2023 Annual Enrollment

USW REPRESENTED EMPLOYEES

TIME SENSITIVE MATERIAL ENCLOSED

October 2022

CCS LLC USW-Represented

2023 Employee Benefits Guide

Reminder:

This is also a great time to update your life insurance beneficiary(ies)
To download a copy of the Beneficiary Designation form visit the Benefits Website at:
www.clevelandcliffs.us/BenefitsWebSite/

What's Inside...

Coverage will not be added if required documentation is not submitted within the Annual Enrollment period.

Cleveland-Cliffs Steel LLC is pleased to present your 2023 Employee Benefits Guide. **2023 Annual Enrollment begins on October 24, 2022 and ends on November 13, 2022.** During Annual Enrollment, you can enroll in or make changes to your benefit elections without having a qualified life event (as described below). This guide explains the benefits available to you. The benefit plan year will run from January 1, 2023 through December 31, 2023.

If you want to enroll in any of the Flexible Spending Accounts (FSAs) for 2023, you will need to take action during Annual Enrollment no later than November 13, 2022. FSA elections can be revised until December 15, 2022; however you must make your initial election no later than November 13, 2022.

Cleveland-Cliffs Steel LLC offers a comprehensive benefit package and employee resources, demonstrating our commitment to you and your family's overall health and wellness. For the upcoming plan year, please make sure to carefully evaluate your needs and learn about your benefit options prior to making your enrollment decisions. At Cleveland-Cliffs Steel LLC, we continue to strive to provide the necessary benefits to protect you and your family's health, finances and future.

NEW: WORKING SPOUSE PROVISION, effective 1/1/2023

- **Your legal spouse can be enrolled in your health care plan, regardless if the legal spouse is offered other employer-sponsored medical, dental, vision and/or prescription drug coverage or if your legal spouse is retired and is offered retiree healthcare coverage by their former employer.**
- **If you have a legal spouse covered under any other Cliffs plans, including the Cliffs Salaried Non Represented plan, you can decline this plan and enroll as a dependent spouse on their Cliffs plan.**
- **If you and your spouse both work for Cleveland-Cliffs, you are eligible to elect one plan to enroll in.**
- **The Spousal Premium Reimbursement Program has been discontinued effective 1/1/2023.**

Qualified Life Events (QLE)

The choices you make during Annual Enrollment will be in effect for the 12-month plan year from January 1, 2023 through December 31, 2023. However, you may make changes during the year if you experience a qualified life event. A qualifying life event is defined as:

- Termination or loss of coverage for yourself or eligible dependents
- Marriage
- Divorce or legal separation
- Death of an eligible dependent
- Birth or adoption of a dependent child

If you need to report a life event during the year, written notice of any change should be sent to UMR (866) 268-3489 no later than 90 days after a qualified life event.

Remember—you must enroll if you want to have an FSA in 2023.

(your current FSA elections will not rollover to 2023)

What about my other benefits? Do I need to re-enroll?

Do I Need To Re-Enroll?	
Medical	Only if you wish to make changes for 2023. (See *Health Care Eligibility Change Form* on page 15)
Dental	Only if you wish to make changes for 2023. (See *Health Care Eligibility Change Form* on page 15)
Vision	Only if you wish to make changes for 2023. (See *Health Care Eligibility Change Form* on page 15)
FSA	YES. If you wish to contribute to an FSA in 2023, you must enroll. 2022 **elections** will not roll over. (See *2023 FSA Benefits Enrollment Form* on page 13)
Life Insurance	Only if you wish to update your Life Insurance coverage* or beneficiaries. *(Visit the Benefits Website at www.clevelandcliffs.us/BenefitsWebSite/* **Life Insurance changes above the non-medical limit are subject to completing an Evidence of Insurability document*.

How to Enroll

If you would like to make changes to your benefit elections or enroll in a 2023 Flexible Spending Account, you must do the following:

- Health Care Changes: Complete the Annual Enrollment Health Care Eligibility Change Form. If this form is not completed and processed by the end of Annual Enrollment, previous year elections will remain the same.
    - Attach any required documentation and forward the completed and signed form to the mailing address, email address or fax number indicated on the respective form.
- Flexible Spending Account: Complete the FSA Enrollment Form to elect enrollment in a Flexible Spending Account for 2023. If this form is not completed and submitted by 11/13/2022, you will not be able to contribute to an FSA for 2023. Your FSA elections from 2022 will NOT rollover into 2023.

If you would like to change your benefit coverage, add/remove eligible dependents, or elect to participate in a Flexible Spending Account for 2023, Annual Enrollment provides you with this opportunity. Your FSA elections from 2022 will NOT rollover into 2023, you will need to elect if you wish to be enrolled in FSA for 2023.

Dependent Eligibility

It is important to confirm the dependent information listed on your plan(s) is accurate and up-to-date. Any questions regarding benefit options, plan rules, dependents or elections, contact the Cleveland-Cliffs Steel LLC Annual Enrollment Help Line at: 1-866-268-3489.
You may also enroll your eligible dependents in the Cleveland-Cliffs Steel LLC benefit plans when you enroll yourself. Your eligible dependents include:

- Your spouse (the person to whom you are legally married).
- Your children under 26 years of age, including natural children (a blood descendant of the first degree), stepchildren, legally adopted children (including children living with the adopting parents during the period of probation), or a child permanently residing in your household of which you are the head and actually being supported solely by you and you have been appointed the child's legal guardian.
- Your children who are otherwise eligible dependents, who are mentally or physically disabled remain covered if they meet the eligibility. To be eligible for coverage as an incapacitated dependent, the dependent must have been incapacitated prior to age 19, meet federal guidelines for a covered dependent, and be covered under this plan prior to reaching age 26. You must provide evidence of your child's incapacity. Contact Highmark at 1--866-267-3280 regarding the disability evidence process.

