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PURPOSE OF THE PLAN

Philip Morris USA Inc. **(the "Company")** recognizes that proper dental care is necessary if you are to maintain your overall good health. For this reason, the Dental Plan for Hourly Employees is designed to encourage regular examinations to help prevent dental disease. The Plan will also help you pay for necessary treatment when dental problems arise.

Benefits are provided through an administration services only agreement with Delta Dental Plan of Virginia ("DDPV").

This booklet describes the Dental Plan benefits. We urge you to read this booklet in order to become familiar with the benefits of the Dental 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, if a service is covered or **if** a claim **has** been paid, contact **DDPV** Member Services at 1-800-367-3531 or 1-800-237-6060. If Delta Dental is unable to resolve your question, call the Benefits Center for assistance. If you try to use your dental benefits and are told that your coverage can't be verified, it may be a computer error. Contact the Benefits Center for assistance. But to avoid further inconvenience, pay for your service or prescription and request an itemized receipt. The Benefits Center will be able to tell you how to obtain reimbursement.

If you are not certain who to call for help, contact HR Direct at 1-888-447-2060.

WHO IS ELIGIBLE?

You are eligible for benefits under this Plan if you are a regular full-time hourly employee in one of the categories listed at the back of this booklet.

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,
- 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 are still dependent on you for support and are not in the military service,
- Your dependent adult child.

The terms underlined above are defined as follows:

Spouse means the husband or wife to whom you are legally married.

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 dental 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. Your domestic partner is not eligible for continued coverage upon your death.

Child means your natural or lawfully adopted child, 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.

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, DDPV will periodically require proof of the continuation of the condition and your child's dependent status. After that, DDPV will require proof no more than once a year.

Each child named in a Qualified Medical Child Support Order as an alternate recipient also is 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, 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. If not a full-time student, he or she must be living with you. Your dependent adult child is not eligible for continued coverage upon your death.

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.

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, 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?

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, you or your spouse, but not both, should enroll them in this Plan.

In addition, if you and your spouse are both hourly-paid employees of the Company, work at the same location, and both enroll in the same dental plan, you may obtain free family coverage under a 2-Worker Contract arrangement. 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, they 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 - either a spouse, domestic partner or an eligible child;
- Employee & Family, to cover yourself and two or more eligible family members.

You need not choose the same type of membership for dental benefits as you choose for medical and vision 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)** months of continuous service. If you have eligible dependents, their coverage will start when yours does, if you enroll them within 60 calendar 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 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, soon after the birth, adoption, or marriage. Call the Benefits Center with the name, date of birth, and Social Security number. See the "How Do I Make A Change In My Coverage?" section for what happens if you fail to enroll them on a timely basis.

HOW DO I ENROLL?

Approximately four weeks after you begin your 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 is effective after three (3) months of continuous service 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. The monthly cost to you is detailed on the Personal Fact Sheet you receive from the Benefits Center as part of your Enrollment Kit.

The cost for dependent coverage is deducted from your pay automatically. Your contributions will be deducted from your pay on a pre-tax basis under the Flexible Benefits Plan for Hourly Employees. Contributions for coverage of a domestic partner, however, must be paid on an after-tax basis unless your domestic partner depends on you for more than one-half of his/her financial support.

Paying for your contributions on a pre-tax basis 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 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 dental coverage, any contributions for medical and vision plan coverage will also be after-tax.

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 with the Annual Enrollment material in the Fall of the year. You can make changes to your coverage for the following calendar year during the Annual Enrollment period.

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 in the 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 your dependents. 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 a change is permitted.

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

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

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 (i.e. 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 coverage 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 (see "Your Eligible Dependents" section). 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.

WHAT IS A PPO NETWORK?

A Dental Preferred Provider Organization (PPO) is a network of dentists who have agreed to provide their services to Delta Dental at a discounted rate. You are not obligated to use a network dentist to receive reimbursement under this Plan. However, if you choose to use a dentist in the Delta Dental PPO network, the fees charged to you and the Company will be at the discounted rate. For a directory of dentists that participate in Delta's Dental PPO network, refer to www.deltadentalva.com or call Delta at 1-800-367-3531.

