

| TABLE OF CONTENTS | PAGE |
|--|-------------|
| PURPOSE OF THE PLAN | 1 |
| WHERE DO I GET ADDITIONAL ASSISTANCE? | 1 |
| WHO IS ELIGIBLE? | 1 |
| YOUR ELIGIBLE DEPENDENTS | 2 |
| What If My Dependent Works for Philip Morris USA Inc.? | 3 |
| Types of Membership | 4 |
| WHEN DOES COVERAGE BEGIN? | 4 |
| HOW DO I ENROLL? | 4 |
| DO I PAY FOR COVERAGE? | 4 |
| HOW DO I MAKE A CHANGE IN MY COVERAGE? | 5 |
| AM I ELIGIBLE IF I RETIRE OR BECOME DISABLED? | 6 |
| HOW DOES THE PLAN WORK? | 6 |
| Summary of Medical Benefits | 7 |
| WHAT IS THE DEDUCTIBLE? | 7 |
| WHAT IS THE OUT-OF-POCKET MAXIMUM? | 8 |
| WHAT IS A REASONABLE -AND-CUSTOMARY EXPENSE? | 8 |
| HOSPITAL ADMISSIONS REQUIRE PRIOR AUTHORIZATION | 8 |
| Other Services for Which You Should Contact CIGNA | 9 |
| MORE DETAIL ABOUT SPECIFIC TYPES OF EXPENSES | 9 |
| Maternity Care | 9 |
| Skilled Nursing Facility | 9 |
| Home Health Care | 9 |
| Oral Surgery/TMJ Treatment | 10 |
| Chemotherapy and Radiation Treatment | 10 |
| Emergency Accident Treatment | 10 |
| Hospice Care | 10 |
| Preventive Care | 10 |
| Well-Child Care | 11 |
| Other Medical Expenses Covered by This Plan | 11 |
| PRESCRIPTION DRUG BENEFIT | 12 |
| Authorization For Prescription Drugs | 12 |
| Mail Services Feature For Maintenance Drugs | 12 |
| Specialty Drugs | 13 |
| MENTAL HEALTH AND SUBSTANCE ABUSE CARE BENEFITS | 13 |
| Using the CBH Network | 13 |
| The Out-of-Network Benefits Choice | 13 |
| Prior Authorization Required for Out-of-Network Hospital Admission | 14 |
| SCHEDULE OF MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS | 14 |
| WHAT COSTS ARE NOT COVERED BY THIS PLAN? | 15 |
| DETERMINATION OF MEDICAL NECESSITY | 17 |
| Determination of Medical Necessity Required Prior To Care | 17 |
| Determination of Medical Necessity Required for Ongoing Care | 18 |
| HOW DO I FILE A CLAIM FOR BENEFITS? | 18 |

INDEMNITY HEALTH PLAN FOR HOURLY EMPLOYEES

| | |
|--|----|
| IF YOUR CLAIM FOR BENEFITS IS DENIED | 19 |
| HOW TO APPEAL THE DENIAL OF A CLAIM OR MEDICAL NECESSITY DETERMINATION | 19 |
| Appeals Procedure | 19 |
| Notice of Benefit Determination on Appeal | 20 |
| Legal Action | 20 |
| HOW TO APPEAL A DENIAL BASED ON ELIGIBILITY DETERMINATIONS | 20 |
| WHEN PAYMENT IS AVAILABLE FROM ANOTHER SOURCE | 21 |
| Coordination of Benefits (COB) | 21 |
| Right of Reimbursement (Subrogation) | 22 |
| Medicare | 22 |
| WHEN DOES COVERAGE STOP? | 23 |
| Termination of Employment | 23 |
| Absence | 23 |
| Dependents' Loss of Eligibility | 23 |
| Moving into a CIGNA POS Network Area | 23 |
| Death – With Five or More Years of Service | 23 |
| Death – With Less Than Five Years of Service | 24 |
| Retirement | 24 |
| Disability | 24 |
| COBRA CONTINUATION COVERAGE | 25 |
| Conversion Privilege | 26 |
| FMLA | 26 |
| GENERAL INFORMATION | 26 |
| Plan Name | 26 |
| Plan Type | 27 |
| Plan Identification | 27 |
| Employer and Plan Administrator | 27 |
| Plan Year | 27 |
| Plan Financing | 27 |
| Plan Continuance | 27 |
| Agent for Service of Legal Process | 28 |
| Collective Bargaining Agreements | 28 |
| STATEMENT OF PARTICIPANT'S RIGHTS UNDER ERISA | 28 |
| Receive Information About Your Plan And Benefits | 28 |
| Prudent Actions By Plan Fiduciaries | 29 |
| Enforce Your Rights | 29 |
| Assistance With Your Questions | 29 |
| ELIGIBLE CATEGORIES OF EMPLOYEES | 30 |

PURPOSE OF THE PLAN

There is probably nothing more important to us than good health. When illness or injury strikes, our first thought is to get well again. At Philip Morris USA Inc., that is our goal, and we maintain the Indemnity Health Plan for Hourly Employees to deliver quality medical care, cost efficiently. Benefits are provided through an administrative services agreement with Connecticut General Life Insurance Company (CIGNA) of Hartford, Connecticut. Prescription drug benefits are provided through an agreement with Caremark Inc. of Northbrook, Illinois.

This Summary Plan Description (SPD) describes the Indemnity Health Plan benefits. This Plan was formerly called the Philip Morris Health Care Network Plan (Out-of-Area Benefits). We urge you to read this SPD in order to become familiar with the benefits of the Indemnity Health Plan and refer to it when you have a question.

WHERE DO I GET ADDITIONAL ASSISTANCE?

To enroll in this Plan and to make any changes once you have enrolled, you should call the Altria Group Benefits Center (the Benefits Center) at **1-800-872-3777**.

For questions about the benefits themselves, such as, whether a service is covered, has a claim been paid, or how to access your health care, contact CIGNA Member Services at the phone number on your CIGNA ID card. If you don't have it available, the Benefits Center can provide the phone number for you. If you haven't yet enrolled in this Plan, call CIGNA at 1-800-633-1110 if you have questions about this Plan's benefits. If CIGNA is unable to resolve your question, call the Benefits Center for assistance.

If you try to use your health plan benefits and are told that your coverage can't be verified, it may be a computer error. Contact the Benefits Center for assistance. To avoid inconvenience, pay for your service or prescription and ask for an itemized receipt. The Benefits Center will be able to tell you how to obtain reimbursement.

WHO IS ELIGIBLE?

You are covered by this Indemnity Plan if:

- You are a regular, full-time hourly employee of the Company in one of the categories listed at the back of this booklet,

And:

- You do not live in a CIGNA Point of Service (POS) geographic area, and you have not elected to participate in an alternative plan, such as an HMO, that is available where you live or work, or
- You are a covered retiree under age 65 eligible for Medicare, or
- You are a disabled former employee, receiving benefits from the Long-Term Disability Plan for Hourly Employees and are also eligible for Medicare (see "[Am I Eligible if I Retire or Become Disabled?](#)" section).

You are not covered by this Indemnity Plan, but are covered by the Cigna POS Health Plan if you live in a CIGNA POS geographic area.

How do you know which health plans are available where you live? The Benefits Center sends you a Personal Fact Sheet when you are hired. It lists the health plan options available to

you along with other important information. After that, you will receive a Personal Fact Sheet annually, in the Fall of each year, prior to Annual Enrollment for the following year.

The Indemnity Plan is administered by CIGNA HealthCare in the U.S. The prescription drug program is administered by Caremark.

YOUR ELIGIBLE DEPENDENTS

If you are covered by this Plan, you may also enroll your eligible dependents if you agree to make the necessary contributions. Eligible dependents are:

- Your spouse, or your domestic partner, under age 65;
- Your unmarried, dependent child(ren) until the end of the month in which they reach age 23, who live with you in a parent-child relationship and depend on you for more than one-half of their support.
- Your dependent adult child.

The terms underlined above are defined as follows:

Spouse means the husband or wife to whom you are legally married. In the event of the death of an active employee with a minimum of 5 years of full time service, the surviving spouse and any eligible dependent children will be allowed to continue participation in the health plan, subject to the following:

- The spouse must have been covered at the time of the employee's death.
- The required monthly contributions are paid.
- Coverage for spouse ends upon the earlier of remarriage, age 65 or death.

