AK Steel Corporation
Section 125/Reimbursement Account

IAM Local 1943
Hourly Employees

Summary Plan Description

Effective March 15, 2007

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WHAT IS THE REIMBURSEMENT ACCOUNT?

The “Reimbursement Account” is a benefit, which coordinates with the company’s health care plan. Your Reimbursement Account is available to you in accordance with Section 125 of the Internal Revenue Code to reimburse you for certain expenses you may incur during a calendar year. The Reimbursement Account allows you to use pre-tax dollars to pay for certain health care expenses and/or dependent care expenses. You may be reimbursed, up to the balance in your Reimbursement Account, for health care expenses not payable by insurance for you and your dependents and for work-related dependent care expenses, subject to certain IRS-imposed limitations.

Since no trust exists for Reimbursement Account payments, the company pays reimbursement directly to you from its general revenues. No reimbursement payment will be made from your Reimbursement Account except in accordance with the terms of the Plan as explained in this section.

Eligibility

In order to be eligible to participate in the Reimbursement Account:

- You must be eligible for health care benefits under the AK Steel Corporation Welfare Benefit Master Plan applicable to you, and

- You must be in a group of employees designated by the company as eligible for Reimbursement Account participation.

- You must be participating in the health care program of the AK Steel Corporation Welfare Benefit Master Plan applicable to you.

If you are not eligible for the Reimbursement Account at the beginning of the plan year, but become eligible because of a transfer, you will be eligible to participate in the Reimbursement Account from the effective date of your transfer under the same conditions as a newly hired employee.

By federal law, dependents will be covered under the Plan in compliance with any qualified medical child support order under the regulations of the Omnibus Budget Reconciliation Act of 1993.

Duration

You will cease to be a participant in the Reimbursement Account if one of the following events occur: termination, retirement, death or transfer to an AK Steel Corporation unit whose employees are not eligible to participate in the Reimbursement Account or any other pre-tax reimbursement program. If you are granted an authorized leave of absence or suffer a disability, you will remain a participant until you lose your health care benefit eligibility under the Welfare Benefit Master Plan.

PARTICIPATION STATUS

New Employee

If you are a new employee, you will have a maximum of 30 days from the date you attain 520 hours of employment to make your Reimbursement Account elections. Any pay reduction you choose will be effective on the earliest pay period as administratively possible, following the date of your election. If you do not make your elections within 30 days after eligibility, you will not be eligible to participate in the Reimbursement Account in the current plan year unless you have a qualified change in family status.

Transfers

If you transfer from an AK Steel Corporation location that was not participating in the Reimbursement Account to an AK Steel Corporation location that does participate, you will have the same elections as a new employee. If you were participating in another type of pre-tax reimbursement arrangement at the previous AK Steel Corporation location, participation in that arrangement will cease upon transfer. You will have a maximum of 30 days from your date of transfer to make your new Reimbursement Account elections.

If you are transferred out of a unit that participates in the Reimbursement Account to a unit which does not participate in the Reimbursement Account or any other pre-tax reimbursement plan, you may be reimbursed from your Reimbursement Account for any expenses incurred prior to your date of transfer. Claims for such reimbursement must be submitted no later than April 15th of the following year.

If you transfer to a location that has a different type of pre-tax reimbursement plan, participation in the Reimbursement Account will cease as of the date of transfer. Your account will remain open until April 15th of the following year so that you may submit claims for reimbursement of expenses incurred prior to the date of your transfer.

ELECTIONS AND FUNDING SOURCES

During the annual enrollment period, you will make certain elections, which determines if you will participate in the Reimbursement Account.

Federal regulations assert that all elections you make during the annual enrollment period are **irrevocable** for the plan year. The only time you can change your elections during the year is if your family status changes.

A change in family status is defined as the occurrence of any one of the following events:

- Marriage,
- Divorce,

- Birth/adoption,

- Death of spouse or child, or

- Loss of spouse's employment or spouse becomes employed.

If one of these events occurs, and you wish to change an election, you'll need to contact your local benefits administrator within 30 days of the event. Please note that all changed elections are handled proactively, never retroactively. For example, if you want to increase or decrease the amount of your payroll reduction because of a change in family status, it will not change what has already been credited to your Reimbursement Account.