Medical Opt-Out Reimbursement

Employees who are eligible for benefits and choose to waive medical coverage will receive a waiver payment. If you elect to waive coverage, you will receive an annual payment of $3,600, which will be prorated and paid to you on a pay period basis. The reimbursement will be taxed as ordinary income and will be shown on your Form W-2. You will be required to show proof of other coverage to UMR to be eligible for this payment. Please Note: If you and your spouse are both entitled to benefits under this active plan, either of you may elect coverage as a dependent spouse under the other's plan. Dependent spouses covered under this plan will not be eligible for a waiver payment. If an employee eligible for this active plan is also a dependent child of a participant under this active plan, such employee may choose to enroll as a dependent child under their parents plan, and not receive a waiver payment.

Flexible Spending Account (FSA)

Carrier: UMR **Website: www.umr.com** **Phone: 1-800-826-9781**

A Flexible Spending Account (FSA) is an easy, convenient way to get more out of your paycheck. It allows you to contribute a predetermined amount of your pretax dollars to use toward eligible expenses. At Cleveland-Cliffs Steel LLC, we offer two types of Flexible Spending Accounts: a Health Care Flexible Spending Account and a Dependent/Elder Day Care Flexible Spending Account, both administered by UMR. To enroll, please complete the 2023 FSA Benefits Enrollment Form on page 25.

IRS rules allow you to contribute to your Flexible Spending Accounts through pretax payroll deductions. This means the money is deposited in your account before any deductions for income tax, Social Security or state withholding taxes are taken from your paycheck. If you don't use the money you put into your FSA by the end of the year you lose it (except for up to $570 of health care FSA money, which you can rollover to the next Plan year). This benefit is optional, and contributions are funded entirely by the employee, not Cleveland-Cliffs Steel LLC.

Health Care FSA

Health Care Flexible Spending Accounts reimburse you for eligible health care expenses that are not covered by your health benefits plan, such as copayments, coinsurance, deductibles or certain vision, hearing or orthodontic care costs. You can submit claims for yourself, your spouse and other covered dependents.

At the start of the plan year, you choose how much you want to set aside, subject to a $2,850* annual maximum. If you enroll in Health Care FSA, when you incur a qualified expense, you can either submit a claim online, fax or mail, along with documentation of the claim, or use your debit card at the point of purchase. If you use your debit card it is important to keep your receipts to substantiate the transaction was for an eligible expense. Please note: When participating in the HRA and the FSA together, it is important to note that the funds from the HRA must be exhausted before claims can be made to your FSA account.

For more information, please refer to IRS Publication 502, entitled "Medical and Dental Expenses." *At the time of this writing, 2023 FSA Limits had not yet been released. These are 2022 limits.

Dependent/Elder Day Care FSA

Dependent/Elder Day Care Reimbursement Accounts reimburse you for the costs of child care or other dependent care services so that you and your spouse can go to work or school. This fund can be used for expenses associated with caring for your dependent children, your spouse or another dependent who is incapable of self-care.

At the start of the plan year, you choose how much you want to set aside, $2,500 maximum if you are married and filing a separate income tax return or $5,000 maximum if you are single or married filing a joint income tax return. If you enroll in a Dependent Care FSA, when you incur a qualified expense, you can either submit a claim online, fax or mail, along with the documentation of the claim, or use your debit card at the point of purchase. If you use your debit card it is important to keep your receipts to substantiate the transaction was for an eligible expense. **Dependent Care FSA Funds do <u>not</u> rollover into the next calendar year.**

For more information, please refer to IRS Publication 503, entitled "Child and Dependent Care Credit."

Institute for Career Development (ICD) Dependent Child Care Match

Eligible Employees* may voluntarily designate any unused funds otherwise available through the ICD Tuition Reimbursement Program to be matched to their personal contributions to a Dependent Care Flexible Spending Account up to $1,800.

Check with your local ICD Coordinator to confirm your eligibility and complete the FSA Election Form indicating the ICD Match. Matching contributions will be a dollar for dollar match of your employee contributions, up to $1,800, and not to exceed a total annual election of $5,000. Matching contributions are only eligible for qualified dependent Child Day Care.

*Columbus, Fleet, Obetz, Brickmason and Monessen excluded.

For more detailed FSA information, please refer to the Summary Plan Description on the Benefits website at:

www.clevelandcliffs.us/BenefitsWebSite/show_doc.asp?docid=1011

ALWAYS SAVE YOUR RECEIPTS!
You may be required to provide documentation.

<u>Consolidated Appropriations Act of 2021</u>

This Act is in addition to the CARES Act, IRS Notices 2020-29 and 2020-30 introduced in 2020. Provisions include Rollover of unused Health Care FSA funds from the 2022 plan year to the plan year ending in 2023.

You will still be able to elect up to the maximum amount of $2,850 per calendar year. **Please note the Rollover does not apply to Dependent Care FSA.**

You will not be allowed to reduce or stop your deposits to a Flexible Spending Account during the year unless you have a qualified life event. You must elect your 2023 FSA annual election amount no later than 11/13/2022 and you will have until 12/15/2022 to refine your annual election. If you are planning on enrolling in an FSA but are not sure of your election amount, you may enroll for the minimum amount of $130 annual.

Medical Coverage

Carrier: Highmark | Website: www.highmarkbcbs.com | Phone: 1-866-267-3280

Cleveland-Cliffs Steel LLC is committed to offering you benefit resources to meet the needs of you and your families healthcare. For the 2023 plan year, Cleveland-Cliffs Steel LLC will provide you with the option of choosing between two different healthcare plans, a Preferred Provider Organization plan (PPO) or a Consumer Driven Healthcare Plan (CDHP), so that you may evaluate and select the plan that best meets your needs. Both medical plans are provided through Highmark Blue Cross and Blue Shield, and are not subject to employee paid premiums, however each plan is designed differently.