Domestic partner means a person of the same or opposite sex with whom you meet all of the following:

- You have lived together for at least six months prior to enrollment and currently share your principal residence, intending to do so permanently;
- You are jointly responsible for each other's common welfare and financial obligations;
- You are both at least 18 years old and not related by blood to a degree of closeness that would prohibit marriage were you of the opposite sex;
- Neither of you are legally married to someone else nor in a domestic partnership with anyone else.

If your domestic partner does not depend on you for more than one-half of his/her financial support, the full cost of health plan coverage for your domestic partner is considered taxable income to you. If you are an active employee, the amount will be shown on your pay statement and annual IRS W-2 form. If you are retired, the amount will be reported annually on the IRS W-2 form you receive.

You may cover either one dependent adult child or a domestic partner under this Plan, but not both.

Domestic partner coverage is not available from certain HMOs that the Company offers. Call the individual health plan to verify coverage before you enroll.

Child means your natural or lawfully adopted child, a stepchild, foster child or other child who depends on you for support and lives with you in a regular parent-child relationship. You must call the Benefits Center to enroll a newborn or a child you acquire after you are

covered by this Plan. If you do not do so within 60 calendar days of the birth (or the date the child becomes your eligible dependent), you may not enroll the child until the next Annual Enrollment period in the Fall of the year.

Coverage for a dependent child who cannot earn a living because of mental retardation or physical handicap may be continued after the date coverage would normally end. To continue the coverage, proof of the condition must be submitted to the Benefits Center for approval within 31 days of the date coverage would otherwise terminate. During the following two years, CIGNA will periodically require proof of the continuation of the condition and your child's dependent status. After that, CIGNA may require proof no more than once a year. Dependent children of employees who have at least five years of vesting service under the Retirement Plan for Hourly Employees at their death, will remain covered as long as they meet the dependent eligibility requirements.

Each child named in a Qualified Medical Child Support Order as an alternative recipient is also eligible for coverage. A Qualified Medical Child Support Order is an order or a judgment from a state court or administrator directing the Plan to cover a child under this Plan. When an Order is received, each affected employee, child and guardian covered by the Order will be notified about the Plan's implementation procedure. Copies of the written procedures are available without charge. Contact the Benefits Center for a copy.

Dependent adult child means your child, as defined above, but who is age 23 or older. The child must be unmarried and dependent on you for more than one-half of his/her financial support and must be living with you in a parent-child relationship. You may cover either one dependent adult child or a domestic partner under this Plan, but not both. Your dependent adult child is not eligible for continued coverage upon your death.

Dependent adult child coverage is not available from certain HMOs that the Company offers. Call the individual health plan to verify coverage before you enroll.

When enrolling a dependent, you will be asked to verify that the dependent meets all of the eligibility requirements described above. In accordance with federal law, you will also be required to supply the Social Security number for each of your eligible dependents.

It is your responsibility to ensure that your covered dependents meet the Plan's dependent definition at all times. The Company reserves the right to request documentation from you to prove eligibility for coverage under this Plan. Depending on the dependent's relationship to you, this may include a copy of a marriage certificate, birth certificate, or income tax return, mortgage document, lease, joint bank account statement, or other proof of shared residence and financial responsibility.

What If My Dependent Works for Philip Morris USA Inc.?

If your spouse or domestic partner works for the Company, he or she will be covered as an employee, if eligible for Plan benefits. If you have eligible children one or the other of you, but not both, should enroll them in this Plan. If you and your spouse are both hourly-paid employees of the Company and work at the same location, you may choose to be covered as an employee or as a dependent of your spouse. If you choose coverage as a dependent under a 2-Worker Contract arrangement, your entire family will obtain healthcare coverage at no cost. You would need to contact the Benefits Center to inform them that both of you are hourly employees and would like to be set up under the same contract number.

If your spouse is a salaried employee, he/she may opt to waive coverage as an employee and choose to be covered as a dependent under your Plan.

Types of Membership

You may choose one of three types of membership:

- Employee Only, to cover yourself
- Employee & One (1) Dependent, to cover yourself and 1 dependent
- Employee & Family, to cover yourself and two or more eligible family members

You need not choose the same type of membership for dental and vision benefits as you choose for medical benefits.

Note: As a Philip Morris USA hourly couple receiving free family coverage, one employee will be enrolled in a 2-Worker Contract; the other employee must “waive” coverage.

WHEN DOES COVERAGE BEGIN?

You are covered under the Plan after three (3) continuous months of employment with the Company. If you have eligible dependents, their coverage will start when yours does, if you enroll them within 60 days of your date of employment and agree to make the necessary contributions.

If you do not choose to enroll all eligible dependents when you are hired, you may enroll them during the Annual Enrollment period held in the Fall of the year for coverage to begin the following January 1. Evidence of good health is not required.

If you acquire eligible dependents while covered under this Plan and want to provide them with coverage it is very important that you enroll them as soon as they become eligible; for example, within 60 days of a birth, adoption or marriage. Call the Benefits Center with the name, date of birth and Social Security number, if applicable. See “[How Do I Make a Change in My Coverage?](#)” for what happens if you fail to enroll them on a timely basis.

HOW DO I ENROLL?

Approximately four weeks after you begin employment, you will receive a personalized Enrollment Kit from the Benefits Center. Follow the instructions in the Enrollment Guide and contact the Benefits Center to enroll. There are no forms to complete.

You do not need to wait until you receive your Enrollment Kit from the Benefits Center to enroll. You may call the Benefits Center at 1-800-872-3777 and enroll as soon as your record is on file at the Center, usually within two weeks of your date of hire. Coverage under this Plan begins after three months of continuous service with the Company as long as you enroll within 60 calendar days of your employment date.

DO I PAY FOR COVERAGE?

The Company currently pays the full cost of this valuable benefit for you, the employee, and 80% of the cost for your dependent coverage. You pay only the remaining 20% of the cost for dependent coverage. You will be advised of payroll deductions for your share of this cost at the time you enroll and as changes occur.

The monthly cost to you is detailed on the Personal Fact Sheet you receive from the Benefits Center as part of your Enrollment Kit. To help offset the cost of dependent coverage, your contributions will automatically be deducted from your pay on a pre-tax basis. This reduces your taxable income and increases your take-home pay when compared to contributing on an after-tax basis. If you prefer to have your medical plan contributions deducted from your pay on an after-tax basis, you must make this election with the Benefits Center at the time

you enroll in the Plan or during Annual Enrollment for the subsequent Plan year. If you choose after-tax contributions for medical coverage, any contributions for dental and vision plan coverage will also be after-tax. Please refer to the separate Flexible Benefit Plan for Hourly Employees booklet for further details. Contributions for coverage of a domestic partner must be paid on an after-tax basis unless the domestic partner depends on you for more than one-half of his/her financial support.

Costs are subject to change annually. You will receive a Personal Fact Sheet prior to each new calendar year confirming your current coverage and costs for the following year. This Personal Fact Sheet is sent in the Fall of each year with information about the Annual Enrollment period during which you can make changes to your coverage for the following calendar year.

HOW DO I MAKE A CHANGE IN MY COVERAGE?

You may make changes to your initial Plan enrollment during the 60 calendar days following your date of employment. After that, changes can only be made if you have a change in status (described below) or during the Annual Enrollment period held each Fall for the following calendar year.

Mid-year changes to your coverage are permitted only if you have a change in status that affects your eligibility for coverage, or that of a dependent. In addition, the change to your coverage must be consistent with the event. These rules are established by federal regulations. The Benefits Center can help you determine whether or not a change is permitted.

These are the events that permit you to make a change within 60 calendar days of the event:

- Marriage, divorce or legal separation (if recognized under state law);
- Birth or adoption of a child, or change legal custody;
- Dependent no longer meets the Plan's eligibility requirements;
- You are required to provide coverage for your child as the result of a court order;
- Death of a spouse, child or dependent;
- Spouse or dependent starting or losing a job;
- Unpaid leave of absence by you, your spouse or your dependent;
- Significant change in the health coverage of you or your spouse attributable to your spouse's employment or to a change in residence or worksite;
- Switching from full-time to part-time employment status or vice versa by you or your spouse; or
- Entitlement to Medicare or Medicaid coverage.

If you wish to enroll a newly eligible dependent – for example, if you marry or if you have a child, contact the Benefits Center to enroll your new dependent immediately. You must do so within 60 calendar days of the date that the dependent first becomes eligible (e.g. birth date or date of marriage). If you do not, you will have to wait until the next Annual Enrollment period to add the dependent for coverage to begin the following January 1 and your dependent will not be eligible for coverage under this Plan for the balance of the year.

