SUMMARY PLAN DESCRIPTION

FOR

USG RETIREE MEDICAL HRA PLAN

January 1, 2021

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HRA SUMMARY

INTRODUCTION

USG Corporation ("USG") has established the USG Retiree Medical HRA Plan (the "HRA") for the benefit of USG's and its participating affiliates' retirees and their spouses. The HRA is a participating program under the USG SelectBenefits Program (the "Plan"). (USG and its participating affiliates are collectively referred to as the "Employer.") The purpose of the HRA is to reimburse eligible retirees for certain medical expenses which are not otherwise reimbursed. The HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (the "Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

This summary plan description ("SPD") explains the principal terms of the HRA in non-technical language. The complete terms and conditions of the HRA are described in a complex legal document. This SPD is not intended to cover every circumstance contained in the Plan document. HRA benefits are paid only if provided for in the official plan document. If there are any differences between this SPD and the official Plan document, the Plan document will control. Except as otherwise noted, this SPD summarizes the HRA and the Plan as in effect on January 1, 2021.

Note that capitalized terms used in this SPD are defined the first time they are used or are defined in the Plan Information Appendix at the end of this booklet. The terms "you" and "your" when used in this SPD refer to a retired employee of an Employer who otherwise meets all the eligibility and participation requirements under the HRA. Receipt of this SPD does not guarantee that the recipient is a participant under the HRA or otherwise eligible for benefits under the HRA.

PART I
GENERAL INFORMATION ABOUT THE HRA

Q-1. What is the purpose of the HRA?

The purpose of the HRA is to reimburse Participants (as defined in Q-2) for Eligible Medical Expenses (as defined in Q-6) which are not otherwise reimbursed by any other plan, program, or insurance policy. Reimbursements for Eligible Medical Expenses paid by the HRA generally are excludable from the Participant's taxable income.

Q-2. Who can participate in the HRA?

You can participate in the HRA if you are a Retiree who either satisfies the requirements to be an Eligible Retiree (see Q-3) or has an Eligible Spouse (see Q-4). Retirees who become covered under the HRA, as explained in Q-3, are called "Participants."

You will be a "Retiree" under the HRA upon retirement from the Employer if:

- You were hired before January 1, 2002;
- You are eligible to retire under the terms and provisions of the USG Corporation Retirement Plan and to receive benefit payments immediately upon your retirement;

- You live in the United States and continue to live in the United States throughout your retirement; and
- You are not eligible for Medicare or, if you are Medicare eligible, you have a Spouse who is not Medicare eligible.

Effective January 1, 2020, you will only be able to become a participant in the HRA upon retirement if you are not Medicare Eligible or if you have an Eligible Spouse who is not Medicare Eligible.

You are not eligible to participate in the HRA unless you were classified by the Employer as an employee before your retirement. If you were not classified as an employee by the Employer, you will not be a Retiree under the HRA, even if you are later determined by a court or governmental agency to be or to have been a former common law employee of the Employer.

Q-3. How do I become a Participant in the HRA?

You become a Participant by satisfying the requirement for being an Eligible Retiree or if you have an Eligible Spouse (see Q-4).

For Retirees who are not Medicare-eligible. You will become an "Eligible Retiree" once you contact Via Benefits to establish your HRA Account. You will remain an Eligible Retiree until:

- You contact Via Benefits to waive your participation in the HRA,
- You notify Via Benefits that you have received or intend to claim a government premium subsidy or tax credit for your purchase of health insurance,
- You become Medicare-eligible and fail to satisfy the requirements for remaining an Eligible Retiree as described below, or
- You become Medicare-eligible and you exhaust your HRA funds earned while you were an Eligible Retiree (see Q-14).

You should contact Via Benefits 30 days before your USG Medical Plan (or other medical insurance) coverage ends to ensure there is no disruption in your medical coverage. You may be required to provide a notice of creditable coverage when you apply for coverage through the Exchange.

For Medicare-eligible Retirees who have an Eligible Spouse who is not Medicare-eligible. If you are Medicare-eligible (including Medicare eligibility due to disability or end stage renal disease), you can only become a Participant if you have an eligible Spouse who is not eligible for Medicare and that Spouse enrolls pursuant to Q-4 below.

