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POINT OF SERVICE (POS) HEALTH PLAN FOR HOURLY EMPLOYEES

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PURPOSE OF THE PLAN

There is probably nothing more important to us than good health. When illness or injury strikes, your first thought is to get well again. This is also the goal of Philip Morris USA Inc. (the Company), and we maintain the Point of Service Health Plan for Hourly Employees (the "POS Plan") to deliver quality medical care cost-efficiently. The POS Plan is the principal health plan for regular, full-time hourly employees and retirees of the Company listed in the back of this booklet. Benefits are provided through administrative services agreements 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 benefits offered under the Point of Service Health Plan. This Plan used to be called the Health Care Network Plan (Network Benefits). We urge you to read this document in order to become familiar with the benefits of the POS 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 (Benefits Center) at 1-800-872-3777.

For questions about your benefits, such as, if a service is covered, has a claim been paid, or how to use your plan benefits, contact Member Services at the phone number on your ID card. If you don't have it available, the Benefits Center can provide the phone number. If you are considering CIGNA but have not enrolled, CIGNA's Member Services can still assist you with benefit questions at 1-800-633-1110. If CIGNA is unable to resolve your question, call the Benefits Center for assistance.

If you try to use your 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.

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

WHO IS ELIGIBLE?

You are covered by the 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,
- You live in a CIGNA POS geographic area, and
- You have not elected to participate in an alternate plan, such as an HMO, that is available where you live or work.

If you live outside a Cigna POS geographic area, but are willing to drive into a Cigna POS geographic area, you can elect to join this plan by calling the Benefits Center at 1-800-872-3777.

Depending on where you live, you may be eligible to join other health plans, instead of the POS Health Plan. This may be the Network Health Plan, the Indemnity Health Plan, or a Health Maintenance Organization (HMO).

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 POS, Network and Indemnity Plans are administered by CIGNA HealthCare in the U.S. The prescription drug program is administered by Caremark.

OTHER HEALTH PLAN OPTIONS

If you choose an HMO available where you live, the following sections of this booklet apply to you and your covered family members:

- PURPOSE OF THE PLAN
- WHERE DO I GET ADDITIONAL ASSISTANCE?
- WHO IS ELIGIBLE?
- YOUR ELIGIBLE DEPENDENTS
- WHEN DOES COVERAGE BEGIN?
- HOW DO I ENROLL?
- DO I PAY FOR COVERAGE?
- HOW DO I MAKE A CHANGE IN MY COVERAGE?
- AM I ELIGIBLE IF I RETIRE OR BECOME DISABLED?
- WHAT HAPPENS IF I BECOME ELIGIBLE FOR MEDICARE?
- PRESCRIPTION DRUG BENEFITS (NOT APPLICABLE FOR PLANS WHERE PRESCRIPTION DRUGS ARE PROVIDED VIA THE HEALTH PLAN)
- VISION CARE BENEFITS
- DETERMINATION OF MEDICAL NECESSITY
- HOW TO FILE A CLAIM FOR BENEFITS (NOT APPLICABLE TO HMO MEMBERS)
- IF YOUR CLAIM FOR BENEFITS IS DENIED?
- HOW TO APPEAL THE DENIAL OF A CLAIM OR MEDICAL NECESSITY DETERMINATION
- HOW TO APPEAL A DENIAL BASED ON ELIGIBILITY DETERMINATIONS
- WHEN DOES COVERAGE STOP?
- COBRA CONTINUATION COVERAGE
- GENERAL INFORMATION
- STATEMENT OF PARTICIPANT RIGHTS UNDER ERISA

The description and schedule of benefits provided by these health plans and what benefits are not covered can be found in the material provided by the individual plan. You will automatically receive this information if you enroll in the health plan. If you do not receive this material, contact the Benefits Center. If you would like a copy to review prior to enrolling, call the health plan. The Benefits Center can provide you with the phone number.

YOUR ELIGIBLE DEPENDENTS

If you are covered by the Plan, you may also enroll your eligible dependents if you agree to make the necessary contributions. Your eligible dependents include your spouse and your unmarried, dependent child(ren) under age 23 who depend upon you for more than one-half of their support.

The terms above are defined as follows:

Spouse means the husband or wife to whom you are legally married. If you have at least five years of vesting service under the Retirement Plan for Hourly Employees (Retirement Plan), upon your death, your spouse remains eligible for the Plan until remarriage or at age 65 or death, whichever is earlier. The spouse must have been covered at the time of the employee's death.

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 will require proof no more than once a year.

If you have at least five years of vesting service under the Retirement Plan, upon your death, your child(ren) will remain covered as long as they meet the dependent eligibility requirements.

Each child named in a Qualified Medical Child Support Order as an alternate 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.

Under the POS Plan your eligible dependents also include your domestic partner or your dependent adult child. You may cover either one dependent adult child or a domestic partner under this Plan, but not both.

The terms above are defined as follows:

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.

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

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. 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.

Dependent adult child coverage or domestic partner coverage may not be available from certain HMOs that are offered. 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, 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 The Company?

If your spouse or domestic partner works for Philip Morris USA, he or she can 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 as your dependents. In addition, 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. The two-worker contract arrangement may continue after retirement. When the hourly retiree or spouse turns age 65 eligibility for the two-worker contract ends.

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 – either a spouse 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 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 “2-Worker Contract”; the other employee must “waive” coverage.

WHEN DOES COVERAGE BEGIN?

You are covered under the Plan after three months of continuous service with the Company. If you have eligible dependents, their coverage will start when yours does, if you enroll them within the same 60 day time period and also agree to make the required contributions.