Funding

During the annual enrollment period, you may elect to have your Reimbursement Account credited by pre-tax payroll contributions. Payroll contributions are taken from your pay before Social Security and income taxes are calculated. Contributions are not included in taxable wages on your W-2. While this produces tax savings to you, it could slightly reduce your Social Security benefit if your total yearly earnings were less than the Social Security total yearly wage base.

The IRS considers any dollars directed to the Reimbursement Account to be employer contributions. The maximum allowable contributions are $70 per week for Health Care expenses and $96 per week for Dependent Care expenses.

Health Expenses/Dependent Care Election

If you elect to participate in the Reimbursement Account, you will need to specify if you want to use your Reimbursement Account for health care expenses, dependent care expenses or both. You can direct all of your account to one category, or split between each fund category.

This will establish the maximum amount available for reimbursement for each type of expense incurred during the plan year. There is a government limitation for reimbursing dependent care expenses. The total reimbursed expenses out of your Reimbursement Account for the year cannot exceed the lesser of your or your spouse's earned income. Additionally, the maximum reimbursement for expenses incurred during the plan year is $5,000 for a single employee or married employee filing a joint return or $2,500 for a married employee filing a separate return.

There will be two fund categories within your Reimbursement Account. The percentage you designate for health care reimbursement can only be used for that purpose and the same applies to dependent care expenses.

Both Spouses Eligible to Participate in the Reimbursement Account

If you and your spouse are employed by AK Steel Corporation and both of you are eligible participants in the Reimbursement Account:

- Each will have separate Reimbursement Accounts;
- Each will have the opportunity to reduce taxable income up to the maximums allowed;
- Each can make a claim for reimbursement from his/her Reimbursement Account for a dependent as long as the claim is not filed twice.

Balance of Reimbursement Account at Year-End

Government regulations stipulate that any funds remaining in the account when the Reimbursement Account is terminated for the plan year must be **forfeited**. In other words, if you don't use it, you lose it. However, to reimburse you for claims incurred late in the plan year, the account will be maintained until April 15th of the following year. After that date, any balance remaining in an account reverts back to AK Steel Corporation. No interest will be credited during the year on your account balance.

It is important to be careful when you estimate how many dollars, if any, you want to put into the Reimbursement Account. If you can use pre-tax Reimbursement Account dollars for reimbursement, it's an effective way to save on your income taxes. If you cannot use the account for reimbursement, you should elect not to participate in the program. See the worksheet at the end of this booklet to help you make your election.

ELIGIBLE REIMBURSEMENT EXPENSES

Health Care Expenses

One category of expenses covered by the Reimbursement Account is health care expenses not payable by AK Steel Corporation's or any other health plan. This includes the deductible amount you will have to pay plus the co-pay portion of your health expenses.

Here is a partial list of expenses that your Reimbursement Account can be used for:

- Acupuncture performed by a licensed practitioner,
- Ambulance services,
- Analysis - psychotherapy by a licensed practitioner,
- Car controls for the handicapped,

- Chiropractic services within scope of license,
- Christian Science practitioners,
- Contact lenses not paid by any vision plans,
- Crutches - purchase or rental,
- Deductibles and co-payments not paid by any health plans,
- Dental or doctor fees not paid by any health plans,
- Eyeglasses - lenses, frames, and exams not paid by any health plans,
- Guide dog - cost of purchase for blind or deaf person,
- Halfway house - care to help individual adjust from life in a mental hospital to community living,
- Hearing aids,
- Hospitalization, including private room, not paid by any health plans,
- Laboratory fees not paid by any health plans,
- Laetrile, if legally qualified as drug where purchased,
- Lasik surgery,
- Learning disability: tutoring by licensed school or therapist for child with a severe learning disability,
- Legal abortions,
- Lifetime care - advance payment to private institution for lifetime care, treatment, or training of mentally or physically handicapped patient,
- Medicines - legally obtained drugs and medicines for treatment of illness or injury not paid by other prescription plans, including birth control pills,
- Nursing home - confinement for treatment of illness or injury,
- Nursing services by registered nurse (RN) or licensed practical nurse (LPN) for medical care,

- Optometrist - services within scope of license not paid by any health plans,
- Oxygen,
- Over-the-counter drugs (see "*Over-the-Counter Drugs"* on page 8),
- Physical therapy,
- Psychologist - services within scope of license,
- Routine physical exams,
- Schools - special schooling to relieve handicap,
- Surgery, excluding experimental and cosmetic procedures,
- Syringes, needles and injections,
- Telephones - special for the deaf,
- Therapy - physical or occupational therapy by a licensed therapist,
- Transplants,
- Prescription vitamins and mineral supplements for treatment of illness,
- Wheelchairs,
- Vaccinations and immunizations not paid by health plans,
- X-ray fees not paid by health plan.

