BENEFITS GUIDE

— 2021 —

Trust for Steel Retirees Medicare Plans

Available to All Steel Trust Retirees and Spouses

Group Plans Providing Choice, Quality and Value

Steel Retiree VEBA Trust

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Overview

The Board of Directors of the Steel Retiree VEBA Trust (the Trust) would like to welcome you to review this Benefits Enrollment Guide that has been created for Retirees of all Steel Industry Companies. Please refer to the Summary Plan Description (SPD) for complete details about your plan. If there is a conflict between this Benefits Guide and a Certificate or Summary Plan Description (SPD), the Certificate or SPD will govern. To receive a copy of the benefit plan materials, please go to www.MyMedPlans.com and download copies of benefit materials. If you would like to have them mailed to you, please contact, Benistar, the plan administrator @ 1-800-236-4782 and they will mail/email you an enrollment packet.

Mission Statement

The goal of the Steel Retiree VEBA Trust is to provide and maintain quality, cost effective benefits, including medical, prescription drugs, dental and vision programs and other healthcare benefits for all eligible Steel Retirees that have worked for in the Steel industry and subsidiaries for at least 5 years.

Protecting Your PHI

The Board, Cone Retiree Healthcare the Healthcare Providers understand the importance of protecting your personal health information. We have the ability to communicate with plan participants and protect their PHI.

Coverage Contact Information

Benistar

Phone: 1-800-236-4782

Your Call Center and Plan Administrator

Mailing Address:
Benistar Retiree Service Center
10 Tower Lane, Suite100
Avon, CT 06001

Fax Enrollment Forms:
1(860)408-7025
Make Checks Payable to:
Benistar Retiree Services

Supplemental Medical Plan Information:

The Hartford Retiree Medicare Plans

The Hartford Insurance Company
Post-Enrollment Benefits and Claims
www.TheHartford.com Benistar (800)236-4782

Medicare Prescription Drug Plans

Aetna Medicare Rx offered by SilverScript Prescription Drug Formulary
www.AetnaRetireePlans.com (800)594-9390

AETNA Medicare Advantage Plan Information:

AETNA Medicare Advantage Plans—Includes both Medical, and Prescription Drugs

Aetna Pre-Enrollment Benefit Inquiries: (800)307-4830
Post-Enrollment Benefits & Claims Aetna Medicare PPO/ESA with PDP: (888)267-2637
Post Enrollment Benefits & Claims
Find Aetna Medical Providers
www.AetnaRetireePlans.com www.Aetna.com/docfind

Dental and Vision Plan Information:

Blue Cross Blue Shield Nationwide Plans (Dental)

Blue Cross Blue Shield of Michigan
www.Mibluedentist.com
Dental Customer Service Find a Doctor (888)826-8152

Blue Cross Blue Shield Michigan (Blue Vision VSP with BCBSM)

BCBSM Customer Service (800)877-7195
www.VSP.com or www.BCBSM.com

Retiree Eligibility For Medicare Plans

If you have worked at least 5 years in the Steel Industry or subsidiaries. The list includes but is not limited to the names of the companies eligible to participate in the Trust. Based on information currently available to the Trust.
If you believe you may be eligible to participate in the Trust and your Steel Industry Company is not listed below, please contact the plan administrator, Benistar @ 1-800-236-4782. A representative will assist you with determining your eligibility into the plans offered through the Trust.

Accurate Processing Co.	Edgewater	LTV Co.	Ohio Pressed	Standard-Burham & Latrobe
Alan Wood Co.	Empire Casting, Inc.	LTV Mining Co.	Pennsylvania Foundry	Superior Casting, Co.
Atlantic Casting Co.	Erie Forge	Mackintosh Hemphill	Pittsburg Forging Co.	Tryco Corp.
Bethlehem Steel Corp.	Falls Tube & Mfg. Co.	Massillon Casting Co.	Potomac Corp.	US Metalsource
Block Corp.	Franklin Industries, Inc.	McLouth Corp.	PTC Alliance Corp.	United Engineering & Foundry
Brockway Pressed Metals, Inc.	Franklin Co.	Michigan Specialty Tube, Co.	Quaker Alloy, Inc.	Valley City Co.
Cann & Saul Co.	Freedom Forge Corp.	Midland Products, Col	Quaker City Iron Works	Valley Vulcan Mold Co.
Commodity & Processing	Hamilton Foundry & Machine	Midvale Heppenstall Co.	Quality Sheet Metal Corp.	Vision Metals, Inc.
Copperweld Co.	Holub Iron & Co.	Moltrup Products, Co.	Republic Steel	Vulcan Iron Works, Inc.
Copperweld Tubing Products	ISG Composite Dies Inc.	Monessen SW Railway	Republic Technologies Int'l	Wean United, Inc.
Crucible Casting Co.	Kulka & Equiptment	National Forge	Rogers Structural Co.	Western Group, Inc.
Dayton Fabricated Co.	Latrobe Die Casting Co.	National Steel	Ronart Industries, Inc.	Wheeling Pittsburg Co.
Decatur Casting	Lebanon Foundry	Oakmont Co.	Rouge	Weirton Steel

It is not a requirement for you to have worked for a company that declared Bankruptcy to be eligible to enroll in these medical plans.

You will find we have excellent healthcare options available to ALL US Steel Retirees and their Dependents through these plans.

Retiree and Family Eligibility

Retiree - As a Steel Retiree VEBA Trust plan participant, you are eligible for the medical, prescription drug, dental and vision benefits outlined within this benefit guide.

Spouse/Domestic Partner Dependent - Spouse or same-gender domestic partner may also be eligible for medical, prescription drug, dental and vision benefits if they meet the guidelines below for eligibility.

Medicare Eligible Retiree/Spouse/Domestic Partner— Anyone Over & Under the age of 65, Medicare eligible, and enrolled in Medicare Part A and Part B— are eligible to participate in the Medicare plans offered through this Trust.

· The Hartford Medicare Supplement Insurance options, "Premium"(Plan G) &"Premium Choice"(Plan F)
· High & Low Aetna Medicare Advantage Plans
· "Standalone" Aetna Prescription Drug Plans
· Blue Cross Blue Shield Nationwide Dental & Vision

Documentation

To provide coverage for a dependent under any of the Trust dental and vision programs, you must submit documentation that supports your relationship to the dependent when dependents are added after initial enrollment into the Trust plans. Please contact the Steel Retiree VEBA Call Center, **Benistar** at **1-800-236-4782** for a list of acceptable documentation.

Persons Not Eligible to Participate (Dependents do not include):

· Individuals on active duty in any branch of military service
· Parents, grandparents or other ancestors
· Grandchildren who do not meet the definition of dependent grandchildren and who are not claimed on you or your spouse's federal income tax return.

Children	Your biological children, stepchildren, legally adopted children, children for whom you have obtained court-ordered guardianship or conservatorship; qualified children placed pending adoption; grandchildren; and children of your domestic partner if you also cover your domestic partner for the same benefit. Your children must be on the federal income tax of the Retiree to be eligible to enroll in the Dental and Vision plans through the Trust.
Dependent Grandchildren	Your unmarried grandchild must meet the requirements listed above and must also qualify as a dependent as defined by the Internal Revenue Service on your or your spouse's federal income tax return.
Disabled Children	To continue coverage past the age limit, your disabled child must otherwise meet the requirements for eligible dependents and must also meet the following definitions: A disabled child is a child who, due to a mental or physical disability, is incapable of earning a living at the time he or she would otherwise cease to be a dependent if the child is covered as a dependent at that time and if at that time he or she depends on you for principal support and maintenance. A disabled child continues to be considered and eligible dependent as long as the child remains incapacitated, unmarried, dependent on you for principal support and maintenance, and you continuously maintain the child's coverage as a dependent under the plan from the date he or she otherwise would lose dependent status. A dependent child who loses eligibility and later becomes disabled is not eligible to be covered. A disabled child who was not covered as a dependent immediately prior to the time he or she would otherwise cease to be a dependent is not eligible to be covered.

What is Medicare? What Are Your Options?

You have important decisions to make when you become eligible for Medicare. Our goal is to help you understand your options and feel confident about choosing coverage based on your needs –when you first enroll and every year after that.

What are the parts of Medicare?

Part A (Hospital Insurance)

Part B (Medical Insurance)

Part D (Prescription Drug Insurance)

Part C (Medicare Advantage)

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare:

What are the coveragechoices?

Original Medicare

(Parts A & B) is provided by the federal government. It helps pay for hospital stays and doctor visits, but it doesn't cover everything.

You may add coverage by enrolling in one or more private Medicare or Medicare-related plans.

- **Medicare supplement insurance plans** (Medigap) help pay someof the out-of-pocket costs that comewith Original Medicare.
- **Medicare prescription drug plans** (Part D) help pay for prescriptionmedications. Original Medicare does not cover prescription drugs.
- **Medicare Advantage plans** (Part C) offer an alternative to Original Medicare. Plans combine Part A and Part B coverage in one plan. They often include prescription drug coverage, too. Some plans offer additional benefits like coverage for routine vision and dental care.