Once you become an Eligible Retiree, an HRA Account will be established for you, and you will automatically be a Participant in the HRA. You will remain an Eligible Retiree as long as you satisfy the above requirements. **If you lose Eligible Retiree status at any time after you become Medicare-eligible, you and your Eligible Spouse will permanently lose eligibility for the HRA.**

Q-4. Can my dependents participate in the HRA?

You are an HRA Participant if you are a Retiree and you satisfy the requirements for participation in the HRA as described in Q-3. Generally, your Eligible Spouse is not a Participant in the HRA (however, see Q-11 regarding survivor coverage), but you will receive Benefit Credits for your Eligible Spouse and may be reimbursed from your HRA Account for any Eligible Medical Expenses you incur on behalf of your Eligible Spouse, as defined below. Reimbursement for your Eligible Medical Expenses is explained in more detail in Q-6 below. Your children's medical expenses are not eligible for reimbursement from your HRA Account.

If your Spouse is not Medicare-eligible. To cover your Spouse who is not Medicare-eligible as an "Eligible Spouse" under the HRA, he or she must contact Via Benefits. He or she will remain an Eligible Spouse until:

- You or your Spouse contacts Via Benefits to waive coverage under the HRA,
- You or your Spouse notifies Via Benefits that your Spouse has received or intends to claim a government premium subsidy or tax credit for his or her purchase of health insurance, or
- Your Spouse becomes Medicare-eligible and you exhaust your HRA funds earned while you were an Eligible Retiree or your spouse was an Eligible Spouse (see Q-14).

Your Spouse should contact Via Benefits 30 days before his or her coverage under the USG Medical Plan (or other medical insurance) ends to ensure there is no disruption in his or her medical coverage. He or she may be required to provide a notice of creditable coverage when applying for coverage through the Exchange.

If you get married after you retire, you should notify the Plan Administrator within 31 days of your marriage. If you timely notify the Plan Administrator, your new Spouse will become eligible for HRA benefits once he or she becomes an Eligible Spouse. If you notify the Plan Administrator more than 31 days after your marriage, your Spouse may become an Eligible Spouse as of the next Plan Year (assuming he or she satisfies all of the requirements for being an Eligible Spouse described in this Q-4).

Q-5. How does the HRA work?

One HRA Account will be established for each HRA Participant. If you are married, a joint HRA Account will be established if you have an Eligible Spouse. Your HRA Account can be used to reimburse you for Eligible Medical Expenses, defined below in Q-6.

Benefit Credits for you (if you are an Eligible Retiree) and your Eligible Spouse, if any, will be credited to your HRA Account as of January 1 of each calendar year. If you become a new Participant or Eligible Retiree in the middle of a year, you will receive a prorated Benefit Credit for you and your Eligible Spouse, if any, for your first year of participation following your enrollment in the HRA. If you get married in the middle of a year, you will receive a prorated Benefit Credit for your new Eligible Spouse as long as you notify the Plan Administrator within 31 days of your marriage. The amount of the annual Benefit Credit will be determined as described in the Appendix at the end of this SPD.

Your HRA Account balance will be reduced from time to time by the amount of any Eligible Medical Expenses for which you are reimbursed under the HRA. At any time, you may receive

reimbursement for Eligible Medical Expenses up to the amount in your HRA Account. Note that the law does not permit Participants to make any contributions to their HRA Accounts.

An HRA Account is merely a bookkeeping account on the Employer's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the HRA are paid entirely from the Employer's general assets.

Q-6. What is an "Eligible Medical Expense"?

An Eligible Medical Expense is an expense incurred by you (if you are an Eligible Retiree) or your Eligible Spouse for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment, or prevention of disease). Beginning January 1, 2021, "Eligible Medical Expense" includes out-of-pocket prescription and over-the-counter drug expenses (including premium expenses for prescription drug plans and menstrual care products).

Some common examples of Eligible Medical Expenses include:

- Premiums for medical and prescription drug coverage (including Medicare Advantage (Part C), Medigap, and Medicare Part D (prescription drug plans)) purchased through the Exchange;
- Premiums for individual dental, vision, or long-term care insurance;
- Medical, dental, or vision deductibles, copays, and coinsurance amounts;
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids;
- Prescription drug costs, including deductibles, copays, and coinsurance amounts that you pay out-of-pocket;
- Wheelchairs; and
- Medicare Part B premiums.