If you do not choose to enroll all eligible dependents when you are hired, you may make changes in your coverage during the Annual Enrollment period held each Fall 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 of the new dependent you want to cover. 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 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. 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.

If you participate in the POS Plan, there are no forms to complete, but you will need to contact CIGNA separately to select a Primary Care Physician (PCP) for yourself and your covered dependents. Directories listing CIGNA-affiliated physicians are available, free of charge, from CIGNA. Call 1-800-633-1110. You can also access the directory at <http://www.cigna.com/> or if you are an existing member at <http://www.mycigna.com/>.

Directories listing the affiliated physicians for other health plan options are available free of charge from your HMO. Call the Benefits Center at 1-800-872-3777 for details.

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 for coverage for you and your dependents is detailed on the Personal Fact Sheet you receive as part of your Enrollment Kit from the Benefits Center. The cost for the vision care benefits portion of the Plan is shown separately.

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 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.

Costs for coverage are subject to change annually. You will receive a Personal Fact Sheet prior to each new calendar year confirming your current coverage and the cost for the following year. This Personal Fact Sheet is sent in the Fall of the 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 for the current year if you have a change in status (described below), or for the following year during the Annual Enrollment period held each Fall.

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 change in status:

- Marriage, divorce or legal separation (if recognized under state law);
- Birth or 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 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;
- 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 in the Fall of the Year 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. 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 as a full-time hourly employee under the Retirement Plan or qualify for benefits under the Long-Term Disability Plan for Hourly Employees (LTD Plan), you and your eligible dependents are eligible for continued coverage under this Plan until age 65. You will not continue to be covered by the POS Plan once you are eligible for Medicare. You must continue to make the required contributions.

WHAT HAPPENS IF I BECOME ELIGIBLE FOR MEDICARE?

Generally, once you are eligible for Medicare, you are no longer covered by the POS Plan. You will be covered by the Indemnity Plan, as will your eligible dependents. If your spouse or domestic partner becomes eligible for Medicare before you do, only he or she will be covered by the Indemnity Plan. You and any other covered dependents will remain in the Plan until you become covered by Medicare.

If you are enrolled in an HMO at the time you or your spouse or domestic partner become eligible for Medicare, you may continue coverage under the HMO if it coordinates its benefits with Medicare. Call the Benefits Center to determine whether your HMO coordinates with Medicare and to determine other plans available to you.

You should apply for Medicare with the Social Security Administration at least three months preceding the date you become eligible. **Failure to enroll in Medicare Parts A and B will result in loss of medical benefits, because the Indemnity Plan will subtract all benefits that would have been paid by Medicare if you had enrolled on a timely basis.** Benefits available under the Indemnity Plan are described in a separate Summary Plan Description.

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

HOW DOES THE POS PLAN WORK?

This POS Plan provides two alternative levels of benefits: In-Network benefits and Out-of-Network benefits. You choose between these benefit levels each time you obtain medical care. This is why the Plan is called a Point of Service or POS plan.

When you access care through your CIGNA-affiliated Primary Care Physician (PCP), you receive In-Network benefits and file no claim forms. When you receive care that is not arranged through your CIGNA PCP, or otherwise authorized by CIGNA, you receive Out-of-Network benefits and need to file a claim for reimbursement. You may decide to have some medical conditions handled by your CIGNA PCP and other medical conditions handled by a non-CIGNA-affiliated physician. The choice is yours each and every time you seek medical care.

Below is a summary of the medical benefits available through this POS Plan. More detail on these provisions follow the Schedule. Mental Health and Substance Abuse benefits are described in a separate section of this Summary Plan Description, as are Prescription Drug and Vision Care benefits. As some of these services require prior authorization by CIGNA, 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.

The deductible, out-of-pocket maximum and lifetime maximum benefit for medical benefits cannot be applied toward Mental Health and Substance Abuse Benefits and vice versa.

SCHEDULE OF POS PLAN MEDICAL BENEFITS

SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
TYPE OF CARE	Care provided or authorized by your CIGNA Primary Care Physician (PCP) Services received at a CIGNA-affiliated hospital, laboratory or other facility, when ordered by your CIGNA PCP, or specialist to whom you've been referred	Care provided by a non-CIGNA physician or care not arranged by your CIGNA Primary Care Physician (PCP); covers treatment of illness and injury only Services received at non-CIGNA affiliated facilities (except in medical emergencies)
ANNUAL DEDUCTIBLE⁽¹⁾	None	\$300 per individual ⁽²⁾ \$600 per family ⁽²⁾
ANNUAL OUT-OF-POCKET MAXIMUM	None	\$3,000 per individual ⁽¹⁾⁽²⁾⁽³⁾ \$6,000 per family ⁽¹⁾⁽²⁾⁽³⁾
CO-PAYMENTS AND YOUR SHARE OF EXPENSES	Co-payments for office visits, hospital admissions, outpatient surgery, emergency room care and prescription drugs	After you meet the annual deductible, the Plan pays 80% of eligible reasonable-and-customary (R & C) expense. You pay 20% for most expenses up to the annual out-of-pocket maximum.

SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
LIFETIME MAXIMUM BENEFIT⁽¹⁾	Unlimited	\$500,000 per person (2)
	Care must be provided or arranged by your CIGNA PCP. Care by a specialist requires a referral from your CIGNA PCP.	Must contact CIGNA Member Services for hospital admissions to receive full out-of-network hospital benefits for all in-hospital care; services must be medically necessary
	Services must be medically necessary or be covered as preventive care.	
OFFICE VISIT TO PCP OR OB/GYN FOR PREVENTIVE CARE (PERIODIC PHYSICALS FOR ADULTS INCLUDING AN ANNUAL GYNECOLOGICAL EXAM FOR WOMEN, AND WELL-CHILD CARE)	\$10 co-payment per visit; then 100%	Not covered
OFFICE VISIT TO PCP OR OB/GYN INCLUDING ALLERGY INJECTIONS AND OFFICE SURGERY	\$10 co-payment per visit; then 100%	80% of UCR after deductible
OFFICE VISIT TO SPECIALIST	\$10 co-payment per visit; then 100%	80% of UCR after deductible
MATERNITY OFFICE VISIT	\$10 co-payment for initial visit; then 100%	80% of UCR after deductible
DIAGNOSTIC X-RAY AND LABORATORY SERVICES	100%	80% of UCR after deductible
CHEMOTHERAPY AND RADIATION TREATMENT	100% (pharmacy co-payment may apply)	80% of UCR after deductible (pharmacy copayment may apply)
INPATIENT HOSPITAL SERVICES (INCLUDING ALL PHYSICIAN EXPENSES) SEMI-PRIVATE ROOM	\$100 co-payment per admission; then 100%	80% of UCR after deductible (if admission is not authorized by CIGNA 60%)

SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
OUTPATIENT SURGERY FACILITY AND PHYSICIAN EXPENSES	\$50 co-payment per procedure; then 100%	80% of UCR after deductible
HOSPITAL EMERGENCY ROOM⁽⁴⁾ VISIT FOR MEDICAL EMERGENCY, OR WHEN DIRECTED THERE BY YOUR PCP FOR EMERGENCY ROOM VISITS NOT LISTED ABOVE	\$25 co-payment (waived if admitted)	\$25 co-payment (waived if admitted)
AMBULANCE	100%	80% of UCR after deductible (if valid emergency will be covered In-Network)
PROSTHETICS AND DURABLE MEDICAL EQUIPMENT	100% when purchased from a CIGNA-affiliated supplier	80% of UCR charges after deductible
HOME HEALTH CARE	100%	80% of UCR after deductible; limited to 120 visits per year (not combined with In-Network visits)
HOSPICE CARE	100%	80% of UCR after deductible
SKILLED NURSING FACILITY	100%; limited to 120 days per year combined with Out-of-Network care	80% of UCR after deductible; limited to 120 days per year combined with In-Network care
PHYSICAL/OCCUPATIONAL/ SPEECH THERAPY/ CHIROPRACTIC CARE	\$10 co-payment per visit; then 100% limited to 120 days per year combined with Out-of-Network care	80% of UCR after deductible; limited to 120 days per year combined with In-Network care

⁽¹⁾ The deductible out-of-pocket maximum and lifetime maximum benefit for medical benefits cannot be applied toward Mental Health and Substance Abuse.

⁽²⁾ Prescription drug expenses are not applied.

⁽³⁾ Expenses not applied to the annual out-of-pocket maximum include the deductible, all In-Network services co-payments, all penalties, and other expenses not covered by the Plan, including amounts that exceed the reasonable and customary limits. Prescription drug expenses are not applied.

⁽⁴⁾ Copayment waived if admitted to the hospital overnight.

HOW DO POS PLAN BENEFITS WORK IF I USE THE CIGNA-AFFILIATED POS PROVIDERS?

Your CIGNA Primary Care Physician (PCP)

When medical care is provided or arranged by your CIGNA Primary Care Physician (PCP), you receive In-Network benefits. This CIGNA PCP is an internist, pediatrician, general, or family practitioner that you select from CIGNA's Provider Directory. Each of your covered dependents may choose his or her own PCP. CIGNA's Provider Directory is available at CIGNA's Website, <http://www.cigna.com/> or, if you are an existing member, at <http://www.mycigna.com/>. You may obtain a paper copy by calling CIGNA at 1-800-633-1110.

Your PCP is your personal doctor. He or she coordinates your medical care, tracks your medical history, and oversees your individual medical needs. He or she is responsible for your basic care, preventive care, and treatment of illnesses and injuries. You pay a copayment for all office care provided by your PCP. Your PCP will also arrange for necessary diagnostic tests and X-rays. If your PCP determines that you need specialized care, he or she will refer you to a CIGNA-affiliated specialist to treat the condition. Your PCP will work with the specialist to ensure that you receive the appropriate care.

To receive In-Network benefits, you must first contact your PCP whenever you need health care. You may change your PCP anytime by contacting CIGNA at the Member Services phone number on your ID card or connecting to <http://www.mycigna.com/>.

Preventive Care

When provided by your CIGNA-affiliated PCP, preventive health care is covered by this POS Plan. You pay only the office visit copayment. Covered services include:

- Physical exams, including diagnostic tests, x-rays, and immunizations for adults given at intervals established by the PCP using standard medical guidelines.
- Immunizations and physical exams for children, as needed.
- Annual gynecological exam by a CIGNA-affiliated gynecologist (see the "[Gynecological Care](#)" section of this SPD.)

If you choose to see someone other than your PCP or CIGNA-affiliated gynecologist for preventive care, these services will not be covered. Out-of-Network benefits do not cover preventive care expenses.

Specialty Care

To receive In-Network benefits for specialty care, including surgery, you must first receive a referral for the care from your PCP. If your PCP determines that you need specialty care, he or she will refer you to an appropriate CIGNA-affiliated specialist.

This referral is valid for a specified time period and a specified number of visits. If the specialist believes that additional visits are needed, he or she must contact your PCP or ask you to do so. In some cases, your PCP may want to see you again to evaluate the need for additional care by the specialist.