WHAT BENEFITS ARE AVAILABLE?

The Plan pays either 50**%** or 100% of the Plan Allowance for covered services up to certain limits.

The maximum benefit available in a calendar year is $1,000 per individual in the BCT bargaining unit. It does not apply to orthodontic or dental surgery expenses. For Craft employees, the calendar year maximum is $1,500, with a deductible of $50 per person or with a maximum of $150 per family. The deductible does not apply to preventive and diagnostic services, such as exams, cleanings and x-rays.

Covered Services	**Benefit**	**Limitations** (see "What Dental Expenses Are Not Covered?")
Routine examinations	100%	Twice in a calendar year
Cleanings	100%	Twice in a calendar year
Space maintainers (appliances used to replace prematurely lost teeth)	100%	Only for covered individuals under age 19
Topical application of fluoride	100%	Twice in a calendar year for covered individuals under age 19
Sealants on non-carious, non-restored permanent molar teeth only	100%	Once per tooth in a 3 year period and only for covered individuals under age 16; third molars are excluded

X-rays	100%	Once every 3 years for full mouth X-rays and twice in a calendar year for supplementary bitewing X-rays
Simple Extractions	100%	Apply to calendar year maximum
Fillings	100%	Amalgam (silver), composite (white), and plastic fillings; repeat treatment is a Covered Benefit 24 months after initial treatment
Crowns, restorations to restore diseased or accidentally broken teeth	100%	Once per tooth every 5 years, and only when existing crown cannot be rendered serviceable; a crown is a covered benefit only if the tooth is damaged by decay or fracture to the point that amalgam or composite restoration cannot restore it; crowns for dependents under 12 years of age are not covered
Dental surgery	100%	Benefits paid are not applied to the annual maximum per covered individual. Surgical extractions are not applied to the calendar year maximum. Oral surgery is not applied to the calendar year maximum. Simple extractions are applied to calendar year maximum.
Endodontics (treatment of dental pulp, including root canal therapy)	100%	Non-surgical applies to calendar year maximum—Surgical does not apply to calendar year maximum
General anesthesia	100%	Limited to anesthesia that is appropriate to and necessary for a covered service
Denture repair and recementation	100%	Provides for repair of existing dentures; recementation of crowns, inlays, and bridges
Periodontal care (disease of bone and tissue supporting the teeth)	50%	Non-surgical applies to calendar year maximum—Surgical does not apply to calendar year maximum
Prosthodontics (dentures and bridgework)	50%	Provides bridges, partial dentures and complete dentures once in a 5 year period
Orthodontics (straightening of teeth)	50%	Maximum lifetime benefit – $2,000 per covered individual

No benefits are payable for fees for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a qualified dental auxiliary if the treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards.

Orthodontics

"Orthodontic treatment" is defined as appliance, surgical, or functional-myofunctional treatment of dental irregularities which result from abnormal growth and development of teeth, gums, or jaws, or as a result of accidental injury which requires repositioning (except for preventive treatment) of teeth to establish normal occlusion. It includes appliances necessary for the treatment of the temporomandibular joint (TMJ) dysfunction. If your dentist has a question as

to whether a certain procedure or appliance is covered by this definition, he or she should consult Delta Dental.

If you or one any of your eligible dependents are already receiving orthodontic treatment at the time you become covered under this Plan, benefits will be paid for that portion of treatment remaining.

If coverage terminates after orthodontic treatment has begun, only those expenses incurred up to the date of termination are covered.

Dental Surgery

Expenses for the following procedures are classified and covered under the Plan as dental surgery:

- Endodontic apicoectomy-surgical treatment through the gum of a tooth root
- Periodontic gingivectomy-surgical treatment of the gum
- Surgical extraction of erupted and impacted teeth
- Tooth implantation/transplantation, if medically necessary
- Oral surgery that does not involve the teeth or the tissue that surrounds and supports the teeth may be covered by your medical plan. This includes surgical treatment of the temporomandibular joint.