Both the PPO and the CDHP Plans give you the choice to receive care from both in-network and out-of-network providers. However, you will maximize your coverage using providers within the network and save on out-of-pocket costs. Both networks includes physicians, specialists, hospitals and other healthcare providers. To find a network provider near you, or to see if your current provider participates in the network, you may visit www.highmarkbcbs.com or 1-866-267-3280. Please see the information below to gain a better understanding of your options.

We operate a passive enrollment meaning if you do not wish to make changes to your medical plan, no action is required and previous year elections will remain. If you would like to make a change to your medical plan, you will need to fill out the Health Care Eligibility Change Form on page 26 no later than November 13, 2022.

Features/ Services	Highmark BCBS			
	Based on Calendar Year			
	Member pays:			
	PPO Plan—USW Recommended		**CDHP**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible*: Individual Family	$200 $400	$500 $1,000	$1,600 $3,200	$3,200 $6,400
Medical Out-of-Pocket Maximum (MOOP): Individual Family	$1,500 $3,000	$2,000 $4,000	$3,000* $6,000* *Annual deductible is included in MOOP total	$6,000* $12,000* *Annual deductible is included in MOOP total
Primary Care Doctor	$20 after deductible	30% after deductible	20% after deductible	40% after deductible
Diagnostic Procedures Outpatient Lab Pathology MRI/MRA, CT/CTA Scan	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Preventive Care Routine GYN Exam	$0	30% after deductible	$0	40% after deductible
Hospital Care Copay Inpatient Stay	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Emergency Room Copay	$50 (waived if admitted)		20% after deductible	20% after deductible
Urgent Care Facility	$30 copay		20% after deductible	20% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Health Reimbursement Account (HRA)	Receive an employer contribution to an HRA by fulfilling the HAI eligibility. Employer contribution in the amount of: EE Only = $400, EE + Children = $600 EE + Spouse or EE + Family = $800		Auto-enrolled in HRA with CDHP enrollment. EE Only Tier = $1,500 Other Tier = $2,500	
Health Awareness Initiative (HAI)	If employees enrolled in the PPO plan fulfill HAI eligibility, the incentive will be an employer contribution in a HRA (see above).		Not HAI Eligible	
NEW for 2023 Assisted Fertilization	$15,000 lifetime benefit for nine different assisted fertilization treatments		$15,000 lifetime benefit for nine different assisted fertilization treatments	

Prescription Drug Coverage

Carrier: CVS/Caremark **Website: www.caremark.com** **Phone: 1-800-925-5795**

When you enroll in either Highmark medical plan, you automatically receive prescription drug coverage through CVS Caremark for the 2023 plan year. Please note that some medications require prior authorization. You are also eligible to receive free flu shots under your CVS Caremark benefit plan.

A summary of the prescription benefits is provided in the chart below.

Prescription Drug Coverage	CVS Caremark			
	PPO		CDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail Up to 30 day supply	Generic: $10 Formulary Brand: $20 Non-Formulary Brand $30	Generic: 50%* Formulary Brand: 50%* Non-Formulary Brand: 50%* *of cost of drug	Generic: 20% Formulary Brand: 20% Non-Formulary Brand 20%	Generic: 50%* Formulary Brand: 50%* Non-Formulary Brand: 50%* *of cost of drug
Mail Order 31 to 90 day supply	Generic: $15 Formulary Brand: $30 Non-Formulary Brand $60	N/A	Generic: 20% Formulary Brand: 20% Non-Formulary Brand 20%	N/A
Specialty 30 day supply or less 31 to 90 day supply	Follow Retail copay structure Follow Mail Order copay structure	N/A	Follow Retail copay structure Follow Mail Order copay structure	N/A

Mail Order Program

The prescription plan includes a Mail Order program through Caremark, which allows you to purchase a 90-day supply of medications you take on an ongoing basis (known as maintenance drugs). This program is mandatory for maintenance drugs; after your first two fills of a maintenance medication at your local pharmacy, you must use mail order. You can obtain a mail order supply at a CVS pharmacy and pay the mail order copay. This program provides you with savings and convenience while minimizing trips to the pharmacy and reducing out-of-pocket costs for prescriptions.

Keep You and Your Wallet Healthy with Generic Medications

Keep in mind that generic drugs are as safe and effective as their brand-name counterparts, and are significantly less expensive. If you are taking several medications, the difference in cost for generics and brand name drugs can be significant.

Be sure that you are using the generic equivalent rather then the brand name drug . If authorization for a brand name drug with a generic equivalent available is not obtained, the brand-name drug will not be covered by the plan.

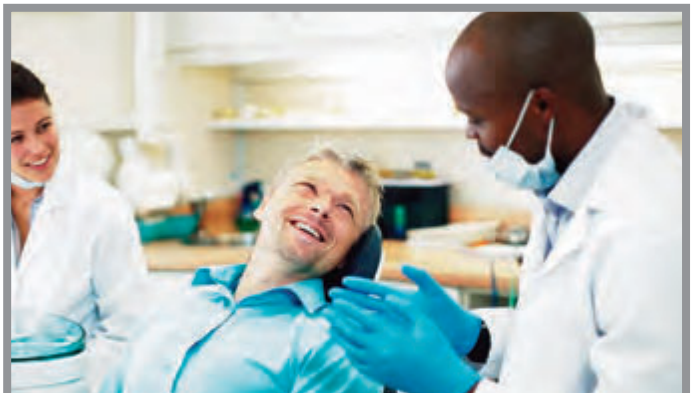
Dental Coverage

United Concordia www.unitedconcordia.com 1-866-267-3280
Delta Dental (Minorca) www.deltadental.com (Minorca) 1-800-524-0149 (Minorca)

The calendar year maximum benefit for dental services is $2,250 per Member for Network providers and $1,750 per Member for Out-of-Network providers. The dental plan gives you the option of going to any licensed provider you choose, but if you go to a dentist who is In-Network, the plan benefits will be based on negotiated rates, thus you will save on dental services. If you visit a dentist that is Out-of-Network, and the dentist charges more than the maximum allowed rate for a particular dental service, you will have to pay the difference. To locate an In-Network Dentist near you, visit the website for your provider listed above.