Your Reimbursement Account cannot be used for:

- Automobile insurance premiums, including the segment of premiums providing medical coverage for persons injured through accident by an employee's car,
- Bottled water,
- Cosmetic surgery, except if the procedure is necessary to treat a deformity caused by a disfiguring disease, related to a congenital deformity or to treat a personal injury resulting from an accident or trauma,
- Cosmetics, toiletries, toothpaste, etc.,

- Costs of sending a problem child to a special school,
- Custodial care in an institution,
- Electrolysis,
- Expenses incurred in connection with an illegal operation or treatment,
- Funeral and burial expenses,
- Health club dues, YMCA dues, steam baths, etc.,
- Household and domestic help,
- Marriage or family counseling,
- Maternity clothes, diaper service, etc.,
- Meals and lodging while away from home for medical treatment or for the relief of specific health conditions,
- Membership fees or costs associated with weight loss programs for general health and well-being purposes,
- Premiums paid for any health care insurance or plan,
- Premiums paid for life insurance policies for accidental loss of life, limb, sight, etc.,
- Salary expenses of a licensed practical nurse (LPN) used to care for a normal and healthy newborn,
- Social activities, such as dance lessons or classes,
- Sterilization or reversal of a previous sterilization procedure,
- Transportation expenses to and from work, even though a physical condition may require special means of transportation,
- Uniforms,
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect,
- Vitamins taken for general health purposes,

Over-the-Counter Drugs

To be reimbursable, over-the-counter items must be:

- For the treatment of an existing or imminent medical condition,
- Accompanied by a store-printed, itemized receipt that includes the name of the item as well as the price,
- The medical condition and prescribing doctor must be noted on the receipt or in a separate statement,
- The name of the person for whom the item is intended must also be noted,
- A reasonable quantity.

The following are not covered:

- Items purchased to have on hand in anticipation of future need,
- Items for general health (e.g., vitamins in the absence of a specific disorder),
- Unreasonably large quantity. (e.g., more than is reasonably needed to treat the medical condition, or that can be used within the plan year),
- General hygiene items such as toothpaste, floss, deodorant, medicated powder, etc,
- Vitamins, unless prescribed for a specific medical condition,
- Special foods or nutritional formulas.

The Plan administrators are required by law to administer claims in accordance with federal regulations. If it becomes too cumbersome or expensive to administer over-the-counter claims, the plan document may be amended to limit coverage. Please help preserve the benefit by using it appropriately and by actively discouraging abuse.

Dependent Care Expenses

The second category of expenses covered by your Reimbursement Account is dependent care expenses. The Reimbursement Account can be used for reimbursement of dependent care expenses that are employment-related. Employment-related expenses are defined as those expenses for household services and expenses for the care of an eligible dependent that enable you to be employed and which would otherwise qualify for the dependent care credit for federal income tax purposes.

An eligible dependent is one who is under age 13, or who is physically or mentally incapable of caring for himself. A spouse is an eligible dependent if that person is physically incapable of self-care.

If the employment-related expenses are incurred for services provided by a dependent care center, the center must comply with all state and local laws and must provide care for more than six individuals (other than residents of the facility).

No benefits shall be payable for dependent care unless you certify that the total reimbursed dependent care expenses for the calendar year do not exceed the lesser of your or your spouse's earned income for the plan year, whichever is lower, or $5,000 for a single employee or married employee filing a joint return, or $2,500 for a married employee filing a separate return. You must also certify that you understand the reimbursed dependent care expense cannot be used to claim a credit on your personal income tax return. This certification is made on the *Request for Reimbursement* claim form. In addition to this certification, the company may also require you to submit other information, which it deems necessary or desirable to implement the dependent care assistance provisions of this Program.

The following provisions apply to the reimbursement of funds paid to relatives for dependent care expenses:

- Dependent care expenses cannot be reimbursed for charges made by anyone who is claimed as a dependent on your tax return.

- You cannot seek reimbursement for payments made to your spouse.

- You cannot seek reimbursement for payments made to your child who is under age 19.