(See the "Dental Coverage vs. Medial Coverage" section before surgery.)

Prosthodontics

Expenses for the following types of prosthodontic services are covered under the Plan:

- Initial installation of fixed bridgework, including inlays and crowns to form abutments (supporting structures)
- Initial installation of partial or full removable dentures, including adjustments during the six-month period following installation
- Replacement of existing partial or full removable dentures or fixed bridgework, or addition of teeth to an existing partial removable denture or fixed bridgework – if satisfactory evidence is provided to the insurance company that:
  1) The replacement or addition of teeth is required to replace natural teeth extracted after the existing denture or bridgework was installed, or
  2) The existing denture or bridgework cannot be made serviceable and at least five years have elapsed since it was installed, or
  3) The existing denture is an immediate temporary denture, and replacement by a permanent denture is required and takes place within 12 months of the date the immediate temporary denture was installed.

WHAT IS PLAN ALLOWANCE?

When you see an in-network DeltaPreferred or DeltaPremier dentist, Delta Dental will pay benefits based on the Plan Allowance. The Plan Allowance is the lowest of the following three items:

- The fee that the dentist bills Delta Dental;

- The most recent fee for the service that the dentist has on file with Delta Dental;

or

- The allowance that the dentist has agreed to accept as full payment (plus deductibles and coinsurances, if any) for the covered benefits that he or she provides to a participant. In all cases, Delta Dental determines the Plan Allowance.

DeltaPreferred and DeltaPremier providers have agreed to accept Plan Allowances as payment in full for covered dental services. This means that you are only responsible for any applicable deductible and/or coinsurances (if any) for covered dental services.

WHAT IS NON-PARTICIPATING DENTIST ALLOWANCE?

When you see an out-of-network dentist, Delta Dental will pay benefits based on the Non-Participating Dentist Allowance. The Non-Participating Dentist Allowance is the lowest of the following three items:

- The fee that the dentist bills Delta Dental; or
- The payment allowance that the Participating Plan (including Delta Dental) has set for the covered benefit that the Non-Participating Dentist provides. This allowance may be lower than the Plan Allowance for the same covered benefit. In all cases, Delta Dental determines the Non-Participating Dentist Allowance.

Non-participating dentists have not agreed to accept Non-Participating Dentist Allowances as payment in full for covered dental services. This means that you are responsible for any applicable deductible, coinsurances (if any) and the differences between the Non-Participating Dentists' charges and the Non-Participating Dentist Allowances for covered dental services. The amount you would owe a non-participating dentist is typically **more** than the amount you would owe a Participating Dentist.

For example, if your non-network dentist charges $100 for preventive care, but the Non-Participating Dentist Allowance is $75, you will have to pay the $25 difference ($100-$75=$25). As another example, suppose your non-network dentist charges you $500 for a periodontal procedure, a major service. The Non-Participating Dentist Allowance is $350. For the purposes of this example, assume that you have already met your calendar year deductible. The Plan benefit is 50% of the $350 Non-Participating Dentist Allowance, or $175. Since your provider is a non-network dentist, you would have to pay the difference between the dentist's charge ($500) and the Plan benefit ($175). Your share is $325.

You receive the maximum benefits under the Plan when you use in-network Delta Dental providers, who have agreed to accept Plan Allowances as payment in full.

ALTERNATE TREATMENT

If alternate services or supplies are used to treat a dental condition, covered expenses will be limited to the services and supplies which are:

- Customarily employed nationwide to treat the condition, and
- Recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the patient's total current oral condition.

WHEN SHOULD A PREDETERMINATION REVIEW BE REQUESTED?

If you expect you will incur dental expenses in excess of $250, you should ask your dentist to submit to DDPV a pre-treatment estimate of the dental work to be performed and the charges.

You and your dentist will be notified as to how much of the charge your dental plan will pay; however, the patient must be eligible on the date treatment is rendered to receive benefits. With this payment estimate, you and your dentist will be better able to discuss treatment and costs. Failure to submit a pre-treatment estimate may result in the denial of benefits.