The Dental Plan Offers:

- **The freedom to see any provider**— You can see any provider, but receiving care from an in-network provider lowers your out-of-pocket expenses.
- **Preventive care coverage —** Qualified Preventive care is covered at no cost to you.
- **An extensive network of providers** — You have access to a large national network of providers. In addition, your provider will submit the claims for you.



Feature/Services	Dental Network	
	Dental PPO	
	In-Network	Out-of-Network
	Annual Maximum Benefit/Person (not to exceed $2,250)	
	$2,250	$1,750
	Member Pays:	
Individual Calendar Year Deductible Excludes diagnostic and preventive services and orthodontia	None	$25
Family Calendar Year Annual Deductible Excludes diagnostic and preventive services and orthodontia	None	$50
Preventive and Diagnostic Routine Oral Exam (2 per 12 month period) Topical Fluoride, Bitewing X-Rays, Space Maintainers	$0	
Basic Services	15%	
Periodontal, Crown, Inlay and Onlay and Oral Surgery	15%	
Orthodontia Limited to children under age 19 Lifetime maximum of $2,500	40%	
Prosthetics	50%	
NEW for 2023 Dental implants for loss of teeth due to medical treatment	100%	

Vision Coverage

Carrier: Davis Vision | Website: www.davisvision.com | Phone: 1-800-999-5431

Vision coverage is provided by Davis Vision for the 2023 plan year. Please refer to the chart below for a summary of your vision benefits. The vision plan gives you the option of going to any licensed provider you choose, but if you go to a provider who is In-Network, the plan benefits will be based on negotiated rates, thus you will save on vision services. To find an in-network provider visit the Davis Vision website at www.davisvision.com.

Davis Vision	
Feature/Service	**Frequency** **Note: Services are available 12 months from the prior date of service**
Eye Exam	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses (in lieu of glasses)	Once every 12 months
In-Network	
Eye Exam	$0
Spectacle Lenses	$0
Frame—retail allowance	$75
Contact Lenses (in lieu of glasses)	
1 Pair Standard Daily Wear Lenses	$0
Medically Necessary	$0
Elective Allowance	$75*
Out-of-Network	
Eye Exam	Covered up to $50
Contact Lens Evaluation & Fitting	
Daily Wear	Covered up to $20
Extended Wear	Covered up to $30
Spectacle Lenses	
Single	Covered up to $50
Bifocal	Covered up to $55
Trifocal	Covered up to $60
Lenticular	Covered up to $65
Frames	Covered up to $75
Contact Lenses	
Non-Disposable	Covered up to $60**
Disposables	Covered up to $75
Medically Necessary	Covered up to $225

*Can be applied toward disposables or specialty contact lenses (including but not limited to extended wear, hard/soft bifocal, toric and gas permeable lenses). ** Can be applied toward standard (hard/soft daily wear) or specialty contact lenses (including but not limited to extended wear, hard/soft bifocal, toric and gas permeable lenses). Benefits include a low vision benefit, a discount contact lens mail order replacement program, and discounts on laser vision correction surgery from select providers.

Health Reimbursement Account (HRA)

Carrier: Highmark | Website: www.highmarkbcbs.com | Phone: 1-866-267-3280

What is a Health Reimbursement Account (HRA)?

A Health Reimbursement Account (HRA) is an account completely funded by Cleveland-Cliffs Steel LLC that reimburses employees for out-of-pocket IRS eligible medical expenses. HRA funds are provided by Cleveland-Cliffs Steel LLC on a pre-tax basis therefore they are not taxable when used. Unlike a cash payment, an HRA contribution is not subject to taxation and provides additional savings to members.

How do I receive my HRA contribution?

Under the PPO Plan: A participant is eligible for an HRA contribution, by fulfilling HAI eligibility under the PPO plan. The employer contribution will be provided in a lump sum annual contribution. For HAI eligibility, if you are enrolled in a Employee + Spouse or Employee + Family tier, both the Employee and the Spouse must complete HAI eligibility to receive the HRA contribution.
Under the CDHP Plan: Employees enrolled in the CDHP plan will automatically receive an HRA contribution.

How do I contribute funds to my HRA?

The HRA account is completely funded by Cleveland-Cliffs Steel LLC. No employee contributions in the HRA are allowed under IRS regulations.

What happens to my HRA balance at the end of the year?

Under the PPO Plan: Active employees who have an HRA account with a balance at the end of the year can rollover an additional $200 for Employee Only or Employee + Children tiers and $400 for Employee + Spouse or Employee + Family tiers from year to year.
Under the CDHP Plan: Active employees can rollover funds from year to year if they remain in the CDHP plan.

Can I participate in an HRA if I am 65 and enrolled in Medicare?

Yes, your participation in Medicare does not effect your eligibility to participate in the HRA benefit.

What can I use my HRA funds for?

HRA funds can be used to pay for IRS eligible expenses that are not covered by your insurance. Please refer to IRS Publication 502 for a list of IRS approved medical expenses. https://www.irs.gov/publications/p502

How can I access my HRA funds?