Important Note: *If you claim dependent care reimbursement in cases where an individual is providing the care (other than a child care center), you are responsible for withholding and payment of Social Security (FICA) and Federal Unemployment Tax (FUTA) taxes from the amount paid to the person providing the dependent care.*

CLAIM PROCESSING

Only those expenses, which you have already paid, may be submitted for reimbursement from your Reimbursement Account. You will be required to certify by your signature on the *Request for Reimbursement* claim form that you have paid each provider the amount you are requesting for reimbursement, that the expenses would otherwise be allowable deductions or credits for federal income tax purposes and that you have not and will not claim such deductions or credits on your federal tax return. You will be required to provide the company with verification of payment and/or deductibility upon request, and you will be responsible for any expense incurred by you or the company if you submit a fraudulent claim.

In order to receive a reimbursement, you must submit a completed *Request for Reimbursement* claim form to your local benefits administrator. Claims for reimbursement of expenses are processed once a month. The deadline for submitting claims is the 20th of each month except for December. The cut-off date for December claims will be December 10th. Expenses incurred in the current year may be submitted for reimbursement no later than April 15th of the following year.

The following documentation must be attached to the reimbursement claim form in order for the Reimbursement Account claim to be processed:

1. For health expenses not covered by your insurance plan and for dependent care, the documentation must clearly state the following:

    a. Name of person that received the service,

    b. Nature of service or supplies furnished,

    c. Name and address of supplier,

    d. Amount charged,

    e. Amount paid,

    f. Date service was rendered.

2. A copy of the insurance carrier's "Explanation of Benefits" statement showing what amounts were paid for health expenses covered by your insurance plan. (If you are enrolled in a managed care plan, there may be times when a statement from the carrier will be required to verify non-covered expenses.)

3. Receipts for co-payments under a managed care plan or prescription drug program.

The Reimbursement Account of the current plan year cannot be used to reimburse claims that were incurred in the preceding plan year. An expense is deemed to have been incurred on the date the service is provided or the date material, supplies or equipment is ordered. A separate claim form must be used for each plan year.

Statements

There will be three types of statements submitted to you during the year:

1. Employee claim statement included with each reimbursement payment;

2. Reimbursement Account quarterly statement of your account balances; and

3. Confirmation of your elections for the new plan year.

GENERAL INFORMATION

Termination of Employment/Retirement

If you retire or cease to be employed by AK Steel Corporation, you may be reimbursed from your Reimbursement Account for any eligible expenses incurred prior to the date of termination. Claims may be submitted after the date of termination, but not later than April 15th of the year following the year in which employment is terminated. If such claims are submitted after the date of termination, reimbursement will be made from the account balance as of the date of termination.

Leave of Absence, Layoff, Disability

If you are off work due to leave of absence, layoff or disability, you will continue to be a Reimbursement Account participant until your health care eligibility terminates.

While eligible for health care benefits, you will continue to receive any Reimbursement Account credits. You may only continue your pay reduction arrangement if your payroll check exceeds the amount of reduction. If you are off due to disability, deductions will not be made from Sickness and Accident Payments. If you are off due to leave of absence, layoff or disability as of January 1, and are still eligible for health care benefits, you must renew your Reimbursement Account election. If you fail to make a new election, you will have no Reimbursement Account funds.

If your health care eligibility terminates in the same year that you go on leave of absence, layoff or disability status and you return to active status in that same year, you will be covered under the same elections that were in effect immediately preceding the date you went on leave of absence or disability. If your health care eligibility terminates in one year and you return to active status the following year, your elections will be administered as a newly hired employee.

Death

In the event of your death, your spouse (or in the absence of a spouse, your eligible dependent children) may continue to use your account for expenses incurred during the remainder of the plan year. Claims for expenses incurred may be submitted until April 15 of the year following the plan year in which your death occurs.

Spendthrift Clause

No money in the Reimbursement Account shall be subject in any manner to any voluntary or involuntary anticipation, sale, transfer, assignment, pledge, encumbrance or charge, including any liability for alimony or other support of a spouse, former spouse or any other relative of the participant or any claims under the community property laws of any state, before actually being received by you or your survivor. No distribution or payment of assets or benefits shall be attachable or subject to any debt, contract, liability,

engagement or tort. If you declare bankruptcy or attempt to anticipate, sell, transfer, assign, pledge, encumber or charge any Plan asset, distribution or payment, whether voluntarily or involuntarily, the AK Steel Corporation Benefit Plans Administrative Committee (BPAC) may hold or cause to be held such asset, distribution, or payment or any part thereof in such manner as BPAC shall, in its discretion, determine.