Some examples of common items that are not Eligible Medical Expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident, or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items are and are not Eligible Medical Expenses, consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Aren't Includible." (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement account.) If you need more information regarding whether an expense is an Eligible Medical Expense under the HRA, contact the Claims Administrator as provided in the Plan Information Appendix.

Only Eligible Medical Expenses incurred by you (if you are an Eligible Retiree) or your Eligible Spouse while you are a Participant in the HRA may be reimbursed from your HRA Account. Eligible Medical Expenses are "incurred" when the medical care is provided, not when you or your Eligible Spouse is billed, charged, or pays for the expense. Thus, an expense that has been paid but not incurred (*e.g.*, pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may <u>not</u> be reimbursed from an HRA Account:

- expenses incurred for qualified long term care services;
- expenses incurred *prior to the date* that you became a Participant in the HRA;
- your Eligible Spouse's expenses incurred prior to the date that your Spouse became an Eligible Spouse;
- expenses incurred *after the date* that you cease to be a Participant in the HRA (except as described in Q-11); and
- expenses that have been reimbursed by another plan or for which you or your Eligible Spouse intend to seek reimbursement under another health plan.

Q-7. When do I cease participation in the HRA?

If you are Medicare-eligible, your status as an Eligible Retiree will permanently end when your Eligible Spouse reaches Medicare eligibility.

If you are not Medicare-eligible, your status as an Eligible Retiree will be suspended if you notify Via Benefits that you have received or intend to claim a government premium subsidy or tax credit for your purchase of health insurance or if you move outside of the United States. While your Eligible Retiree status is suspended, you will not receive new Benefit Credits, and your medical expenses incurred during this suspension period will not be eligible for reimbursement. If you again satisfy the requirements for an Eligible Retiree, your HRA benefits will resume.

Your participation in the HRA will also be suspended if you are rehired by the Employer as an active employee. While your Participant status is suspended, neither you nor your Eligible Spouse, if any, will receive new Benefit Credits, and medical expenses incurred by you or your Eligible Spouse, if any, during this suspension period will not be eligible for reimbursement. Upon your subsequent retirement, if you again satisfy the requirements to be an HRA Participant, your coverage will resume, and your HRA balance prior to your suspension will be restored.

In addition, you will cease to be an Eligible Retiree, and your participation in the HRA will permanently end, on the earliest of:

- your date of death;

- the effective date of any amendment terminating your eligibility under the HRA; or
- the date the HRA or the Plan is terminated.

Your Spouse will permanently cease to be an Eligible Spouse on the earlier of:

- the date you cease to be a Participant in the HRA, other than because of your death (see Q-11 regarding survivor coverage);
- in the case of an Eligible Spouse, the date of your divorce;
- the effective date of any amendment terminating reimbursement for Eligible Spouse expenses under the HRA; or
- the date the HRA or the Plan is terminated.

Your Spouse's status as an Eligible Spouse will be suspended if you or your Spouse notifies Via Benefits that he or she has received or intends to claim a government premium subsidy or tax credit for his or her purchase of health insurance. While Eligible Spouse status is suspended, you will not receive new Benefit Credits for your Eligible Spouse, and your Eligible Spouse's medical expenses incurred during this suspension period will not be eligible for reimbursement. However, if your Spouse is not eligible for Medicare, he or she may again become an Eligible Spouse by timely contacting Via Benefits, as described in Q-4.

If you or anyone acting on your behalf makes a false statement on the application for enrollment, provides forged or falsified documentation or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the plan, the Plan shall be entitled to recover its damages, including legal fees, from you, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. Your HRA participation may be terminated if you or your Eligible Spouse commits fraud or makes an intentional misrepresentation of material fact with respect to your Plan or HRA coverage. To the extent permitted by law, your participation may be terminated retroactively.

You may not obtain reimbursement of Eligible Medical Expenses incurred after the date your or your Eligible Spouse's eligibility ends. (For the definition of "incurred," see Q-6.)