Visit www.Highmarkbcbs.com. Once logged in, click on the "Claims and Spending" tab and then the blue "Access" button to manage your account.

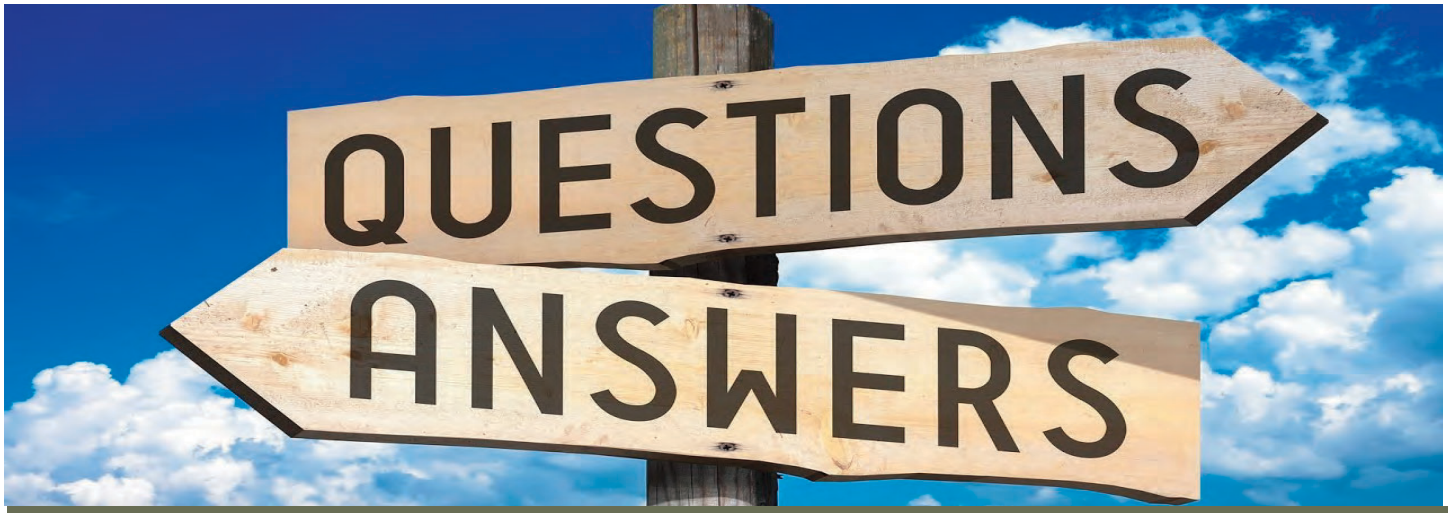
Can I participate in an HRA and FSA?

You are eligible to participate in both the HRA and the Medical Flexible Spending Account (FSA) for the 2023 plan year. The HRA funds are contributions from Cleveland-Cliffs Steel LLC and the FSA funds are employee contributions, both allow for IRS eligible medical expenses and require documentation (receipts) to substantiate all claims. When participating in the HRA and the FSA together, it is important to note that the funds from the HRA must be exhausted before claims can be made to your FSA account.

Benefit:	PPO Plan with Deductible	CDHP Plan with Deductible and Health Reimbursement Arrangement
Flexible Spending Account (FSA)	Eligible to participate in both Health Care and Dependent/Elder Day Care FSA. If participate in both FSA and HRA, HRA funds must be exhausted before FSA funds.	Eligible to participate in both Health Care and Dependent/Elder Day Care FSA. If participate in both FSA and HRA, HRA funds must be exhausted before FSA funds.
FSA Rollover	Health FSA allows for $570 rollover from year to year	Health FSA allows for $570 rollover from year to year
Health Reimbursement Account (HRA)	Receive an Employer Contribution in a HRA only if HAI eligibility is met. $400 EE Only $600 EE + Children $800 EE + Spouse or EE + Family	Auto enrolled in HRA if enrolled in the CDHP. Employer contribution to the HRA: $1,500 EE Only $2,500 EE & Spouse, EE & Children
HRA Rollover	Active employees can rollover $200 for Employee Only and Employee + Children tier or $400 for Employee + Spouse or Employee + Family tier from year to year.	Active employees can rollover funds from year to year if they remain in the CDHP plan.
Health Awareness Initiative (HAI) Verification Form	Health Wellness Exam must be completed between 10/01/2021—09/30/2022 Completed Forms to be submitted by 11/15/2022 to be eligible for funding 01/01/2023.	Not eligible for HAI

Do you have a question about your coverage?

Contact the appropriate vendor directly for questions regarding benefits, claims process, choosing a doctor, ID cards and copayments and deductibles.



Contact Information

Benefit	Provider	Web Site or Email Address	Phone Number
Medical Coverage	HIGHMARK.	www.highmarkbcbs.com	1-866-267-3280
Prescription Drug Coverage	CVS CAREMARK	www.caremark.com	1-800-925-5795
Dental	UNITED CONCORDIA DENTAL	www.unitedconcordia.com/dental-insurance/	1-866-267-3280, then Press #4
Dental (Minorca)	DELTA DENTAL	www.deltadental.com	1-800-524-0149, then say "Subscriber"
Vision Coverage	DavisVision	www.davisvision.com	1-800-999-5431
Health Reimbursement Account	HIGHMARK.	www.highmarkbcbs.com	1-866-267-3280
Flexible Spending Accounts	UMR A UnitedHealthcare Company	Email: UMR-FlexEligibility@umr.com	1-877-310-3539 then say "member"
Disability	ReedGroup	https://clevelandcliffs.myleaveproservice.com/#/home	1-844-507-5388
Annual Enrollment/ Eligibility Questions	Cleveland-Cliffs Steel LLC Annual Enrollment Hotline at UMR	Email: cliffs@umr.com	1-866-268-3489

NOTICE REGARDING WELLNESS PROGRAM

The Health Awareness Initiative ("HAI") is a voluntary wellness program available to all employees that enroll in the Preferred Provider Organization plan ("PPO"). The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health screening that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the health screening or other medical examinations.