There are four situations when you do not need a referral from your PCP to receive In-Network benefits:

- An annual exam and routine care by a CIGNA-affiliated gynecologist,
- Care for a medical emergency,
- Urgent care when you are away from your POS geographical service area,
- Mental health and substance abuse treatment, if provided by the CIGNA Behavioral Health network.

Gynecological Care

You can see a CIGNA-affiliated gynecologist for all gynecology care without a referral from your PCP.

You pay only the office visit co-payment for an annual preventive care exam or other office visit. Recommended Pap tests and screening mammograms at CIGNA-affiliated facilities are covered in full. If you need surgery or hospital care, your gynecologist will work with CIGNA to obtain any required authorizations. Your gynecologist cannot refer you to another specialist; you must contact your PCP for the referral.

Benefits for infertility are limited to the diagnosis and correction of the condition. Artificial insemination, in-vitro fertilization, GIFT, ZIFT and similar procedures are not covered by this POS Plan.

Maternity Care

If you are pregnant, your PCP will work with you to identify a CIGNA-affiliated obstetrician. You pay one office visit co-payment for the initial visit to confirm the pregnancy. The obstetrician will coordinate your admission to a CIGNA-affiliated hospital and will keep your PCP informed of your overall health.

When you use a CIGNA-affiliated obstetrician, you will pay only the hospital co-payment. This covers your baby's care as well, if the baby is discharged at the same time you are. A separate co-payment will apply if the baby remains hospitalized after your discharge.

This Plan provides for a maternity hospitalization of no less than 48 hours following a vaginal delivery or 96 hours following a C-section delivery. But if you and your doctor agree, you are permitted to be discharged earlier. If medically necessary, your physician will coordinate with CIGNA to arrange any extension in your stay beyond the minimum.

Remember to 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 in the Fall for the following year. (See the ["How Do I Make a Change in My Coverage?"](#) section of this SPD.)

Hospital Care

If you require hospitalization, your PCP, or the CIGNA-affiliated specialist to whom you were referred by your PCP, will arrange the hospital admission to a CIGNA-affiliated facility. Your cost for the hospital care is the co-payment. If you are readmitted to the hospital for the same condition within 30 days, a second co-payment is not required. If you elected to be admitted to a non-CIGNA-affiliated hospital, you will receive Out-of-Network benefits for your stay.

In an emergency, seek medical care immediately. You do not need authorization for emergency care and you're covered no matter where you are, 24 hours a day. Advise CIGNA Member Services of your emergency care visit or hospital admission (or have someone call for you) within 48 hours or as soon as reasonably possible. Call your PCP for follow-up care. If you follow these procedures, your cost for a hospital admission is the copayment.

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. This Plan covers up to 120 days (combined In and Out-of-Network) per year of such care if your PCP or CIGNA-affiliated specialist recommends such care and CIGNA approves it. Your physician will work with CIGNA to make the necessary arrangements.

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. Services provided by an inpatient or home-based program of coordinated care that meets the physical, psychological, spiritual, and social needs of you and your family are covered. Your physician will work with CIGNA to make the necessary arrangements.

Organ Transplants

The CIGNA LIFESOURCE Organ Transplant Network® is an organization of participating hospitals that provides organ transplant services. If you receive care from CIGNA LIFE-SOURCE, you will also be eligible for travel benefits. These include coverage for the patient and a family member for travel, food and lodging up to a \$10,000 limit. If the patient is a child, the travel benefits of \$10,000 cover both parents. If you need this special care, your PCP, with the authorization of CIGNA's Medical Director, will refer you to a CIGNA LIFE-SOURCE hospital. Your co-payment for admission is the same as any hospital. If you do not use a CIGNA LIFESOURCE hospital in connection with an organ transplant, your benefits, if covered, will be paid as if you had used an Out-of-Network provider.

Durable Medical Equipment

Durable medical equipment means equipment that is primarily used to serve a medical purpose, and is not generally useful in the absence of illness or injury. It must be appropriate for use in the home, and able to withstand repeated use. Examples include a wheelchair, oxygen, respiratory equipment and sleep apnea monitors.

The rental or, at CIGNA's option, the purchase of medical equipment that meets this definition is covered when prescribed by your PCP or CIGNA-affiliated specialist and determined to be medically necessary by CIGNA. To receive In-Network benefits you must rent or purchase the equipment from a CIGNA-affiliated supplier.

Emergency And Urgent Care

If you have a medical emergency, you are covered by In-Network benefits, even if you are away from home or receive care at a non-CIGNA-affiliated hospital. When is a condition an emergency? A medical emergency is a serious accident or sudden illness that requires immediate medical care, which, if not treated immediately, may result in serious medical complications. Some examples of a medical emergency are:

- Chest pain
- Shortness of breath
- Inability to swallow
- Uncontrolled bleeding
- Seizure or loss of consciousness, lack of responsiveness
- Sudden slurred speech or paralysis of an arm or leg
- Broken bones, severe cuts and burns
- Miscarriage
- Suspected overdose of medication or poisoning.

If you have a medical emergency, at home or away from home, go to the nearest medical facility for care and treatment immediately. Show your CIGNA ID card and call CIGNA Member Services within the next 48 hours, or as soon as reasonably possible. If you can't call, have someone make the call for you. This will ensure that you receive In-Network benefits and you will be responsible for only the copayment. You will receive Out-of-Network benefits if CIGNA determines your emergency was not an acute condition requiring immediate medical attention. This determination will be made by a CIGNA physician based on generally accepted medical standards. You should contact your PCP for all follow-up care.