Appeals Process

If you apply for benefits under any of these plans and you believe that the Plan provisions have not been applied correctly or have any other claim regarding the Plan, you should submit your written claim to your AK Steel benefits administrator.

Within 90 days you will receive written notice of the decision on your claim. In special circumstances this period may be extended for an additional 90 days by written notice.

If the claim is wholly or partially denied, the written notice denying your claim will set forth an explanation of the specific findings and conclusions on which the denial is based. If you disagree with the denial, you may file a written request for review of the denial with the Benefit Plan Administrative Committee (BPAC) at AK Steel Corporation, 9227 Centre Pointe Drive, West Chester, Ohio 45069. The appeal must be delivered within 60 days after you receive notice of the denial of your claim, must state the basis on which you disagree with the determination, and must include any additional information you wish BPAC to consider.

BPAC will fully and fairly review the matter, make a final determination within 60 days of the receipt of your request for review of the disputed claim, and send you a written reply. (In special circumstances this period may be extended for an additional 60 days.) If BPAC denies your claim, its reply will clearly explain the reasons for its denial.

Discontinuance and Amendment

AK Steel Corporation has every intention of continuing the Plan, but the Company, through action of the Benefit Plans Administrative Committee, reserves the right to amend, suspend or terminate the Plan or any premium payments and contributions on your behalf, in whole or in part for any reason. This may be done without the consent of any employee, beneficiary or any other person.

The Company also reserves these rights, if required, in order to comply with the applicable requirements of the Internal Revenue Code or future ERISA regulations.

If the Reimbursement Account is terminated in whole or in part, or for any class of eligible employees, such affected participants will not have any right to reimbursement for claims incurred after the plan's termination date.

Claims must be filed within 90 days of the Plan's termination date (or such longer period as BPAC may determine) or claims will not be reimbursed. No participant shall have any claim against AK Steel Corporation or any officer, director or employee thereof or

against any fiduciary or administrator of the Plan for any credit balance maintained for or on behalf of such participant under the Plan regardless of the reason for the plan's termination.

LEGAL AND ADMINISTRATIVE INFORMATION

Plan Administrator and Agent for Service of Legal Process

The AK Steel Corporation Benefit Plans Administrative Committee (BPAC) is the Plan Administrator and agent for service of legal process. BPAC has the authority to interpret all plan provisions in administration of the Plan. The insurance carrier is your primary source of information regarding this plan. However, if the insurance carrier cannot satisfactorily respond to your question or request for information within a reasonable time, you should contact your local benefits administrator. If the local administrator cannot satisfactorily respond to your question or request for information within a reasonable time, you may write or contact BPAC at this address:

AK Steel Corporation
Benefit Plans Administrative Committee
9227 Centre Pointe Drive
West Chester, Ohio 45069

The Plan Administrator exercises it power solely in the interest of plan members and their dependents.

Rights of the Plan Administrator

The Benefit Plans Administrative Committee, the Plan Administrator, shall have the power and authority in its sole, absolute and uncontrolled discretion to control and manage the operation and administration of the Plan and shall have all powers necessary to accomplish these purposes. The responsibilities and authority of the Plan Administrator shall include, but not be limited to, the following:

- Determining all questions regarding the eligibility of employees to participate;

- Determining the amount and kind of benefits payable to any participant, spouse or beneficiary;

- Establishing, reducing to writing and distributing to any participant or beneficiary a claims procedure and administering that procedure, including the processing and determination of all appeals thereunder; and

- Interpreting the provisions of the Plan, including the publication of rules for the regulation of the Plan, as it in its sole, absolute and uncontrolled discretion are deemed necessary or advisable and which are not inconsistent with the express terms thereof or ERISA.

If you have any questions about the Plan, you should contact your local benefits administrator.

Family and Medical Leave Act

Subject to the requirements of the Family and Medical Leave Act of 1993 (FMLA), as amended, any participant entitled to FMLA may continue his/her coverage and any dependent coverage under this Plan as if continually employed during the FMLA leave period. You may be entitled to FMLA for the following reasons:

- Birth of a child or placement of a child with you for adoption or foster care,
- To care for a seriously ill spouse, child or parent,
- To care for a covered service member if you are the spouse, child, parent or next of kin of the covered service member, or
- You are unable to perform your job functions due to a serious health condition.