However, eligible employees who choose to participate in the wellness program will receive an employer contribution to their health reimbursement account ("HRA"). Although you are not required to complete the health screening, only employees who do so will receive the employer contribution to their HRA.

The information from your health screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and ArcelorMittal may use aggregate information it collects to design a program based on identified health risks in the workplace, the HAI provider will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are those professionals, such as a registered nurse or doctor, who will only have access in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making

any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, you will be notified immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding the Health Awareness Initiative, please contact the Steelworkers Health and Welfare Fund at 888-831-3863.

☑ ANNUAL ENROLLMENT* ○ NEW HIRE ENROLLMENT

CLIFFS

ACTIVE REPRESENTED EMPLOYEE
2023 FSA BENEFITS ENROLLMENT
FORM (Please print)

*If you enroll in the FSA before the end of Annual Enrollment you will have until 12/15/2022 to make changes to your election amount

Employee Information		
Last Name:	First Name:	Middle Initial:
Social Security Number:	Payroll No.	Date of Birth:
Address:		Hire Date:

The *Health Care Spending Account* allows you to be reimbursed for qualified health care expenses incurred by you and your dependents. Eligible expenses include medical and prescription drug copays, coinsurance and deductibles up to an annual maximum of **$2,850**.

Health Care Spending Account Election	
○ I Elect Coverage	Annual Deduction: $
○ I Decline Coverage	

The *Dependent/Elder Day Care Spending Account* allows you to be reimbursed for qualified day care expenses in order to allow you and your spouse to work or go to school up to an annual maximum of **$5,000.** If you wish to enroll, you must only choose either Option A **OR** Option B.

Dependent / Elder Day Care Spending Account	
○ OPTION A – Dependent / Elder Care with ICD Match*	○ OPTION B – Dependent / Elder Care without ICD Match
Annual Employee Deduction: $	
○ I Decline Coverage	

* Applicable groups that elect an ICD Match are eligible to receive a dollar-for-dollar contribution with an $1,800 max match. For more details visit the Benefits website/Flexible Spending Account/Summary Plan Description

* The following groups are NOT eligible to participate in the ICD Dependent / Elder Care match:

- Brickmason
- Columbus Coating
- Monessen
- Fleet
- Obetz

IMPORTANT: PER IRS REGULATIONS, HEALTH CARE SPENDING ACCOUNT AND DEPENDENT/ELDER DAY CARE FSA ELECTIONS MADE DURING ANNUAL ENROLLMENT WILL BECOME EFFECTIVE 1/1/2023 AND CANNOT BE CHANGED OR DROPPED UNLESS THERE IS AN IRS-QUALIFIED LIFE EVENT

Authorization

To the best of my knowledge the information above is correct and I elect to participate in Cleveland-Cliffs Steel LLC FSA benefit plans as indicated. I understand my employee contribution will be deducted from my earnings or any applicable disability benefits payments on a pre-tax basis in an amount based on my coverage election(s) above.

Authorization			
Signature	Date	Work Phone	Home Phone

After signing, make a copy for your records and return form by:

Email: UMR-FlexEligibility@UMR.com
Fax: 866-751-2440
Mail: NOT ACCEPTED – MUST FAX OR EMAIL
Questions call: 800-826-9781

IMPORTANT*: *Retain proof of submission

(1) Email – retain e-mail and delivery notification for confirmation purposes
(2) Fax – retain fax confirmation delivery for confirmation purposes

Forms sent to Cleveland-Cliffs Steel LLC will be returned to the sender, ***not*** forwarded to UMR. Your FSA elections will be confirmed in writing within 14 business days of receipt.

☐ QUALIFIED LIFE EVENT ☑ ANNUAL ENROLLMENT ☐ NEW HIRE ENROLLMENT

CLEVELAND-CLIFFS STEEL LLC — HEALTH CARE ELIGIBILITY CHANGE FORM
REPRESENTED HOURLY or O&T EMPLOYEES

Last Name	First Name	M.I.	Payroll No.	Social Security Number - -

Please check the changes that you need to make to your member records: (Check all that apply.)

- ○ Add spouse due to marriage
- ○ Terminate spouse due to divorce
- ○ Terminate spouse due to death
- ○ Add child-birth / adoption / stepchild
- ○ Terminate child due to death
- ○ Terminate child-no longer eligible
- ○ Change/Update Dependent status-handicap
- ○ Terminate dependent due to gaining other coverage
- ○ Enroll due to losing other coverage
- ○ Add dependent due to losing other coverage
- ○ Waive / Terminate coverage*
- ○ Gender Change
- ○ Other: _____

*If you elect to waive coverage under this plan and receive the annual payment of $3,600.00, payment will be prorated and paid to you on a pay period basis.