You are also covered for situations that aren't emergencies, but still require prompt medical attention. Some examples of urgent conditions are:

- Severe sore throat
- Sprains and strains
- High fever, vomiting
- Minor burns
- Rashes
- Ear or eye infection
- Urinary tract infection

For these urgent conditions, if you are not outside your CIGNA Point of Service area, first contact your PCP and follow his or her instructions to receive In-Network benefits. All PCPs have a 24-hour answering service to handle emergency and urgent care. Your PCP may prescribe care you can provide at home, ask you to come to his/her office for treatment, or direct you to a CIGNA-affiliated hospital or urgent care facility for treatment. As long as you call and follow the instructions of your PCP, you will receive In-Network benefits. If you are directed to treatment away from your PCP's office, call CIGNA Member Services after you have been treated to report the visit.

If you are away from home, go to any physician, urgent care facility, or hospital for treatment that cannot wait until you return home. You may have to pay the full cost of emergency or

urgent care. Ask for an itemized bill so that you can file a claim with CIGNA to be reimbursed. In order to ensure your expenses receive In-Network benefits, call CIGNA Member Services within 48 hours or as soon as reasonably possible. Contact your PCP for any follow-up care required.

Here's a recap of what is required for In-Network benefits if you need emergency or urgent care:

<i>If you are...</i>	<i>And you need...</i>	<i>Then...</i>
Within your service area	EMERGENCY CARE	Go to the nearest emergency room. Call your PCP for follow-up care. Call CIGNA Member Services within 48 hours or as soon as reasonably possible to report the visit.
	URGENT CARE	Call your PCP. He or she will provide instructions for care. If your PCP is unavailable, the office will refer you to another doctor. If care is not provided by your PCP, call CIGNA Member Services within 48 hours or as soon as reasonably possible to report the visit.
Temporarily away from home	EMERGENCY CARE	Go to the nearest emergency room. Call your PCP for all follow-up care. Call CIGNA Member Services within 48 hours or as soon as reasonably possible to report the visit.
	URGENT CARE	Go to any physician, urgent care facility or hospital. Call your PCP for follow-up care. Call CIGNA Member Services within 48 hours or as soon as reasonably possible to report the visit.

Oral Surgery/TMJ Treatment

Oral Surgery expenses are eligible for In-Network benefits with a referral from your PCP. "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. Some examples of oral surgery covered by this Plan are:

- Resetting a jaw
- Removal of a cyst or tumor
- Insertion and removal of stitches.

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. Its benefits are described in a separate SPD. TMJ treatment refers to the temporomandibular joint and conditions caused by its dysfunction. Medically necessary TMJ treatment is covered by this POS Plan, with a referral from your PCP. Orthodontia or other appliances are not covered by the POS Plan. This treatment is covered by the Dental Plan, subject to its provisions.

Coverage For An Extended Stay Away From Home

If you or a covered dependent are away from home for a long period of time for a reason such as attending school away from home, or family separation caused by a divorce, you may receive In-Network benefits by:

1. Staying Enrolled in Your Home CIGNA Network

The option chosen most often is to remain enrolled in the home area CIGNA Point-of-Service network. For most care, you can come home to see your PCP and use your In-Network benefits. For both emergency and urgent care, which may be received while away from home, In-Network benefits are available. And, of course, you always have the choice of Out-of-Network benefits.

2. Guest Membership in Another CIGNA-Affiliated Network

A second option is to enroll as a guest member in a local CIGNA POS network if one is available. If you are interested in this option, call CIGNA Member Services at the phone number on your ID card to determine whether this is an option for you or the family member who will be away from home. If so, CIGNA will make the arrangements. You need to request coverage in the new network prior to the 25th of the month in order for coverage to be effective the first of the following month.

Alternatively, you may enroll your dependent in the Indemnity Plan if a CIGNA provider network is not available where the dependent lives.

HOW DO POS PLAN BENEFITS WORK IF I DO NOT USE THE CIGNA-AFFILIATED POS PROVIDERS?

When you do not receive or arrange your medical care via your CIGNA PCP, you receive Out-of-Network benefits for expenses that are covered by the Plan. There is an annual deductible before benefits are payable. Covered expenses over the deductible amount are reimbursed at 80% of reasonable-and-customary fees. You will need to file claim forms for reimbursement.

If you receive care from a physician, hospital or other medical service provider that is part of CIGNA's POS provider network, but without your CIGNA PCP's referral, the benefits paid and your 20% share of the covered expense will be based on the fees CIGNA has negotiated with the provider. You won't receive In-Network benefits, but your 20% share of covered expenses will be lower.

For care you receive outside the CIGNA POS provider network, you pay the first \$300 of expenses incurred each year. This is the annual individual deductible. If you cover dependents, deductibles are limited to \$600 per family per year. After you meet the deductible, benefits for eligible Out-of-Network expenses are paid at 80%.

Expenses over the reasonable-and-customary amount are not covered. The reasonable-and-customary amount is defined as the amount usually charged for a particular medical service in a geographic area of the U.S. as determined by industry statistics. Comprehensive and up-to-date statistical data on medical charges is collected and maintained to determine the range of allowable reasonable-and-customary fees. You are responsible for all charges that exceed the reasonable-and-customary limit. If you have a question about whether your doctor's charges are within the reasonable-and-customary range for fees, contact CIGNA Member Services with the procedure code and the zip code of your doctor.