The Company is responsible for determination of your eligibility, rights, or the length of leave period for FMLA, and shall notify the Plan for purposes of continuing your coverage under this Plan.

COBRA - Continuation of Coverage at Your Own Expense

Under a federal law commonly known as COBRA, you, your spouse and dependent children may elect to temporarily continue your current health care benefits coverage under the company medical, dental, and vision plans and the health care flexible spending account in certain instances where coverage otherwise would end. Individuals entitled to COBRA continuation (qualified beneficiaries) are you, your spouse and your dependent children who are covered at the time of a qualifying event. In addition, a child who is born to you or adopted or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary.

<u>Qualifying Events</u>

If your employment terminates with the company for any reason other than your gross misconduct or if your hours worked are reduced so that your Plan coverage is reduced or terminated, you, your covered spouse and dependent children may continue your current health care benefits coverage under the Plan for up to 18 months.

If you as an employee of the company should die, become divorced or become entitled to Medicare, your covered dependents whose health coverage under the Plan would be reduced or terminated may continue current health care benefits coverage under the Plan for up to 36 months. Also, your covered children may continue their current health

care benefits coverage election for up to 36 months after they no longer qualify as covered dependents under the terms of the Plan.

Any period of coverage provided by the Company after a qualifying event as stated in this section may run concurrently with continuation coverage eligibility. For example, if the Company provides coverage for 12 months after a qualifying event, the company may apply those 12 months to your 18-month period of COBRA eligibility.

COBRA continuation for the health care flexible spending account is only available if the benefit available at the time of the qualifying event exceeds the COBRA premium for the remainder of the plan year.

In no case, other than for a covered retiree and the retiree's covered family members during the company's bankruptcy proceedings, may the total amount of continued coverage be more than 36 months.

Certain events may extend an 18-month COBRA continuation period:

- If your dependent(s) experience a second qualifying event such as death, divorce or change in dependent status, within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event). If you as an employee, cancel coverage on a spouse in anticipation of a divorce, upon receiving notice of the divorce, the company is required to make COBRA continuation available, effective on the date of the divorce, but not for any period before the date of divorce.

- In the case of a qualified beneficiary who is born to, or placed for adoption with a covered employee during a period of COBRA continuation, the duration of COBRA coverage is measured from the date of the covered employee's qualifying event. If a second qualifying event occurs before the actual birth or adoption placement, the duration of coverage will be for 36 months from the date of the original qualifying event.

- If you as an employee of the company became entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (such as your termination of employment or reduction in hours of work) happens within 18 months, your dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.

- If you or your dependent is disabled (as determined by the Social Security Administration) on the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months). In the case of a qualified beneficiary who is born to, or placed for adoption with a covered employee during a period of COBRA

continuation, the 60-day period is measured from the date of the child's birth or placement for adoption. To qualify for this disability extension, your local benefits administrator must be notified of the person's disability status both within 60 days after the Social Security disability determination is issued *and* before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify your local benefits administrator within 30 days after this determination.

- Important Note: If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary (whether or not disabled) may further extend COBRA coverage for 7 more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

Giving Notice That A COBRA Event Has Occurred

To qualify for COBRA continuation upon divorce or loss of a child's dependent status under the company health plan, you are required to notify the Plan Administrator of the divorce or loss of dependent status within 60 days after the later of the event or the date the individual would lose coverage under the Plan. Your covered dependent will then be contacted with instructions for continuing your current benefits coverage. Individuals already on COBRA must notify the Plan Administrator within these deadlines if a divorce or loss of child's dependent status occurs that would extend the period of COBRA coverage for your spouse or covered dependents.

For other qualifying events (if your employment ends, your hours are reduced, or you become entitled to Medicare), you will be contacted with instructions for continuing your medical coverage. In the event of your death, the company will notify your covered dependents how to continue medical coverage.

Should you be on a Family Medical Leave of Absence and elect not to return to work, your qualifying event occurs on the last day of your FMLA leave.

Electing and Paying for COBRA Continuation Coverage

You and/or your covered dependents must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered dependents would lose coverage as a result of the qualifying event; or

- The date the company notifies you and/or your covered dependents of your right to choose to continue coverage as a result of the qualifying event.

A qualified beneficiary is entitled to the coverage made available to similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not occurred.

In computing deductible credits and other plan limits for family and family units receiving COBRA coverage, the plan is required to take into account only expenses incurred before the qualifying event by family members who elect COBRA.