To cancel enrollment and payroll deductions for a dependent who is no longer eligible to be covered, contact the Benefits Center immediately. Regardless of whether or not you notify the Benefits Center, coverage ends at the end of the month in which the individual no longer

meets the definition of an eligible dependent. However, payroll deductions do not end until you notify the Benefits Center. No refund of contributions for ineligible dependents will be made if you fail to notify the Benefits Center on a timely basis.

AM I ELIGIBLE IF I RETIRE OR BECOME DISABLED?

If you retire under the Retirement Plan for Hourly Employees, your coverage will continue until age 65. Your spouse may continue coverage until age 65 and your eligible dependents may continue coverage until they are no longer deemed dependents.

You should apply for Medicare with the Social Security Administration at least three months prior to your 65th birthday. At age 65 your health care coverage with the Company will end. You will receive a Medicare Subsidy if you furnish a copy of your Medicare card to the Benefits Center.

If you qualify for benefits under the Long-Term Disability (LTD) Plan for Hourly Employees, you and your eligible dependents are eligible for continued coverage under this Indemnity Plan until age 65. You must make the required contributions. If you reside in a CIGNA POS area and are not eligible for Medicare, you are covered by the POS Health Plan. Benefits available under the POS Plan are described in a separate booklet in your three-ring binder.

If you are enrolled in an HMO at the time you or your spouse become eligible for Medicare prior to age 65, you may continue coverage under the HMO if it coordinates its benefits with Medicare. Call the Benefits Center to determine whether your HMO does so.

Disabled employees who qualify for Long Term Disability (LTD) benefits should enroll in Medicare Parts A & B once they are eligible. The cost of the Medicare Part B premium will be reimbursed to you by the Company through your monthly LTD check until age 65. You need to send a copy of your Medicare card to the Benefits Center in order to receive the reimbursement. **Failure to enroll in Medicare Parts A and B will result in loss of medical benefits from the Company because the Plan will subtract all benefits that would have been paid by Medicare if you had enrolled on a timely basis.**

Coverage continues until age 65, you are no longer eligible for LTD benefits, you stop making required contributions, or the Company ceases to participate in the Plan, whichever is earlier. If you die, your eligible dependents may continue coverage as long as they make the required contributions. Your spouse's coverage ends upon remarriage or at age 65.

The Company reserves the right to modify these eligibility requirements at any time (see the "[Plan Continuance](#)" section).

HOW DOES THE PLAN WORK?

The Plan provides Medical Benefits and Mental Health/Substance Abuse Benefits. Mental Health and Substance Abuse Benefits are described in a separate section of this SPD.

To be covered by this Plan, care must be medically necessary. This means that the service or supply must be necessary for the treatment or evaluation of a medical condition, and consistent with both the diagnosis and with generally accepted standards of medical practice.

Below is a summary of the Medical Benefits payable under this Plan. More detail follows the

table. You should contact CIGNA Member Services at the toll-free number on your ID card anytime you have a question about what is or is not covered by this Plan.

| Summary of Medical Benefits | |
|--|--|
| Annual Calendar Year Deductible | \$150 per individual/\$300 per family |
| Annual Calendar Year Out-of-Pocket Maximum | \$1,000 per individual/\$3,000 per family |
| Lifetime Individual Benefit Maximum | \$1,000,000 |
| Type of Expense | Percentage of Reasonable-and-Customary Charges Paid by Plan for Covered Services and Supplies. |
| Inpatient Hospital Expenses | 80% for 365 days per calendar year if the admission is precertified (see the section, "Hospital Admissions Require Prior Authorization") 60% for admissions that are not precertified |
| Inpatient Surgery (including Obstetrics) | 80% if precertified; 60% if not precertified |
| Skilled Nursing Facility | 80% for 120 days per calendar year |
| Home Health Care | 80% for up to 120 professional home visits per calendar year. One visit equals 4 hours. |
| Oral Surgery | 80% |
| Chemotherapy and Radiation Treatments | 100% with no deductible |
| Emergency Accident | 100% with no deductible for care on the day of or the day following the accident |
| Hospice Care | 80% |
| Preventive Care for Employee and Spouse or Domestic Partner | Once every 2 years: 100% with no deductible for covered examination, up to \$200 |
| Well-Child Care | 100% to age 5 with no deductible |
| Prescription Drugs Administered by Caremark 1-866-862-0758 | 3 tier drug program 2 times retail co-pay for 90-day supply |

A description of expenses that are not covered are provided in the "[What Costs Are Not Covered by This Plan?](#)" section.

WHAT IS THE DEDUCTIBLE?

The deductible is the amount of initial cost in a calendar year that is paid by you. After you pay this amount, the Plan then pays 80% of the remaining covered expenses incurred in the calendar year. The deductible is \$150 per person. You pay the first \$150 of covered medical expenses in a calendar year, the Plan pays 80% of the next \$5,000, and 100% of the remaining reasonable-and-customary expenses.

If several covered family members are sick or injured in a given calendar year, the total of the covered medical expenses that are applied to satisfy the deductibles is limited to \$300. After the \$300 family limit has been satisfied, no additional deductibles will apply in that calendar year.

Certain medical expenses are not subject to the deductible. These include: chemotherapy and radiation treatment; emergency accident treatment; and covered preventive and well-child care.

WHAT IS THE OUT-OF-POCKET MAXIMUM?

When the Plan pays 80% of covered reasonable-and-customary expenses, you pay the remaining 20%. The out-of-pocket maximum limits the amount of your 20% payments in a calendar year.

If you have spent \$1,000 in one calendar year as a result of your 20% portion for covered medical expenses for yourself or a dependent, additional covered reasonable-and-customary expenses for that individual in that calendar year will be paid in full. To prevent undue financial hardship in case several covered family members are sick or injured in a given calendar year, the Plan includes a \$3,000 family limit on out-of-pocket expenses.

Certain expenses that you pay do not count toward the out-of-pocket limit. These are the deductible; any expense or part of an expense that is not covered by this Plan, including amounts over the reasonable-and-customary fee limit; and 20% of a hospital bill if the admission or days are not approved by CIGNA (see the "[Hospital Admissions Require Prior Authorization](#)" section).

WHAT IS A REASONABLE-AND-CUSTOMARY EXPENSE?

To be covered by this Plan, an expense must be reasonable-and-customary. For a charge to be within the reasonable-and-customary range of fees, it must not be greater than the fee usually charged for that service by qualified providers within the same zip code area, as determined by CIGNA. Comprehensive and up-to-date statistical data on medical charges is collected and maintained by CIGNA to determine the range of allowable reasonable-and-customary fees.

If you have a question about whether your provider's charges are within the reasonable-and-customary range for fees, contact CIGNA Member Services at 1-800-633-1110 with the procedure code and the zip code of your provider.

HOSPITAL ADMISSIONS REQUIRE PRIOR AUTHORIZATION

To receive 80% benefits for an overnight confinement, your hospital admission requires authorization from CIGNA. To request pre-admission authorization, call CIGNA Member Services at the toll-free number on your identification card at least ten days prior to the date of admission. You will be asked for some information regarding the hospitalization. If your admission is an emergency, call CIGNA within 48 hours, or ask someone to make the call for you. If you are hospitalized outside of the U.S., this authorization requirement does not apply.

CIGNA will contact your doctor's office to review your admission and treatment plan. The review will be completed quickly and in most cases you can be admitted as planned. If there is a

difference of opinion, a CIGNA doctor will work with your doctor to develop an appropriate treatment plan. When the review is complete, CIGNA will notify your doctor.

If you call, receive written authorization and follow CIGNA's guidelines, you will receive benefits of 80% of covered hospital and physician charges associated with your stay. These expenses are subject to the annual deductible. If you do not call for authorization, or fail to follow CIGNA's guidelines, your benefits will be reduced to 60% of all covered charges during your hospital stay, including those made by a physician or surgeon for your care. The additional 20% you pay does not count toward your \$1,000 annual out-of-pocket maximum.

Be aware that the authorization procedure described here is separate from the authorization procedure for Mental Health and Substance Abuse Care (see the section, "[Prior Authorization Required for Out-of-Network Admission](#)").

Other Services for Which You Should Contact CIGNA

Home health care, hospice care, skilled nursing facility care, the rental or purchase of durable medical equipment, and private duty nursing are services for which you should contact CIGNA Member Services for information before obtaining care. Prior authorization is not required but by contacting CIGNA Member Services in advance you can verify what information or review is necessary for your care to be eligible for benefits. Of course, anytime you have a question about what is covered by this Plan, you can contact CIGNA Member Services for assistance.