If you have paid \$3,000 for covered medical expenses for yourself or a covered dependent in a calendar year as a result of your 20% payments, additional covered expenses for that year will be paid in full for that individual. If you cover dependents, there is a \$6,000 family limit on these 20% out-of-pocket medical expenses in a calendar year. Certain expenses that you pay do not count toward these limits. 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 section, "[Out-of-Network Hospital Admissions Require Prior Authorization.](#)")

Preventive Care

Expenses for annual physical exams, well-woman, well-child care, immunizations, and routine diagnostic tests are not eligible for Out-of-Network benefits. Preventive care is covered only when it is provided or arranged by your CIGNA PCP.

Out-of-Network Hospital Admissions Require Prior Authorization

Out-of-Network benefits are available for non-emergency hospital stays not arranged by your CIGNA PCP. However, your hospital stay requires authorization from CIGNA in order to receive Out-of-Network benefits at the 80% level. You do not need authorization for maternity stays of 48 hours for a normal delivery or 96 hours for a C-section.

To request pre-admission authorization, call CIGNA Member Services at the toll-free number on your identification card prior to the date of admission. You will be asked for some information regarding the hospitalization. If your admission is an emergency, call CIGNA Member Services within 48 hours, or ask someone to make the call for you.

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 charges after you have met your annual deductible. However, if you do not call for authorization, or fail to follow CIGNA's guidelines, your benefits will be reduced to 60% of covered charges.

Be aware that the prior authorization procedures described here are separate from those for Mental Health and Substance Abuse Care, which are described in a separate section in this document.

Other Services For Which You Should Contact CIGNA

Home health care, hospice care, skilled nursing facility care and the rental or purchase of durable medical equipment may be covered Out-of-Network. Contact CIGNA Member Services to verify what information is necessary for review in order for your care to be covered by Out-of-Network benefits. You can also obtain information about CIGNA-affiliated providers that may result in lower out-of-pocket costs for you.

Out-of-Network Surgical Fees

Once you have met the Out-of-Network benefits annual deductible, surgical fees from a physician are paid at 80% of the reasonable-and-customary charge. It is a good idea to ask your surgeon what his or her fee is for a proposed surgical procedure. Then you can call Member Services at CIGNA and find out whether it is within the range of covered reasonable-and-customary charges.

If your surgeon performs more than one procedure at the same time, this Plan considers the full fee for the most expensive procedure and one-half of the amount otherwise covered for the other procedures to be eligible charges for Out-of-Network benefits.

If another surgeon assists with your surgery, it must be medically necessary. The eligible charge for Out-of-Network benefits is 20% of the reasonable-and-customary fee allowed for the primary surgeon's fee.

Emergency And Urgent Care

Out-of-Network benefits apply to emergency and urgent care when:

- You receive emergency room care for a condition that does not qualify as an emergency, or urgent care for a condition that does not qualify as urgent.
- You are within your local CIGNA service area and you do not call your PCP before receiving urgent care, or you call, but do not follow your PCP's instructions for receiving urgent care.

After you meet your annual deductible, you will be reimbursed for 80% of the covered expenses you incurred, subject to the reasonable-and-customary limits.

MENTAL HEALTH AND SUBSTANCE ABUSE CARE

Mental health and substance abuse treatment are provided by a separate provider network specializing in behavioral health care. This network is administered by CIGNA Behavioral Health, Inc. (CBH).

The CBH provider network works like the CIGNA medical care provider network. When you need mental health or substance abuse care, you can use the CBH provider network, or you can go outside of the CBH provider network for services. Your out-of-pocket costs are lower if you use the CBH provider network. **You do not need a referral from your CIGNA PCP to access care from CBH.**

When you need assistance, you have two ways of accessing care:

- You can reach CBH by calling CIGNA Member Services at 1-800-633-1110. After business hours, call 1-800-370-5647.
- Call your Employee Assistance Program at 1-800-645-5575, at anytime, 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 licensed provider who is located near you. You will be responsible for setting up the appointment and visiting the provider. After meeting with you, the provider 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 offered. There are no deductibles and, like the medical care network, 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. These Out-of-Network deductibles for Mental Health and Substance Abuse Benefits are separate from the Out-of-Network deductibles for medical care received outside CIGNA's medical provider network.
- 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 fail to 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 BENEFITS	OUT-OF-NETWORK BENEFITS
EAP ASSESSMENT VISITS	Up to 3 covered in full	None
MENTAL HEALTH AND SUBSTANCE ABUSE CARE ANNUAL DEDUCTIBLE (1)	\$0	\$300 per individual ⁽²⁾ \$600 per family ⁽²⁾
ANNUAL OUT-OF-POCKET MAXIMUM (1)(3)	None	\$3,000 per individual ⁽⁴⁾ \$6,000 per family ⁽⁴⁾
LIFETIME MAXIMUM BENEFIT (1)	None	\$500,000 per individual
INPATIENT: HOSPITAL SEMIPRIVATE ROOM AND BOARD; SERVICES AND SPECIALIST SERVICES	\$100 co-payment; then 100%	80% of reasonable-and-customary expenses with CBH authorization; 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 after deductible

(1) The deductible, out-of-pocket maximum and lifetime maximum benefit for Mental Health and Substance Abuse benefits are separate from those for medical benefits. The Lifetime Maximum benefit available for mental health treatment is the same as for treatment of other health conditions.

(2) Applies to all covered mental health/substance abuse services and is not included in the annual calendar year out-of-pocket maximum.

- (3) Out-of-pocket expenses for In-Network mental health/substance abuse 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, In-Network co-payments, all penalties, amounts that exceed the reasonable-and-customary limit, and the 50% you pay for Out-of-Network outpatient visits and group therapy.

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 prescription and \$35 for a non-formulary brand 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 there 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, if a generic equivalent is not available. 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).