If you are denied coverage by another party which is in violation of applicable law, (including HIPAA) you will be considered a qualified beneficiary if a qualifying event has occurred.

If you are incapacitated a legal representative may elect COBRA coverage on your behalf or other dependent qualified beneficiaries.

If you elect continuation coverage, you or someone on your behalf must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. The cost of COBRA coverage is 102% of the full cost of Plan coverage. The cost of coverage for the 19th through 29th months of coverage under the disability extension is 150% of the full cost of coverage, except as provided below.

COBRA coverage is 102% of the full cost of Plan coverage. The cost of coverage for the 19th through 29th months of coverage under the disability extension is (1) 150% of the full cost of coverage for all family members participating in the same coverage option as the disabled individual, and (2) 102% for any family members participating in a different coverage option than the disabled individual, except as provided below.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual subsequently becomes disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, the 19th through 29th month), then the rates are (1) 150% for all family members participating in the same coverage option as the disabled individual, and (2) 102% for any family members in a different coverage option than the disabled individual.

If you elect COBRA continuation but then fail to pay, or the responsible party fails to pay the premiums due within the initial 45-day grace period, or you or the responsible party fails to pay any subsequent premium by the due date, your coverage will be terminated. Your coverage can be reinstated if payment is made by the end of the 30-day grace period.

Payment is considered to be made on the date it is sent to the company based on the postmark. If you make a timely but incorrect payment to the company in an amount that is not significantly less than the cost of your continuation coverage, you will be notified by the company of the amount of the deficiency. You will have 30 days from the date of the notice from the company to pay the full amount.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The company reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Coverage During the Continuation Period

If coverage under the company medical, dental and vision plans is changed for active employees (non-COBRA beneficiaries), the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods or if a change in status occurs, or at other times under the Plan to the same extent that active employees (non-COBRA beneficiaries) may do so.

When COBRA Continuation Coverage Ends

The COBRA coverage under the company medical, dental and vision plans will end for any person when the first of the following occurs:

- The applicable continuation period ends.

- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected or any subsequent premium is not paid within 30 days after it is due.

- You become covered under another health plan, and any preexisting conditions, exclusions or limitations of that plan do not apply or are satisfied by you. (This provision applies individually to each individual with COBRA coverage.) In some cases, a plan's preexisting conditions exclusion period may be reduced by each month that you and your family had continuous coverage (including COBRA continuation coverage) with no break in coverage greater than 63 days.

- After the date COBRA is elected, the qualified beneficiary becomes entitled to Medicare. (This does not apply to other qualified beneficiaries who are not entitled to Medicare.)

- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.

- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends unless a second qualifying event has occurred.

- The company terminates health coverage for all employees.

Special Note Regarding Medicare

If you (the employee) become entitled to Medicare (that is, you become enrolled, not just eligible) before you elect COBRA, your Medicare enrollment has no affect on the maximum COBRA continuation period available to you. However, if you elect COBRA continuation *first* and then enroll in Medicare, your Medicare enrollment will terminate your COBRA coverage immediately.

Conversion

If you do not wish to purchase COBRA continuation coverage as described above, you may—within 90 days—convert your medical insurance to a policy offered by the insurance carrier to individual subscribers. If you purchase COBRA continuation coverage, the conversion privilege is available to you when your COBRA continuation coverage ends.

Coverage levels will be different from what is available under the company Plan. You have to pay your premiums directly to the insurance carrier.

Dependent children who no longer qualify for the company Plan may also convert their coverage to an individual policy if they do not wish to purchase COBRA continuation coverage or after their COBRA continuation coverage has ended. Again, the coverage will be different from the company Plan and required plan premiums will be paid directly to the insurance carrier.

Contact the Plan Administrator for further details. Also, if you or your spouse have changed your address, please notify the Plan Administrator.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rules with these limits as follows:

1. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you because of HIPAA's restrictions on pre-existing condition clauses, the Company may terminate your COBRA coverage.

2. You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Company reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Protected Health Information (PHI)

HIPAA requires that health plans must protect the confidentiality of your private health information. A complete description of your rights under HIPAA will be found in the Plan's privacy notice, which will be distributed to you upon enrollment and will be available from your local benefits administrator.

This Plan and the Plan Sponsor will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan will require all of its business associates to observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact your local Benefit Plan Administrator. The Company's Privacy Official will be your contact if you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA.