MORE DETAIL ABOUT SPECIFIC TYPES OF EXPENSES

Maternity Care

Maternity benefits are provided on the same basis as treatment for other medical conditions. However, authorization from CIGNA is not required for a hospital stay of less than 48 hours for a normal delivery or 96 hours for a C-section. You must contact CIGNA Member Services if your stay, or your baby's will be longer. If you cannot make the call, someone else may do so on your behalf. Provided you do so, the Plan pays 80% of the reasonable-and-customary hospital, obstetrician, and other physician charges associated with your care and that of your baby. These expenses are subject to the annual deductible. Benefits are paid at 60% if your stay is longer than 48 hours, or as applicable, 96 hours and you do not follow the authorization requirement.

Call the Benefits Center to enroll your baby in the Plan as soon as possible after the birth.

If you do not do so within 60 calendar days of the birth, coverage for the baby will be terminated. You will not be able to enroll your baby as a dependent until the next Annual Enrollment period for the following year. (See the "[How Do I Make a Change in My Coverage?](#)" section.)

Skilled Nursing Facility

A skilled nursing facility is a licensed institution that provides inpatient physical rehabilitation services or skilled nursing and medical care to assist your recovery from an illness or injury. The Plan pays 80% of reasonable-and-customary skilled nursing facility expenses for 120 days per calendar year. This type of expense is subject to the annual deductible.

Custodial care is not covered. This is care that is not required to be performed by trained medical personnel. It includes services related to watching or protecting a person, or performing or assisting with daily living activities.

Home Health Care

The Plan pays 80% of reasonable-and-customary expenses for up to 120 professional home visits per calendar year. One visit equals up to four hours. This type of expense is subject to the annual deductible.

The home health care must be provided by a qualified home health care agency and your physician must supply the agency with a written treatment plan for your care. As described above in the "Skilled Nursing Facility" section, custodial care is not covered.

Oral Surgery/TMJ Treatment

Oral surgery refers to procedures for the mouth or jaw not in connection with the treatment of teeth or the tissues that surround and support the teeth. Procedures performed in connection with the treatment of teeth or the tissues that surround and support the teeth are covered under the Dental Plan for Hourly Employees.

The Plan pays 80% of reasonable-and-customary expenses for oral surgery. This type of expense is subject to the annual deductible. Some examples of oral surgery procedures are resetting a jaw, removal of a cyst or tumor, or the insertion and removal of stitches.

TMJ treatment refers to the temporomandibular joint and conditions resulting from its dysfunction. It is covered by this Plan. However, orthodontia or other appliances required by TMJ treatment are not covered by this Plan, but rather by the Dental Plan for Hourly Employees.

Chemotherapy and Radiation Treatment

The Plan pays 100% of reasonable-and-customary expenses. The deductible does not apply.

Emergency Accident Treatment

The Plan pays 100% of reasonable-and-customary expenses resulting from an accident for treatment on the day of or the day following the accident. The deductible does not apply. Covered services include:

- Hospital and physician care
- Ambulance service for transportation from the site of the accident to the emergency room
- Diagnostic X-ray and laboratory tests
- Administration of oxygen and anesthesia

Charges for medicines, drugs or other medical supplies are not included in this category of expenses.

Hospice Care

If you are terminally ill with a prognosis of less than six months to live, hospice care services are covered by this Plan. Hospice care is an inpatient or home-based program of coordinated care that meets the physical, psychological, spiritual and social needs of you and your family. The Plan pays 80% of reasonable-and-customary expenses. This type of expense is subject to the annual deductible.

- Artificial limbs
- Ambulance service to the first hospital after being stricken by illness
- Treatment by a podiatrist for foot disorders
- Treatment by a physical therapist or chiropractor
- Speech therapy to restore speech to the level that existed prior to an illness or injury (such as after a stroke or traumatic accident).
- Charges for prompt treatment of injury to a natural tooth and cosmetic surgery required as a result of an accident that occurs while coverage is in effect. If the services are performed on the day of, or the day following, the accident, see the “[Emergency Accident Treatment](#)” section of this SPD. If the services are performed after the day following the accident, they are considered to be other medical expenses. For administrative reasons, expenses resulting from an accidental injury to a tooth will be paid under the Plan only if an individual is not enrolled under the Dental Plan for Hourly Employees.

PRESCRIPTION DRUG BENEFIT

Prescription drugs are provided through Caremark. When you receive a prescription from your physician and have it filled at any Caremark-affiliated pharmacy, there are no claim forms to fill out – only a co-payment to the pharmacy. The co-payment is \$7 for a generic prescription, \$15 for a brand name, and \$35 for a non-formulary prescription for up to a 30-day supply. Caremark-affiliated pharmacies are listed at <http://www.caremark.com/>. A list of the Caremark-affiliated pharmacies closest to you can be found in the brochure containing your Caremark ID card. You can also call Caremark Member Services at the number on your Caremark ID card for assistance in locating a pharmacy.

If you fill your prescription at a pharmacy not affiliated with Caremark, you must pay for your prescription, obtain a detailed receipt and complete and submit a claim form to Caremark for reimbursement. In addition to the standard co-payment, you will be responsible for any costs in excess of the network price of the drug (discounted cost at participating network pharmacies).

If you are a newly hired or transferred employee and need to fill a prescription prior to receiving your Caremark ID card, you may contact the Benefits Center to expedite your Caremark eligibility. Alternatively, you can pay for your medication, obtain a detailed receipt and submit it to Caremark for reimbursement. As long as you use a network pharmacy, your reimbursement will be processed as if you had presented your Caremark ID card.

Authorization For Prescription Drugs

A small number of medications require preauthorization from Caremark before they are covered by this Plan. Generally, these are newer, more costly medications for which an equally effective, less expensive medication might be available, or they may be medications used for conditions which require verification of medical necessity. If Caremark’s preauthorization is required, your pharmacist or prescribing physician will advise you.

Mail Service Feature For Maintenance Drugs

A mail order service is also available from Caremark. It can help you save time and money on maintenance medications (those taken regularly to treat a chronic condition). When you use mail order, you pay \$14 for a 90-day supply of a generic medication. You pay \$30 for a 90-day supply of a brand name medication on the Primary Drug List, or \$70 for each brand name prescription not on the Primary Drug List. Call 1-866-862-0758 for information or see <http://www.caremark.com/>.

Specialty Drugs

Caremark, through its Specialty Pharmacy Services, will dispense some of the biotech injectable medications used to treat acute conditions such as Hemophilia, Multiple Sclerosis and growth hormone disorders. Others will continue to be dispensed by your doctor or in a hospital and paid through the health plan. If you or any of your dependents are being treated for a condition that requires biotech injectable medications, please contact your health plan or Caremark to ascertain which carrier will be responsible for your case. All drugs dispensed through Caremark will be subject to a co-payment (these medications are generally considered to be brand-name drugs).

MENTAL HEALTH AND SUBSTANCE ABUSE CARE BENEFITS

For care received in the U.S., this Plan provides two alternative levels of benefits for mental health or substance abuse treatment: In-Network or Out-of-Network benefits. You choose between them each time you obtain mental health or substance abuse care. In-Network refers to care that is provided by a network of specialty providers administered by CIGNA Behavioral Healthcare, Inc. (CBH). Out-of-Network refers to care that is provided by a practitioner or facility that is not part of the CBH provider network. If you or a dependent needs care, you can use the CBH network, or you can seek care outside of the network. Your out-of-pocket expenses are lower when you use the CBH network.

Using the CBH Network

When you need assistance, there are two ways to access care:

- You can reach CBH by calling CIGNA Member Services at 1-800-633-1110. After business hours, call 1-800-370-5647. You can access CBH's website at www.cignabehavioral.com.
- Call the Employee Assistance Program at 1-800-645-5575 at any time, 24 hours a day, seven days a week.

When you reach CBH, the specialist who answers your call will ask you some questions about your situation. If it's an emergency, you will be connected with a licensed mental health crisis counselor. The counselor will help you obtain emergency assistance.

If your situation is not an emergency, you will be referred to an appropriate CBH specialist who is located near you. You will be responsible for setting up the appointment and visiting the specialist. After meeting with you, the specialist will work with you to develop the course and length of treatment, and work with CBH to obtain required authorization.

When you use the CBH provider network and follow the authorized treatment plan, you will receive the highest level of benefits payable. There are no deductibles and you have no claim forms to file.