You may request reimbursement of Eligible Medical Expenses you incurred until your funds have been exhausted. If you die without a surviving Spouse, your estate or designated representatives may submit requests for reimbursement on your behalf. If you have a surviving Spouse upon your death, see Q-11.

Q-8. What happens if I do not use all of the credits allocated to my HRA Account during the Plan Year?

If you do not use all of the amounts credited to your HRA Account during a Plan Year, those amounts will be carried over to the following Plan Year and can be used to reimburse you for Eligible Medical Expenses incurred during subsequent Plan Years.

Q-9. How do I receive reimbursement under the HRA?

You must complete a reimbursement form and mail or fax it to the Claims Submission Agent as listed in the Plan Information Appendix, along with a copy of your insurance premium bill and

proof of payment. For requests for reimbursement of Eligible Medical Expenses other than insurance premiums, you should include an "explanation of benefits" or "EOB" from your health insurance plan showing the amount of the unreimbursed expense or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred.

If you are Medicare-eligible, you can download a reimbursement form at my.viabenefits.com/usg or request a form from the Claims Administrator identified in the Plan Information Appendix.

If you are not Medicare-eligible, you can download a reimbursement form at marketplace.viabenefits.com/usg or request a form from the Claims Administrator identified in the Plan Information Appendix.

Your claim is deemed filed when it is received by the Claims Submission Agent. (Do not mail your form to the Claims Administrator or Plan Administrator, as this may result in a delay in processing.) Automatic reimbursement may be available for your Exchange health insurance premiums. Contact the Claims Administrator for more information about automatic reimbursement.

Routine requests for information regarding your benefits under the HRA and other similar inquiries will not be considered reimbursement "claims" that require processing under ERISA and the Plan's claims and appeals procedures. If you wish to make a claim for HRA benefits in accordance with your rights under ERISA, you must follow the procedures described above.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

Your HRA reimbursements will be made by check sent to the address on file with the Plan. Any reimbursement payment made by check must be cashed within one year after it is issued. If any reimbursement check is not presented for payment within one year of the date of issue, the check will be voided, and the reimbursement amount will be forfeited. Within one year of the original issue date, you may request that the check be reissued. Payment under the reissued check will be made under the terms and provisions of the HRA as in effect when the claim was originally processed, and no interest will be payable on that amount. If you misplace a reimbursement check, you should contact the Claims Administrator to request that the check be re-issued.

You may designate an authorized representative (including an attorney) to pursue a claim or appeal on your behalf. The Claims Administrator or Plan Administrator (or their designee) may establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. You will bear the fees and expenses of any authorized representative whom you designates to act on your behalf.

You may provide the Claims Administrator or Plan Administrator (or their designee) with a written authorization, on a form approved by the Claims Administrator or Plan Administrator, for an authorized representative to represent and act on your behalf and consent to release of information related to you to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Claims Administrator or Plan Administrator. If a

party is not properly designated as an authorized representative under the Plan, the Claims Administrator or Plan Administrator will not communicate with that party with respect to any benefit claim or other exercise of your rights under the Plan. An assignment of benefits by you to a health care provider does not constitute a designation of an authorized representative for purposes of the Plan.

Q-10. What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified, and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your claim is denied based on your eligibility to participate in the HRA, the eligibility status of your Eligible Spouse, or the amount of your annual Benefits Credits, the notice of denial may come from the Plan Administrator.

If your request for reimbursement under the HRA is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent (or the Plan Administrator, as applicable), you may file a written appeal. You should file your appeal with the Claims Fiduciary at the address provided in the Plan Information Appendix no later than 180 days after receipt of the denial notice. If your claim relates to your eligibility to participate in the HRA, the eligibility status of your Eligible Spouse, or the amount of your annual Benefits Credits, you should instead submit your appeal to the Plan Administrator within 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial as needed to perfect your claim, as well as any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Claims Fiduciary (or the Plan Administrator, as applicable) receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial described above. If your appeal is based on your eligibility to participate in the HRA, the eligibility status of your Eligible Spouse, or the amount of your annual Benefits Credits, the decision on appeal will come from the Plan Administrator.

