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## PURPOSE OF THE PLAN

Philip Morris USA Inc. (the Company) recognizes that proper vision care is necessary if you are to maintain your overall good health. For this reason, the Company maintains the Vision Plan for Hourly Employees for full-time, hourly employees and retirees under age 65.

Benefits are provided through an administrative services only agreement with CIGNA HealthCare, Hartford, Connecticut.

This booklet describes the Vision Plan benefits. We urge you to read this booklet in order to become familiar with the benefits of the Vision Plan and to refer to it when you have a question.

## WHERE DO I GET ADDITIONAL ASSISTANCE?

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

For questions about the benefits themselves, such as, if a service is covered, has a claim been paid, or how to use your Vision Plan benefits, contact CIGNA Member Services at 1-800-633-1110. If you haven't yet enrolled in this Plan, but you have questions about this Plan's benefits call CIGNA 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 vision 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 request an itemized receipt. The Benefits Center will be able to tell you how to obtain reimbursement.

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

## WHO IS ELIGIBLE?

You are covered by this Plan if you are a regular, full-time hourly employee in one of the categories listed at the back of this booklet.

## YOUR ELIGIBLE DEPENDENTS

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

- Your spouse or your domestic partner;
- Your unmarried, dependent child(ren), until the end of the month in which they reach age 23;
- Your dependent adult child.

The terms underlined above are defined as follows:

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

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

- You have lived together for at least six months prior to enrollment and currently share your principal residence, intending to do so permanently;
- You are jointly responsible for each other's common welfare and financial obligations;

- You are both at least 18 years old and not related by blood to a degree of closeness that would prohibit marriage were you of the opposite sex;
- Neither of you are legally married to someone else or 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 the Vision Plan coverage for your domestic partner is considered taxable income to you. If you are an active employee, the amount will be shown on your pay statement and annual IRS W-2 form. If you are retired, the amount will be reported annually on the IRS W-2 form you receive.

You may cover either one dependent adult child or a domestic partner under this Plan, but not both. Your domestic partner is not eligible for continued coverage upon your death.

Child means your natural or lawfully adopted child, stepchild, foster child or other child who depends on you for support and lives with you in a regular parent-child relationship. You must call the Benefits Center to enroll a newborn or a child you acquire after you are covered by this Plan. If you do not do so within 60 calendar days of the birth (or the date the child becomes your eligible dependent), you may not enroll the child until the next Annual Enrollment period.

Coverage for a dependent child who cannot earn a living because of mental retardation or physical handicap may be continued after the date coverage would normally end. To continue the coverage, proof of the condition must be submitted to the Benefits Center for approval within 31 days of the date coverage would otherwise terminate. During the following two years, 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.

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.

Dependent adult child means your child, as defined above, who is age 23 or older. The child must be unmarried and dependent on you for more than one-half of his/her financial support. If not a full-time student, he or she must be living with you. Your dependent adult child is not eligible for continued coverage upon your death.

You may cover either one dependent adult child or a domestic partner under this Plan, but not both. Your dependent adult child is not eligible for continued coverage upon your death.

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

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

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

If your spouse **or domestic partner** works for the Company, he or she will be covered as an employee, if eligible for Plan benefits. If you have eligible children, you or your spouse, but not both, should enroll them in this Plan.

In addition, if you and your spouse are both hourly-paid employees of the Company, work at the same location, and both enroll in the same **Vision Plan**, 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 vision coverage at no cost. You would need to contact the Benefits Center to inform them that both of you are hourly employees and would like to be set up under the same contract number.

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

### **Types of Membership**

You may choose one of three types of membership:

- Employee Only, to cover yourself;
- Employee & One (1) Dependent, to cover yourself and 1 dependent - either a spouse, domestic partner or an eligible child;
- Employee & Family, to cover yourself and two or more eligible family members.

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

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

### **WHEN DOES COVERAGE BEGIN?**

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

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

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

### **HOW DO I ENROLL?**

Approximately four weeks after you begin your employment, you will receive a personalized Enrollment Kit from the Benefits Center. Follow the instructions in the Enrollment Guide and contact the Benefits Center to enroll.

You do not need to wait until you receive your Enrollment Kit from the Benefits Center to enroll. You may call the Benefits Center at 1-800-872-3777 and enroll as soon as your record is on file at the Center, usually within two weeks of your date of hire. Coverage under this Plan begins after three (3) months of continuous service with the Company as long as you enroll within 60 calendar days of your employment date.

### **DO I PAY FOR COVERAGE?**

Depending on whether you choose to enroll dependents in the Plan, you may be required to pay for a portion of the cost of coverage.