The Out-of-Network Benefits Choice

If you go outside the CBH provider network for care, you may receive benefits, but you will pay more for covered services. Also, you will have to:

- Pay the first \$300 of covered expenses in the year for each individual or a maximum of \$600 per family before the Plan pays a portion of the total charges. This \$300 out-of-net-

work deductible for Mental Health and Substance Abuse Benefits is separate from the \$300 deductible for other medical benefits.

- File claim forms for reimbursement.

Prior Authorization Required for Out-of-Network Hospital Admission

If you require inpatient or partial hospitalization at an out-of-network hospital for the treatment of a mental health condition or substance abuse, or if your referral is from an out-of-network provider, you must contact CBH for authorization at the toll-free number on your CIGNA ID card.

If you call, receive authorization and follow CBH guidelines for length of stay, you will receive benefits of 80% of covered charges after you have met your annual deductible. If you do not call for authorization, or follow CBH length-of-stay guidelines, your benefits will be reduced to 60% of covered charges (see the “[Schedule of Mental Health and Substance Abuse Benefits](#)” below).

SCHEDULE OF MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

| Service | In-Network | Out-of-Network Benefits |
|--|--|--|
| EAP Assessment visits | Up to 3 covered in full | none |
| Annual Deductible for Mental Health and Substance Abuse Care ⁽¹⁾ | \$150 co-pay per course of treatment, then 100% with Cigna Behavioral Health Authorization | \$300 Individual ⁽²⁾ \$600 Family ⁽²⁾ |
| Annual Out-of-Pocket Maximum ^{(1) (3)} | none | \$3,000 Individual ⁽⁴⁾ \$6,000 Family ⁽⁴⁾ |
| Lifetime Maximum Benefit ⁽¹⁾ | unlimited | \$500,000 |
| Inpatient: Hospital semiprivate room and specialist services | \$150 co-payment; then 100% with CBH authorization | 80% of reasonable-and-customary expenses; limited to 30 days per calendar year and 2 substance abuse confinements per lifetime. Contact CBH for precertification; if not obtained, benefits reduced to 60% |
| Inpatient Partial Hospitalization: A partial day is at least 6 hours of intensive treatment per day. Patient does not stay overnight | \$75 co-payment per course of treatment; then 100% | 80% of reasonable-and-customary expenses; limited to 60 days per calendar year. Contact CBH for precertification; if not obtained, benefits reduced to 60% |
| Outpatient Visits/Group Therapy | \$10 co-payment per visit; then 100% | 50% of reasonable-and-customary expenses ⁽⁵⁾ |

- ⁽¹⁾ The deductible, out-of-pocket maximum and lifetime benefit maximum applied toward your Medical benefits do not apply toward the Mental Health and Substance Abuse benefits and vice versa. The Lifetime Maximum benefit available for mental health treatment is the same as for treatment of other health conditions.
- ⁽²⁾ Applies to all covered services and is not included in the annual calendar year out-of-pocket maximum.
- ⁽³⁾ Out-of-pocket expenses for In-Network services do not apply toward the annual calendar year out-of-pocket maximum for Out-of-Network services.
- ⁽⁴⁾ Expenses that are not applied to the out-of-pocket maximum include the deductible; all In-Network expenses; all penalties; any amount that exceeds the reasonable-and-customary cost; 50% coinsurance you pay for Out-of-Network outpatient visits and group therapy.
- ⁽⁵⁾ Does not apply toward annual out-of-pocket maximum.

WHAT COSTS ARE NOT COVERED BY THIS PLAN?

This Plan does not cover expenses:

- For care, treatment or a supply that is not medically necessary as determined by CIGNA/CBH, for the treatment of an injury or sickness.
- For charges that would not have been made if you were not covered by this Plan.
- For surgery or treatment that is primarily for cosmetic purposes. However, prompt repair of an accidental injury is covered.
- For therapy to improve general physical condition, including, but not limited to, cardiac rehabilitation and pulmonary rehabilitation unless authorized by CIGNA.
- For repair or replacement of an artificial limb or external prosthetic due to wear and tear, loss, theft or destruction or, for an orbital prosthetic, or any biomechanical external prosthetic device.
- For penile prostheses or transsexual surgery, including hormonal therapy.
- For, or in connection with, in vitro fertilization, artificial insemination or similar procedures
- For drugs or medicines obtainable without prescription or for prescription diet products and those used primarily for cosmetic purposes such as Minoxidil or Retin-A.
- For experimental drugs or substances not approved by the Food and Drug Administration or for drugs labeled "caution-limited by federal law to investigational use."
- For expenses related to vision correction except as provided by the Vision Plan for Hourly Employees. Services not covered include orthoptics, vision training, vision aids, and the surgical or laser correction of a refractive error.
- For dental work, other than that required for prompt treatment of an accidental injury to natural teeth sustained while covered by this Plan; or for oral surgery performed in connection with the teeth or the tissues that surround and support the teeth.
- For hearing exams or hearing aids.
- For charges covered by Workers' Compensation or similar law.

- For charges made by a hospital owned or operated by, or that provides care or performs services for, the United States Government, unless there is a legal obligation to pay such charges.
- To the extent that you or any one of your dependents is in any way paid or entitled to payment for those expenses by or through a public program.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For charges made by any covered provider who is a member of your family or your dependent's family.
- For charges that the covered individual is not legally required to pay.
- To the extent that the charges exceed reasonable-and-customary limits.
- For custodial care. This means care not required to be performed by trained medical personnel. It includes services related to watching or protecting a person, or performing or assisting a person with daily living activities.
- For, or in connection with, educational services or supplies in which the primary purpose is one of the following: training in the activities of daily living (except training directly related to an illness or injury that resulted in a loss of a previously demonstrated ability), scholastic instruction, vocational training or treatment of a learning disability. Educational services or supplies also includes any service or supply to promote development beyond any level of function previously demonstrated.
- For modifications made to a home, property or automobile, such as ramps, elevator, spa, air conditioners and car hand controls.
- For charges made by a physician for or in connection with surgery that exceed the following maximum when two or more surgical procedures are performed at one time. The maximum amount payable will be the amount otherwise payable for the most expensive procedure, and one-half of the amount otherwise payable for all other surgical procedures.
- For charges made by an assistant surgeon in excess of 20% of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20%. (For purposes of this limitation, "allowable charge" means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)
- For charges made for, or in connection with tired, weak or strained feet for which treatment consists of routine foot care, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary.
- For, or in connection with, speech therapy, if it is used to improve speech skills that have not fully developed or can be considered custodial or educational or is intended to maintain speech communication. Speech therapy that is not restorative in nature is not covered.
- For experimental treatment that is defined as treatment methods which are not approved by the American Medical Association or the appropriate medical specialty society.
- For mental health therapies that do not meet national standards for mental health professional practice.

- For educational testing
- For psychological testing (except for diagnosing or treating a psychiatric disorder).
- For expenses payable under mandatory no-fault and uninsured motorist automobile insurance laws.

DETERMINATION OF MEDICAL NECESSITY

In general, in order to be covered by this Plan, health services, benefits and prescription drug benefits must be medically necessary. Medically necessary benefits may include preventive care.

The procedures used by CIGNA, Caremark or an HMO (collectively referred to as your “Health Plan”) for determining medical necessity vary, according to the type of service or benefit requested. In some cases, medical necessity determinations are made prior to receiving care or while it is ongoing, as described below. If you do not obtain the required prior authorization, and your benefit or service is later determined to be medically necessary, you may have to pay a \$500 penalty. In certain circumstances, your Health Plan may have a policy of covering certain preventive health services which are deemed medically necessary if the Health Plan’s guidelines are followed and no individual determination of medical necessity will be required.

When services or benefits are determined to be not medically necessary, you will be notified in writing by your Health Plan (see the [“If Your Claim For Benefits Is Denied”](#) section), and you may appeal the determination. Appeal procedures are described in the section [“How To Appeal The Denial Of A Claim Or Medical Necessity Determination”](#).

Determination of Medical Necessity Required Prior To Care

In addition to most hospital admissions, certain other medical services also require prior authorization in order to be covered by the Plan. Prior authorization is also referred to as “pre-service medical necessity determination.” If you are not sure whether a procedure, treatment, therapy or device is covered by the Plan, contact your Health Plan at the toll-free number on your ID card before you seek or obtain the care.