"Qualified Medical Child Support Orders"

The Plan will comply with any Qualified Medical Child Support Order (as such term is defined in ERISA § 609) by providing group coverage under the health care plan to the named child or children (alternate recipient) based upon conditions specified by a Qualified Medical Child Support Order. Procedures regarding Qualified Medical Child Support Orders are available free of charge from your local Plan Administrator.

Newborns' and Mothers' Health Protection Act

In accordance with the "Newborns' and Mothers' Health Protection Act," the Plan may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

Special Enrollment Rights

If you have declined coverage under an AK Steel Corporation group health plan for yourself or your dependents because you (or your dependents) are covered under another health insurance arrangement, you may be able to subsequently elect coverage under an AK Steel Corporation group health plan if such other coverage is lost for any of the following reasons: exhaustion of COBRA or state law continuation rights, loss of eligibility due to legal separation, divorce, death, termination of employment or reduction in hours, or the cessation of employer contributions for non-COBRA continuation coverage. To enroll yourself or your dependents, you must contact your employee benefits office and request enrollment within 30 days after your other coverage ends. The employee benefits office will determine whether you are eligible to elect coverage.

Additionally, if you acquire a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to elect coverage under an AK Steel Corporation group health plan for yourself, your spouse or the new dependent. To elect such coverage, you must contact your employee benefits office within 30 days after the marriage, birth, adoption, or placement for adoption. The employee benefits office will determine whether you are eligible to elect coverage.

Qualified Change in Family Status

Under IRS regulations, elections for health care coverage and flexible spending accounts may not be changed after the annual open enrollment period. However, if any of the following changes in family status occur, you may change an election that is consistent with the change in family status:

- Marriage,
- Divorce, annulment or legal separation,

- Death of spouse,
- Birth, death or adoption of child or placement for adoption,
- Significant cost or coverage change,
- Employee or spouse switching from full-time to part-time or part-time to full-time,
- Employee or spouse taking or returning from an unpaid leave of absence,
- Significant change in health coverage of the employee or spouse attributable to the spouse's employment,
- Separation from service,
- Cessation of required contributions,
- Commencement or termination of spouse's or dependent's employment,
- Reduction in hours by employee, spouse or dependent including full-time or part-time,
- Dependent satisfies or ceases to satisfy requirement for unmarried dependent, or
- Change in place of residence or work of employee, spouse or dependent

Changes in health care elections must be consistent with the change in family status. For instance, if you get married, you may change from single to family coverage. Changes in family status must be reported in writing to your local benefits administrator within 30 days following the change.

ERISA Statement of Rights

As a participant in the AK Steel Corporation Welfare Benefit Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

<u>Receive Information About Your Plan and Benefits</u>

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

If you have creditable coverage under another plan, it may reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the plan, or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not

sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Important Plan Information	
Plan Sponsor	AK Steel Corporation
Plan Administrator	Benefit Plans Administrative Committee
Name of Plan	AK Steel Insurance Benefits Plan (Section 125 Plan)
Plan Type	Welfare Benefit Plan
Plan Year	January 1 through December 31
Employer Identification Number	31-1267098
Plan Identification Number	501

REIMBURSEMENT ACCOUNT WORKSHEET

This worksheet can be used to help you decide how much, if any, to contribute into the Reimbursement Account. This is important for two reasons.

1. Unused money will be forfeited when the account is closed.

2. Money that is specified for one type of expense cannot be used to pay another. For example, if you designated 100% of your Reimbursement Account to be used for Dependent Care Expenses, none of it could be used for Health Care Expenses.

Health Expenses	**This Year's Out-Of-Pocket Expenses**	**Next Year's Estimated Out-Of-Pocket Expenses**
Doctor Visits	$_____	$_____
Surgical Expenses	$_____	$_____
Hospital Expenses	$_____	$_____
Prescription Drugs	$_____	$_____
Vision Care	$_____	$_____
Routine Physicals	$_____	$_____
Dental Care	$_____	$_____
Immunizations	$_____	$_____
Other	$_____	$_____
Total Health Expenses	$_____	$_____
Dependent Care Expenses	$_____	$_____
Total of Estimated Health Expenses & Dependent Care Expenses	$_____	$_____
Percentage of Total	_____% Health Expenses	_____% Health Expenses
	_____% Dependent Care Expenses	_____% Dependent Care Expenses