The monthly cost for vision coverage is detailed on the Personal Fact Sheet you receive as part of your Enrollment Kit from the Benefits Center. Your contributions will be deducted from your pay automatically on a pre-tax basis under the Flexible Benefits Plan for Hourly Employees. Contributions for coverage of a domestic partner, however, must be paid on an after-tax basis unless your domestic partner depends on you for more than one-half of his/her financial support.

**Paying for your contributions on a pre-tax basis** reduces your taxable income and increases your take-home pay when compared to contributing on an after-tax basis. If you prefer to have your contributions deducted from your pay on an after-tax basis, you must make this election with the Benefits Center at the time you enroll in the Plan or during Annual Enrollment for the subsequent Plan year. If you choose after-tax contributions for medical coverage, any contributions for dental and vision plan coverage will also be after-tax.

Costs are subject to change annually. You will receive a Personal Fact Sheet prior to each new calendar year confirming your current coverage and costs for the following year. This Personal Fact Sheet is sent with the Annual Enrollment materials in the Fall of the year. You can make changes to your coverage during the Annual Enrollment period and they will be effective January 1 of the following calendar year.

### **HOW DO I MAKE A CHANGE IN MY COVERAGE?**

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

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

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

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

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

To cancel coverage and payroll deductions for a dependent who is no longer eligible to be covered, contact the Benefits Center immediately. Regardless of whether or not you notify the Benefits Center, coverage ends at the end of the month in which the individual no longer meets the definition of an eligible dependent (see page 1 for 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 or qualify for benefits under the Long-Term Disability (LTD) Plan for Hourly Employees, you and your eligible dependents are eligible for continued coverage under this Vision Plan until age 65 if you make the required contributions.

Coverage continues until you are age 65, no longer eligible for LTD benefits, stop making required contributions, or the Company ceases to participate in the Plan, whichever is earlier.

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

#### **What Level Of Benefits Apply?**

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, up to the maximum amounts specified below, for eye exams, lenses and frames to correct vision.

<b>Covered Expenses</b>	<b>Maximum Benefit</b>
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.

**Interpretation of the Plan**

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

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

**HOW DO I FILE A CLAIM FOR BENEFITS?**

When you receive routine vision care, you will need to file a claim for reimbursement. Routine vision care claims should be submitted to CIGNA HealthCare. Claim forms, which also contain the mailing address, may be obtained from CIGNA Member Services at 1-800-633-1110, or on the internet at [www.mycigna.com](http://www.mycigna.com).

You will need to submit an itemized bill with your completed claim form, if your provider has not completed the provider section of the form. The itemized bill must include the patient's name, date of service, description of the service, charge for each service and diagnosis. Be sure to send a separate completed claim form with each claim submission. Prompt filing of any required claim 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 CIGNA. In the event any materials are lost in the mail, you will not need to obtain duplicates.

Once a claim has been received and processed by CIGNA, 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.

### Claims Processing

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

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

If your claim is denied, you will be provided with a written or electronic notification of an adverse benefit determination. The notice will include all of the following information:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable, including a statement of your rights to bring a civil action under section 501(a) of ERISA following a denial on appeal;
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit;
- in the case of a claim involving urgent care, a description of the expedited review process applicable to the claim.

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

If you have a question concerning your claim, call CIGNA at 1-800-633-1110.

### HOW TO APPEAL THE DENIAL OF A CLAIM

You or your authorized representative may request a review of a denied claim by submitting a written request for review to CIGNA within 180 calendar days after you receive a notice of the decision. The request for review must be sent to:

Vision Legacy System  
CIGNA HealthCare  
P.O. Box 5200  
Scranton, PA 18505-5200

When requesting a review, you may submit written comments, documents, records, and other information relating to your claim. In addition, you will be provided, upon request and without charge, reasonable access to, and copies of, all documents, records, and other information

relevant to your claim. The review will be conducted by a person who was not involved in the initial benefit decision (and who is not a subordinate of such individual), and will not defer to the initial benefit decision. The reviewer will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision.

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

CIGNA must notify you of the Plan's benefit determination upon review of a denied claim within:

- (i) 72 hours for an urgent care claim.
- (ii) for pre-service claims, no later than 30 days after the Plan's receipt of your request of a review of an adverse benefit determination.
- (iii) for post-service claims, you will be notified no later than 60 days after receipt of your request of a review of an adverse benefit determination.

You will be provided written or electronic notification of CIGNA's decision. The notification will include:

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

CIGNA customer service representatives are available during regular business hours to answer your questions. CIGNA's telephone number is (800) 633-1110.