PART A — Quick Overview

PART A - Provides help with the cost of inpatient hospital stays and skilled nursing services following a hospital stay, plus some other skilled care

Description

Medicare Part A insurance helps pay for "medically necessary" care (care for an illness or medical condition) that involves an inpatient stay in the hospital. Part A also helps pay for a stay in a skilled nursing facility as a follow-up to a hospital stay, hospice care for the terminally ill and some skilled home health care for the homebound. Part A also helps pay for some blood transfusions.

PART B — Quick Overview

Part B - Helps pay for doctor visits and outpatient care.

You cannot be denied Part B coverage. You may go to any doctor or qualified health care provider in the United States who participates in the Medicare program and is accepting Medicare patients.

Description

Medicare Part B insurance helps pay for a variety of medically necessary care — that is, care for an illness or medical condition. This includes services like doctor's office visits, care in hospitals and clinics when you are not admitted for an inpatient stay, laboratory tests and some diagnostic screenings, and some skilled nursing care at home, if you're homebound.

Part B also covers most doctor services you receive as a hospital inpatient, although other hospital services are covered by Part A. Part B is voluntary, but most people sign up when they first become eligible.

Medicare Part B is making it easier to get preventive care. It now covers an annual wellness exam plus additional preventive screenings at no cost to you.

PART C Quick Overview

PART C - Provides help with the cost of inpatient hospital stays and skilled nursing services following a hospital stay, plus some other skilled care

Description

Medicare Part C plans are usually referred to as "Medicare Advantage" plans. All Medicare Advantage plans are run by private companies, and they all combine coverage for hospital stays with coverage for doctor visits. You can choose a plan that includes prescription drug coverage, often at no additional premium, or you can choose a plan without prescription drug coverage.

Congress added Medicare Advantage plans to give Medicare participants more choices about how they receive their health care. Medicare Advantage plans put a cap on your out-of-pocket costs for Part A and B services covered by the plan. This offers financial protection. You must be enrolled in both Part A and Part B to be eligible for a Part C plan.

We try to offer Medicare Advantage plans where the cap, or maximum on your out-of-pocket spending, fits your budget. Our plans give you access to a large network of doctors. With the plans provided through the Trust you will have options with both prescription drug coverage and a coordinated care Medicare Advantage PPO with prescription drug coverage built in. You can't combine a stand-alone prescription drug plan with a coordinated care Medicare Advantage plan.

PART D Quick Overview

Part D – Provides help with the cost of prescription drugs

Description

Medicare Part D helps pay for the prescription drugs you use. Medicare Part D coverage is not automatic. You decide whether to enroll in a Medicare Part D plan. If you delay signing up after you are eligible, though, you may pay a penalty on your premium, unless you qualify for an exception.

Prescription drug coverage is an insurance policy you buy from private companies. You can buy a separate policy just for drugs, called a prescription drug plan (PDP). Or you can buy some types of Medicare Advantage plans that include drug coverage.

The federal government has created guidelines for the types of drugs that must be covered by drug plans and set minimum standards of benefits. Insurance companies that offer Medicare Part D plans must meet these standards. But all plans are not the same. They vary by cost and by their formulary, or list of specific drugs covered. You must be enrolled in Part A or Part B to be eligible for a Part D plan.

MED SUPP Quick Overview

MED SUPP - Medicare supplement insurance helps pay some out-of-pocket costs that come with Original Medicare.

Description

Medicare supplement insurance plans are standardized by the federal government. Each is labeled with a letter. Every plan with the same letter offers the same benefits, no matter what state it's offered in or by which insurance company. Massachusetts, Minnesota and Wisconsin standardized plans differently.

The level of coverage varies. There are standardized plans that cover all your Medicare deductibles, copayments and coinsurance, while others leave some costs for you to pay on your own. Medicare supplement plans provide nationwide coverage.

Additional Medicare Coverage

STEP 1

Enroll in Original Medicare.

Original Medicare
Provided by the federal government

PART A — Helps pay for hospital stays and inpatient care

PART B — Helps pay for doctor visits and outpatient care

STEP 2

Decide if you need additional coverage. There are two ways to get it.

OPTION 1 — OR — OPTION 2

Add one or both of the following to Original Medicare.

Medicare Supplement Insurance Plan
Offered by private companies

MED SUPP — Helps pay some of the out-of-pocket costs that come with Original Medicare

The Hartford

Medicare Part D Plan
Offered by private companies

PART D — Helps pay for prescription drugs

aetna

Choose a Medicare Advantage plan.

Medicare Advantage Plan
Offered by private companies

PART C — Combines Part A (hospital insurance) and Part B (medical insurance) in one plan

PART D — Prescription drug coverage

May offer additional benefits not provided by Original Medicare

aetna

How does cost sharing work?

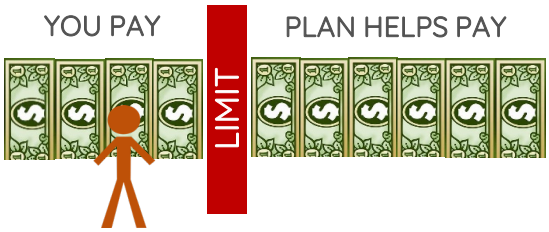
Four words you have got to know

Understanding how Medicare shares costs is a big part of choosing the right Medicare benefits for you. You need to understand these terms: **premium, deductible, co-pay, co-insurance**. These words have special meanings in Medicare, and mastering them will pay off. The words are names for different methods that Medicare uses to share the cost of your care with you. Medicare's reasoning is simple. If you pay some of the cost of the health care you use, you will use it more carefully. And you will be encouraged to do things that help keep you healthy and that may reduce your need for medical care.

1 Premium

Premium is a fixed amount you have to pay to participate. Most Medicare premiums are charged by the month.

Cost-Sharing Methods



2 Deductible

Deductible is a preset amount that you have to pay first, before Medicare or a private insurance company begins to help with your costs.

3 Co-Payment

Co-payment is a fixed amount that you pay, like $10, for a service or product. Some people call this a "co-pay".

4 Co-insurance

Co-insurance is splitting your health care costs with the plan on a percentage basis. For example, you pay 20% and the plan pays the remaining 80%.

It is easy to focus only on your premium amount when you shop for plans and policies, but you should also look at how much you will spend on cost sharing (deductibles, co-pays and co-insurance). Sometimes a plan with a lower premium could cost you more because it has higher cost sharing than the services you use. Remember that the Medicare premiums, deductibles and co-pays may change from year to year.

Open Enrollment

Annual Enrollment Periods
The Annual Enrollment begins November 01 - December 31 each year. Enrolling as early as possible allows you plenty of time to receive your new insurance cards in a timely manner. Don't confuse the Trust's open enrollment period with the Individual Market's open enrollment period which is from November 01 to December 7th. This Trust is a Group plan, therefore, we are able to extend the annual open enrollment period until December 31st of each year.

Enrollment for Newly Eligible Retirees or Retirees Enrolling for the 1st Time in Our Plans
If you are retiring or becoming Medicare eligible, your enrollment period to enroll in a Medicare plan will follow the same timeline that you would follow if you were enrolling in the individual market. Your Pre-65 insurance will typically end on the last day of the month prior to your 65th birthday. You will have up to 3 months prior to your 65th birthday and 3 months following your 65th birthday to enroll in a Medicare plan. If you do not enroll in a Medicare plan during that time period, you may be subject to permanent penalties from Medicare for not enrolling in a timely manner, so make sure that you take the proper steps to get enrolled in the time allowed.

What can I change during Open Enrollment

During open enrollment, you can:
•Return to Original Medicare from an existing Medicare Advantage (MA) plan if you are currently enrolled in a Medicare Advantage plan
•Enroll in Medicare Plan D (prescription drug plan) or move to another coverage level in the Trust
•Drop your Plan D coverage if you plan to get your prescription drug coverage through a private insurance provider.
•Switch from one Medicare Advantage plan to a different one
•Make changes to your Dental or Visions options available to the eligible plan participants and their dependents, regardless of their age.

Verify your Contact Information is updated

Please Visit our Website! **www.MyMedPlans.com**
It is very important to have the most up to date contact information for Steel Retirees that are eligible to participate in the healthcare programs the Steel Trust offers. Please go to the www.mymedplans.com and click on the Steel Trust option, following the dropdown box to Medicare to take you to the Medicare options offered through this Trust.
Don't Forget to Update Your Contact Information!
To update your contact information, go to our website, www.mymedplans.com and click on the "Join our Mailing List" button found on bottom of each page to provide your latest contact information.

Important Reminders for Medicare Eligible Retirees Enrolled in Group Plans

Retirees that turn 65 and continue on group coverage with their spouse or through another company, are not required to enroll in Medicare until spousal coverage terminates or the Retiree leaves group coverage through another plan without incurring a penalty assessment.

Enroll now Call

1-800-236-4782
To Enroll Today!

