request, claimant will also have access to, and the right to obtain copies of, all documents, records and information relevant to the claim free of charge.

Prudential shall make a determination on the second claim appeal within 45 days of the receipt of the appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished within the initial 45-day period. However, if the period of time is extended due to

failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent until the date on which a response is made to the request for additional information.

The decision to submit a benefit dispute to this voluntary second level of appeal has no effect on rights to any other benefits under this plan. If the claimant elects to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that the claimant failed to exhaust administrative remedies. If the claimant elects to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, the claimant will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the claimant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished within the time frames mentioned above, the claim shall be deemed denied on appeal.

9. GENERAL INFORMATION

9.1 Name of Plan

The name of the Plan is the "ArcelorMittal USA LLC VEBA Retiree Benefits Plan"

9.2 Plan Sponsor

The Plan Sponsor for the Plan is:

ArcelorMittal USA LLC
3210 Watling St., MC 7-550
East Chicago, IN 46312

9.3 Plan Administrator

The Plan Administrator is:

Division Manager, Employee Benefits
ArcelorMittal USA LLC
3210 Watling St., MC-7-550
East Chicago, IN 46312

9.4 Third Party Administrator

The Third Party Administrator is:

Solidarity Health Network, Inc.
4853 Galaxy Parkway, Suite K
Cleveland, OH 44128
(877) 474-8322

9.5 HCTC Provider/Administrator

The HCTC Provider/Administrator is:

Blue Cross Blue Shield of Michigan
PO Box 2888
Detroit, MI 48231
(313) 225-9000

9.6 Medicare Advantage Provider/Administrator

The Medicare Advantage Provider/Administrator is:

Aetna
PO Box 14079
Lexington, KY 40512
(888) 267-2637

9.7 Medicare Part B Subsidy Provider/Administrator

The Third Party Administrator is:

Solidarity Health Network, Inc.
4853 Galaxy Parkway, Suite K
Cleveland, OH 44128
(877) 474-8322

9.8 Life Insurance Provider/Administrator

The Life Insurance Provider/Administrator is:

The Prudential Insurance Company of America
751 Broad Street
Newark, NJ 07102
(973) 802-6000

9.9 Trustee

The Trustee is:

JPMorgan Chase Bank, N.A.
1 Chase Manhattan Plaza
New York, NY 10005

9.10 Identification Numbers

The Plan Sponsor's Employer Identification Number (EIN) assigned by the Internal Revenue Service is 71-0871875. The Plan number is 515.

9.11 Type of Plan and Administration

This Plan is called a "welfare benefit plan" which provides benefits through self-funded contracts with a third party claims administrator and, as applicable, through a life insurance policy. Claims are paid out of the Plan assets held within the trust associated with the Plan.

9.12 Plan Year

The Plan's fiscal records are kept on a Plan year basis beginning January 1 and ending on December 31.

9.13 Agent for Service of Legal Process

Legal process may be served on the Plan Administrator.

Service of legal process may also be made upon the Trustee.

9.14 Your Rights and Privileges under ERISA

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

Under ERISA, you are entitled to:

(A) Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Sponsor's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts 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 or its designee, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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 the summary annual report.

(B) 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 for the rules governing your COBRA continuation coverage rights.

9.15 Reduction or Elimination of Exclusionary Periods of Coverage for Preexisting Conditions under Your Group Health Plan, if You Have Creditable Coverage from Another Plan

You should be provided a certificate of creditable coverage, free of charge, from your group health plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

9.16 Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for you, ERISA imposes duties upon the people who are responsible for operating the 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 benefit or exercising your rights under ERISA.

9.17 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the

plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you 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.

9.18 Assistance with Your Questions

If you have any questions about your Plan, you should contact the Third Party 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 Third Party 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 NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

9.19 Controlling Documents

The provisions of this Summary Plan Description are subject to and controlled by the provisions of the trust associated with the Plan and the Labor Agreement. In the event of any conflict between the provisions of this Summary Plan Description and the provisions of either the Master Trust Agreement or the Labor Agreement, the applicable provisions of those agreements shall prevail.

9.20 Title to Trust Fund

Except with respect to the right to receive benefits for which a Beneficiary or dependent qualifies under this Plan, no individual shall have any right, title, or interest in and to the assets of the trust associated with the Plan or to the contributions thereto, such contributions being made and held in the trust for the sole purpose of providing benefits in accordance with its terms.

9.21 Amendment or Termination of the Plan

The Plan Sponsor reserves the right to change or discontinue the benefits set forth in this Plan at any time, subject to the bargaining obligations of ArcelorMittal USA LLC and the USW under the Labor Agreement.