Treatment must commence within 60 days of the date the treatment plan is submitted to DDPV by the treating dentist for authorization, or a new treatment plan must be obtained by the patient and resubmitted by the dentist to DDPV.

DENTAL COVERAGE VS. MEDICAL COVERAGE

Determining what procedures are covered under the dental plan versus the medical plan is not always easy. Although there are many procedures that are only covered under the dental plan, (such as cleanings, oral exams, fluoride treatments, fillings, crowns, dentures, root canal therapy, simple extractions and braces), some dental related procedures may be covered under the medical plan.

Often the decision about which plan provides coverage is based on the cause of the problem. Each dental claim is reviewed by DDPV and based on information provided by the dentist, a decision is made.

If you or your dentist are unsure about coverage, you should submit a predetermination of benefits to DDPV before receiving services.

In general, procedures relating to the teeth or supporting structures are considered dental. Therefore, look to the dental plan first for coverage of dental surgery to include gum surgery (periodontal surgery), complicated extractions/impacted teeth and apicoectomies.

However, if you need to be hospitalized for any dental procedure, the hospitalization would be covered under the medical plan. Also, some outpatient dental surgery involving cysts and tumors may be medical in nature, therefore in order for you to receive maximum benefits under the medical plan, your Primary Care Physician (PCP) must authorize treatment and/or refer you to an oral surgeon. This is because oral surgeons are considered “specialists” under managed care medical plans and may require a referral from a primary care physician.

Other services that are associated with the mouth, yet are covered under the medical plan, include treatment for jaw fractures or dislocations, cuts on the lip or in the mouth that need stitches and removal of foreign objects from the nose or sinus cavity. In the case of accidental injury to sound natural teeth, you should seek appropriate treatment (i.e., at the nearest emergency room) and contact your PCP immediately.

ARE THERE LIMITS ON THE AMOUNTS PAID?

Each covered person in the BCT bargaining unit and their covered dependents may receive benefits up to a maximum of $1,000 for each calendar year for all services, except dental surgery and orthodontia.

Coverage for Craft employees and their covered dependents is $1,500 for each calendar year, for all services, except dental surgery and orthodontia, with a deductible of $50 per person or a maximum of $150 per family. The deductible does not apply to preventive and diagnostic services, such as exams, cleanings and x-rays.

Payment for a covered service will be applied against the maximum for the year in which the service is completed. Accordingly, payment for bridgework (including inlays and crowns to form abutments) is applied to the maximum for the year in which all work on the appliance is completed.

Payments for orthodontia do not count against the annual maximum, but they are subject to a separate lifetime limit of $2,000 per covered person.

WHAT DENTAL EXPENSES ARE NOT COVERED?

This Plan does not cover expenses for the following:

- Services which are not covered under the Plan Allowance as determined by Delta Dental.
- Services covered by Workers' Compensation or similar law.
- Services to correct congenital malformations; cosmetic surgery; or dentistry for cosmetic reasons.
- Care provided before coverage under this Plan begins. This includes charges for crowns or inlays ordered before coverage begins.
- Prescription drugs, premedications and/or relative analgesia, charges for hospitalization; general anesthesia (except when appropriate to and necessary for a covered service); preventive control programs.
- Treatment by anyone other than a dentist, except for teeth cleaning or scaling and fluoride applications performed by a qualified dental auxiliary under the supervision and guidance of a dentist.
- Appliances or restorations for increasing vertical dimension.
- Stolen or misplaced prosthetic appliances.
- Sealants on anterior teeth for individuals age 16 and older.
- Replacement of any lost or stolen orthodontic or prosthetic appliance or device.
- Services covered by your Philip Morris health plan.
- Charges for failure to keep appointments with the dentist or for completion of forms; DDPV covered patients should not be charged for completion of forms.
- Services or supplies that are payable or provided by the government or a subdivision of the government.
- Injuries caused by acts of war.