If a prior authorization is requested and denied, you have a right to have your request reviewed within the time periods described in this section. Your Health Plan may provide you with procedures that give you greater, but not less, rights. When a prior authorization is requested, you will be notified of a decision within 15 days after your request is received. However, if more time is needed due to matters beyond the control of the Health Plan, you will be notified of the reason for the delay within 15 days after receiving your request. At that time, you will be provided the date a decision can be expected, which will be no more than 30 days after receipt of your request for prior authorization by the Health Plan. If more time is needed because necessary information is missing from the request, the notification will specify what information is needed, and you must provide the specified information within 45 days after receiving the notice. The Health Plan’s obligation to decide your claim within 30-days will be suspended on the date a notice of missing information is sent out, and will resume on the date the requested information is provided.

If the waiting periods above would (a) seriously jeopardize your life, health or ability to regain maximum function, or (b) in the opinion of a physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services

(together referred to as “urgent care”), a decision will be made on an expedited basis. Your treating physician will be consulted in determining if an expedited review is necessary. If the treating physician cannot be reached, the decision will be made applying the judgment of a prudent layperson possessing an average knowledge of health and medicine. You will be notified of the expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, you will be notified within 24 hours after receiving the request of the specific information that is needed to complete the claim. You must provide the specified information within 48 hours after receiving the notice. You will be notified of the decision within 48 hours after you respond to the notice. Expedited decisions may be provided orally, followed within 3 days by written or electronic notification (for example, e-mail).

If you fail to follow the procedures for requesting a prior authorization, you will be notified of the failure within 5 days (or 24 hours if an expedited determination is required, as described above) after receiving the request and the notice will describe the proper procedures for filing. This notice may be provided orally, unless you request written notification.

Determination of Medical Necessity Required for Ongoing Care

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you must make the request for continued treatment at least 24 hours prior to the expiration of the approved period of time or number of treatments to avoid any lapse in treatment coverage. When you request such a determination, you will be notified of the determination within 24 hours after receiving the request.

HOW DO I FILE A CLAIM FOR BENEFITS?

For most claims, you file a claim for reimbursement directly with CIGNA at the address on your CIGNA ID card. Claims for Mental Health/Substance Abuse Out-of-Network benefits should be submitted to CBH directly. Claim forms, which also contain the mailing address, may be obtained from CIGNA Member Services, or your Human Resources Website.

When you receive care inside the CIGNA Behavioral Health (CBH) network of providers, you do not need to file a claim. Once you have paid the required copayment, all reimbursement is handled between the provider of care and CBH directly.

When you file a claim with CIGNA or CBH, you will need to submit an itemized bill with your completed claim form, if your provider has not completed the provider section of the form. The itemized bill must include the patient’s name, date of service, description of the service, charge for each service, and diagnosis. Be sure to send a separate completed claim form with each claim submission. Prompt filing of any required claim forms results in faster payment of your claims. All claims must be submitted within two years of the date the service is rendered or supplies are received to be eligible for reimbursement.

It is a good idea to keep photocopies of all material you submit to CIGNA/CBH. In the event any materials are lost in the mail, you will not need to obtain duplicates.

Once a claim has been received and processed by CIGNA/CBH, an Explanation of Benefits form will be mailed to you. It will include a check if benefits are payable to you. Checks not deposited prior to the earlier of the void date on the check, or one year from the date of issue, are void. You may refile the claim to obtain reimbursement.

If you have a question concerning your claim, call CIGNA or CBH Member Services at the toll-free numbers on your ID card.

IF YOUR CLAIM FOR BENEFITS IS DENIED

If a claim for benefits or request for a medical necessity determination is denied, you will be notified in writing. The notice will be provided in writing or electronically, and will include all of the following information:

- (1) the specific reason or reasons for the denial;
- (2) reference to the specific Plan provisions on which the determination is based;
- (3) a description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary;
- (4) a description of the Plan's review procedures and the time limits applicable, including a statement of your rights to bring a civil action under section 502(a) of ERISA following a denial on appeal;
- (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit;
- (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to the claim.

In the case of an adverse benefit determination involving a claim for urgent care, the information described above may be provided to you orally within the permitted time frame provided that written or electronic notification is furnished to you no later than 3 days after such oral notification.

HOW TO APPEAL THE DENIAL OF A CLAIM OR MEDICAL NECESSITY DETERMINATION

If you are not satisfied with the decision on your claim or determination, you can start the appeals procedure. You have the right to have your appeal determined within the time limits described below. CIGNA, Caremark, or an HMO (collectively referred to as your "Health Plan") may provide you with procedures which may give you greater, but not less, rights.

If you or a covered dependent is denied eligibility to participate in the Plan, see the "[How to Appeal a Denial Based on Eligibility Determinations](#)" section, below, for the procedures on how to file a claim.

Appeals Procedure

To initiate an appeal, you must submit a request for an appeal in writing to your Health Plan within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information (such as documents, records and comments) supporting your appeal. If you are unable or choose not to write, you may ask your Health Plan to register your appeal by calling the toll-free number on your ID card. Your Health Plan will provide at least one level of appeal, but may provide two levels of appeal.

The reviewer will make his or her own independent decision on appeal without regard to the results of the initial claim determination. Also, the reviewer may not be the same person that made the initial determination on your claim, or a subordinate of that person. Appeals involving medical necessity, clinical appropriateness, or on any other medical judgment will be consid-

ered by a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Upon request, your Health Plan will provide the name of medical experts, if any, whose advice was obtained in making the adverse benefit determination.

If your Health Plan provides for two appeals you will be notified of a decision within fifteen (15) calendar days after the appeal is received for a pre-service or ongoing coverage determination, and within thirty (30) calendar days for an appeal for a post-service claim. If your Health Plan provides for only one appeal, you will be notified of a decision within thirty (30) calendar days after the appeal is received for a pre-service or ongoing coverage determination, and within sixty (60) calendar days for an appeal for a post-service claim.

You may request that the appeal process be expedited if, (a) your claim involves urgent care (as defined above); or (b) your appeal involves non-authorization of an admission or continuing inpatient hospital stay. Your treating physician will be consulted in determining if an expedited appeal is necessary. If the treating physician cannot be reached, then the decision will be made applying the judgment of a prudent layperson possessing an average knowledge of health and medicine. When an appeal is expedited, you will be notified orally with a decision within seventy-two (72) hours, followed up in writing.

Notice of Benefit Determination on Appeal

When the appeals process is concluded, you will be notified of the result. Every notice of a determination on appeal will be provided in writing or electronically and will include:

- (1) the specific reason or reasons for the determination;
- (2) reference to the specific Plan provisions on which the determination is based;
- (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other relevant information;
- (4) a statement describing any voluntary appeal procedures offered by the Plan and your right to bring an action under ERISA section 502(a);
- (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Legal Action

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against your Health Plan until you have completed this appeal process.

HOW TO APPEAL A DENIAL BASED ON ELIGIBILITY DETERMINATIONS

Your Health Plan (including CIGNA, Caremark, or an HMO) makes all determinations as to whether certain medical benefits or services are covered under your Health Plan. The Plan Administrator makes all determinations as to whether you and your dependents are eligible to participate in the Plan. (See the "Employer and Plan Administrator" section toward the end of this document.)

If it has been determined that you or your dependent is not eligible to participate in the Plan (for example, a dependent ceases to be such, or you have failed to make the necessary contri-

butions during leave), you may appeal such determination by filing a written request for review within 365 days with the Philip Morris USA Inc. Management Committee for Employees Benefits (MCEB) at P. O. Box 26603, Richmond, VA 23261.

An appeal request should contain those issues, comments and documents that you (or your authorized representative) believe support your position. All pertinent documents in the possession of the appropriate Plan Administrator, Insurance Company or the Company may be examined by you (or your authorized representative), provided the request for review specifies the documents to be reviewed.

If your eligibility claim relates to urgent care, the MCEB (or its delegate) will notify you of the decision within 72 hours. If your eligibility claim relates to pre-service claims you will be notified within 15 days, and within 30 days for post-service claims. If your eligibility claim does not involve a current medical claim, you will be notified of the decision within 60 days (the 60 day period may be extended for special circumstances, but may not exceed 120 days).

If your appeal request is denied by the MCEB, in each case you will be notified in writing or electronically, and the notice will include the following information:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable, including a statement of your rights to bring a civil action under section 502(a) of ERISA following a denial on appeal;
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

WHEN PAYMENT IS AVAILABLE FROM ANOTHER SOURCE

Coordination of Benefits (COB)

This Plan coordinates its benefits with other health benefit plans under which you or a dependent is covered as a member of a group. The plan that pays first is the primary plan; the plan that pays after the primary plan has paid its benefits is called the secondary plan. If this Plan is the "primary plan," it pays benefits first without regard to any other plan. Then the secondary plan pays benefits based on its own COB provision.