Choose the Right Plan for You

2 Retiree Group Plans Premium Choice (Plan F) Premium (Plan G)	THE HARTFORD Retiree Medicare Plans include the administration fee of $ 14.95 per month.
2 Medicare Advantage Plans	The AETNA Medicare Advantage Plans include both medical & prescription drug. A $10 administration fee will be added per member per month.
2 Blue Cross Blue Shield Dental and 1 Vision Plan	Standalone option, add a $4.25 administration fee to the cost of the bundled Dental & Vision plan. If elected with a Medical and/or Prescription Drug plan, there is no additional cost for the administration fee.
3 Standalone Prescription Drug Plans	The Prescription Drug plan as a Standalone plan without a medical plan option through this Trust, you will also need to add a $10.00 administration fee.

Retiree and Spouse/Domestic Partner must each pay for their own Administration fee. If both enroll in the same exact plan, an admin fee will be required for each participant.

The Hartford Retiree Medicare Plans		Aetna Medicare Advantage Plans		Blue Cross Blue Shield Dental and Vision Plans		Aetna Prescription Drug Plans		
Plan F	Plan G	National Flat Rate except FL (call Benistar for rates)	Extra Services	Blue Vision VSP	Blue Dental PPO	High PDP	Low PDP	Value Plan

enroll NOW

CALL

1-800-236-4782

Retiree Medicare Group Plans

The total monthly cost for your coverage is per person per month, and listed below based on your age:

$ 14.95 admin fee already included (plan administration, billing and claims)	INSURED'S AGE BANDED RATES				
	Under 65	65-69	70-74	75-79	80+
Premium Plan (Mirrors Plan G)	$ 291.15	$ 169.89	$202.13	$ 233.66	$ 243.84
Premium Choice Plan (Mirrors Plan F)	$ 308.92	$ 187.66	$ 219.90	$ 251.43	$ 261.61

5 Year Bands - Upon the 1st day of your birthday month

NOTE REGARDING AGE BANDED RATES: Use the age bracket appropriate for yourself (i.e. the retiree) – and use the age bracket appropriate for your spouse. Your spouse could have a different rate than you if you are in separate age brackets. Please make sure to use your age as of the first of the month of your coverage effective date. Both you and your spouse must be age 65 or older in and enrolled in Medicare Parts A & B in order to participate in this plan.

THE HARTFORD
Retiree Medicare Group Plans

BENEFIT DESCRIPTION	Premium Choice Mirrors Plan F	Premium Mirrors Plan G
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible (CYD)	$0	$0
Part A		
Part A Deductible (days 1-60; Part A Deductible)	100%	100%
Hospital Confinement (days 61-90; 25% of Part A Deductible) (days 91-150; 50% of Part A Deductible)	100%	100%
Extended Hospital Confinement (Additional 365 days) payable at 100%	100%	100%
Skilled Nursing Facility Confinement (days 21-100; 12 1/2% Part A Deductible)	100%	100%
Part B		
Part B Deductible	100%	Not Covered
Physician Services Benefit	100%	100%
Specialist Services Benefit	100%	100%
Outpatient Hospital Services and Ambulatory Surgical Care	100%	100%
Outpatient Diagnostic and Radiology Services	100%	100%
Outpatient Mental Health and Substance Abuse Services	100%	100%
Outpatient Rehabilitative and Cardiac Rehabilitative Services	100%	100%
Emergency Care Benefit	100%	100%
Urgent Care Benefit	100%	100%
Ambulance Services Benefit	100%	100%
Durable Medical Equipment and Prosthetics Benefit	100%	100%
Part B Excess	100%	100%
Additional Services		
Preventive Care Cancer Screening	100%	100%
Hospice (Inpatient respite care, drugs)	100%	100%
Blood Deductible	100%	100%
Foreign Travel Emergency ($250 Deductible; 80% coinsurance up to $50,000 Lifetime Maximum)	√	√
Private Duty Nursing ($20 Copay; up to 30 shifts per year; $500 Calendar Year Maximum)	Not Included	Not Included
Silver&Fit Exercise Program (free)	Paid for by trust board in 2021	Paid for by trust board in 2021

THE HARTFORD
Retiree Medicare Group Plans

PREMIUM CHOICE PLAN - Plan F

Calendar Year Deductible - $ 0
Lifetime Maximum - Unlimited

PREMIUM PLAN - Plan G

Calendar Year Deductible - $ 0
Lifetime Maximum - Unlimited
★ You pay ONLY for your Part B Deductible

PART A SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	PREMIUM CHOICE (F) YOU PAY	PREMIUM (G) YOU PAY
HOSPITALIZATION [2] - Semi-private room and board, general nursing, and miscellaneous services and supplies:				
First 60 days	All but the Part A Deductible	100% of Medicare Part A Deductible	$0	$0
61st through 90th day	All but 25% of Medicare Part A Deductible per day	100% of Medicare Part A Coinsurance	$0	$0
91st through 150th day (60 day Lifetime Reserve Period)	All but 50% of Medicare Part A Deductible per day	100% of Medicare Part A Coinsurance	$0	$0
Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime	$0	100%	$0	$0
SKILLED NURSING FACILITY CARE - Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies. You must meet Medicare's requirement which includes hospitalization of at least 3 days. You must enter a Medicare-approved facility within 30 days after leaving the hospital:				
First 20 days	All approved amounts	$0	$0	$0
21st through 100th day	All but 12.5% of Medicare Part A Deductible per day	Up to 100% of Medicare SNF Coinsurance	$0	$0
101st through 365 day	$0	$0	All other charges	All other charges
BLOOD DEDUCTIBLE – Hospital Confinement and Out-Patient Medical Expenses When furnished by a hospital or skilled nursing facility during a covered stay.				
First 3 pints Additional amounts	$0 100%	100% $0	$0 $0	$0 $0
HOSPICE CARE - Pain relief, symptom management and support services for terminally ill.				
As long as Physician certifies the need	All costs, but limited to costs for out-patient drug and in-patient respite care	Co-insurance charges for in-patient respite care, drugs and biologicals approved by Medicare	All other charges	All other charges

THE HARTFORD
Retiree Medicare Group Plans

PART B SERVICES

OUT-PATIENT MEDICAL EXPENSES
The Policy may cover the following Medicare Part B Benefits:
Physician Services Benefit
Specialist Services Benefit
Outpatient Hospital Services and Ambulatory Surgical Care Benefit
Outpatient Diagnostic and Radiology Services Benefit
Outpatient Mental Health and Substance Abuse Services Benefit
Outpatient Rehabilitative and Cardiac Rehabilitative Services Benefit
Emergency Care Benefit
Urgent Care Benefit
Ambulance Services Benefit
Durable Medical Equipment and Prosthetics Benefit
All Medicare Part B Benefits are based on per visit, except Ambulance Services Benefit, which is based on per trip, and Durable Medical Equipment and Prosthetics Benefit, which is based on per device.

SERVICES	MEDICARE PAYS(1)	PLAN PAYS(1)	PREMIUM CHOICE (F)	PREMIUM (G)
			YOU PAY	YOU PAY
Medicare Part B Deductible	$0	Premium Choice 100% of Medicare Deductible Premium $0 (must pay Part B deductible)	$0	100%
Remainder of Medicare-approved amounts	80%	100% of the remaining Medicare Part B Coinsurance	$0	$0
Part B Excess Charges for Non- Participating Medicare providers covers the difference between the 115% Medicare limiting fee and the Medicare-approved Part B charge	$0	100%	$0	$0
ADDITIONAL SERVICES				
PREVENTIVE MEDICAL CARE & CANCER SCREENINGS(3) Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services, cancer screenings, and any other tests or preventive measures determined to be appropriate by the attending Physician. (Refer to your Medicare and Your handbook for more information on Preventive services.)				
"Welcome to Medicare" Physical Exam -within first 12 months of Part B enrollment	100%	$0	$0	$0
Annual Wellness Visit	100%	$0	$0	$0
Vaccinations	100%	$0	$0	$0
Preventive Care Cancer Screening Benefits(3)	Generally 100% for most preventive screenings. Some screenings subject to the Medicare Part B Deductible and Coinsurance	100% of remaining covered expenses Incurred not covered by Medicare	$0	$0
Silver&Fit Exercise Program (free)	Paid for by trust board in 2021	Paid for by trust board in 2021		

Steel Retiree VEBA Trust

Silver&Fit®

SOMETHING FOR EVERYONE

Welcome to the enhanced Silver&Fit® Healthy Aging and Exercise program

Members will discover a better life balance in a program with flexibility, personalized support, and the following features tailored to meet their unique needs:

National Network of 14,000+ Fitness Centers

- No-cost membership at 14,000+ participating fitness centers and YMCAs
- Many fitness centers and YMCAs also offer:*
  - Group fitness classes tailored to older adults
  - Dance or yoga studios and/or swimming pools (where available)

One-on-One Silver&Fit Healthy Aging Coaching

In weekly sessions by phone, trained health coaches guide members in areas like:

- Being active
- Healthy eating
- Lifestyle choices
- Aging well
- Managing conditions

Silver&Fit's ASHConnect Mobile App

- Enhanced fitness center search with photos and location details to help members find fitness centers and YMCAs with their favorite features
- Activity tracking on over 250 wearable fitness devices, including Apple Watch®, apps, and exercise equipment**
- Virtual streaming group exercise videos so members can work out on their schedule

Home Fitness Kits

- Members who prefer to work out at home receive up to 2 kits per benefit year

35 unique options available, including a Fitbit® Connected! kit

Member Resources

- 48 Healthy Aging classes
- The Silver Slate® quarterly newsletter

Silver&Fit®

Q What is included in the Silver&Fit® Healthy Aging and Exercise program?