WHEN PAYMENT IS AVAILABLE FROM ANOTHER SOURCE

Coordination of Benefits (COB)

This Plan coordinates its benefits with other dental benefit plans under which you or a dependent are 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 Dental Plan for Hourly Employees is the secondary plan, benefits are paid as follows:

- If the primary plan paid less than the amount the Dental Plan would have paid, then the Dental Plan for Hourly Employees 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 Plan Allowance and cannot include a service that is not covered by the Dental Plan for Hourly Employees.

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

Here are the rules which 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 dental 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 Dental Plan, DDPV 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. You may appeal in accordance with the "Claims Processing" section of this booklet.

Interpretation of the Plan

The Plan Administrator has full discretionary authority to interpret and apply the provisions of the Plan and this summary plan description ("SPD"). While the SPD is intended to be complete and accurate, remember that it is only a summary of the Plan's provisions. In interpreting this SPD, the Plan Administrator will rely on the governing Plan document. In the event of any conflict between this SPD and its governing document, the Plan document will always control. The explanations in the SPD cannot alter, modify, or otherwise change the controlling Plan document, nor can any rights accrue by reason of any statements or omissions in the SPD.

With the exception of denied claims which may be appealed as described in the section entitled "Claims Processing", the Company's decisions regarding the interpretation of the Plan document and summary plan description are conclusive and binding on all persons. The Company may, however, delegate some of its interpretation and decision-making authority to the claims administrator of the Plan. Benefits under this Plan will be paid only if the claims administrator or its delegate decides in its discretion that the applicant is entitled to them.

HOW DO I FILE A CLAIM FOR BENEFITS?

As a member with Delta Dental Plan of Virginia (DDPV), when you use a participating dentist, benefits are automatically paid to the dentist. You are only responsible for your share of the bill. If you use a non-participating dentist, benefits cannot be assigned to your dentist. You will

be responsible for the dentist's entire bill and DDPV will reimburse you directly. Exception: In North Carolina, special arrangements have been made to allow non-participating dentists to be paid directly. The only requirement is that the dentist must complete an "Acceptance of Benefit Form" along with the claim. Only by completing this form will DDPV pay non-participating dentists directly. This special arrangement does not apply to Richmond or Louisville participants. To obtain a claim form, please contact a DDPV customer service representative at (800) 237-6060. Claim forms are also available on our website at "www.deltadentalva.com". All claims should be submitted promptly after services are completed. However, there are timely filing limitations. In all cases, a claim for Covered Benefits will only be paid if it is filed with DDPV within one year after (1) the date on which the service is performed, or (2) if a series of related services is performed, the last day on which the last service in the series is performed.

It is a good idea to keep photocopies of all materials you submit to your claims administrator. That way, if materials are lost in the mail, you can resend them without waiting for your dentist to complete new forms.

Claims Processing

If your claim under the Dental Plan is wholly or partially denied, you will be notified of the decision, after the Plan's receipt of your claim within (i) 72 hours for an urgent care claim, (ii) 15 days for a pre-service claim, or (iii) 30 days for a post-service claim. A determination regarding your request for the Plan to approve an on-going course of treatment will be made sufficiently in advance of the proposed reduction or termination of treatment to allow you to appeal before the benefit is reduced or terminated.

Under special circumstances the notice period may be extended for an (i) additional 48 hours for urgent care claims, (ii) 24 hours for concurrent care decisions, (iii) 15 days for pre-service claims, and (iv) 15 days for post-service claims. If an extension is required, you will be notified of the special circumstances involved and the date by which a final decision is expected to be made. If the extension of time is required because you failed to provide information necessary to decide the claim, the notice of extension will describe the additional required information and you will be notified of the deadline for providing the specified information.

If your claim is denied, you will be provided with a written or electronic notification of an adverse benefit determination. The notice will include all of 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 complete 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 501(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;
- 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.

If you have a question concerning your claim, call Delta Dental of Virginia Member Services at 1-800-367-3531.

In the course of processing your claim, your claims administrator is entitled to request and receive dental X-rays, models, charts and written reports. Your claims administrator may also require a separate oral examination at its own expense.