When the Indemnity Plan is the secondary plan, benefits are paid as follows:

- The Indemnity Plan doesn't pay any benefits if the primary plan paid the same or more than the amount the Indemnity Plan would normally pay.
- If the primary plan paid less than the amount the Indemnity Plan would have paid, then the Indemnity Plan pays the difference, up to the amount that it would normally pay, or the remaining expense, whichever is less. The remaining expense must be within the reasonable-and-customary limits and cannot include a service that is not covered by the Indemnity Plan. If your primary plan is Medicare, see the Medicare section of this SPD.

- The amount paid by the primary plan includes the total benefits for which you are eligible under the primary plan, whether or not you have claimed them.

Here are the rules that determine which plan is primary and which is secondary:

When both plans cover the expenses and only one has a COB provision, the plan without the COB is the primary plan.

If both plans have COB provisions, the primary plan is:

- The plan covering the person as an active employee, rather than as a dependent or a retiree.
- The plan of the parent whose birthday comes first during the calendar year if a child is covered under both parents' plans. If both parents have the same birthday, the benefits of the plan which covered the parent longer is the primary plan.

If the parents are separated or divorced and the court has established one parent as financially responsible for the child's health care, the plan of the parent with that responsibility is primary.

If there is no court order, the plans pay the child(ren)'s expenses in the following order:

1. The plan of the natural parent who has custody
2. The plan of a stepparent married to the parent with custody
3. The plan of the natural parent without custody

If none of these situations apply, the plan that has covered the person longer is primary.

If you cover your dependents under the Indemnity Plan, CIGNA periodically requests information about your spouse's employment in order to determine when COB applies to a claim for benefits. You must respond to this request before benefits can be issued for your dependent's claims. If you fail to respond, your claim will be denied after 90 days.

Right of Reimbursement (Subrogation)

If you or a covered dependent is injured or becomes ill and a third party is responsible, claims for health care services will not be paid unless you sign an agreement to reimburse this Plan from the proceeds from any judgment or settlement you receive from the responsible third party, his or her insurance company, or from any other source.

Upon receiving information that a third party may be at fault for an injury or illness, CIGNA will send you a questionnaire and a reimbursement agreement. Benefits will be paid once you complete and return both to CIGNA.

Medicare

This Federal program is available to individuals at age 65 and also to recipients of Social Security Disability benefits after two years. The effect of Medicare on your Indemnity Health Plan benefits depends on whether you are covered by the Plan as an employee or former employee.

If you or a covered dependent is disabled, Medicare will be the primary plan after you or your dependent has been receiving Social Security disability benefits for at least 24 months or immediately if you have chronic kidney disease, with secondary benefits payable by the Indemnity Health Plan. When the Indemnity Health Plan is secondary to Medicare, it pays

what it would have paid less whatever benefits are payable under Parts A and B of Medicare.

Make sure that your doctor participates in the Medicare program. If he or she drops out, the Indemnity Health Plan will base its benefits on an estimate of what Medicare would have paid if your doctor participated in Medicare.

WHEN DOES COVERAGE STOP?

This section explains when Company-provided coverage under the Plan stops. The two sections that follow – “[COBRA Continuation Coverage](#)” and “[Conversion Privilege](#)” - explain how you and your dependents may purchase continued group or individual coverage in the event coverage is lost as a result of the events below.

Termination of Employment

Coverage for you and your dependents under the Health Plan stops on the last day of the month in which your employment ends. If you receive benefits from the Income Protection Plan for Hourly Employees (IPP), you are covered by this Plan until the end of the month following the month in which your IPP benefits end.

Absence

If your employment is not terminated, but you stop active work for any reason, you must contact your Human Resources representative to find out if you will be covered during your absence. For example, coverage under this Plan is continued during an authorized absence that is caused by illness or injury, maternity or family and medical leave. You need to contact the Benefits Center for information on submitting dependents' insurance premiums. If a leave is unauthorized, coverage is normally discontinued as of the last day of the month in which your leave begins. For information on Plan coverage if you enter the uniformed services of the United States, contact the Benefits Center at 1-800-872-3777.

Dependent's Loss of Eligibility

If your spouse, domestic partner or children, including a dependent adult child, are no longer eligible dependents (see the “[Who Is Eligible?](#)” section of this SPD) – for example, due to divorce or a child reaching age 23 – their coverage under the Plan will stop as of the last day of the month in which they cease to be eligible.

Moving Into a CIGNA POS Network Area

If you are eligible for coverage under this Plan and change your primary residence to a location served by the POS Plan, your coverage will be changed to the POS Health Plan. Its terms and provisions are described in a separate booklet in your three-ring binder.

Death – With Five or More Years of Service

If you die while a full-time employee covered under this Plan and after you have completed at least five years of vesting service under the Retirement Plan for Hourly Employees, your eligible dependents may continue to participate in this Plan if they make the required contributions. To be eligible for this continued coverage, your dependent needs to have been

enrolled in this Plan at the time of your death. Coverage will continue for your spouse until remarriage or age 65, and for your eligible children, as long as they meet the dependent eligibility requirements. If a dependent drops the coverage for any reason, while still eligible, re-enrollment is not permitted. Your Domestic Partner or Dependent Adult Child are not eligible for continued coverage upon your death.

Death – With Less Than Five Years of Service

If you die while covered under this Plan and have not completed five years of vesting service, coverage for your eligible dependents under the Plan will terminate on the last day of the month in which your death occurs.

Retirement

If you retire from the Company, your coverage under the Indemnity Health Plan will continue for you and your spouse until age 65 and you make the required contributions for yourself and any covered dependents. Your coverage and your spouse's coverage ends the first day of the month in which you or your spouse reaches age 65. Following your retirement, you may add an eligible dependent during the Annual Enrollment period in the Fall or if you have a change in status. (See "[How Do I Make a Change in My Coverage](#)" in this SPD.)

If you are retired under the Retirement Plan for Hourly Employees, within 90 days before you reach age 65 and your coverage stops, you will be sent information by the Benefits Center on how to receive the Medicare Subsidy.

Upon reaching age 65, you should enroll in Medicare Parts A & B. To do so, call the Social Security Administration. The Company will pay a predetermined amount (generally the negotiated dollar amount based on your retirement date) towards the cost of your Medicare Part B premium. You must submit a copy of your Medicare Part B card to the Benefits Center to receive the Medicare Subsidy. The Medicare Subsidy will be included in your pension check beginning with the first check you receive after the Benefits Center has received a copy of your card.

Disability

If you qualify for benefits under the Long-Term Disability Plan (LTD) for Hourly Employees, coverage for you and your eligible dependents under this Plan will continue until age 65 as long as you make any required contributions and continue to qualify for LTD benefits. If you become disabled after your 60th birthday and qualify for LTD Plan benefits, you will be covered under the Indemnity Plan for a maximum of five (5) years or to age 70, whichever comes first, provided you continue to receive LTD Plan benefits.

When you become Medicare eligible, you should enroll in Medicare Parts A & B. Your medical benefits payable under Medicare Parts A and B will be subtracted before amounts payable under this Plan are calculated. To enroll in Medicare Part B, you must go to your local Social Security Administration Office.

Once you receive your Medicare HIC (Health Insurance Claim) card, you must provide a copy to the Benefits Center to receive reimbursement for the cost of the Medicare Part B premium through your monthly LTD check as long as you continue to qualify for benefits under this Plan.

When your coverage ends at age 65, you will be sent information by the Benefits Center on how to receive the Medicare Subsidy.

After your death, your eligible dependents may continue coverage until you would have reached your LTD benefit recalculation date (your 65th birthday unless you became disabled after age 60. See the Long-Term Disability Plan for Hourly Employees booklet for details). If dependent eligibility is lost and then regained, re-enrollment is not permitted unless your death occurs after your LTD benefit recalculation date.

Your eligible dependents may continue coverage until age 65 after the LTD benefit recalculation date if you had five years of vesting service when you originally became disabled. If dependent eligibility is lost and then regained, re-enrollment is permitted.

COBRA CONTINUATION COVERAGE

A federal law, commonly known as COBRA, permits you or a dependent to continue coverage under this Plan for a period of time if Company-provided coverage ends as the result of:

- Termination of your full-time employment for any reason other than gross misconduct, or a reduction in your hours of employment
- Your death
- Your divorce
- Your legal separation, if you elect not to continue to make dependent contributions for your spouse
- Your child is no longer an eligible dependent under the Plan's provisions
- Your entitlement to Medicare

If elected by you or a covered dependent, you must pay the full cost of the coverage. This is the total cost to the Company plus a 2% administrative fee. Coverage may be continued for up to:

- 18 months if you terminate full-time employment; or
- 36 months for all other qualifying events.