A The Silver&Fit Healthy Aging and Exercise program provides Silver&Fit members with access to no-cost fitness memberships through a robust network of participating fitness centers and select YMCAs. If the member is not interested in joining a fitness center or YMCA, the Silver&Fit program offers a Home Fitness option where members can choose up to 2 home fitness kits per benefit year from 35 available options.

In addition, enrolled Silver&Fit members receive access to one-on-one Silver&Fit Healthy Aging Coaching by phone where trained health coaches give members personalized attention in areas like being active, healthy eating, lifestyle choices, aging well, and managing conditions in up to 52 sessions per benefit year, and Silver&Fit's ASHConnect™ mobile app that includes virtual streaming exercise videos and activity tracking on over 250 wearable fitness devices and apps, including Apple Watch®. Members may also view 48 Healthy Aging classes and The Silver Slate® quarterly newsletter online at www.SilverandFit.com (materials can be mailed to enrolled members upon request).

Q What are the different types of fitness centers that participate in the Silver&Fit program?

A Members can select from the following:

Full Coed Fitness Centers, which offer Silver&Fit-endorsed exercise classes in addition to their standard membership with cardiovascular and resistance training equipment

Basic Coed Fitness Centers, which offer standard membership access to cardiovascular and resistance training equipment

Gender-Specific Fitness Centers, which offer a standard membership and the opportunity to work out with others of the same gender

Exercise Centers, which may include pools, yoga studios, and/or Pilates studios

Q How does a member enroll in the Silver&Fit program?

A Members can simply bring their Enrollment Flier to their chosen participating fitness centers or YMCAs. If members prefer to enroll with a Customer Service agent, they may call toll-free 1.877.427.4788 (TTY/TTD: 711).

QUESTIONS & ANSWERS

Q Can a member continue to use their existing fitness center or YMCA?

A If the fitness center or YMCA is part of the Silver&Fit network, then yes. The member can advise the fitness center or YMCA to end their membership. After enrolling on the website, the member can visit their location and present their Silver&Fit card. If the fitness center or YMCA is not a part of the Silver&Fit network and the member would like to use their Silver&Fit benefit, the member will need to switch to a participating fitness center or YMCA. The member should go online to www.SilverandFit.com for more information.

Q How does a member nominate a fitness center or YMCA?

A Members can nominate a fitness center or YMCA by going online to www.SilverandFit.com, using the ASHConnect mobile app, or by calling Silver&Fit Customer Service.

Q Can members participate at multiple fitness centers or YMCAs at a time?

A Yes, members can be enrolled in one or more participating fitness centers or YMCAs at a time.

Q Do Silver&Fit members get a Silver&Fit card? If so, how is one obtained?

A Yes. The Silver&Fit card is included in the member's Welcome Letter, along with the name and location of their chosen fitness center or YMCA. Members who enroll online can download or print their Silver&Fit card immediately.*

Q If a member belongs to a fitness center or YMCA that leaves the network, what is the process for notifying the member?

A Members will receive a letter notifying them that the fitness center is leaving the network, 30 days in advance (when possible). This letter includes a listing of up to 10 fitness centers or YMCAs closest to the member's address and advises the member to go online or call Silver&Fit Customer Service to choose a new participating fitness center or YMCA.

Q What is the investigative process for complaints against a fitness center or YMCA?

A American Specialty Health Fitness, Inc., provider of the Silver&Fit program, will assess complaints and follow up accordingly. Some methods of investigation are an inquiry letter, a site visit, or a secret shopper call.

Q If a member chooses the Silver&Fit Home Fitness program during the enrollment process, how long will it take for their kits to arrive?

A Members' first fitness kits will be mailed within 10 days of enrolling. If they picked out a second kit at the same time as the first, both kits will be shipped together.

Q If a member chooses the Silver&Fit Home Fitness program during the enrollment process and then changes their mind, how long must they wait before they can join a fitness center or YMCA?

A Members may call Silver&Fit Customer Service at any time to enroll with a participating fitness center or YMCA. The effective date for the fitness center or YMCA will be the day following their call. After switching to a fitness center or YMCA, the member will not receive any unsent home fitness kits.

Q If a member is participating in the Silver&Fit Home Fitness program and then switches to a fitness center or YMCA, does the member need to return the fitness kit(s)?

A No, the member may keep the kit(s).

Q Do members ever have to pay a fitness center or YMCA directly for Silver&Fit benefits?

A No. However, members are responsible for paying any fees associated with upgrading their fitness center or YMCA membership, or for using any non-standard services or amenities that require separate, non-standard fees.

Q What is Silver&Fit Healthy Aging Coaching and how does it work?

A At no additional cost, members can enroll into the Silver&Fit Healthy Aging Coaching program which includes weekly one-on-one telephone-based sessions with a trained health coach (up to 52 sessions per benefit year). These sessions are tailored towards older adults and cover health and wellness areas like being active, healthy eating, lifestyle choices, aging well, and managing conditions. The initial kick-off session lasts for up to 30 minutes, with subsequent sessions lasting approximately 15 minutes.

Q What is the Silver&Fit Connected!™ tool?

A The Silver&Fit Connected! tool is available through Silver&Fit's ASHConnect mobile app or at www.SilverandFit.com. The Connected! tool allows members to track their exercise and activity from approved wearable fitness devices, including Apple Watch,® apps, and exercise equipment (a full list is available online). After logging their information on their chosen device, the member needs to pair their device with the Silver&Fit Connected! program so their exercise and activity can be converted into points to earn rewards (if applicable). Purchase of a wearable fitness device or application may be required and is not reimbursed by the Silver&Fit program.

Q How does a member earn rewards through the Silver&Fit Connected! program?

A Rewards, if available, are outlined by the member's health plan. Members are rewarded based on the amount of points they accumulate within the reward period.

Q What are the types of rewards members can choose from?

A When members reach 300,000 points in a benefit quarter, they can choose to receive a Silver&Fit-branded visor, baseball cap, or floppy hat. After the initial hat reward, members receive a collectible pin each time they reach 300,000 points in a subsequent quarter.

Q How does a Silver&Fit member dis-enroll from the program?

A Members must call Silver&Fit Customer Service at 1.877.427

Prescription Drug Plan Information

The 2021 Coverage Gap (Donut Hole) and what it means for your cost when purchasing Prescription Drugs

The donut hole is a gap in the Part D coverage of your prescription drug costs. The Initial Coverage Limit (the negotiated retail dollar value of a senior's prescription drug purchases used to determine when a person enters into the Donut Hole or coverage gap phase of their Medicare Part D plan).
Medicare beneficiaries will enter the donut hole or coverage gap when the total negotiated retail cost of their prescription drug purchases reaches the initial coverage limit that is determined each year by CMS. In 2021, the donut hole begins when your total out of pocket cost including the cost to your provider is $4,130. -True Out-of-Pocket Costs (the actual dollar figure a person spends to get out of their donut hole or coverage gap, excluding monthly premiums) – The out-of-pocket threshold (or TrOOP) will usually increase each year by CMS. People who reach their donut hole will receive a discount on brand-named drugs while in the coverage gap. However, the full retail cost of medications purchased in the donut hole will still count toward meeting a person's total out-of-pocket expense limit.

Coverage in the "Coverage Gap" for 2021 is 25% for Generics and 25% of the cost of the Drugs for Brand and Preferred Brand Drugs. Once an enrollee reaches the total out-of-pocket limit during the coverage gap of $6,550, they are bumped into "catastrophic coverage."

Catastrophic coverage guarantees that once an enrollee has spent up to his or her plan's out-of-pocket limit for covered prescriptions the person will only pay a nominal coinsurance fee or copayment for their drugs for the rest of the year. This currently works out to the enrollee paying about 5% or $3.70 whichever is greater for Generics, and $9.20 for all other drugs.

Medicare's Program for Extra Help with Medicare Prescription Drug Plan Costs

Low Income Subsidy (LIS): Social Security provides the Program for extra help with Medicare Prescription Drug Plan Costs, also called the Low Income Subsidy (LIS), for people who have limited income and resources. To learn more about this program, please visit www.ssa.gov/prescriptionhelp or you can call Social Security at 1-800-772-1213 (available 24/7).

Prescription Drug (Part D) Coverage is Important even for those not currently using Drugs!