If the above change will affect your enrollment status, please check the appropriate box below. If it does not, leave blank"

ONLY COMPLETE THE SECTIONS THAT APPLY TO CHANGES IN YOUR ENROLLMENT STATUS:

Street Address	City	State	Zip Code	Phone

	Employee ○Add ○ Waive ○ Change	Spouse ○Add ○ Drop ○ Change	Dependent ○Add ○ Drop ○ Change	Dependent ○Add ○ Drop ○ Change
Social Security Number.	- -	- -	- -	- -
Previous Last Name				
New Last Name				
First Name Middle Initial				
Sex (M/F)	○ M ○ F	○ M ○ F	○ M ○ F	○ M ○ F
Membership Status	○ Single ○ Married	○ Spouse	○ Child ○ Stepchild ○ Other ○ Handicapped > 26	○ Child ○ Stepchild ○ Other _____ ○ Handicapped > 26
Documentation Required	See other side.	See other side.	See other side.	See other side.
Birth Date	Month Day Year / /	Month Day Year / /	Month Day Year / /	Month Day Year / /

List additional dependent information on plain paper and attach. ○ Check here if you are attaching a list of additional dependents.

- **Attach required documentation per instructions on page 2 of this form. Retain proof of submission –** (1) Email (2) Faxed Confirmation Delivery
- **For Annual Enrollment must be sent by 11/13/2022 11:59** pm CST

☐ I elect to enroll in the **PPO** Medical/Rx, Vision & Dental Coverage as: ○ Employee Only ○ Employee & Spouse ○ Employee & Family ○ Employee & Child(ren)

☐ I elect to enroll in the CDHP Medical/Rx, Vision & Dental Coverage as: ○ Employee Only ○ Employee & Spouse ○ Employee & Family ○ Employee & Child(ren)

☐ I elect to **waive all health care coverage** (Medical/RX, Vision and Dental) for myself and my eligible dependents.
Note: To elect this option you must attach the required proof of other coverage.

☐ I elect to **waive Medical/RX only coverage** for myself and my eligible dependents.
Note: To elect this option you must attach the required proof of other coverage.

Signature	Date	Work Phone	Cleveland-Cliffs Business Unit/Location

After signing, make a copy for your records and return form by:
Email: cliffs@umr.com
Fax: 855-307-8354
Questions call: 866-268-3489

Internal Use Only:
Status: ○ Approved ○ Incomplete ○ Late Termination/Change
Date_____ Initials _____
Notes:_____

TO MAKE CHANGES TO YOUR COVERAGE OR TO CHANGE THE INFORMATION IN YOUR HEALTH CARE BENEFIT FILE, YOU MUST PROVIDE THE FOLLOWING DOCUMENTATION (CHECK OFF FORMS TO BE ATTACHED AND SEND COPIES ONLY, NO ORIGINALS):

1. Add spouse due to marriage
   - Marriage Certificate
     - If spouse was previously married, death certificate or divorce decree for prior marriage
   - Spouse's Birth Certificate
   - Spouse's Social Security Card
   - Proof of spouse's other insurance (if covered under employer's plan)
2. Terminate spouse due to divorce
   - Divorce decree
3. Terminate spouse or child due to death
   - Death Certificate
4. Add child - Birth
   - Birth Certificate
   - Social Security Card
5. Add child - Adoption
   - Birth Certificate
   - Adoption Order
   - Social Security Card
6. Add stepchild
   - Birth Certificate
   - Social Security Card
   - Proof of other insurance, if any
   - Additional documentation may be requested if stepchild's custodial parent (employee's spouse) is not added to the plan
7. Change/Update Dependent Status-Handicap
   - Handicapped Dependent Certification Form
   - Tax return showing dependent status
8. Terminate/add dependent due to losing/gaining other coverage.
   - Source of other coverage (is dependent covered as an employee or as a dependent of another person)
   - Proof of date other coverage begins/terminates
   - If *adding* spouse/dependent, Marriage Certificate, Birth Certificate and Social Security Card
9. Waive Coverage
   - Proof of other coverage, including coverage start date
10. Reinstatement from a Waiver
    - Proof of other insurance termination letter, Marriage Certificate, Birth Certificate and Social Security Card
11. Gender Change
    - Only completed HC change form required, no other documentation needed for previously enrolled dependents

Benefit enrollment requires a birth certificate and social security card as well as marriage certificate for spouse. This represents the acceptable documentation for benefit enrollment, without exception.

IMPORTANT: Retain proof of submission – For Annual Enrollment your request must be sent prior to 11/13/2022 11:59 pm CST
Acceptable Proof of submission: (1) Email or (2) Faxed Confirmation Delivery

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.highmarkbcbs.com or call 1-866-267-3280. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-866-267-3280 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 individual/$400 family in-network. $500 individual/$1,000 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits, preventive care services, outpatient surgery fee, emergency room care, emergency medical transportation, urgent care, outpatient mental health, outpatient substance abuse, rehabilitation services, eye exam, hospice services are covered before you meet your in-network deductible. Copayments and coinsurance amounts don't count toward the in-network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 individual/$3,000 family in-network $2,000 individual/$4,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, prescription drug expenses and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a in-network provider?	Yes. See www.highmarkbcbs.com or call 1-866-267-3280 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit Deductible does not apply.	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information. Out-of-network: No charge for Zoster Vaccine (Shingles), deductible does not apply.
	Specialist visit	$20 copay/visit Deductible does not apply.	30% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	30% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Precertification may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-866-267-3280.	Generic drugs	Not covered	Not covered	Prescription drugs are not covered.
	Brand drugs	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	$50 copay/visit Deductible does not apply.	$50 copay/visit Deductible does not apply.	Copay waived if admitted as an inpatient.
	Emergency medical transportation	No charge Deductible does not apply.	No charge Deductible does not apply.	----------none----------
	Urgent care	$30 copay/visit Deductible does not apply.	$30 copay/visit Deductible does not apply.	----------none----------
If you have a hospital stay	Facility fees (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit Deductible does not apply.	30% coinsurance	Precertification may be required.
	Inpatient services	10% coinsurance	30% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) In-Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsuranc	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Out-of-network: 30 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Rehabilitation services	$20 copay/visit Deductible does not apply.	30% coinsurance	Combined in-network and out-of-network: 60 combined physical medicine and occupational therapy visits per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	10% coinsurance	30% coinsurance	Precertification may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification may be required.
	Hospice services	No charge Deductible does not apply.	No charge Deductible does not apply.	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	$20 copay/visit Deductible does not apply.	30% coinsurance	Combined in-network and out-of-network: One diabetic eye exam per benefit period.
	Children's glasses	Not covered	Not covered	----------none----------
	Children's dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Prescription drugs
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See http://www.bcbsa.com
- Assisted fertilization procedures - $15,000 maximum/lifetime
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Your plan administrator/employer.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$20
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,390**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$4,000**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$200
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$30
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$440**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-267-3280.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield and Highmark Choice Company which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1-855-873-4106.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to http://benefits.arcelormittalusa.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$ 0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No	See the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$1,500** individual/**$3,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges (unless balanced billing is prohibited), and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.caremark.com or call 1-888-202-1654 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill).
Do you need a referral to see a specialist?	NA	