All decisions and communications relating to claims by participants, denials of claims, or claims appeals shall be held strictly confidential by the participant, his beneficiaries (or other claimants), the Claims Fiduciary, the Plan Administrator, your Employer, and their agents during and at all times after your has been submitted in accordance with the claim procedures for the Plan.

The Claims Fiduciary's or Plan Administrator's decision on appeal is final and binding. Benefits will be paid under the HRA only if the Claims Submission Agent, the Claims Fiduciary, or the Plan Administrator (as applicable) determines, in its discretion, that you are entitled to them. You cannot bring any legal action against USG, your Employer, the Plan, the Plan Administrator, the Claims Administrator, the Claims Fiduciary, or the Claims Submission Agent until you have properly submitted a request for benefits or reimbursement as described in this section and all required reviews of your claim have been completed.

After completing the Plan's claims and appeals process, if you want to bring a legal action for HRA benefits, you must do so within 90 days of the date you are notified of the Plan's final decision on your appeal. **If you do not file a legal action within this 90-day time period, you lose any rights to bring such an action against USG, your Employer, the Plan, the Plan Administrator, the Claims Administrator, the Claims Fiduciary, and the Claims Submission Agent.** If you choose to bring a legal action for benefits, the evidence that you may present in your case will be strictly limited to the documents, information, and other evidence timely presented to the Claims Submission Agent, the Claims Fiduciary, or the Plan Administrator, as appropriate, in connection with the Plan's claims and appeals procedures.

Q-11. What happens if I die?

If you (the Participant) die with no surviving Spouse, your HRA Account is immediately terminated upon your death, but your estate or representatives may submit claims for Eligible Medical Expenses incurred before your death. Claims must be submitted within 180 days of your death. Any amounts remaining in your HRA Account after all timely submitted claims have been processed will be forfeited.

If you die with a surviving Eligible Spouse, your Eligible Spouse will become the Participant with respect to your HRA Account and may submit claims for your Eligible Medical Expenses incurred prior to your death. Your Eligible Spouse will continue to receive annual Benefit Credits for himself or herself (your surviving Eligible Spouse will not receive your share of the Benefit Credits for the years following your death) and may continue to submit his or her Eligible Medical Expenses for reimbursement. Your HRA Account will be terminated upon your surviving Eligible Spouse's death after all timely submitted claims have been processed.

Q-12. Are my benefits taxable?

The HRA is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. The Employer cannot guarantee the tax treatment to any given Participant or Spouse, as individual circumstances may produce different results and tax rules are subject to change. If there is any doubt, you should consult your own tax advisor.

Q-13. What happens if I receive an overpayment under the HRA or a reimbursement is made in error from my HRA Account?

If it is later determined that you or your surviving Eligible Spouse received an overpayment or a payment was made in error (*e.g.*, you were reimbursed from your HRA Account for an expense that is later paid by another health plan), you or your surviving Eligible Spouse will be required to refund the overpayment or erroneous reimbursement to the HRA.

If you do not refund the overpayment or erroneous payment, the Plan Administrator reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the HRA. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Q-14. How long will the HRA remain in effect?

If you are a Medicare-eligible Retiree and you had an HRA Account on December 31, 2019, no new Benefit Credits (see Q-5) will be added to your HRA Account for any Medicare-eligible individual after 2019, but you may continue to request reimbursement from your HRA Account for Eligible Medical Expenses incurred by you or your Medicare-eligible Eligible Spouse until you have exhausted all the funds in your HRA Account. USG's intent is for HRA Accounts for Participants who are Medicare-eligible (and who do not have an Eligible Spouse who is not Medicare-eligible) to terminate after all timely submitted claims are paid.

Currently, USG has no plans to sunset the HRA for Eligible Retirees who are not eligible for Medicare. However, USG has the right to amend, modify, or terminate the HRA and the Plan at any time for any reason, including the right to change the classes of persons eligible for participation, the types of expenses eligible for reimbursement, and the amounts credited to HRA Accounts. USG also reserves the right to reduce or eliminate any amounts currently credited to a Participant's HRA Account.

Employers participating in the HRA other than USG (such as a related affiliate of USG) may terminate their participation in the HRA at any time upon 60 days written notice to USG and Plan Administrator.