Please remember, everyone on Medicare must be enrolled in a Part D Prescription Drug plan when you become eligible for Medicare, or you will be subject to a penalty that will affect your premium for the rest of your life, if you fail to enroll in a timely manner. It does not matter if you do not use drugs or purchase your drugs at a local pharmacy such as Walmart and you only have inexpensive generics. You must be enrolled in a Part D plan to meet Medicare requirements when you become Medicare eligible.

Enrolling in the Supplement Medical Plans and Prescription Drug Plans

To enroll in a Supplement Medical plan and/or a Prescription Drug Plan, please complete, sign and date the Enrollment forms and return them to Benistar at the address found on the form indicating your selections

- Premium (Plan G) or
  Premium Choice (Plan F)
- PDP High, PDP Low, PDP Value
- Blue Dental/Blue Cross Blue Shield Dental
- Blue Vision (VSP)

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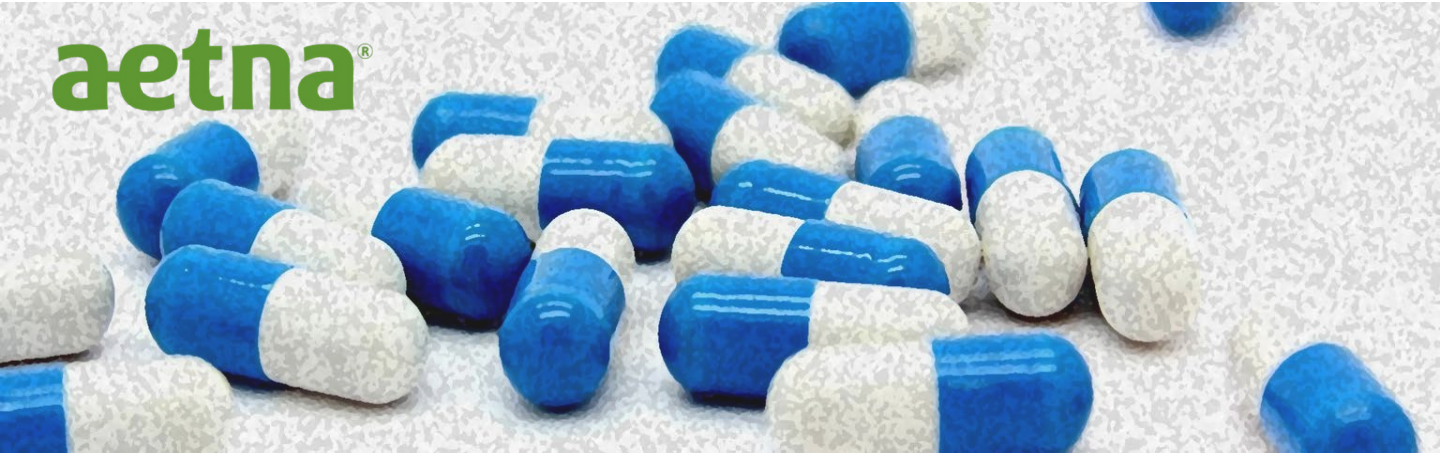

AETNA PRESCRIPTION DRUG PLANS	Plan #1		Plan #2	
	PDP High RX (11S3)		PDP Low RX (1203)	
Annual Deductible	$0		$0	
Initial Coverage Limit (ICL) - $4,130 in total drug expenditures (total cost of prescriptions and includes co-pays).				
	Retail or Mail Order 1 month supply cost are the same in 2021	Retail 90 day supply Retail and Mail Order cost are the same in 2021	Retail or Mail Order 1 month supply cost are the same in 2021	Retail 90 day supply Retail and Mail Order cost are same for 2021
Preferred Generic Tier 1	$2 copay	$4 copay	$2 copay	$4copay
Non-Preferred Generic Tier 2	$10 copay	$20 copay	$10 copay	$20 copay
Preferred Brand (includes some high-cost generics)	$40 copay	$80 copay	$40 copay	$80 copay
Non-Preferred Brand	$75 copay	$150 copay	$75 copay	$150 copay
Specialty-Tier Medications	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Coverage Gap – Once the total drug expenditures reaches the Initial Coverage Gap of $4,130 and continues until the total True Out of Pocket (TrOOP) member expenses reaches $6,550 in 2021				
Preferred Generic Tier 1	$2 copay	$4 copay	25% coinsurance for Generics	
Non Preferred Generics Tier 2	$10 copay	$20 copay		
Generics Tier 3 Preferred Brand	25% coinsurance	25% coinsurance	25% coinsurance	
Preferred Brands, Brands Tier 4 and Tier 5 Specialty Tier	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Catastrophic Tier – Begins after member expenditures reach out-of-pocket (TrOOP) in 2021 of $6,550				
Generic or Those Treated as Generic	Greater of $3.70 or 5%	Greater of $3.70 or 5%	Greater of $3.70 or 5%	Greater of $3.70 or 5%
All Other Covered Drugs	Greater of $9.20 or 5%	Greater of $9.20 or 5%	Greater of $9.20 or 5%	Greater of $9.20 or 5%

AETNA PRESCRIPTION DRUG PLANS	Plan #3 PDP Value RX (1303)	
Annual Deductible	$240 Deductible Required Before Co-Pays	
Initial Coverage Limit (ICL) - $4,130 in total drug expenditures (total cost of prescriptions and includes copays)		
	Retail or Mail Order 1 month supply cost is the same in 2021	Retail 90 day supply Retail & Mail Order costs are the same in 2021
	2X copay = 90 day supply	**2X copay = 90 day supply**
Preferred Generic Tier 1	$2 copay	$4 copay
Non-Preferred Generic Tier 2	$10 copay	$20 copay
Preferred Brand (includes some high-cost generics) Tier 3	$40 copay	$80 copay
Non-Preferred Brand Tier 4	$75 copay	$150 copay
Specialty Medications Tier 5	27% coinsurance	
Coverage Gap – Once the Total drug expenditures reach the Initial Coverage Gap Limit ($4,130 in 2021), the Coverage Gap begins and continues until the total True Out of Pocket (TrOOP) member expenses reaches $6,550		
Preferred Generic Tier 1	25% coinsurance	
Non-Preferred Generic Tier 2	25% coinsurance	
Tier 3 Preferred Brand (includes some high cost generic and preferred brand drugs)	25% coinsurance	
Generics Tier 4 and Tier 5	25% coinsurance	
Brands Tier 4 and Tier 5	25% coinsurance	
Catastrophic Tier – Begins after member expenditures reach out-of-pocket (TrOOP) for 2021 is $6,550		
Generic or Those Treated as Generic	Greater of $3.70 or 5%	

AETNA Medicare Advantage Plans

What is a Medicare Advantage Plan (also called Medicare Part C)?

Medicare Advantage is a plan in which a private insurance company contracts with and is approved by Medicare to provide covered healthcare services. With this type of plan, you receive all Medicare Parts A and B benefits and additional benefits in one plan. Two common types of Medicare Advantage plans that may be available are PPOs or HMOs, which work differently than Supplemental plans. If you elect to join an Aetna Medicare Advantage PPO plan offered through the Trust, the plan will provide your Part A (hospital insurance) and Part B (medical insurance) benefits and will include Medicare prescription drug coverage (Part D).

You must continue to be enrolled in Part A and Part B of Medicare to be eligible to enroll in a Medicare Advantage plan. In addition, since the Aetna Medicare Advantage PPO plans offered are group Medicare plans, you have the ability to enroll now or at another time during the year when you experience a life event. When moving to a group plan you don't have to wait for the "Medicare Annual Enrollment Window". The Centers for Medicare and Medicaid Services (CMS) regulate the Medicare Advantage plans and determine the rules by which the contracted insurance carriers, such as Aetna, are required to follow. Your out-of-pocket costs for benefits or services you receive can vary by Medicare Advantage plan. The plans will also have predefined rules for how you get services (for example whether you need a referral to see a specialist, or if you have to go only to plan-specific doctors, facilities, or suppliers for non urgent care or nonemergency). These rules can change each year. The two Aetna Medicare Advantage PPO plans the Trust offer are (1) Aetna Medicare $20 PPO with the Medicare Prescription Drug Plan 11S3 (High), and (2) Aetna Medicare $25 PPO with the Medicare Prescription Drug Plan 1203 (Low).

Depending on where you reside, you may be eligible for either the Aetna Medicare℠ Plan (PPO) or the Aetna Medicare℠ (PPO) plan with an Extended Service Area (ESA).

2 Aetna Medicare Advantage Plans ℠

These plans offer high-quality benefits beyond Original Medicare. They also include special services and programs only available to Aetna members. These plans allow you to see a doctor and/or visit a hospital in or out of the plan's nationwide network. Covered services received from in- network providers will generally cost less. Our providers have completed a detailed credentialing review process, giving you an additional level of assurance that you are receiving quality care. (A higher cost may apply for covered services received from out-of-network providers.)