VISION CARE BENEFITS

Vision care benefits are part of the Plan, but to receive them you need to elect to participate in this portion of the Plan when you enroll for your Health Plan benefits. You may enroll for just the Vision care benefits portion of this Plan if you elect to enroll in an HMO.

The Vision care benefits reimburse you for a portion of the cost of routine vision exams and corrective eyewear. You do not have to use a specific network of providers. No deductible applies. Once every 24 months, the Plan pays 100% of expenses up to the maximum amounts specified below for eye exams, lenses and frames to correct vision.

Covered Expenses	Maximum Benefit
Examination	\$70
Single lenses (pair)	\$60
Bifocal lenses (pair)	\$80
Trifocal lenses (pair)	\$110
Frames	\$60
Contact lenses	\$120*

*\$210 is paid if the contact lenses are prescribed because visual acuity is not correctable to 20/40 by conventional lenses, or for aphakic lenses following cataract surgery.

Covered vision care expenses are:

- Complete eye examination, including refraction to measure vision, by an ophthalmologist or optometrist.
- Lenses, when glasses are acquired for the first time or for a change in prescription.
- Frames, if the lenses are covered.

The Plan does not cover expenses for lost, stolen, duplicate or broken lenses/frames. Nor does it cover charges for tinting (for sunglasses or light-sensitive glasses.)

The Plan covers either lenses and frames, or contact lenses, but not both during a 24-month period.

WHAT COSTS ARE NOT COVERED BY THIS POS PLAN?

This Plan does not cover the following expenses:

- For care, treatment or a supply that is not medically necessary as determined by CIGNA/CBH/Caremark, for the treatment of an injury or illness. To be medically necessary, 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.

- 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 any preventive care not arranged through your CIGNA PCP or gynecologist for any routine physical examination not required for a health reason.
- 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 external prostheses due to wear and tear, loss, theft or destruction, for any biomechanical external prosthetic devices, and for orbital prosthetics.
- 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, 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 for investigational use."
- For expenses related to vision correction except as provided by the Vision Care Benefits described separately in this SPD. 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 the Plan; or for oral surgery performed in connection with the teeth or the tissues that surround and support the teeth.
- For routine 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 expense 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 or car hand controls.
- 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, 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, your Health Plan may treat it as an Out-of-Network benefit (this does not apply to an HMO where Out-of-Network benefits are not available). 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 (refer to ["If Your Claim For Benefits Is Denied"](#)), 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." Some examples of these services include: elective MRI and PET scans, acupuncture, infertility treatments, tonsillectomy and cochlear implants. 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. For In-Network benefits, your physician will arrange any prior authorizations that are required. If you are using a provider that is not in the network, you will need to initiate the prior authorization process by calling your Health Plan at the toll free number on your ID card (this does not apply to an HMO where Out-of-Network benefits are not available).

If a prior authorization is requested, 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 TO FILE A CLAIM FOR BENEFITS (NOT APPLICABLE TO HMO MEMBERS)

If you receive care inside the Health Plan's network of providers, you do not need to file a claim. Once you have paid the required co-payment, all reimbursement is handled between the provider of care and Health Plan directly. If you receive a bill from your physician, a specialist, hospital or other provider for expenses other than your co-payment, call Member Services at your Health Plan to determine whether you are responsible for payment. In most cases, you are not.

However, you may need to file a claim:

- if you receive routine health care outside of the Health Plan's network of providers,
- if you are denied further care on account of a decision that your benefit or service is not medically necessary (a "medical necessity determination"). See the "[Determination of Medical Necessity Required For Ongoing Care](#)" section above, or
- if your course of treatment has been reduced or terminated for any other reason, other than by reason of an amendment to the Plan or the termination of the Plan.

Medical claims for Out-of-Network benefits should be submitted to the address on your Health Plan ID card. Claims for routine vision care and Mental Health/Substance Abuse Out-of-Network benefits should be sent to the address on the claim form. Claim forms may be obtained from your Health Plan, or your Human Resources Website.

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 and diagnosis, as well as the provider's name and Taxpayer Identification Number. Be sure to send a completed form with each claim submission. Prompt filing of any required claim form results in faster payment of your claim. 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 the Health Plan. In the event any materials are lost in the mail, you will not need to obtain duplicates.

If you file a claim for benefits, whether with an itemized bill as described above, or because you dispute a medical necessity determination, or if your course of treatment is reduced or terminated for any other reason (other than by reason of an amendment to or termination of the Plan), the Health Plan will process your claim or notify you of any missing information within 30 days after receiving the claim. However, if more time is needed due to matters beyond the Health Plan's control, the Health Plan will notify you within 30 days after receiving the claim of the reason for the delay and the date when it expects to complete the processing of your claim, which will be no more than 45 days after receipt of the claim. If more time is needed because necessary information is missing from the request, the notice will also 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 45 days will be suspended on the date the Health Plan sends a notice of missing information, and will resume on the date you provide the requested information.

Once a claim has been processed by the Health Plan, 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. You must refile your claim within two years of the date the service is rendered or supplies are received.

If you have a question concerning your claim, call the Health Plan Member Services at the toll free phone number 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.

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.

Level One 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 considered 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.

Level Two Appeal

If your Health Plan provides for two levels of appeal and you disagree in whole or in part with the level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Your level two appeal will not be reviewed by anyone involved in the level one appeal or an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. For appeals involving medical necessity or clinical appropriateness, the Health Plan will consult with at least one physician in the same or similar specialty as the care under consideration, as determined by your Health Plan.

For pre-service and ongoing care coverage determinations, the level two appeal will be completed within fifteen (15) calendar days and for post-service claims, the review will be completed within thirty (30) calendar days.