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	NA	NA	
	Specialist visit	NA	NA	
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)	NA	NA	
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://benefits.arcelormittalusa.com	Generic drugs	$10/retail prescription, $15/mail prescription	50%/retail prescription	Retail covers up to a 30-day supply; Mail Order covers up to a 90-day supply.
	Preferred brand drugs	$20/retail prescription, $30/mail prescription	50%/retail prescription	After 2 retail pharmacy fills, maintenance drugs are covered only if purchased through the mail order program.
	Non-preferred brand drugs	$30/retail prescription, $60/mail prescription	50%/retail prescription	Brand name drugs with generic equivalents are not covered unless authorized by CVS Caremark, listed payment amounts apply if authorized. Coverage for certain drugs is subject to prior authorization and/or quantity, dose or duration limits. To confirm whether this applies to a certain drug, contact CVS Caremark by calling 1-888-202-1654.
	Specialty drugs	Same as above	50%/retail prescription	Most specialty drugs require prior authorization and must be filled at CVS Caremark Specialty Pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	NA	NA	
	Physician/surgeon fees	NA	NA	
If you need immediate medical attention	Emergency room care	NA	NA	
	Emergency medical transportation	NA	NA	
	Urgent care	NA	NA	
If you have a hospital	Facility fee (e.g., hospital room)	NA	NA	

* For more information about limitations and exceptions, see the plan or policy document at http://benefits.clevelandcliffs.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
stay	Physician/surgeon fees	NA	NA	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	NA	NA	
	Inpatient services	NA	NA	
If you are pregnant	Office visits	NA	NA	
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	NA	NA	
If you need help recovering or have other special health needs	Home health care	NA	NA	
	Rehabilitation services	NA	NA	
	Habilitation services	NA	NA	
	Skilled nursing care	NA	NA	
	Durable medical equipment	NA	NA	
	Hospice services	NA	NA	
If your child needs dental or eye care	Children's eye exam	NA	NA	
	Children's glasses	NA	NA	
	Children's dental check-up	NA	NA	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Routine foot care
- Cosmetic surgery
- Weight loss programs
- Dental care
- Long-term care
- Medical Services

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

n/a

* For more information about limitations and exceptions, see the plan or policy document at http://benefits.arcelormittalusa.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [Yes]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at http://benefits.arcelormittalusa.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$200
Specialist *[coinsurance]*	10%
Hospital (facility) *[coinsurance]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$10
Coinsurance	$1,240
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,510**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$
Hospital (facility) *[cost sharing]*	%
Other *[cost sharing]*	%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$180
Coinsurance	$273
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$708**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$
Specialist *[cost sharing]*	$
Hospital (facility) *[cost sharing]*	%
Other *[cost sharing]*	%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$113
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$313**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.highmarkbcbs.com or call 1-866-267-3280. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-866-267-3280 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,600 individual/$3,200 family in-network. $3,200 individual/$6,400 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services, surgery fees, hospice services are covered before you meet your in-network deductible. Copayments and coinsurance amounts don't count toward the in-network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 individual/$6,000 family in-network. $6,000 individual/$12,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a in-network provider?	Yes. See www.highmarkbcbs.com or call 1-866-267-3280 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your in-network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information. Out-of-network: No charge for Zoster Vaccine (Shingles), deductible does not apply.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-866-267-3280.	Generic drugs	Not covered	Not covered	Prescription drugs are not covered.
	Brand drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network: Subject to in-network deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network: Subject to in-network deductible.
	Urgent care	20% coinsurance	40% coinsurance	----------none----------
If you have a hospital stay	Facility fees (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
	Inpatient services	20% coinsurance	40% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) In-Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Out-of-network: 30 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Combined in-network and out-of-network: 60 combined physical medicine and occupational therapy visits per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification may be required.
	Hospice services	No charge Deductible does not apply.	No charge Deductible does not apply.	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	Combined in-network and out-of-network: One diabetic eye exam per benefit period.
	Children's glasses	Not covered	Not covered	----------none----------
	Children's dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Long-term care
- Prescription drugs
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See http://www.bcbsa.com
- Assisted fertilization procedures - $15,000 maximum/lifetime
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Your plan administrator/employer.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,070**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$70
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$5,170**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,810**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-866-267-3280.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield and Highmark Choice Company which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1-855-873-4106.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

This Employee Benefits Guide is intended as a summary and reference guide for Cleveland-Cliffs Steel LLC employees. While this guide does not address every plan detail, an official plan document is available for full benefit information. If there is a discrepancy between the summaries described in this document and the plan document, the plan document will prevail.

Cleveland-Cliffs Steel LLC
3300 Dickey Road
East Chicago, IN 46312

ADDRESS SERVICE REQUESTED