Members who reside within the Aetna Medicare PPO network can elect the following options:

- Medicare 20 PPO with High Rx (11S3)
- Medicare 25 PPO with Low Rx (1203)

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Medicare Advantage Plans	Medical $20 PPO with High RX (11S3)		Medical $25 PPO with LOW RX (1203)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$0	$0	$0	$0
Annual Out-of-Pocket	$6,700	$10.000 for in and out of network services combined	$6,700	$10.000 for in and out of network services combined
Primary Care Physician Selection	Optional	Not Applicable	Optional	Not Applicable
Referral Requirement	There is no requirement for member pre-certification. Your provider will do for you.		There is no requirement for members pre-certification. Your provider will do for you	
PREVENTATIVE CARE				
Annual Wellness Exams	$0	20%	$0	25%
Routine Physical Exams	$0	20%	$0	25%
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	$0		$0	
Routine GYN Care)Cervical and Vaginal Cancer Screening	$0	20%	$0	25%
Routine Mammograms (Breast Cancer Screening) one Annual Screening	$0	20%	$0	25%
Routine Prostate Cancer Screening Exam for males over age 50, every 12 months	$0	20%	$0	25%
Routine Colorectal Cancer Screening	$0	20%	$0	25%
Routine Bone Mass Measurements	$0	20%	$0	25%
Additional Medicare Preventative Services	$0	20%	$0	25%
Routine Eye Exams NEW!	$0	20%	$0	25%
Routine Hearing Screening NEW!	$0	20%	$0	25%
Physician Services				
Primary Doctor Office Visit	$10 copay	20%	$25 copay	25%
Specialist Office Visit (includes mental health & substance abuse)	$20 copay	20%	$25 copay	25%
Outpatient Diagnostic Testing, Imaging, X-ray, Complex Imaging	$20 copay	20%	$25 copay	25%
Emergency/Urgent Care Services				
Emergency Care Worldwide (copay waived, if admitted)	$50 copay	$50 copay	$90 copay	$90 copay
Urgent Care: Worldwide	$35	$35	$25	$25
Ambulance	$0	$100	$25 copay	25%
Hospital Services				
Hospital Admissions member cost sharing applies to covered benefits incurred during member's inpatient stay	Covered 100%	20%	$250 per stay	25%

Prescription Drug Plans	Medical $20 PPO with High RX (11S3)		Medical $25 PPO with LOW RX (1203)	
Annual Deductible	$0		$0	
Initial Coverage Limit (ICL) – total drug expenditures determined each year by CMS (total cost of prescriptions includes copays).				
aetna®	Retail (1 month supply)	Mail Order/ Local Aetna Pharmacy (3 month supply)	Retail (1 month supply	Mail Order/ Local Aetna Pharmacy (3 month supply)
Tier 1 Preferred Generic	$2 copay	$4 copay	$2 copay	$4 copay
Tier 2 Generic	$10 copay	$20 copay	$10 copay	$20 copay
Tier 3 Preferred Brand	$40 copay	$80 copay	$40 copay	$80 copay
Tier 4 Non-Preferred Drug	$75 copay	$150 copay	$75 copay	$150 copay
Specialty- Tier Medications	33% coinsurance	33% coinsurance	33% coinsurance	Limited to monthly
Coverage Gap – Once the total drug expenditures reach the Initial Coverage Gap Limit of $4,130, the Coverage Gap begins and continues until the total True Out of Pocket (TrOOP) member expenses reach $6,550 in 2021				
Tier 1 Preferred Generic	$2 copay	$4 copay	Member pays 25% for Generic and Brand	
Tier 2 Generic	$10 copay	$20 copay		
Tier 3 Preferred Brand Includes some high cost Generics and Preferred Brand Drugs	Member pays 25% for Generic and Brand	Member pays 25% for Generic and Brand		
Tier 4 Preferred Brand Includes some high cost Generics and Preferred Brand Drugs	Member pays 25% for Generic and Brand	Member pays 25% for Generic and Brand		
Tier 5 Specialty Drugs Includes high-cost/unique generic and brand drugs	25% Generic and Brand Limited to 1 month supply	25% Generic and Brand Limited to 1 month supply	25% Generic and Brand Limited to 1 month supply	
Catastrophic Tier – Begins after member expenditures reach out-of-pocket (TrOOP) (2021 begins at $6,550)				
Generic or Those Treated as Generic	Greater of $3.70 or 5%	Greater of $3.70 or 5%	Greater of $3.70 or 5%	Greater of $3.70 or 5%
All Other Covered Drugs	Greater of $9.20 or 5%	Greater of $9.20 or 5%	Greater of $9.20 or 5%	Greater of $9.20 or 5%

**Please refer to Medicare.gov for updated information on the 2021 numbers on chart below. They had not been updated at the time this brochure was printed.*

Initial Coverage

In this drug payment stage:
You pay a co-pay or co-insurance (percentage of a drug's total cost).
The plan pays the rest
You stay in this stage until your total drug costs reach $6,550

Coverage Gap (Donut Hole)

After your total drug costs reach $4,150:
You pay:
– 25% of the cost of brand name drugs
– 25% of the cost of generic drugs
You stay in this stage until your total out-of-pocket costs reach $6,550

Catastrophic Coverage

After your total out-of-pocket costs reach $6,550:
You pay $3.70 or 5% for generic and greater of $9.20 or 5% for all other drugs.
You stay in this stage for the rest of the plan year

Telehealth Services

Medicare has temporarily expanded its coverage of telehealth services to respond to the current Public Health Emergency. These services expand the current telehealth covered services, to help you have access from more places (including your home), with a wider range of communication tools (including smartphones), to interact with a range of providers (like doctors, nurse practitioners, clinical psychologists, licensed clinical social workers, physical therapists, occupational therapists, and speech language pathologists). During this time, you will be able to receive a specific set of services through telehealth including evaluation and management visits (common office visits), mental health counseling and preventive health screenings without a copayment if you have Original Medicare. This will help ensure you are able to visit with your doctor from your home, without having to go to a doctor's office or hospital, which puts you and others at risk of exposure to COVID-19.

•You may be able to communicate with your doctors or certain other practitioners without necessarily going to the doctor's office in person for a full visit. Medicare pays for "virtual check-ins"—brief, virtual services with your physician or certain practitioners where the communication isn't related to a medical visit within the previous 7 days and doesn't lead to a medical visit within the next 24 hours (or soonest appointment available).

•You need to consent verbally to using virtual check-ins and your doctor must document that consent in your medical record before you use this service. You pay your usual Medicare coinsurance and deductible for these services.

•Medicare also pays for you to communicate with your doctors using online patient portals without going to the doctor's office. Like the virtual check-ins, you must initiate these individual communications.

•Since some people don't have access to interactive audio-video technology needed for Medicare telehealth services, or choose not to use it even if offered by their practitioner, Medicare is allowing people to use an audio-only phone.

•You may use communication technology to have full visits with your doctors. Also, you can get these visits at rural health clinics and federally qualified health clinics. Medicare pays for many medical visits through this telehealth benefit.

BCBSM Dental Plan - $50 Deductible for Class 2 and 3 Services

Network access information
With Blue Dental PPO Plus, members can choose any licensed dentist anywhere . However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.
Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit mibluedentist.com or call 1-888-826-8152.
1) Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
2) A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.
Blue Par Select Arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles . To find a dentist who may participate with BCBSM, please visit mibluedentist.com.
Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Benefits	Low Plan Coverage	High Plan Coverage
Deductible (Applies to Class 2 and Class 3 services only)	$50 per member limited to a maximum of $150 per family per calendar year	$50 per member limited to a maximum of $150 per family per calendar year
Class 1 services	100% Covered	100% Covered
Class 2 services	80%	80%
Class 3 services	50%	50%
Class 4 services	Not covered	Not covered
Annual maximum for Class 1, 2 and 3 services	$3,000 per member	$3,000 per member
Lifetime maximum for Class 4	N/A	N/A
Class 3: Major Restorative	35%	35%
Class 4: Orthodontia	N/A	50%

Dental Rates (Standalone or with another option)

The rates below are priced for eligible plan participants enrolling in the Dental Plan Only.

	Low Plan Rate	High Plan Rate
Single	$56.59	$60.41
Two-Person	$113.18	$120.82
Family	$169.77	$181.23

When enrolling in Dental Only, an Administration Fee of $4.25 must be added to the rate.

BCBSM Dental Plan – High Dental Plan vs. Low Dental Plan

The Trust offers dental coverage through Blue Cross Blue Shield of Michigan (BCBSM). The dental plans provide a wide variety of covered services – either covered in full or partially by the plans. Members will continue to have the choice to enroll in High or Low dental and/or vision which requires an application to be completed.