Q-15. How does the HRA interact with other medical plans?

Only medical care expenses that have not been and will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). You must first submit any claims for medical expenses to your other plans before submitting the expenses to the HRA for reimbursement.

If you are also a participant in a health flexible spending account sponsored by your Employer during the year of your retirement, the expenses covered both by the HRA and the health flexible spending account must be submitted first to the health flexible spending account.

Q-16. What is "continuation coverage" and how does it work?

Under a federal law called "COBRA," an Eligible Spouse under the HRA may elect to continue coverage under the HRA for a limited time after the date he or she would otherwise lose HRA benefits because of a divorce or legal separation from the Participant. You (the Participant) and your Eligible Spouse are also eligible for continuation coverage if you would otherwise lose coverage under the HRA because the Employer files for bankruptcy. Individuals who would lose HRA coverage as a result of one of these "qualifying events" are referred to as "qualified beneficiaries."

Note that you or your Eligible Spouse is required to notify the COBRA Service Provider in writing of a divorce or legal separation within 60 days of the event. If you or your Eligible Spouse do not provide notice to the COBRA Service Provider, your Eligible Spouse will lose the right to continue coverage under the HRA.

If a qualified beneficiary elects to continue coverage, the qualified beneficiary is entitled to the level of coverage under the HRA in effect immediately preceding the qualifying event. For subsequent years, the qualified beneficiary may also be entitled to Benefit Credits equal to the amounts credited to the HRA Accounts of a similarly situated Participant or Eligible Spouse (subject to any restrictions applicable to similarly situated Participants or Eligible Spouses, so long as the qualified beneficiary pays the applicable premium on time each month.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The COBRA Service Provider will notify qualified beneficiaries of the applicable premium at the time of a qualifying event. The qualified beneficiary will have forty-five (45) days from the date of the COBRA election to pay the first premium, which includes the period of coverage from the date of the COBRA election retroactive to the date of the qualifying event. Subsequent COBRA premiums are due on the first day of the month for which coverage is to be provided. If the required COBRA premiums are not paid when due, the qualified beneficiary's COBRA coverage will terminate and cannot be reinstated. After the first payment, COBRA premium payments will be considered timely only if made no later than thirty (30) days following the due date.

For divorce or legal separation, coverage may continue for up to 36 months following the qualifying event. In the event of the Employer's bankruptcy, qualified beneficiaries may continue their coverage under the HRA until the date of your (the Participant's) death. If a Participant dies while receiving COBRA continuation coverage, his or her surviving Eligible Spouse qualified beneficiary may elect to continue coverage for up to thirty-six (36) additional months after the Participant's death. However, COBRA continuation coverage will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary notifies the COBRA Service Provider that he or she wishes to discontinue coverage;
- The date any required monthly premium is not paid when due or during the applicable grace period;
- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary;

- The date, after the date of the qualified beneficiary's election to continue coverage, that he or she becomes covered under Medicare (this rule does not apply in the case of bankruptcy); or
- The Employer ceases to provide any group health plan.

Q-17. Who do I contact if I have questions about the HRA or the Plan?

If you have any questions about the HRA or the Plan, you should contact the Claims Administrator or the Plan Administrator. Contact information for the Claims Administrator and the Plan Administrator is provided in the Plan Information Appendix.

PART II
ERISA RIGHTS

The Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that you, as a Participant in the HRA, will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites 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 Employee Benefits Security 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 apply 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 Plan Coverage

You and your Eligible Spouse have the right to continue HRA coverage if there is a loss of coverage under the HRA as a result of a qualifying event. However, you and/or your Eligible Spouse may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

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.

Enforcement of Your Rights

You may make a written claim for benefits with the Plan Administrator as described above. Routine requests for information regarding your benefits under the Plan and other similar inquiries will not be considered benefit "claims" that require processing under ERISA or the Plan's claims procedures. If you wish to make a claim for plan benefits in accordance with your rights under ERISA, you must do so in writing to the Plan Administrator.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal

any denial, all within certain time schedules. After exhaustion of the Plan's claims and appeals procedures described above in Q-9 and Q-10, any further legal action taken against USG, your Employer, the Plan, the Plan Administrator, the Claims Administrator, the Claims Fiduciary, or the Claims Submission Agent must be filed in a court of law no later than 90 days after the Plan Administrator's final decision on the 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 Plan Administrator.