HOW TO APPEAL THE DENIAL OF A CLAIM

You or your authorized representative may request a review of a denied claim by submitting a written request for review to the claims administrator within 180 calendar days after you receive a notice of the decision.

The request for review must be sent to:

Attn: Appeals

Delta Dental Plan of Virginia

4818 Starkey Road, S.W.

Roanoke, Virginia 24014

When requesting a review, you may submit written comments, documents, records, and other information relating to your claim. In addition, you will be provided, upon request and without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. The review will be conducted by a person who was not involved in the initial benefit decision (and who is not a subordinate of such individual), and will not defer to the initial benefit decision. The reviewer will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision.

If your claim was denied due to a dental judgment, the reviewer will consult with a dental care professional who has appropriate training and experience in the field of dentistry involved in the dental judgment. The dental care professional consulted will not be the same person consulted in connection with the initial benefit decision (nor be the subordinate of that person). The decision on review also will identify any dental experts who advised the Plan in connection with your benefit decision, even if the advice was not relied upon in making the decision.

The claims administrator will notify you of the Plan's benefit determination upon review of a denied claim within (i) 72 hours for an urgent care claim; (ii) for pre-service claims, no later than 30 days after the Plan's receipt of your request for review; or (iii) for post-service claims, no later than 60 days after the Plan's receipt of your request for review.

You will be provided written notification of the claims administrator's decision. The notification will include:

- the specific reason or reasons for the determination,
- reference to the specific Plan provisions on which the determination is based,

- 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,
- a statement describing any voluntary appeal procedures offered by the Plan and your right to bring an action under ERISA section 502(a);
- 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.

Delta customer service representatives are available during regular business hours to answer your questions. Delta's telephone number is (800) 237-6060.

Disputes relating to this Plan, including claim denials, may be settled by voluntary arbitration in accordance with Chapter 21, Title 8.01 of the Code of Virginia (or any successor provisions) if they cannot be settled by the appeals process.

HOW TO APPEAL A DENIAL BASED ON ELIGIBILITY DETERMINATIONS

DDPV 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 contributions 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 Employee Benefits (the "MCEB") at P.O. Box 26603, Richmond, Virginia 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 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 Committee, 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;
- in the case of a claim involving urgent care, a description of the expedited review process applicable to the claim.

WHEN DOES COVERAGE STOP?

This section explains when Company-provided coverage under the Plan stops. The "COBRA Continuation Coverage" section of this booklet explains how you and your dependents can purchase continued group coverage in the event coverage is lost as a result of the events below.

Termination of Employment or Death

Coverage for you and your dependents under the Dental Plan For Hourly Employees stops on the last day of the month in which your employment ends.

If you die while an active employee, coverage for your dependents under the Dental Plan continues until the last day of the month in which your death occurs.

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. 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.

Dependents' 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 booklet) – 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.

Retirement

If you retire from the Company and have completed at least five years of vesting service under the Retirement Plan for Hourly Employees, and you continue to make the required contributions, your Dental Plan coverage will stop on the later of:

- Your retirement date, or
- The first day of the month in which you turn 65.

You may continue coverage for your eligible dependents under age 65 – even after your own retiree coverage ends – as long as the required contributions are made.

If, at the time of your death, you have dependents covered by this Plan, coverage will continue as long as they are under 65, make the required contributions and meet the definition of an eligible dependent (see "Your Eligible Dependents" section.)

Disability

If you qualify for benefits under the Long Term Disability (LTD) Plan for Hourly Employees, your Dental Plan coverage will stop:

- On your 65th birthday, if you become disabled before age 60
- After five years or to age 70 (whichever is earlier) if you became disabled after age 60

Coverage for your spouse and other eligible dependents can be continued for as long as your own coverage continues, if you make the necessary contributions (currently 20% of the cost of dependent coverage).

If you or one of your covered dependents are totally disabled (but not eligible for LTD Plan benefits) at the time coverage would normally end, benefits will continue for the disabled person during the period of total disability for a maximum of 12 months.