You may request that the appeal process be expedited if, (a) you are considered to be in need of 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 deciding 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.

The Health Plan, as claims administrator of the Plan, has full discretion and authority to interpret the terms of the Plan. Its decision is final and binding.

Voluntary Independent Review Procedure

If you are not fully satisfied with the decision of your Health Plan's appeal review regarding a claim based on medical necessity or clinical appropriateness, you may be able to request that your appeal be referred to an independent review organization. An independent review organization is composed of persons who are not employed by your Health Plan. Please contact your Health Plan directly to determine if this option is available to you.

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 the Level One and, if applicable, the Level Two appeal process. If your appeal is expedited, there is no need to complete the Level Two appeal, if otherwise required by your Health Plan, prior to bringing legal action.

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 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 (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, 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 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 POS Plan is the secondary plan, benefits are paid as follows:

- The POS Plan doesn't pay any benefits if the primary plan paid the same or more than the amount the POS Plan would normally pay.

- If the primary plan paid less than the amount the POS Plan would have paid, then the POS Plan pays the difference, up to the amount that it would normally pay.
- 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 step-parent 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 POS 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)

Benefits are payable under this Plan subject to the Plan's right of subrogation and reimbursement. This means that if benefits are provided under the Plan to you or any covered dependent, the Plan has the right to pursue all of your or your covered dependent's rights of recovery against any person or entity for the injury or illness and has the right to be reimbursed from any recovery due you or any covered dependent, whether by settlement, judgment or otherwise, to the extent of the benefits provided by the Plan.

The Plan's right to reimbursement is not reduced because of a partial recovery, or because the proceeds are allocated exclusively to non-medical expense damages.

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 POS Plan benefits depends on whether you are covered by the POS Plan as an employee or former employee. The POS Plan remains the primary plan if you are an active employee age 65 or older.

Medicare is the primary plan for employees on Long-Term Disability. See the section in this SPD, [“Am I Eligible If I Retire or Become Disabled?”](#)

If you become eligible for Medicare, you are no longer eligible to be covered by this POS Plan. Instead you will be covered by the Indemnity Plan. In some geographic areas you may also have an HMO alternative available. You will be notified by the Benefits Center about the need to change plans.

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 Plan stops on the last day of the month in which your employment ends.

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.

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) – 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 Out Of a Provider Network Area

If you are eligible for coverage under this Plan and change your primary residence to a location not served by a network of providers, your coverage will be changed to the Indemnity Plan. Its terms and provisions are described in a separate SPD.

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, your eligible dependents may continue coverage as long as they make the required contributions. Only eligible dependents enrolled at the time of your death may continue coverage. Your spouse may continue coverage until age 65 or remarriage. Your dependent children may continue coverage until age 23. (See the section, [“Your Eligible Dependents”](#).) If a dependent drops the coverage for any reason, while still eligible, re-enrollment is not permitted. Your domestic partner is not eligible for continued coverage under the POS Plan upon your death. Your dependent adult child is 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 this Plan will stop on the last day of the month in which your death occurs.

Retirement

If you retire from the Company as a full-time employee, your coverage under the Plan will continue until age 65 as long as you make any required contributions. Your coverage and your spouse's coverage ends the first day of the month in which you or your spouse reaches age 65. You may also continue coverage for your eligible dependents if you make the required contributions. You may add an eligible dependent following your retirement during the Annual Enrollment period or if you have a change in status. (See [“How Do I Make a Change in My Coverage”](#) section.)

You will receive information from the Benefits Center on how to receive the Medicare Subsidy within 90 days before you reach age 65. Upon reaching age 65, you should enroll in Parts A&B of Medicare. 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 (LTD) Plan, your coverage will continue as described in the [“Am I Eligible If I Retire or Become Disabled?”](#) section. If you become disabled after your 60th birthday and qualify for LTD Plan benefits, your Health Care will continue 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. You will no longer be eligible to be enrolled in the POS Plan. You will receive information from the Benefits Center regarding the Plans you will be eligible to enroll in once you are covered by Medicare. Your medical benefits payable under Medicare Parts A and B will be subtracted before amounts payable under your Health Plan is calculated.

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

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 benefit-eligible employment for any reason other than gross misconduct;

- Your death;
- Your divorce;
- Your legal separation, if you do not continue to make dependent contributions for your spouse;
- Your child is no longer an eligible dependent under the 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
- 36 months for all other qualifying events.

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 any event may qualify you or a covered dependent for COBRA continuation coverage under the Plan, it is important that you contact the Benefits Center as soon as possible (within 60 calendar days at the latest) to avoid disruption in coverage. 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.

Conversion Privilege

When your COBRA continuation coverage ends, if you participate in the POS Plan, you and your eligible dependents may convert to an individual medical policy from CIGNA HealthCare. The plan available to you will not be the same as the POS 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.

GENERAL INFORMATION

This document 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 Connecticut General Life Insurance Company ("CIGNA"), Southern Health, Aetna or Blue Cross Blue Shield North Carolina. Under these agreements, the named companies process the payment of claims, but do not insure the benefits. CIGNA Behavioral Health, 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 provided to you upon enrollment.

The actual provisions of the Plan, service agreement or 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 Point of Service Health Plan, referred to in this booklet as the "POS Plan" or simply as "the Plan", is included in the Health Care Plan for Hourly Employees. The POS Plan provides both the In-Network and Out-of-Network benefits described in this booklet.

Plan Type

The Health Care Plan for Hourly Employees is an employee welfare benefit plan under 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.

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

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 and the Administrator have 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, 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 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 Point of Service 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

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