The table below provides an overview of the dental plans benefits. For specific details about the plans, please refer to the Benefits-at-a-Glance summary of benefits on the website at www.MyMedPlans.com

LOW PLAN

Annual Dental Maximum per Person	$3,000
Class I Service	
Includes but not limited to: Oral Exams Bitewing X-rays Full Mouth X-Rays Dental prophylaxis (Teeth Cleaning) Fluoride Treatment - Under19y/o	$0 = Your Deductible 0% = Your Coinsurance * 100% coverage for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class II Service	
Includes but not limited to: Fillings (for permanent & primary teeth) Root Canal Oral Surgery General anesthesia or IV sedation	$50 = Your Deductible per member to a maximumof $150 per family per calendar year 20% = Your Coinsurance * 80% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class III Service	
Includes but not limited to: Dentures (complete & partial) Occlusal biteguards Endosteal Implants Onlays, crowns and veneer fillings- permanent teeth age 12 and older Bridge Installations	$50 = Your Deductible 50% = Your Coinsurance * 50% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class IV Service	
Orthodontic services for dependents under age 19	Not Covered

HIGH PLAN

Annual Dental Maximum per Person	$3,000
Class I Service	
Includes but not limited to: Oral Exams Bitewing X-rays Full Mouth X-Rays Dental prophylaxis (Teeth Cleaning) Fluoride Treatment -Any age**	$0 = Your Deductible 0% = Your Coinsurance * 100% coverage for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class II Service	
Includes but not limited to: Fillings (for permanent & primary teeth) Onlays, Crowns,Veneers,Inlays - permanent teeth** Occlusal biteguards** Oral Surgery Root Canal	$50 = Your Deductible per memberto a maximumof $150 per family per calendar year 20% = Your Coinsurance * 80% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class III Service	
Includes but not limited to: Dentures (complete & partial) Endosteal Implants Bridge Installations	$50 = Your Deductible 50% = Your Coinsurance * 50% Coverage is for reasonable & customary charges. In no event will the covered charge be greater than the percentile of the prevailing fee data for a particular service in a geographic area.
Class IV Service	
Orthodontic services for dependents under age 19**	50% = YourCoinsurance
Class IV Lifetime Maximum per Individual	$2,500

*Before getting any major procedure, make sure to check with your provider for complete rates and coverage information.
**Consider these upgraded benefits when selecting the High Plan vs. Low Plan.

2021 Vision Benefits

Member's responsibility (copays)		
Benefits	VSP network doctor	Non-VSP provider
Eye exam	$10 copay	$10 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined $15 copay	Member responsible for difference between approved amount and provider's charge, after $15 copay
Medically necessary contact lenses	$15 copay	Member responsible for difference between approved amount and provider's charge, after $15 copay
Note: No copay is required for prescribed contact lenses that are not medically necessary.		
Eye exam		
Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$10 copay	Reimbursement up to $45 less $10 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		
Lenses and frames		
Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or grounded, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$15 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less $15 copay (member responsible for any difference)
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor •Progressive Lenses – Covered when rendered by a VSP network doctor	One pair of lenses, with or without frames in any period of 12 consecutive months	
Standard frames	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance)	Reimbursement up to $70 less %15 copay (member responsible for any difference)
One frame in any period of 24 consecutive months Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.		
Contact Lenses		
Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$15 copay	Reimbursement up to $210 less $15 copay (member responsible for any difference)
One pair of contact lenses in any period of 12 consecutive months		
Elective contact lenses that improve vision (prescribed, but not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)

Blue Vision Plan Information (VSP)

Insurance offered through VSP

Blue Vision insurance can be elected with any of the medical or prescription drug options, but if elected without a medical plan, you must purchase dental and vision together.

To enroll in a vision plan, please complete, sign and date the enrollment form and return it to **Benistar** at the address on the form. Please send your enrollment form, a copy of your 1099R form, or one of your PBGC checks, or another form of proof that shows you are a retiree from one of the eligible Steel companies.

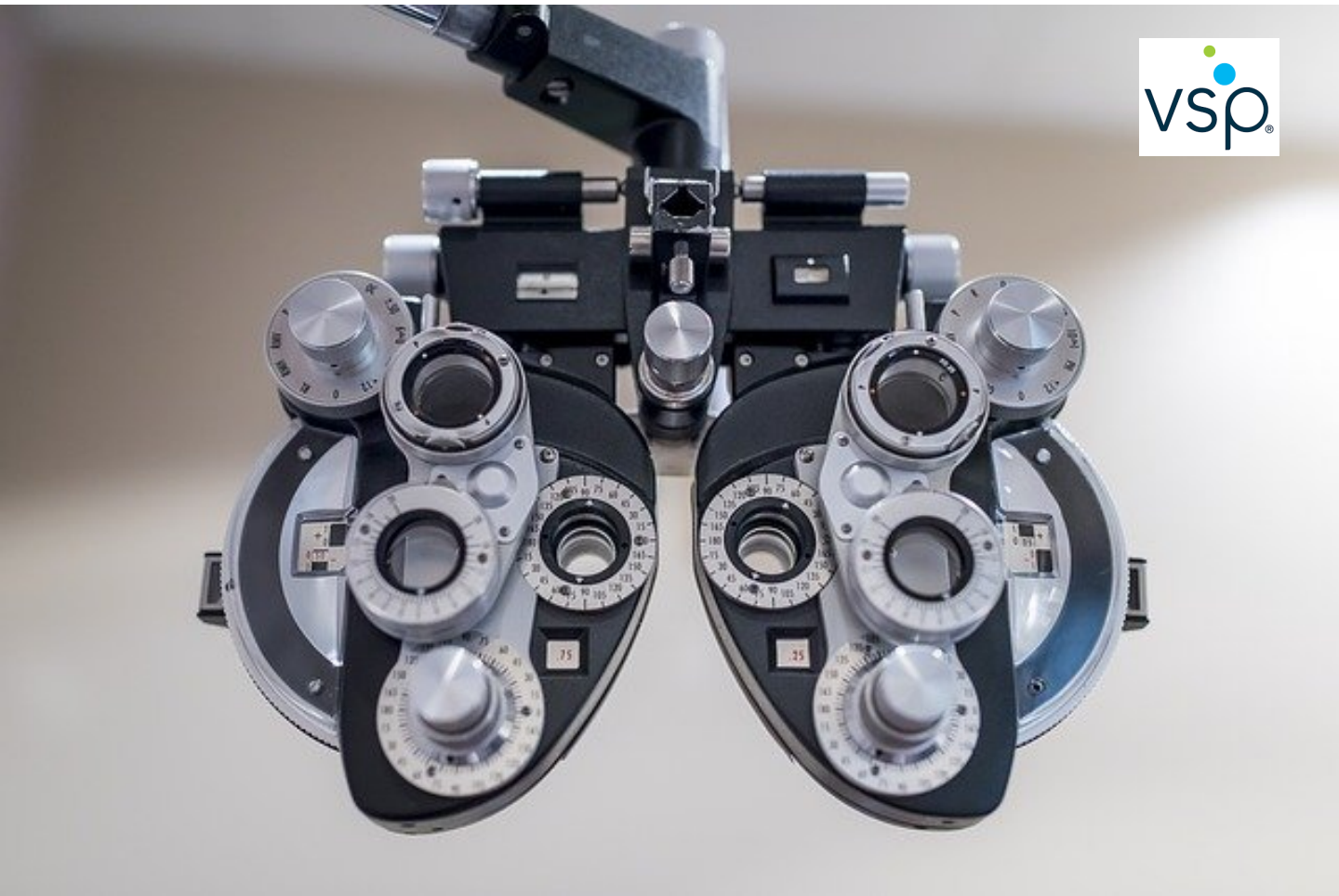
Eyewear: Choose the eyewear that's right for you and your budget. From classic styles to the latest designer fashions, you'll find hundreds of options for you or your family.

Choice of Providers: With open access to see any provider, you can see the one who's right for you.

2021 Blue Cross Blue Shield Vision Rates (VSP)

Single	$ 5.28	These Rates do NOT include the admin fee
Two-Person	$ 10.56	
Family	$ 15.84	

If purchased separately must be bundled with Vision plan and pay admin fee of $4.25