#### **HOW TO APPEAL A DENIAL BASED ON ELIGIBILITY DETERMINATIONS**

CIGNA makes all determinations as to whether certain medical benefits or services are covered under the 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, in each case you will be notified in writing, and the notice will include the following information:

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

## **WHEN PAYMENT IS AVAILABLE FROM ANOTHER SOURCE**

### **Coordination of Benefits (COB)**

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

**When the Vision Plan for Hourly Employees is the secondary plan, benefits are paid as follows:**

- The Vision Plan doesn't pay any benefits if the primary plan paid the same or more than the amount the Vision Plan would normally pay.
- If the primary plan paid less than the amount the Vision Plan would have paid, then the Vision 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 Vision 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. You may appeal in accordance with the "[Claims Processing](#)" section of this booklet.

### **WHEN DOES COVERAGE STOP?**

This section explains when Company-provided coverage under the Vision Plan stops. The section that follows - "[COBRA Continuation Coverage](#)" - explains how you and your dependents may purchase continued group 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 Vision Plan stops on the last day of the month in which your employment ends. If you receive benefits from the Income Protection Plan (IPP) for Hourly Employees, you are covered by this Plan until the end of the month following the month in which your IPP benefits end.

#### **Absence**

If your employment is not terminated, but you stop active work for any reason, you must contact your Human Resources representative to find out if you will be covered during your absence. For example, coverage under this Vision 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.

#### **Death – With Five or More Years of Service**

If you die while covered under this Vision Plan and have completed at least five years of vesting service under the Retirement Plan for Hourly Employees, coverage for your eligible dependents under this Vision Plan may continue as long as they make the required contribution. Only eligible dependents enrolled at the time of your death may continue coverage until age 65 or remarriage, whichever comes first. If a dependent drops the coverage for any reason, while still eligible, re-enrollment is not permitted. Your Domestic Partner or Dependent Adult Child are not eligible for continued coverage upon your death.

**Death – With Less Than Five Years of Service**

If you die while covered under this Vision Plan and have not completed five years of vesting service under the Retirement Plan for Hourly Employees, coverage for your eligible dependents under this Vision 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 and have at least five years of vesting service under the Retirement Plan for Hourly Employees, 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.)

**Disability**

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

**COBRA CONTINUATION COVERAGE**

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

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

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

- 18 months if you terminate full-time employment or have a reduction in hours; or
- 36 months for all other qualifying events.

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

If a dependent child ceases to be a dependent under the Plan or you become divorced or legally separated, it is your responsibility to contact the Benefits Center as soon as possible

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

Each individual who is eligible to elect continuation coverage has a separate right to elect COBRA coverage. For example, upon your termination of employment, your spouse or dependent child may elect COBRA coverage even if you do not elect to do so. In addition, a dependent child born to, or adopted by, an employee during a period of COBRA coverage has the right to continuation coverage. The child may be added to COBRA coverage upon notification to the Plan Administrator.

### **FMLA**

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

### **GENERAL INFORMATION**

This booklet is the "Summary Plan Description" called for by the Employee Retirement Income Security Act of 1974 (ERISA). It provides accurate and essential information about the Plan, but it is not a complete description. Benefits are provided through an administrative services only agreement with Connecticut General Life Insurance Company ("CIGNA").

The actual provisions of the Plan, the 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 Vision Plan for Hourly Employees, referred to in this booklet simply as "the Plan," or the "Vision Plan", is included in the Health Care Plan for Hourly Employees. The Vision Plan provides the vision benefits described in this booklet.

### **Plan Type**

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

**Plan Identification**

The Plan is identified by the following numbers:

Employer Identification Number: 13-1607658

Plan Number: 501

**Employer and Plan Administrator**

The employer and Plan sponsor is Philip Morris USA Inc., P.O. Box 26603, Richmond, Virginia 23261; telephone (804) 274-2000.

The Administrator of the Plan is the Philip Morris USA Inc. Management Committee for Employee Benefits, 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 the Company and Plan participants.

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

**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 Committee 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**

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

**STATEMENT OF PARTICIPANT'S RIGHTS UNDER ERISA**

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

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

**Receive Information About Your Plan And Benefits**

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, 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 vision 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 Vision Plan for Hourly Employees covers regular full-time hourly-paid employees in the following categories who meet the eligibility requirements described in this booklet.

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

Bakery, Confectionery, Tobacco Workers and Grain Millers International Union

Philip Morris USA Inc. Coordinated Craft Unions:

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

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