If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court after you have completed the Plan's claims and appeals procedures described above in Q-9 and Q-10. 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 (e.g., if it finds your claim is frivolous).

Please remember that you may not file a lawsuit in federal court to enforce your rights until you have exercised, and exhausted, all administrative claim and appeal rights described in the Plan and this SPD, and then, further legal action, if any, must be filed in a court of law within 90 days after the Plan Administrator's final decision regarding the claim.

Assistance with Your Questions

If you have any questions about the Plan or the HRA, 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, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration at 1-866-444-3272 or online at www.dol.gov/ebsa.

PART III
LEGAL NOTICES

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 and its applicable regulations (HIPAA) is a federal law that, in part, requires health plans like the Plan to protect the privacy and security of your confidential health information. As required under the HIPAA privacy rules, the Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, plan administration, or as required or permitted by law. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the USG Notice of Privacy Practices, which has been provided to you. You can receive another copy of the Plan's Notice of Privacy Practices by contacting the Plan Administrator.

Mothers' and Newborns' Health Protection Act

Group health plans and health insurance issuers generally 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 issuers 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).

PLAN INFORMATION APPENDIX

GENERAL PLAN INFORMATION

Name of Plan:	USG Retiree Medical HRA Plan (the "HRA") *The HRA provides retiree health benefits to eligible retirees and their dependents. The HRA is a participating program under the USG SelectBenefits Program (the "Plan")*
Effective Date of this SPD:	January 1, 2021
Name, address, and telephone number of the Plan Sponsor:	USG Corporation 550 W. Adams St. Chicago, IL 60661 (312) 606-4000
Name, address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	USG Corporation 550 W. Adams St. Chicago, IL 60661 (312) 606-4000
Agent for Service of Legal Process:	Service of legal process may be made upon the General Counsel of USG Corporation or the Plan Administrator at the address listed above
Sponsor's federal tax identification number:	36-3329400
Plan Number:	501
Plan Year:	The Plan's fiscal records are kept on a plan year basis beginning each January 1 and ending on December 31

Claims Administrator: HRA benefits are administered under a contract with the Claims Administrator.	Towers Watson 10975 South Sterling View Drive Suite A-1 South Jordan, UT 84905 (844) 448-7303 Medicare: https://my.viabenefits.com/usg Pre-65: https://marketplace.viabenefits.com/usg
Claims Submission Agent: All HRA reimbursement forms and supporting documentation must be provided to the Claims Submission Agent. Forms should not be mailed to the Claims Administrator or Plan Administrator. The Plan Administrator has delegated responsibility for deciding HRA reimbursement claims for Eligible Retirees and Eligible Spouses to the Claims Submission Agent.	Willis Towers Watson P.O. Box 981155 El Paso, TX 79998-1155 Fax: 866-886-0879
Claims Fiduciary: The Plan Administrator has delegated responsibility for making final HRA reimbursement appeals determinations to the Claims Fiduciary.	USG Corporation 550 W. Adams St. Chicago, IL 60661 (312) 606-4000
COBRA Service Provider The Plan Administrator has delegated responsibility for administration of COBRA continuation coverage to the COBRA Service Provider.	National Benefit Services (NBS) 3736 Center Park Dr #120, West Jordan, UT 84084 (801) 282-1269
Funding:	Benefits are paid from the Employer's general assets. There is no trust or other fund from which benefits are paid

BENEFIT CREDITS

HRA Benefit Credits are based on the retiree's benefit service with USG.

Years of USG Benefit Service	Not Medicare Eligible
Less than 10	$0
10	$1,429
11	$1,600
12	$1,771
13	$1,943
14	$2,114
15	$2,286
16	$2,457
17	$2,629
18	$2,800
19	$2,971
20	$3,143
21	$3,314
22	$3,486
23	$3,657
24	$3,829
25	$4,000
26	$4,000
27	$4,000
28	$4,000
29	$4,000
30 plus	$4,000