FAQs

Frequently Asked Questions

Eligibility and Administration

Q.	Does the Hartford plan provide Flat Rates or "Age Banded rates" in all 50 states?	A.	This plan provides "age-banded" rates for The Hartford Retiree Medicare "Plans F" and "Plan "G" where The Hartford offers Retiree Medicare Plans. Rates are determined by age in all states except Florida where age & zip-code are used.
Q.	What healthcare options will be available under the Steel Trust plan?	A.	You have the ability to enroll in Medical, Prescription Drugs, Dental, and Vision plans for Retirees eligible for Medicare. This includes Medicare Supplement Plan "F" and Plan "G" in most States, as well as Medicare Advantage Plans, Dental and Vision plans.
Q.	What insurance carriers will we have a choice of for the Insurance Trust VEBA program?	A.	The Hartford is the insurance carrier for the 2 Medicare medical plans (medical and prescription drug) and AETNA will be providing the Medicare Advantage Plans and Prescription Drug Plans and Blue Cross Blue Shield will be the Dental provider with Blue Vision (VSP) as the Vision Plan.
Q.	Who is my retiree health coverage going to be administered by?	A.	The administrator for plans is Benistar! You can reach them at **1-800-236-4782**
Q.	I am permanently disabled and am on Medicare and under age 65. Can I qualify for the Hartford program?	A.	Yes, you are eligible for the Hartford Medical Plan and AETNA Medicare Advantage Plan, along with Dental and Vision plans through the Trust as long as you are eligible for Medicare and enrolled in Medicare Part A and Part B.
Q.	I am a retiree from United and on Medicare. Am I eligible to participate in this Trust? When can I enroll?	A.	Yes. You are eligible to join any of the Medicare plans as long as you meet the Medicare eligibility requirements. You will have the option of enrolling in the Supplement Plans, Medicare Advantage plans both over and under the age of 65 and on Medicare. These are group plans therefore, you have the ability to enroll in them without pre-existing conditions and you don't have to wait until open enrollment each year to enroll. If you are a retiree from any US Steel Industry or one of its subsidiaries, then you are eligible for this Trust. You can enroll today!
Q.	What is the Steel Trust and what is its relationship to my former employer?	A.	This Trust is an independent, tax-exempt Steel VEBA Trust set up to be the plan sponsor and policy holder of the group medical policy for retirees who have worked in eligible Steel companies and their subsidiaries. Spouses, Domestic partners, and Survivors of retirees are also eligible to participate.
Q.	Can I choose to participate in the medical plan without participating in the prescription drug, dental or vision plans?	A.	Yes. You can enroll in standalone plans for the medical and prescription drug plans as well as the dental & vision plan (when bundled) as standalone plan options, if you choose.
Q.	Will the VEBA run out of money, and if it does, will this program go away?	A.	No. VEBA programs are funded with a small administrative fee that is included in the monthly premium each month ($3). The admin fee is determined by the cost associated with maintaining the plan (insurance and board members administration fees, meeting expense, administrative expense, legal fees, etc.). For 2021, the admin fee for the Trust will be $3.
Q.	Am I eligible to participate in the Trust if I reside outside the United States?	A.	No. The Trust plan will not cover claims incurred by residents of a foreign country. You must reside in the United States to receive benefits under the Steel VEBA Trust Retirees Plan.

FAQs

Frequently Asked Questions
(Continued) – Page 2

Enrollment

Q.	Do I have to complete an enrollment form to enroll?	A.	Yes. You must complete the enrollment form and return it to **Benistar**. For the Medicare Advantage PPO, Medicare Prescription Drug, and the Supplement Retiree Medicare plans, you will be billed after your enrollment is approved by Medicare and your Medicare eligibility is verified.
Q.	Can my spouse and I enroll in different medical and prescription drug coverage in these Medicare- eligible plans?	A.	Yes. You may enroll in different plans and different levels of coverage in the plans. One of you can enroll in the Plan F and Low PDP while the other enrolls in the Low Medicare Advantage plan. Keep in mind, each participant must pay their own admin fee as required by the plan administrator in 2021.
Q.	Do I have to worry about pre-existing conditions?	A.	No, this Medicare group plan has no preexisting conditions to be considered when enrolling.
Q.	Are these plans guaranteed issue coverage or will I have to fill out a medical questionnaire?	A.	These plans are guaranteed issue and you will not be denied coverage since it is a group plan. There are no medical questions to answer when you enroll and the rates you are quoted will not change because this is a group plan.
Q.	As a new enrollee, when will I receive ID cards for these plans?	A.	Approximately 2-3 weeks following your enrollment you will receive your ID cards in the mail. The Hartford and Aetna will mail out your ID cards for the Medical Plans, Medicare Advantage Plans & Prescription Drug Plans and Blue Cross Blue Shield will mail out the Dental & Blue Vision. You will also receive a card for your Silver&Fit enrollment. You should receive your cards if you are enrolling for the first time in the plans and in some cases, if you are already enrolled, you will not receive a new card each year.
Q.	Who can I call to get more information about the plans? Or request new insurance cards if I lose mine?	A.	You can call the **Benistar Retiree Service Center at 1-800-236-4782**, Monday through Friday, 8am to 4:30 pm Eastern time zone for help.
Q.	Do you have a website where I can find information about the insurance programs you have for Steel Retirees?	A.	Yes, we have a website www.MyMedPlans.com provided by Cone Retiree Healthcare Group, our broker. You can log into this website to help you with any information you might need regarding your Medicare benefits you may be eligible to enroll in if you are a retired Steel employee or a dependent of a retired Steel employee or one of their subsidiaries. Dependents are eligible regardless of age if they are on the retiree federal tax return. Contact Benistar the Call Center for more information 1-800-236-4782
Q.	Can I enroll in this Trust at anytime?	A.	Yes, you can enroll in the Medicare Plans available in this trust at any time during the year however, you may be subject to penalties if you are not enrolled in a Medicare medical and prescription drug plan when you are Medicare eligible and not enrolled in an employer group plan.
Q.	Can I enroll in the Dental and Vision without enrolling in the Medical plan or Prescription drug plan?	A.	Yes, you can elect Dental and Vision coverage only. Your coverage elections are for a 12 month period, or until the next enrollment period, whichever comes first. There will be a $4.25 admin fee for the bundled dental and vision only election.
Q.	Is my first month's premium payment required when I submit my enrollment form?	A.	No, you will be billed by the plan administrator, Benistar, for your first month's payment once you have completed the enrollment process.

FAQs

Frequently Asked Questions
(Continued) – Page 3

Claims and Medicare Coverage

Q.	How are my medical claims paid if I am enrolled in The Hartford Retiree Medicare Supplement Medical **Plan "F"** through the Trust?	A.	When you go to visit your doctor, simply present your ID card. Your provider will submit a claim to Medicare and if there are costs for items that are Medicare eligible and not fully paid by Medicare. The Hartford Medicare plan will be responsible for the additional charges as long as the provider accepts assignment. You will not need to file any paperwork, however you will receive an Explanation of Benefits (EOB.)
Q.	Are there any subsidies available to Retirees in this Trust? How do I apply for a subsidy?	A.	No, There are no subsidies available through this Trust other than the Trust itself providing Free membership to the "Silver & Fit" Program coverage to those enrolled in the Hartford Medical Plan or "Silver Sneaker" to those enrolled in AETNA Medicare Advantage plans through the Trust.
Q.	I only worked for Weirton Steel for 7 years, am I still eligible to participate in this trust along with my wife, now that we are Medicare eligible?	A.	Yes, you are eligible to participate in this trust as long as you can show proof that you worked for Weirton Steel or any US Steel Industry company for that matter, for at least 5 years. Your spouse/domestic partner is also eligible to participate in this Trust as long as you are eligible for the Trust.
Q.	What will my cost be if I go in the hospital and I am enrolled in the The Hartford Plan "F" Supplement program?	A.	You will not be responsible for any cost associated with your hospital stay as long as it is Medicare approved charge, The Hartford will pick up all the cost. The Supplement Plan "F" has ZERO out of pocket cost and ZERO deductibles for Medicare approved charges.
Q.	If I select your Medicare Advantage Plan, will I have out of pocket cost associated with the plan if I go into the hospital or go to the doctor?	A.	Yes, you may be required to pay co-pays and out of pocket costs associated with the services you receive in the Medicare Advantage plan you choose. Medicare Advantage plans are designed for Retirees looking for a cost effective plan with a smaller monthly cost, yet providing a complete benefits package. If you choose the High Medicare Advantage plan, there is no charge for a hospital stay. The Low Plan has a $250 one time cost for a hospital stay.
Q.	Is there a lifetime maximum on these medical plans?	A.	No, there is no lifetime maximum on these plans.
Q.	Is there a Prescription Drug Plan that I can buy to meet the CMS mandatory enrollment in a PDP but don't use many drugs?	A.	Yes. The Value Plan is designed for Retirees that do not use any or many drugs and are looking for a plan that will meet the Part D PDP requirement. This plan has a $240 deductible however, if you don't use drugs, you don't have to pay the $240.
Q.	Do you have a Prescription Drug plan that provides for coverage through the donut hole?	A.	Yes, the High plan provides for coverage through the donut hole with Generics in Tier 1 and Tier 2 for a co-pay .
Q.	Can I get my 90 day supply for my prescriptions from my local pharmacy that partners with Aetna?	A.	Yes, you can get your 90 day supply of Prescription drugs from your local pharmacy for 2 times copay at no additional cost. You also have the option of suing mail order if you prefer.
Q.	I do not use many Drugs, and never reach the "donut hole", do you have a plan for me?	A.	Yes, we offer a Low Plan. The Low plan has No deductible and some limited coverage in the gap This plan meets the Part D CMS (Medicare) requirement. Please remember, you will be subject to a lifetime penalty for not enrolling in a Part D plan each year regardless of your drug usage.

TRUST WEBSITE
www.MyMedPlans.com

Steel RETIREE VEBA TRUST

TRUST BOARD

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BENISTAR RETIREE SERVICE CENTER

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AETNA Medicare Advantage Plans
AETNA Prescription Drugs

BCBSM - Dental

VSP Blue Vision - Vision