Dental Work-in-Progress

- As a general rule, Dental Services started before the effective date of your coverage under this Contract are generally not covered. Examples of these types of services include, but are not limited to:

  (1) Fixed bridgework and a full or partial denture, but only if the Dentist took first impressions or fully prepared the abutment teeth before the effective date of your coverage under this Plan; and

  (2) A crown, but only if the Dentist fully prepared your tooth before the effective date of your coverage under this Plan; and

  (3) Root canal therapy, but only if the Dentist opened the pulp chamber of your tooth before the effective date of your coverage under this Plan.

  Without exception, to be covered under this Contract, the services listed in this paragraph must also be listed as Covered Services in the section of this Plan entitled "What Benefits Are Available?"

- As a general rule, Dental Service is not covered if you receive the service after your coverage under this Plan ends. However, there are exceptions for Dental Services that require multiple visits to the Dentist's office. The only exceptions to this general rule are:

  (1) Fixed bridgework and a full or partial denture, but only if (a) the Dentist takes first impressions or fully prepares the abutment teeth before the date your coverage under this Plan ends and (b) your bridgework or denture is delivered or installed within 30 days after that date; and

  (2) A crown, but only if (a) the Dentist fully prepares the tooth to be treated before the date your coverage under this Plan ends and (b) your crown, inlay or onlay is installed within 30 days after that date; and

  (3) Root canal therapy, but only if the Dentist opens the pulp chamber of your tooth before the date your coverage under this Plan ends and (b) your treatment is completed within 30 days after that date.

  Without exception, to be covered under this Plan, the services listed in this paragraph must also be listed as Covered Services in the section of this booklet entitled "What Benefits Are Available?"

- Delta makes periodic payments for covered orthodontic services, up to the Benefit Maximum, over the entire course of treatment. Except as otherwise explained in this paragraph, Delta pays part of its total allowance for the banding portion of the orthodontic service. Delta pays the balance of its total allowance over the remainder of the treatment period. If your course of orthodontic treatment begins before your effective date under this Plan, Delta reduces its total allowance by the amount that any prior dental service carrier or self-insured plan has paid or was obligated to pay on your behalf. If your coverage under this Plan ends during your course of orthodontic treatment, Delta covers the banding portion of the service only if the bands are installed prior to the date your coverage ends. In addition, if your coverage under this Plan ends during your course of treatment, Delta covers follow-up visits to the orthodontist only if you are enrolled on the first day of the month in which the visit takes place.

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; or
- Your child is no longer an eligible dependent under the Dental Plan's provisions.

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% administration fee. Coverage may be continued for up to:

- 18 months if you terminate full-time employment or have a reduction in hours; 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 of continuation coverage 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 Dental 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 also 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 Dental 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.

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 upon 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 administration services only agreement with Delta Dental Plan of Virginia, Inc., 4818 Starkey Road, S.W., Roanoke, VA 24014. Under this agreement, DDPV processes the payment of claims, but does not insure the benefits.

The actual provisions of the Plan and, the service agreement 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 Dental Plan for Hourly Employees, referred to in this booklet simply as "the Plan" or the "Dental Plan" is included in the Health Care Plan for Hourly Employees. The Dental Plan provides the dental 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, VA 23261; telephone (804) 274-2000.

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. The Company currently pays the full cost of employee coverage and 80% of the cost for dependent coverage. The remaining 20% of the cost for dependent coverage is paid by the employee. For retiree coverage, the Company pays the full cost of the retiree coverage (until age 65) and 80% of the dependent coverage for retirees.

Benefits are payable for employees, retirees and dependents from Delta Dental Plan of Virginia (DDPV), 4818 Starkey Road S.W., Roanoke, VA 24014. All claims for benefits will be processed by, and your check will be received from, DDPV.

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 which the Company may make to the Plan.

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

This Plan is 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 and 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 and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for 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 dental 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, 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 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 "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 Dental Plan for Hourly Employees covers regular full-time hourly-paid 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