If you (or your covered dependent) are determined to have been disabled under the Social Security Act at any time during the first 60 days of the first 18 months of continuation coverage, your continuation coverage may last for a maximum of 29 months. This 11-month extension of coverage is also available to your non-disabled spouse and dependents. The 18-month period may be extended if another qualifying event takes place during that time, but not beyond 36 months from the date of the original event.

If a dependent child ceases to be a dependent under the Plan or you become divorced or legally separated, it is your responsibility to contact the Benefits Center as soon as possible (within 60 calendar days at the latest) to avoid disruption in coverage. It is a good idea to contact the Benefits Center when any event occurs that may qualify you or a covered dependent for COBRA continuation coverage under the Plan. The Benefits Center will provide the information needed to enroll and the current full premium cost. Within 60 calendar days of the later of termination of coverage or the date this written information is provided, you or your dependent must call the Benefits Center to enroll for COBRA continuation coverage. The Benefits Center will bill you for the premiums due and answer any questions you have.

Each individual who is eligible to elect continuation coverage has a separate right to elect COBRA coverage. For example, upon your termination of employment, your spouse or dependent child may elect COBRA coverage even if you do not elect to do so. In addition, a dependent

child born to or adopted by an employee during a period of COBRA coverage has the right to continuation coverage. The child may be added to COBRA coverage upon notification to the Plan Administrator.

CONVERSION PRIVILEGE

When your COBRA continuation coverage ends, you and your eligible dependents may convert to an individual medical policy from CIGNA. The plan available to you may not be the same as the Indemnity Health Plan. You need not take a physical examination to be eligible for the individual policy, but you must make written application and send your first premium payment to CIGNA within 45 days after your COBRA continuation coverage ends. Contact the Benefits Center for information.

FMLA

If you take family or medical leave under the terms of the Family and Medical Leave Act of 1993 (FMLA), you may continue or suspend coverage while you are on leave. If you choose to continue coverage during your absence, you will be required to pay any monthly premiums while you are on leave. Coverage will continue as if you were actively working until the earlier of: (i) the expiration date of your FMLA leave, (ii) the date you discontinue paying for the coverage, if applicable or (iii) the date you give notice to the Company that you will not return from your leave. If you do not choose to continue (or otherwise cease) such coverage while on FMLA leave, you may elect to resume coverage from your timely return from FMLA leave.

GENERAL INFORMATION

This booklet is the "Summary Plan Description" called for by the Employee Retirement Income Security Act of 1974 (ERISA). It provides accurate and essential information about the Plan, but it is not a complete description. Benefits are provided through an administrative services only agreement with Connecticut General Life Insurance Company ("CIGNA"). Under this agreement, the health plan processes the payment of claims, but does not insure the benefits. CIGNA Behavioral Healthcare, Inc., a CIGNA company, processes claims for mental health and substance abuse benefits, but does not insure benefits either. Caremark, Inc. processes the claims for prescription drug benefits, but also does not insure benefits. Benefits for all other Health Maintenance Organizations (HMOs) that the Company makes available are provided by fully insured group contracts with the individual HMO. Each HMO separately processes claims for benefits and has a separate claims procedure if a claim of a benefit is denied in whole or in part. You can find the address of the HMO in the materials it provides you upon enrollment.

The actual provisions of the Plan, service agreement, or the group contract will govern in settling any questions that may arise. These documents are on file in your Employee Benefits Department.

Plan Name

The official name of the Plan is the "Health Care Plan for Hourly Employees." The Health Care Plan for Hourly Employees consolidates into a single plan the employee welfare plans set forth in Exhibit I to the Health Care Plan for Hourly Employees. A copy of Exhibit I may be obtained by Plan participants and beneficiaries upon written request to the Plan Administrator, c/o the Employee Benefits Department.

The Indemnity Health Plan for Hourly Employees, referred to in this booklet as the “Indemnity Health Plan”, “Indemnity Plan” or simply “the Plan,” is included in the Health Care Plan for Hourly Employees. The Indemnity Plan provides the benefits described in this booklet.

Plan Type

The Health Care Plan for Hourly Employees is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA). The benefits under the Plan are not insured by the Pension Benefit Guaranty Corporation.

Plan Identification

The Plan is identified by the following numbers:

Employer Identification Number: 13-1607658

Plan Number: 501

Employer and Plan Administrator

The employer and Plan sponsor is Philip Morris USA Inc., P.O. Box 26603, Richmond, Virginia 23261; telephone (804) 274-2000. The administrator of the Plan is the Philip Morris USA Inc. Management Committee for Employee Benefits (MCEB), P. O. Box 26603, Richmond, Virginia 23261.

The MCEB is charged with overseeing the operations of the Plan. The MCEB may delegate some of its responsibilities. Each of the fiduciaries to the Plan decide all questions that come before them in a fair and equitable manner for all Plan participants and their beneficiaries and are granted the discretion to interpret the provisions of the Plan, to determine the groups that are eligible to participate, as well as to interpret the Plan and to resolve ambiguities, inconsistencies and omissions.

Plan Year

The Plan and all of its records are kept on a calendar year basis, beginning on January 1 and ending on December 31 of each year.

Plan Financing

Plan contributions are made by Philip Morris USA Inc. and Plan participants.

Benefits are payable for employees, retirees and dependents from CIGNA or Caremark. All claims for benefits will be processed by, and your check will be received from, CIGNA or Caremark.

Plan Continuance

The Company reserves the right to change or terminate the Plan in whole or in part at any time. The Company may terminate, in whole or in part, the participation of its employees, retirees and dependents or may change the terms of participation. For example, the Company may amend the Plan to change the percentage of employer and employee (or retiree) contributions; the types or amounts of Plan benefits that an employee, retiree or dependent may receive, even if the amendment restricts or terminates for the future a type or amount of Plan benefit now available; and to exclude one or more classes of employees (or retirees) from coverage under the Plan. The foregoing are not the sole changes that the Company

may make to the Plan. In addition, the MCEB has been delegated the authority to amend the Plan if the amendment(s) will not increase the annual expenditure of the Plan by more than stated dollar limits. These dollar amounts may be increased in the future. Except as expressly authorized by the Plan document or the Company in any action causing the termination of any benefit or the entire Plan, no further benefit payments affected by the action are to be provided by the Plan, other than for claims for covered expenses incurred before the date of termination.

Agent for Service of Legal Process

The person designated as agent for service of legal process is the Secretary, Philip Morris USA Inc. Management Committee for Employee Benefits, P.O. Box 26603, Richmond, Virginia 23261. Legal process may also be served on the Plan Administrator.

Collective Bargaining Agreements

These Plans are maintained pursuant to one or more collective bargaining agreements. Employees may obtain copies of these agreements by writing to the Plan Administrator. In addition, copies of these agreements are available for examination at your Labor Relations Department.

STATEMENT OF PARTICIPANT'S RIGHTS UNDER ERISA

The Department of Labor (DOL) requires that you be provided with a statement of your rights under ERISA with respect to this Plan. The following statement was designed by the DOL to satisfy this requirement.

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan And Benefits

1. 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.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, 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 these copies.
3. 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.
4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan 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 your coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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 your Plan, see the section entitled “[Where Do I Get Additional Assistance?](#)”. For information on how to contact the Plan Administrator, call the Benefits Center at 1-800-872-3777. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical

Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, 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.

ELIGIBLE CATEGORIES OF EMPLOYEES

The Indemnity Health Plan for Hourly Employees covers full-time hourly employees in the following categories who meet the eligibility requirements described in this booklet.

This booklet describes Plan benefits for York Manufacturing Hourly Employees, Williamsburg, Virginia and employees represented by the following unions:

Bakery, Confectionery, Tobacco Workers and Grain Millers International Union

Philip Morris USA Inc. Coordinated Craft Unions:

- International Association of Machinists and Aerospace Workers Lodge No. 10
- International Association of Machinists and Aerospace Workers Local Lodge No. 108
- International Association of Machinists and Aerospace Workers Local No. 681
- United Association of Journeyman Pipefitters Local No. 522
- United Association of Journeyman Plumbers Local No. 107
- International Brotherhood of Electrical Workers Local No. 369
- International Brotherhood of Firemen and Oilers Local No. 320
- Sheet Metal Workers Local No. 110
- Kentucky State District Council of Carpenters Local No. 64

March 2004